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Factors that Promote and Inhibit Client Disclosure of Suicidal Ideation

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Running head: FACTORS THAT PROMOTE AND INHIBIT CLIENT DISCLOSURE

Factors that Promote and Inhibit Client Disclosure of Suicidal Ideation

by

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DISSERTATION

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of Doctor of Psychology in the Department of Clinical Psychology
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Department of Clinical Psychology

DISSERTATION COMMITTEE PAGE

The undersigned have examined the dissertation entitled:

**FACTORS THAT PROMOTE AND INHIBIT CLIENT DISCLOSURE OF
SUICIDAL IDEATION**

presented on June 3, 2014

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Abstract

Approximately 36,000 people commit suicide in the U.S. each year, making it the fourth leading cause of death for adults between 18 and 65-years-old. Clients participating in psychotherapeutic treatment are at elevated risk for suicide, due to the emotional distress that drives their entry into psychotherapy. Therapists cannot know the full extent of their clients' risk for suicide if clients do not fully confide their thoughts and intentions. The current study sought to discover factors that inhibit and promote client disclosure of these thoughts and behaviors. The study utilized the Suicidal Ideation in Psychotherapy Questionnaire (SIPQ), a questionnaire developed for this study that assesses attitudes and behaviors regarding suicidal ideation during psychotherapy. The Working Alliance Inventory-Short Version Revised (WAI-SR) was also used to assess therapeutic alliance. These questionnaires were administered online to a sample of 85 participants who were over 18-years-old, currently involved in psychotherapy, and had thoughts of suicide during treatment. A hierarchical linear regression was conducted to identify which factors are most predictive of suicidal ideation disclosure. Specifically, this study assessed the degree to which the following are predictive of client disclosure of suicidal ideation: working alliance, the degree to which the therapist asked interpersonal theory of suicide assessment questions from the perspective of the client, how the therapists asks about suicidal ideation, and client fear of negative consequences for disclosure. Results suggested that the strength of the working alliance, the degree to which interpersonal theory of suicide assessment questions were asked, and lower levels of biased or awkward therapist questions about suicidal ideation all significantly predicted client disclosure of suicidal ideation. Implications explored include the utility of these identified factors in promoting a psychotherapeutic environment that optimizes the conditions associated with disclosure of suicidal ideation. Limitations of the study include methodological restrictions

of online data collection as well as the homogeneity of the sample. Future directions include the importance of continuing research to identify more specific and different factors that both promote and inhibit client disclosure of suicidal ideation. The importance of researching factors associated with increased disclosure with varying demographic factors and diagnoses is also suggested.

Keywords: suicidal ideation, interpersonal theory of suicide, disclosure, working alliance

Factors that Promote and Inhibit Client Disclosure of Suicidal Ideation

Introduction and Relevant Research

Suicide is an Important Mental Health and Social Problem

About 100,000 people attempt suicide in the United States each year, and more than 36,000 of these people die (American Foundation for Suicide Prevention, 2012). This is equivalent to approximately one suicide every 14 minutes. Suicide is the tenth leading cause of death in the United States and fourth leading cause for adults between the ages of 18 and 65 years of age. Of persons who attempt suicide, 90% are estimated to have a diagnosable and treatable psychiatric disorder (American Foundation for Suicide Prevention, 2012). While an exact statistic on frequency of suicides that occur during a course of psychotherapy is unavailable, surveys by several investigators over the past two decades suggest that about one out of every four psychotherapists (Chemtob, Hamada, Bauer, Torigoe, & Kinney, 1988; McAdams & Foster 2000), and one out of every two psychiatrists (Chemtob et al., 1988; Menninger, 1991) have experienced the suicide of at least one client during their careers.

Psychologists are ethically responsible for good faith efforts to protect the welfare of those with whom they work (American Psychological Association, 2010a). One measure of this responsibility is the psychologist's obligation to protect clients deemed at high risk for harming themselves or others. The ability of clinicians to act on this responsibility is dependent on their knowledge of a client's suicidal thoughts. A better understanding of factors that promote disclosure of suicidal ideation will equip clinicians to make more informed judgments to assess client safety; develop safety contracts or safety plans; and make referrals to more appropriate treatment providers, which may include inpatient hospitalization.

In the following literature review, research relating to suicide and client disclosure of

suicidal ideation will be presented. First, predictors of suicide and protective factors will be outlined. Next, the interpersonal theory of suicide as suggested by Joiner (2005) will be presented as a basis for suicide assessment. Following this, the effect that disclosure has on treatment and the frequency of disclosures in clinical practice will be discussed, as well as the association between disclosure and more severe suicidal behaviors.

Predictors of Suicide

Empirically supported risk factors for completed suicide and suicide attempts include demographic, psychiatric, social, and personal variables. Joiner, Walker, Rudd, and Jobes (1999) have developed a suicide risk assessment model that attempts to prioritize factors most predictive of suicide risk, presented in order of most to least predictive below.

Previous suicide attempts. Prior suicide attempts are predictive of future attempts (American Foundation for Suicide Prevention, 2012; Centers for Disease Control and Prevention, 2010; Cheng, Chen, Chen, & Jenkins, 2000; Peruzzi & Bongar, 1999). The American Foundation for Suicide Prevention found that 20 – 50% of people who die by suicide have at least one previous suicide attempt (American Foundation for Suicide Prevention, 2012). The more medically serious past attempts have been, the more likely a person will be to complete suicide in the future (Peruzzi & Bongar, 1999).

Feeling of isolation. Social isolation puts one at higher risk of suicide (Centers for Disease Control and Prevention, 2010; McLean, Maxwell, Platt, Harris, & Jepson, 2008; Plutchik & Van Praag, 1994). Joiner (2011) notes that career-orientated, middle-aged white males are at particularly high risk for social isolation, because they place less importance on developing and maintaining relationships than other cultural groups. This gradual erosion of social support over their careers can lead to depression and self-destructive behaviors including suicide.

Major life stressors/events. Having a recent loss—either relational, social, work, or financial—has been shown to significantly predict completed suicide (Centers for Disease Control and Prevention, 2010; Cheng et al., 2000; Peruzzi & Bongar, 1999). For example, Cheng and colleagues found that 84% of people who die by suicide versus 32% of controls experienced a major loss event prior to the completed suicide. De Wilde and colleagues (1992) found that adolescents who attempted suicide were significantly more likely than adolescents who did not attempt suicide to have experienced stressful life events including separation/divorce of parents, sexual and physical abuse, change in caretaker, change in living situation, and change in residence at some point during their life. Other studies have also found that suicide attempters are more likely to have been abused than individuals who have not been abused (Wagner, 1997; Yang & Clum, 1996). Belonging to a community where a suicide has occurred also puts an individual at increased risk for suicide (Centers for Disease Control and Prevention, 2010).

Psychiatric disorders. One of the strongest predictors of suicide attempts and completions is having a diagnosable psychiatric disorder (Agerbo, Nordentoft, & Mortensen, 2002; American Foundation for Suicide Prevention, 2012; Centers for Disease Control and Prevention, 2010; Plutchik & Van Praag, 1994). Multiple studies report that approximately 90% of suicide completers have a diagnosable psychiatric disorder (American Foundation for Suicide Prevention, 2012; Arsenaault-Lapierre, Kim, & Turecki, 2004; Mosiki, 1997). Research suggests that disorders with particularly high rates of suicide include depression or major depressive disorder (e.g., Cheng et al., 2000; Plutchik & Van Praag, 1994), bipolar disorder (e.g., Fagiolini & colleagues, 2004), schizophrenia (e.g., Palmer, Pankratz, & Bostwick, 2005), eating disorders (e.g., Pompili et al., 2006), and borderline personality disorder (e.g., Pompili, Girardi, Ruberto, & Tatarelli, 2005b). In a meta-analysis, Neeleman (2001) reported that individuals diagnosed

with depression are 19.7 times more likely, and those with bipolar disorder, schizophrenia, and personality disorders 17.1, 12.3, and 9.2 times more likely, respectively, to die by suicide than the general population. Rihmer and Kiss (2002) analyzed existing empirical evidence of suicidal behavior in those diagnosed with mood disorders, and found that the rate of previous suicide attempts was highest with bipolar II (24%), second with bipolar I (17%), and the lowest in unipolar major depression (12%).

Gender appears to moderate the suicide risk associated with mental disorders. Men who commit suicide tend to have elevated rates of substance-related problems, personality disorders, and past childhood disorders, whereas women who commit suicide tend to be diagnosed with affective disorders, which are less common among men (Arsenault-Lapierre et al., 2004).

Self-harm behavior also puts one at increased risk for a completed suicide. For example, Neeleman (2001) reported that deliberate self-harm was found to increase risk of suicide by 24.7 times. Psychiatric hospitalization is also a significant predictor of suicide (Qin, Agerbo, Westergård-Nielsen, Eriksson, & Mortenson, 2000). A history of psychiatric hospitalization is likely indicative of past suicidal ideation or attempts, as these are common reasons for hospitalization.

Alcohol and substance use/disorders. Alcohol misuse is estimated to increase by a factor of 8.5 a person's chance of dying by suicide (Neeleman, 2001). Similarly, having a substance-related disorder makes an individual 10 times more likely to die by suicide (Wilcox, Conner, & Caine, 2004). Other researchers have suggested that illicit drug users are approximately 10 times more likely to die by suicide than individuals who do not use illicit drugs (Neeleman, 2001). Being under the influence of a substance elevates the risk of suicide attempts, due to impaired judgment and reduced impulse control (Cherpitel, Borges, & Wilcox, 2004;

Moscicki, 1997).

Family history of loss and psychiatric illness. Individuals who have a family member who has engaged in suicidal behavior (Cheng et al., 2000) or who committed suicide (American Foundation for Suicide Prevention, 2012; Centers for Disease Control and Prevention, 2010; Peruzzi & Bongar, 1999) are at significantly higher risk for attempting suicide. This has been shown to be especially true of parental suicide (Agerbo et al., 2002). Furthermore, having a family history of psychiatric illness (Agerbo et al., 2002; American Foundation for Suicide Prevention, 2012) or a history of familial psychiatric hospitalization (Agerbo et al., 2002) is associated with higher risk of suicide. Early parental death, low parental income, unemployment, poor education, and parental divorce have all been suggested as risk factors for suicide attempts and completed suicide in their children (Agerbo et al., 2002).

Personality traits. Neuroticism, extroversion, and hopelessness have all been identified as risk factors for suicide attempts (Brezo, Paris, & Turecki, 2006). High neuroticism has been found to make young people about 2.3 times more likely to commit suicide than the general public (Neeleman, 2001). Individuals with an inclination towards impulsivity are also more likely to act on suicidal ideation (American Foundation for Suicide Prevention, 2012; Centers for Disease Control and Prevention, 2010; Plutchik & Van Praag, 1994). Anger and aggressive tendencies also increase a person's risk for suicide completion (Centers for Disease Control and Prevention, 2010; Plutchik & Van Praag, 1994). Feelings of hopelessness are also associated with higher risk for suicide attempts and completions (Centers for Disease Control and Prevention, 2010; Elliott & Frude, 2001; Peruzzi & Bongar, 1999).

Access to lethal means. Having access to lethal means such as firearms or medication increases risk for completed suicide (Centers for Disease Control and Prevention, 2010;

Moscicki, 1997). In a study assessing 47 adolescent suicide victims, Brent and colleagues (1991) found that firearms were twice as likely to be found in the homes of suicide victims as in the homes of suicide attempters, independent of the type of gun (handgun versus long gun).

Physical illness. Having a physical or chronic illness increases the risk for attempting suicide (Centers for Disease Control and Prevention, 2010). Cheng and colleagues (2001) found that people who committed suicide were found to have higher rates of serious physical illness, chronic pain, and disablement when compared to controls. Having a diagnosis of epilepsy, in particular, has been identified as a risk factor (e.g., Pompili, Girardi, Ruberto & Tatarelli, 2005a). Neeleman (2001) reported that epilepsy confers a threefold risk and organic brain syndromes a fourfold risk of dying by suicide.

Socioeconomic status and employment. Lower socioeconomic status (SES) and poverty are positively correlated with completed suicide (Neeleman, 2001; Rehkopf & Buka, 2006). Unemployment has also been identified as a risk factor (Neeleman, 2001; Platt & Hawton, 2000).

Demographic characteristics. Females attempt suicide about 2 to 3 times more often than males (Center for Disease Control and Prevention, 2009), yet males are 3 to 5 times more likely to die by suicide than females, due to their selection of more lethal means (American Foundation for Suicide Prevention, 2012; Center for Disease Control and Prevention, 2009). Elderly Caucasian males have the highest suicide rate of any demographic group (American Foundation for Suicide Prevention, 2012). LGBT individuals are also at increased risk for suicide compared to heterosexual individuals (Eisenberg & Resnick, 2006).

Factors That Protect Against Suicide

Social support and social connection. Social supports are strong protective factors

against suicide (Centers for Disease Control and Prevention, 2010; McLean et al., 2008; Plutchik & Van Praag, 1994). High levels of social adjustment appear to protect against suicide behavior (Kelly, Soloff, Lynch, Haas, & Mann, 2000). Positive relationships with parents (Lorant, Kunst, Huisman, Bopp, & Mackenbach, 2005; Pharris, Resnick, & Blum, 1997) and having a significant other (Nisbet, 1996) have been demonstrated to reduce the risk of suicide.

Reasons for living. Being able to identify reasons to live has been shown to be a strong protective factor against suicide. Linehan (1986) developed the Reasons for Living scale to test this effect, which measured survival and coping beliefs, responsibility to family, child-related concerns, fear of suicide, fear of social disapproval, and moral objections. The results suggested that individuals who endorsed more reasons for living were less likely to attempt suicide. Other research has also suggested that having identified reasons for living (e.g., children, spouse, parents, life goals) is a protective factor (Malone et al., 2000).

Help seeking and psychotherapy. The willingness to seek support from mental and physical health care providers also serves as a protective factor. Willingness to seek support and availability of mental and physical health care decreases the likelihood of suicide (Centers for Disease Control and Prevention, 2010). The support derived from relationships with mental and medical health care workers is proposed to be at the basis of this protection, reinforcing the importance of a supportive therapeutic relationship.

Positive psychology factors. Hopefulness is negatively correlated with suicidal behavior (Hirsch et al, 2006; Meadows et al., 2005). More hopeful clients have been shown to use problem-focused coping skills, which is also a protective factor (Elliot & Frude, 2001).

Skills in problem solving and problem-focused coping strategies make an individual less likely to commit suicide (Centers for Disease Control and Prevention, 2010; Chapman, Specht,

& Cellucci, 2005; Elliott & Frude, 2001; Meadows, Kaslow, Thompson, & Jurkovic, 2005).

Cultural and religious beliefs that are incongruent with suicide (e.g., belief of suicide leading to hell) are also protective against suicide (Centers for Disease Control and Prevention, 2010).

Joiner's Interpersonal Theory of Suicide

Thomas Joiner and his colleagues (Joiner, 2005; Joiner, Orden, Witte, & Rudd, 2009) have developed a broad theory of suicide risk, the interpersonal theory of suicide, which provides an organizing framework for what research has found to be the most powerful risk factors. Joiner's work is informed by earlier developments in the field of suicidology, including the contributions of Edwin S. Shneidman. Shneidman (as cited in Leenarrs 2010) proposed ten commonalities of suicide.

- I. The common purpose of suicide is to seek a solution.
- II. The common goal of suicide is cessation of consciousness.
- III. The common stimulus in suicide is intolerable psychological pain.
- IV. The common stressor in suicide is frustrated psychological needs.
- V. The common emotion in suicide is hopelessness-helplessness.
- VI. The common cognitive state in suicide is ambivalence.
- VII. The common perceptual state in suicide is constriction.
- VIII. The common action in suicide is egression.
- IX. The common interpersonal act in suicide is communication of intention.
- X. The common consistency in suicide is with lifelong coping patterns.

Shneidman's concepts of intolerable psychological pain and frustrated psychological needs are foundational to Joiner's interpersonal theory of suicide. Psychological pain, or "psychache," (Schneidman, 1985) describes the feeling of being hurt or anguished in the psyche. *Frustrated psychological needs* refers to necessity of meeting basic psychological drives, which includes social connection (Leenaars, 1999; Leenaars, 2010).

Joiner and colleagues (2009) used the premises in existing theories of suicide to develop a novel theory using their empirical research identifying predictors of suicide. To this end, Joiner and colleagues conducted research with participants who had suicidal ideation or had attempted

suicide. Joiner also assessed common themes in suicide notes left behind by individuals who committed suicide. Through this research, Joiner found that individuals who commit suicide must have both the desire for suicide and an acquired capacity for lethal self-injury. The desire to die is comprised of two factors: perceived burdensomeness and thwarted belongingness.

Perceived burdensomeness refers to the belief that one is a burden to their loved ones or has let them down in some way. As a result, these individuals feel they are worth more to others dead than they are alive and no longer have a sense of purpose. Thwarted belongingness refers to the sense of being isolated from others. This disconnection from others can lead to an increased desire for suicide (Joiner, 2005; Joiner et al., 2009).

While perceived burdensomeness and thwarted belongingness are necessary conditions for suicide, they are not sufficient. Individuals who commit suicide also must overcome a powerful innate human drive or instinct for self-preservation. The ability to enact lethal self-injury is learned over time through various channels. Desensitization to the fear of suicide can take place, for example, via painful traumatic experiences, increasingly lethal and reckless self-harm, or past suicide attempts. Individuals can also erode the instinct for self-preservation through exposure to others' pain and bodily injury. For example, the higher rate of suicide among physicians and surgeons may reflect habituation to violations of bodily integrity that they routinely witness. Through these experiences, people become acclimated to danger and self-injury. The combination of the desire and capacity for suicide thus leads to higher risk of death (Joiner, 2005; Joiner et al., 2009).

Joiner (2005) suggests that clinicians should assess the desire for suicide by asking about thoughts of suicide and wanting to be dead, and assess thwarted belongingness by asking clients if they feel connected to other people—such as the people with whom they live—if they have

someone to talk with for support, and if they have experienced a loss through death or divorce. To assess perceived burdensomeness, clinicians can ask clients to what extent they believe that they are a burden to others, or if they have a perceived loss of competency (e.g., lost home, lost job). Lastly, capability for suicide should be assessed through questions regarding past suicide attempts, self-harm behavior, or risky behavior (e.g., physical violence). Clients with a capability for suicide are more likely to have resolved plans and preparation for suicide (Joiner, 2005; Joiner et al., 2009).

The interpersonal theory of suicide offers important recommendations for suicide assessment grounded in empirical research. However, the information collected by any evaluation of suicide risk is dependent on what the client is willing to disclose to the clinician. The subject of client disclosure in treatment will be explored in the following sections.

Implications of Disclosure and Nondisclosure for Psychotherapy

Disclosure may affect treatment outcome. All methods and orientations of psychotherapy share a common expectation that clients will discuss the nature and causes of their distress. Therapeutic change depends on a client's disclosure of his or her thoughts, feelings, and behaviors. As Farber and Hall (2002) state, "psychotherapy is a process within which patients have the opportunity and even the responsibility to express thoughts and feelings that are not easily articulated elsewhere" (p. 359). Furthermore, Jourard (1968) proposes that the more a client is willing and able to disclose to their therapist, the more he or she will benefit from the treatment. Research assessing the relationship between general disclosure and treatment outcome is sparse. Strassberg and colleagues (1978) investigated the relationship between disclosure and psychotherapy outcome with a sample of 53 clients and 26 graduate student therapists and found that intimate client self-disclosure was significantly related to treatment outcome as assessed by

the therapist. More recently, Farber and Sohn reported a nonsignificant positive trend between client self-disclosure and self-perceived improvement. Furthermore, self-disclosure was significantly correlated with an increase of self-understanding in treatment. These researchers also explored therapeutic outcome in relation to the degree of discrepancy between what clients disclose and what they think is most important to talk about. Results suggested that the smaller the discrepancy between what clients disclose in therapy and what they feel is salient or important to talk about, the greater the perceived therapeutic improvement. Thus, the sense that the most important or salient issues are being discussed is more predictive of outcome than “raw” amount of disclosure (Farber, and Sohn, 2001).

Some research has suggested that different types of disclosure and nondisclosure may be predictive of treatment outcome. Hill, Thompson, Cogar, and Deman (1993) identified three types of nondisclosure or “covert processes:” (a) hidden reactions, (b) things left unsaid, and (c) secrets. *Hidden reactions* refer to unspoken thoughts and feelings clients have in response to therapist interventions. *Things left unsaid* describe a client’s failure to share thoughts or feelings experienced during the session. *Secrets* are major life experiences, facts, or feelings that clients withhold from their therapist (Hill et al., 1993). Farber (2002) proposed that a fourth category might include *concealment*, which involves deliberate lying (actively inventing untruths) or the misrepresentation of events.

Investigating 24 cases of six-session courses of individual therapy, Regan and Hill (1992) found that clients who kept behaviors and cognitions private (secrets) rated sessions as superficial and treatment as less satisfying. This pattern likely reflects both client perception that treatment is less helpful when they fail to disclose personally meaningful information, and a lower probability of disclosure when client’s perceive psychotherapy as unhelpful.

Frequency of nondisclosure in psychotherapy. Nondisclosure appears to be a common occurrence in psychotherapy. In a survey of 79 psychotherapy outpatients, 42% reported withholding relevant information from their therapists (Weiner & Schuman, 1984). Similarly, in a survey of 42 community hospital outpatients, 41% admitted to keeping secrets relevant to therapy (Kelly, 1998). A graded approach to disclosure is undoubtedly part of the therapeutic process, yet nondisclosure becomes potentially dangerous with suicidal ideation.

Disclosure in the Treatment of Suicidal Clients

It is likely that some of the salient information that clients are electing not to disclose is related to suicidal ideation and intent. Clinicians commonly report shock and disbelief in the wake of a client suicide (Hendin, Lipschitz, Maltzberger, Haas, & Wynecoop, 2000; Menninger, 1991), which implies that these clinicians are not aware of their clients' imminent risk of suicide and, absent that awareness, were not empowered to intervene. Further evidence for the possibility that clinicians may be unaware of their clients' suicidal ideation or intent can be inferred from research on clients with Major Depressive Disorder (MDD). As stated earlier, it is estimated that 60% of all people who die from suicide meet the criteria for MDD (American Foundation of Suicide Prevention, 2010). Research also suggests that clients with MDD may be less likely to disclose their symptoms to their therapists than clients without MDD. Hook and Andrews (2005) surveyed 85 current or former therapy clients from a British self-help organization. These researchers found that 54% of the sample indicated that they had not disclosed troubling symptoms or behaviors related to depression or other distressing experiences to their therapists. While this sample consisted of a relatively homogeneous white, highly educated sample, this research indicates that some individuals with MDD have difficulty disclosing their symptoms.

Failure to disclose is associated with more severe suicidal behaviors. As described earlier, interpersonal isolation or a feeling of being cut off from others has been associated with greater risk for suicide attempts (Centers for Disease Control and Prevention, 2010). Low levels of self-disclosure are likely related to suicidal behavior both because less disclosure of thoughts and feelings tends to be associated with feelings of isolation, loneliness, and suffering, and because less disclosure precludes potentially lifesaving interventions from significant others.

The predictive significance of self-disclosure in relation to suicide has been demonstrated among both adults and adolescents. In a study of 80 adult inpatient psychiatric clients with a depressive disorder who were divided into four groups of 20 clients each (suicidal ideation only, nonserious suicide attempts, severe suicide attempts, and no suicidal behavior), participants with more severe suicidal behavior disclosed less than individuals with more mild suicidal behavior. In addition, lack of disclosure was associated with elevated isolation, loneliness, and suffering (Apter, Horesh, Gothelf, Graffi, & Lepkifker, 2001). Similarly, in a study of 87 inpatient adolescents (53 of whom had made a suicide attempt, and 34 of which had never shown suicidal behavior), researchers found a significant relationship between suicidality and lower levels of self-disclosure. Therefore, less self-disclosure to immediate family increases suicidal risk, with high levels of depression and anxiety mediating this relationship (Horesh & Apter, 2006).

In summary, research indicates that individuals who are most at risk of committing suicide have increased difficulty disclosing their thoughts to their support system, including therapists. The increased difficulty with disclosure in suicidal clients points to the importance of identifying factors that would optimize client disclosure.

Predictors of Client Disclosure in Psychotherapy

Therapeutic alliance/attachment. Therapeutic alliance is among the most thoroughly

studied and robust predictors of client disclosure. Hall and Farber (2001) found that stronger therapeutic alliance was associated with higher levels of client disclosure. Similarly, Kelley and Yuan (2009) found that clients who reported keeping a clinically relevant secret from their therapists rated the working alliance as significantly lower than clients who reported that they were not keeping a clinically relevant secret from their therapists. Therapists of these clients also reported the alliance to be weaker, even though they were unaware that the clients were withholding secrets. Furthermore, a client's secure attachment to the therapist has also been shown to predict both client disclosure and feelings of relief following disclosures (Saypol & Farber, 2010).

Duration of treatment. The more time clients spend in treatment, the more opportunities they have to disclose topics of clinical importance. Research indicates that the duration of therapy is the second strongest predictor of disclosure (Hall & Farber, 2001). This finding may provide evidence for the benefits of long-term treatment.

Gender. Recent research has found that the gender of the client is a weak predictor of disclosure (Farber & Hall, 2002). Many studies suggest that females disclose more than males in situations not specific to the therapeutic setting (e.g., Alloy, Schuldt, & Bonge, 1985; Jourard, 1971). Conversely, other research suggests that females disclose less than males (Weiner & Shuman, 1984). In a meta-analysis of 205 studies of gender differences in self-disclosure in various social settings, Dindia and Allen (1992) found that females disclosed slightly more often than males in both gender-matched and gender-mismatched dyads. Farber and Hall's (2002) findings indicate that this relatively weak effect of gender on general disclosure might reasonably be assumed to extend into a therapeutic setting.

Fear of consequences. Fear of potential negative consequences may also discourage

disclosure. Dew and colleagues (2007) interviewed 33 patients of general medical practitioners in New Zealand. Participants reported hesitation to disclose symptoms for fear of making others aware of potential mental health problems, facing the unknown, judgment by the practitioner, and treatment associated with the problem. Some participants also feared negative repercussions related to loss of autonomy, including loss of parental rights, being institutionalized, and losing control over their lives. Fear of negative consequences is likely associated with the degree of client disclosure of mental health symptoms within the realm of psychotherapy as well (Dew et al., 2007)

Shame proneness. Research indicates that client proneness to shame also inhibits disclosure in therapy (Hill et al., 1993; Hook & Andrews, 2005; Kelly, 1998). This finding has been particularly found to be true for clients with eating disorders (Swan & Andrews, 2003). However, other studies testing the relationship between shame and disclosure did not find a significant effect (e.g., Farber & Hall, 2002).

Proposed Factors Contributing to Nondisclosure of Suicidal Ideation

While some research suggests factors that promote and inhibit general client disclosure in psychotherapy, we have much less research directly addressing factors associated with disclosure of suicidal ideation in particular. Shea (2002) proposes that many clients feel that thoughts of suicide are a sign of weakness and discussing these thoughts with a clinician emphasizes this weakness. Shea also suggests that some clients feel that thoughts of suicide do not align with cultural values and thus may be immoral, sinful, or taboo. Further, clients may fear that if they reveal thoughts of suicide they will be seen as crazy or insane (Shea, 2002). Clients may also fear consequences to personal autonomy of disclosing thoughts of suicide, such as anticipating being “locked up” or hospitalized. Furthermore, clients may believe that no one can help them

with their thoughts of suicide, and thus do not disclose them. Many clients may not want to be helped with their thoughts and do not want anyone to stop them. Shea (2002) also indicates that the way in which a clinician asks about suicidal thoughts or intent may inhibit client disclosure. Clinicians may ask about thoughts of suicide in a leading way that promotes nondisclosure (e.g. “you are not thinking of suicide are you?”).

Summary of Literature Review

Although there is a dearth of research on the proportion of suicides committed by persons involved in some form of psychotherapy or psychopharmacological treatment, it is clear that the rate of suicides in psychological treatment warrants better understanding of clinician and client factors supporting disclosure and help-seeking. Risk factors for suicide completion include having a psychiatric disorder, having an alcohol or substance use/disorder, past suicide attempts, specific personality variables or traits, demographic variables (gender, age, race), family history of psychiatric illness, abuse, or suicidal behavior, stressful life events, attraction to death, lower socio-economic status and unemployment, less help-seeking behavior, and physical illness. Furthermore, the tendency to fail to disclose suicidal thoughts to social supports has also been associated with more severe suicidal behaviors. Thus, when one is isolated and not disclosing their thoughts and feelings to those close to them, this puts them at a higher risk for completing suicide. There are also several factors that protect against suicide. These factors include positive skills and beliefs, positive psychology factors, help seeking behaviors, and strong social support and social connection.

A review of Joiner’s (2005) interpersonal theory of suicide is helpful in both organizing the factors leading to suicide and guiding how clinicians should conduct suicide assessments. Joiner proposes that people commit suicide when they have a sense of thwarted belongingness,

perceived burdensomeness, and have systematically desensitized themselves to death and physical self-harm. Joiner proposes that clinicians should ask clients about these topic areas to assess risk.

Disclosure in therapy has been associated with better treatment outcomes. However, nondisclosure is common in psychotherapy, including nondisclosure of clinically relevant information. Numerous factors are associated with greater client disclosure in treatment, including stronger therapeutic alliance/attachment, longer duration of treatment, less client fear of negative consequences regarding disclosure, less client proneness to shame, and female gender.

There is a gap in our understanding of factors influencing disclosure of suicidal ideation, specifically. Some possible factors contributing to disclosure of suicidal clients have been suggested (e.g. shame, fear of consequences), but have not been empirically studied. If clinicians can identify factors that promote and inhibit disclosure of suicidal ideation, they will increase their capacity to foster a relationship that encourages disclosure, and therefore become better able to intervene appropriately. The purpose of this dissertation is to acquire a better understanding of factors that promote and inhibit the disclosure of suicidal ideation. This research question was investigated through a survey of persons who both identify as having experienced suicidal ideation and have engaged in psychotherapy.

Method

Research Question

The study was designed to assess the predictive association between client report of disclosure of suicidal ideation and client report of each of the following: working alliance (*working alliance*), degree to which Joiner's interpersonal theory of suicide assessment questions

(thwarted belongingness, perceived burdensomeness, and systematically desensitizing to death and physical self-harm) were asked by the therapist (*interpersonal theory of suicide factors*), client fear of consequences of disclosing of suicidal ideation (*fear of negative consequences*) and the degree to which the therapist asked biased or awkward questions from the client's perspective (*how therapist asked*).

Participants

In order to address this question, 85 participants who were currently attending psychotherapy while dealing with thoughts of suicide were recruited to participate in the study. A sample of 85 participants was needed to have enough statistical power to find the anticipated moderate effect size at the 95% confidence level (Cohen, 1992). Demographic features of the sample are described in Table 1, below.

Table 1

Sample Demographic Characteristics

	N	%		
Gender				
Female	56	65.9		
Male	29	34.1		
Race/Ethnicity				
Caucasian	55	64.7		
Asian American	12	14.1		
Hispanic/Latino/a	10	11.8		
African American	5	5.9		
Other	3	3.5		
Sexual Orientation				
Heterosexual	54	63.5		
Bisexual	18	21.2		
Homosexual	10	11.8		
Asexual	2	2.4		
Other	1	1.8		
Client Report of Primary Psychological Diagnosis				
Depressive Disorders	35	41.2		
Unknown/None	28	32.9		
Anxiety Disorders	7	8.2		
Bipolar Disorders	6	7.1		
Eating Disorders	2	2.4		
PTSD	2	2.4		
ADHD	2	2.4		
Personality Disorders	2	2.4		
Schizophrenia Spectrum Disorder	1	1.8		
	Range	Mean	SD	
Age	18-62	29	9.6	
Psychotherapists Seen in Lifetime	1-29	4.2	4.1	
Experimental Variables that Affect Disclosure of Suicidal Ideation (Likert Scale, 1-7)				
Disclosure	1-7	3.8	1.5	
Working Alliance	2.2-7	5.0	1.2	
Interpersonal Theory of Suicide	1-7	4.8	1.4	
Fear of Consequences	1-6.6	3.9	1.3	
How Therapist Asked	1-5.8	3.2	1.5	

Recruitment. Participants were recruited through the use of Socialsci.com, an online survey design and data collection service designed for academic research. Socialsci.com has its own participant pool. The participant pool remains anonymous, as participant information is stored based on username only; compensation is also delivered anonymously. Accurate responding to survey questions is monitored through comparing demographic data provided by the same anonymous username across multiple surveys. Inconsistent responding decreases a respondent's credibility score, which can result in removal from the pool. Thus, participants from this website are more likely to be honest in their responses than those recruited from other Internet websites and listserves. Researcher subscribers to this service can request individualized participant pools based on the sampling requirements for their research. For this project, participants needed to be 18 years old or over, be currently involved in psychotherapy/counseling, and have had thoughts of suicide during that treatment. Socialsci.com staff selected these participants based on how they responded to previous surveys. Email invitations displayed the name of the study, which was listed as "talking about thoughts of suicide during counseling." Email requests also provided prospective participants with a brief description of the study (see Appendix A).

After following the link the survey, Socialsci.com then asked prospective participants to answer two additional screening questions to ensure they qualified for the study (See Appendix B). These questions asked prospective participants if they were currently involved in treatment and if they have had thoughts of suicide during treatment. Participants were transferred to this study only if they answered in the affirmative to both of these questions.

Informed consent. Prospective participants were informed about the confidential nature of their responses to questionnaires. Participants were told the purpose of the research,

approximate duration, and procedures. The study did not use deception, and prospective participants were fully informed of the content of the research questions. Risks of participation included the possibility of emotional distress related to the content of the questions. There is, however, no known safety risk associated with asking about suicidality (e.g., Psych Central, 2012). In addition, the risk associated with the study was deemed to be minimal because the questionnaire did not ask about specific thoughts, feelings, or means of suicide. Instead, the study was designed to assess how suicide is talked about it in therapy and what makes it easier or more difficult to discuss. Furthermore, the questions were constructed to be both direct and respectful.

The potential benefits of participation include enhanced understanding of one's behaviors in treatment. Benefits also included the possibility that participants may have developed a greater sense of what makes it easier or more difficult for them to talk about this information, which may increase the likelihood that they will disclose in the future. Participants also received points from Socialsci.com, which can go towards an Amazon.com gift card or a donation to the Public Library of Science. The point value is assigned by Socialsci.com and was equivalent to a cash value of 85 cents.

Prospective participants were also given the contact emails for the researcher, study advisor, and IRB if they had further questions or concerns (Standard 8.02, American Psychological Association, 2010). The informed consent was provided online for the participants to read and electronically indicate consent before taking the questionnaire (see Appendix C).

Measures

Demographic Information Questionnaire. This questionnaire which inquired about gender, age, race, length of most recent psychotherapy treatment, and number of lifetime

psychotherapy treatments (see Appendix D).

Suicidal Ideation in Psychotherapy Questionnaire (SIPQ). The next questionnaire participants completed was newly created for this study, the Suicidal Ideation in Psychotherapy Questionnaire (SIPQ). The SIPQ assesses what clients experience relating to suicidality at the time of psychotherapy, what clients are asked about, what clients disclose to their therapist, reasons why it is harder to disclose, reasons why it is easier to disclose, and a brief assessment of suicide attempt and hospitalization history (see Appendix E).

Working Alliance Inventory-Short Version Revised (WAI-SR). The Working Alliance Inventory-Short Version Revised (WAI-SR; Hatcher & Gillaspay, 2006) is a condensed measure of therapeutic alliance derived from a factor analysis of the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989) and the Working Alliance Inventory/Short (WAI-S; Tracey & Kokotovic, 1989). The 12 items of the WAI-SR (client form) assess three domains of therapeutic alliance including goals (collaboratively agree on and working towards goals), tasks (collaboratively doing things that inspire change), and bonds (client feels that therapist likes and cares about him or her).

The WAI-SR has been demonstrated to have good psychometric properties. All the subscale scores' coefficient alphas ranged from .85–.90, while the total score alphas ranged from .91–.92. Correlations were also strong between the WAI-SR and the original WAI, ranging from .94–.95). This indicates that the WAI-SR is a good shorter version of the WAI, and thus a valid measure of therapeutic alliance (Hatcher & Gillaspay, 2006).

Experimental Variables that Affect Disclosure of Suicidal Ideation

The current study's criterion variable was disclosure of suicidal ideation as measured by the SIPQ. The predictor variables included *therapeutic alliance* as measured by the WAI-SR, the

degree to which Joiner's interpersonal theory risk assessment questions were asked (*interpersonal theory of suicide factors*), client fear of consequences of disclosure (*fear of negative consequences*) and the degree to which the therapist asked biased or awkward questions about suicidality (*how therapist asked*), which were all measured by the SIPQ.

Client disclosure of suicidal ideation. Disclosure of suicidal ideation was assessed in the SIPQ through questions about the degree to which respondents felt that their therapist was aware of their suicidal thoughts, the depth in which (intensity) they discussed these thoughts in therapy, how often (frequency) they felt they have discussed suicidality, the degree to which they have omitted information pertaining to suicidal ideation in therapy, and the degree to which they told untruths about suicidal ideation to their therapist. The scale of measurement involved in these 5 items from the SIPQ is interval level, with a 7-point Likert rating scale. The items that were used to indicate this variable are displayed in Table 2 below.

Therapeutic alliance. Therapeutic alliance served as a predictor variable. It was measured by the 12 items of the Working Alliance Inventory-Short Version Revised. The scale of measurement involved in this variable is interval, measured with a 1–7 Likert rating scale.

Degree to which Joiner's interpersonal theory risk assessment questions were asked. The predictor variables also included items pertaining to the degree to which Joiner's interpersonal theory suicide risk assessment questions were asked by the therapist (*interpersonal theory of suicide factors*). The scale of measurement involved in this variable is interval, as this factor was measured by 4 items of the SIPQ with a 1–7 Likert rating scale (see Table 2).

Client fear of consequences of disclosure. Predictor variables also included client fear of consequences of disclosure (*fear of negative consequences*), also measured by 7 items from the SIPQ with a 1–7 Likert rating scale (see Table 2).

Degree to which the therapist asked biased or awkward questions about suicidality.

Finally, predictor variables also included degree to which the therapist asked biased or awkward questions about suicidality (*how therapist asked*). Again, this variable was measured by 4 items from the SIPQ with a 1–7 Likert rating scale (see Table 2).

Table 2

Items Which Contribute To Variables of Interest

Disclosure of Suicidal Ideation

SIPQ #	Question
2	I feel my therapist was fully aware of my suicidal thoughts and plans
3	I talked about this topic fully during treatment
4	My therapist and I often discussed this difficulty
5 (reverse scored)	I did not tell my therapist the whole truth about my suicidal thoughts
6 (reverse scored)	I told my therapist I was not having suicidal thoughts when this was not true

Degree to Which Interpersonal Theory of Suicide Questions Were Asked by Therapist

SIPQ #	Question
12	My therapist asked about the degree to which I felt connected to others.
13	My therapist asked about the degree to which I felt as though I was a burden to others.
14	My therapist asked about self-harm behavior or dangerous behavior (e.g. cutting, excessive substance use).
15	My therapist asked about past suicide attempts.

Client Fear of Consequences of Disclosure

SIPQ #	Question
25	I do not want to be seen as crazy.
26	It is sinful or wrong to have these thoughts.
27	I am afraid that I will receive negative consequences or punishments if I do.
28	I am concerned the law enforcement authorities will be called.
29	I am worried I will be hospitalized or "locked up."
30	I am concerned that I may lose custody of my children.
39 (reverse scored)	I am comfortable that I will not experience negative consequences if I do talk about it.

Degree to Which the Therapist Asked Biased or Awkward Questions

SIPQ #	Question
20	My therapist asked about it in a leading way ex: "You're not thinking about suicide are you?"
21	My therapist asked about it in an awkward way.
34 (reverse scored)	My therapist asked about it in an open and sincere way.
35 (reverse scored)	My therapist asked about it in a direct way.

Hypothesis

This study sought to determine the factors that are most predictive of therapeutic disclosure of suicidal ideation. Specifically, it was designed to identify whether the strength of the working alliance (*working alliance*), the degree to which Joiner's (2005) interpersonal theory of suicide assessment questions were asked by the therapist from the perspective of the client (*interpersonal theory of suicide factors*), client fear of consequences of disclosure of suicidal ideation (*fear of negative consequences*), and the degree to which the therapist asked biased or awkward questions about suicidal ideation (*how therapist asked*) are most predictive of disclosure of suicidal ideation. Further, the study examined whether *how therapist asked* and *fear of negative consequences* contributes to the ability to predict disclosure of suicidal ideation, when controlling for *working alliance* and the *interpersonal theory of suicide factors*. It was predicted that all four variables would contribute to the variance in predicting level of client disclosure of suicidal ideation. Working alliance was expected to be the strongest of this set of predictors.

Results

A hierarchical linear regression analysis was used to test the research hypothesis, which proposed that when controlling for *working alliance* and *interpersonal theory of suicide factors*, *fear of negative consequences* and *how therapist asked* will also add to the accuracy of predicting *disclosure of suicidal ideation*.

Developing Variables

The following section outlines how the variables were constructed for the SIPQ.

Client Disclosure of Suicidal Ideation. *Disclosure of suicidal ideation* was derived from the mean of SIPQ items 2-4, 5 reversed scored, and 6 reversed scored. Subscale scores ranged

from 1-7, with a mean of 3.80 and a standard deviation of 1.50. Internal consistency was good, with $\alpha=.84$.

Working Alliance. The working alliance score was derived from the WAI-CSF items. The score was calculated by averaging 1-3, 4-reversed, 5-9, 10-reversed, and 11-12. Subscale scores ranged from 2.17-7, with a mean of 4.98 and a standard deviation of 1.19. As stated previously, this measure has been shown to have good to excellent subscale score coefficient alphas, ranging from .85–.90.

Interpersonal Theory of Suicide Factors. The degree to which Joiner's interpersonal theory of suicide assessment questions (i.e. perceived burdensomeness, thwarted belongingness, and desensitization to the fear of suicide) were asked by the therapist from the client's perspective score (*interpersonal theory of suicide factors*) was calculated from the mean of SIPQ items 12-15. Refer to Table 2 in the Methods section for SIPQ questions that contribute to the *Joiner's questions asked by therapist* score. Subscale scores ranged from 1-7, with a mean of 4.76, a standard deviation of 1.44. Internal consistency was good, with $\alpha=.81$.

Fear of Negative Consequences. The client fear of negative consequences of disclosure (fear of negative consequences) score was formulated from the mean of SIPQ items 25-30, and 39-reversed. Refer to Table 2 in the Methods section for SIPQ questions that contribute to the client fear of consequences of disclosure score. Subscale scores ranged from 1–6.57, with a mean of 3.93 and a standard deviation of 1.30. Internal consistency was acceptable, with $\alpha=.77$.

How Therapist Asked. The variable addressing how the therapists asks about suicidality from the perspective of the client variable (how therapist asked) was calculated from the mean of SIPQ items 20, 21, 34-reversed, and 35-reversed. Refer to Table 2 in the Methods section for SIPQ questions that contribute to the degree to which the therapist asked biased or awkward

questions. Subscale scores ranged from 1–7, with a mean of 3.25 and a standard deviation of 1.49. Internal consistency was acceptable, with $\alpha=.66$.

Correlations Among Variables.

The correlation matrix for the study variables is displayed in Table 3 below. Of primary interest are the correlations between disclosure of suicidal ideation and the four predictor variables.

Table 3

Correlation Matrix for Regression Analysis

	Disclosure	WAI	Joiner	How Asked	Fear
Disclosure					
WAI	.42*				
Joiner	.54*	.46*			
How Asked	-.59*	-.55*	-.69*		
Fear	-.16	-.26*	-.05	.26*	

Note. * Significant at the .05 level.

Hierarchical Linear Regression Analysis

Order of entry into the model. *Working alliance* and *interpersonal theory of suicide factors* were entered in the first block because literature has established that working alliance has an effect on disclosure and interpersonal theory of suicide factors has an effect on suicide risk. Thus, it was predicted that these two variables would have strong predictive power. The *how therapists asked* variable and the *fear of negative consequences* variable were entered in a subsequent block, because there is less basis for estimating their relationship to disclosure of suicidal ideation. Thus, the analysis aimed to determine whether how the therapist asks about suicide and client fear of consequences *add* to prediction of disclosure, over and above the more obvious predictors of *working alliance* and *interpersonal theory of suicide factors*.

The results of the hierarchical linear regression analysis are displayed in Table 9, below. As expected, *working alliance* and *interpersonal theory of suicide factors* significantly predicted *disclosure of suicidal ideation*. This model accounted for approximately 32.5% of the variance for the level of disclosure, which was statistically significant, $F(2,82) = 19.73$, $p < .001$. The regression equation can be written as follows: $y = .30 + .27$ (*working alliance*) $+ .46$ (*interpersonal theory of suicide factors*). The addition of the second block provided a significant increment in variance accounted for, with an R^2 change = .06, $p = .023$. This model accounted for

38.6% of the variance for the level of disclosure, which is statistically significant, $F(4,80)=12.57$, $p < .001$. Thus, when controlling for *working alliance* and *interpersonal theory of suicide factors*, *how therapist asked* significantly predicted the disclosure score, $t=4.31$, $p < .01$. The regression equation can be written as follows: $y = 3.23 + .13 (\textit{working alliance}) + .26 (\textit{interpersonal theory of suicide factors}) - .35 (\textit{how therapist asked})$.

Table 4

Factors That Predict Disclosure of Suicidal Ideation

Variable	Model 1			Model 2		
	<i>B</i>	<i>SE B</i>	β	<i>B</i>	<i>SE B</i>	β
WAI	.27	.13	.21	.13	.14	.10
Joiner	.46	.11	.44	.26	.13	.25
How Asked				-.35	.13	-.35
Fear of Consequences				-.04	.11	-.03
R^2	.33			.39		
<i>F</i>	19.72 *			12.57 *		

* $p < .01$

Discussion

This study was designed to explore whether client self-report of disclosure of suicidal ideation in therapy (*disclosure of suicidal ideation*) could be predicted by client self-report of each of the following factors: working alliance (*working alliance*), degree to which Joiner's interpersonal theory of suicide assessment questions were asked by the therapist (*interpersonal theory of suicide factors*), client fear of consequences of disclosure of suicidal ideation (*fear of negative consequences*) and the degree to which the therapist asked biased or awkward questions from the client's perspective (*how therapist asked*). This study also sought to test whether *fear of negative consequences* and *how therapist asked* would provide incremental prediction of *disclosure of suicidal ideation*, beyond that afforded by the *working alliance* and the *interpersonal theory of suicide factors*. It was predicted that all four variables would contribute to the variance in predicting level of client disclosure of suicidal ideation.

The results confirmed the expected positive correlation between working alliance and disclosure of suicidal ideation, and between therapist inquiries aligned with Joiner's (2005)

interpersonal theory and disclosure of suicidal ideation. In addition, we found a negative correlation between degree to which the therapist asked biased or awkward questions and disclosure. While working alliance and the degree to which Joiner's interpersonal theory of suicide assessment questions predicted client disclosure of suicidal ideation, the degree to which the therapist asked biased or awkward questions about suicidal ideation contributed further predictive power. Thus, the results suggest that clients are more likely to disclose suicidal ideation when clinicians develop a strong working alliance with their clients, ask suicide assessment questions as proposed by Joiner's interpersonal theory (i.e., perceived burdensomeness, thwarted belongingness, and desensitization to the fear of suicide), and ask direct and open questions regarding suicidality.

The results of this study have important clinical implications for psychotherapists working with clients who may have suicidal ideation. The results suggest that therapist behavior is among the predictors of disclosure of suicidal ideation. Through attending to the study's identified factors, clinicians can help construct a therapeutic environment which would support clients in being open and honest regarding their suicidal thoughts and behaviors. Thus, clinicians should focus on developing a strong working alliance, use interpersonal theory of suicide assessment questions, and ask questions to assess suicidal ideation in a direct and non-awkward way in order to encourage disclosure of suicidal ideation. As disclosure increases and clients confide more of their thoughts and intentions related to suicidal ideation, clinicians can better know the extent of their clients' risk for suicide. Clinicians can then use this knowledge to intervene appropriately.

However, a therapist attending to these disclosure-promoting factors inherently involves a degree of difficulty and requires a level of skill to enact; this is especially true in promoting a

strong working alliance. It should be noted that while clinicians can attempt to focus on building a strong working alliance with their clients, this is limited by how much the client is willing or capable to do so. For instance, some studies have reported that the quality of the working alliance correlates positively with client characteristics including psychological mindedness, expectation for change, and quality of object relations. Furthermore, studies have also suggested that the quality of the alliance is negatively correlated with client characteristics of avoidance, interpersonal difficulties, and depressonogenic conditions (e.g., Castonguay, Constantino, and Holtforth, 2006). While individual client differences do affect the quality of the working alliance, there are things that clinicians can do to increase the potential of forming a strong alliance. For instance, research has suggested that clinician warmth, flexibility, and accurate interpretations are positively correlated with the quality of the working alliance. Furthermore, therapists who refrain from being rigid, critical, and avoid using inappropriate self-disclosure have been shown to support the development of the working alliance. Therapists who are more self-aware in session have also been shown to build more quality working alliances with their clients (e.g., Castonguay et al., 2006). Through attending to these therapist specific factors which support the quality of the therapeutic relationship, clinicians can also support the likelihood of client disclosure of suicidal ideation.

It is possible that clinicians may unintentionally ask awkward or indirect questions about suicidal ideation because they are fearful of getting a response that indicates a level of risk. Alternatively, clinicians may unintentionally ask biased or awkward questions because they might feel that the direct way of asking about suicidality may be interpreted as off-putting. While therapists may face personal challenges in asking clients if they are having thoughts of suicide in a direct way, it is imperative that these challenges be addressed. Clinicians must develop skills in

becoming more comfortable with asking if clients if they have thoughts of suicide in a direct and honest way in order to promote disclosure of suicidal ideation.

Another factor that may inhibit appropriate therapist questioning is a lack of awareness about the predictive validity of thwarted belongingness, perceived burdensomeness, and risk taking, in relation to suicidal behavior. Through awareness of this body of research and the application of its findings in suicide assessment, clinicians will gather more complete and accurate information relevant to making clinically informed decisions.

The clinical implications of the results are especially important for the training of clinicians. Many clinicians in training may be fearful of client suicide risk and find suicide risk assessment challenging. The results of this study suggest important considerations that can provide early level clinicians with guidance in how to best assess clients with suicidal ideation. First, training programs should communicate the importance of developing a strong working alliance with clients in order to encourage the disclosure of suicidal ideation. While clinicians in training are likely taught about the importance of building the working alliance in therapy in general, the role of the alliance in encouraging disclosure of suicidal ideation should be emphasized. Trainees should also be educated about Joiner's interpersonal theory of suicide and the corresponding assessment questions. Clinical trainees should also be encouraged to be direct and open when asking clients about thoughts of suicide. Additionally, training should cultivate self-awareness of personal inhibitions associated with inquiring about suicide,

Limitations of Current Study

Several limitations of this study should be considered. First, the sample was relatively homogeneous in terms of race/ethnicity and the sample size, although producing a moderate effect, was small. African Americans were underrepresented in the sample while Asian

Americans were overrepresented in relation to the distribution of ethnicities/races in the general United States population. Another limitation is the possibility that collection of data online decreased motivation to be honest when answering the survey, although the website used has procedures that increase the likelihood of honest responding.

The SIPQ was not tested for reliability or validity prior to its use in this study. The SIPQ asks questions directly, without deception, thus appearing to have strong face validity. However, without empirical evaluation of its reliability and validity, it is possible that the questionnaire may not adequately or consistently capture the constructs that it was developed to encompass.

The self-report retrospective nature of the data also carries limitations. First, it is important to recognize that participants' memories are fallible and are not purely accurate representations of what occurred in therapy. Furthermore, it is possible that the social demands of the questions may influence how participants remember their experience in therapy. Thus, the act of reading and responding to the questionnaire may influence participants' memories of therapy.

Finally, it should be noted that in one section of the survey, the Likert scale selection was mislabeled. Instead of reading "strongly disagree, disagree, somewhat disagree, neutral, somewhat agree, agree, strongly agree", it read "strongly disagree, disagree, *somewhat agree*, neutral, somewhat agree, agree, strongly agree." However, the anchor labels of strongly disagree and strongly agree were correct and the labels disagree and agree were also correct. Furthermore, the distribution of responses in these items was variable, suggesting that participants understood the 7-point Likert range, and thus were able to mentally correct the misspelling in their mind. It remains possible that the mislabeling may have confused some participants.

Future Directions

Despite the current study's limitations, the results represent a first step in the field's

understanding of factors that promote client disclosure of suicidal ideation. The following suggestions for future areas of research are informed by the promising results of this study as well as its limitations. The results suggest that specific variables (working alliance, use of interpersonal theory assessment questions, and asking direct questions) can predict the level of client disclosure of suicidal ideation. While these findings are directly applicable to clinical practice in encouraging disclosure of suicidal ideation, the results also raise more questions and opportunities for further research. First, future research should test the reliability and validity of the SIPQ to assess its capacity to measure what it presumes to measure. Identifying the items with the highest validity and reliability may inform the construction of a stronger version of the SIPQ in order to assess predictive factors that promote and inhibit client disclosure of suicidal ideation. Furthermore, future research should build on the results of this study and acquire a larger and more heterogeneous sample. By doing so, this will increase statistical power and allow for measurement of the predictive relationship between individual items in the SIPQ and disclosure. Through comparing individual items to disclosure, this will allow for identification of specific predictors instead of the more generalized predictors constructed in this study. Analyzing individual items would be particularly valuable in identifying how specific client fears of negative consequences influence disclosure of suicidal ideation. Using a larger sample for this more specific data analysis will provide a more focused glimpse into the factors that are predictive of disclosure of suicidal ideation.

As this research has identified that therapist behavior is among the predictors of disclosure of suicidal ideation, it would be important to learn more about the molecular therapist behaviors that may encourage disclosure. To this end, additional research should be designed to identify and utilize factors that promote disclosure of suicidal ideation in real-time longitudinal

clinical studies. Longitudinal research in clinical settings should be conducted to help identify more specific therapist behaviors and therapeutic factors, which promote disclosure in a more controlled research-based therapeutic environment. Further research could then be designed to implement the factors identified as to optimize the conditions associated with disclosure. The effect of these interventions could then be viewed in a longitudinal clinical trial to test its affect on disclosure in a real therapeutic relationship. This would help develop the most appropriate interventions for individuals with suicidal ideation.

More generally, additional research is necessary to help identify additional and more specific client and therapist factors that promote or inhibit client disclosure of suicidal ideation. While the results found in this study do identify three predictors of disclosure of suicidal ideation, it is reasonable to speculate that factors not analyzed in this study may also add to the ability to predict disclosure. For example, future research may assess the influence of normalizing the experience of suicidal thoughts on clients' willingness to disclose. Furthermore, factors which were not assessed include more client-specific characteristics, including the role of client shame, more specific client fears of disclosure, client concern for feelings of therapist, and the possibility that clients might not want help with their suicidal thinking. Clinicians can then address these client-specific variables through more tailored interventions in therapy as a means to encourage disclosure. The SIPQ as well as an expansion of this measure may be used towards the purpose of identifying other predictive factors. Alternatively, qualitative research using interviews with clients who have suicidal ideation in therapy might also be valuable in identifying other potential variables that promote or inhibit disclosure of suicidal ideation in psychotherapy.

While a plethora of research exists that has identified risk and protective factors of suicide attempt and completion, a gap in the current literature exists regarding the identification of factors influencing client disclosure of suicidal ideation in psychotherapy. It is critical to identify what factors promote and inhibit disclosure of suicidal ideation so clinicians can help support this type of disclosure with their clients. As client disclosure of suicidal ideation increases, clinicians will become better informed about the mental status of their clients and be able to intervene appropriately in providing the best treatment. While this study serves as a positive step towards identifying factors that could prove useful in the treatment and protection of psychotherapy clients who have suicidal ideation, more research is required to obtain a more nuanced view of this clinically and social relevant topic.

References

- Abelson, R.P. (1995). *Statistics as Principled Argument*. Hillsdale, N.J.: Lawrence Erlbaum Associates, Publishers.
- Agerbo, E., Nordentoft, M., & Mortensen, P. (2002). Familial, psychiatric, and socioeconomic risk factors for suicide in young people: Nested case-control study. *BMJ: British Medical Journal*, 325, 74-77. doi:10.1136/bmj.325.7355.74
- Alloy, D.A., Schuldt, W., & Bonge, D. (1985). Sex differences in self-disclosure. *Representative Research In Social Psychology*, 15, 10-15.
- American Foundation for Suicide Prevention (2010). *Facts and figures: National statistics*. Retrieved from:
<http://www.afsp.org/understanding-suicide/facts-and-figures>.
- American Foundation for Suicide Prevention. (2012). *Risk factors and warning signs*. Retrieved from: <http://www.afsp.org/understanding-suicide/risk-factors-and-warning-signs>.
- American Psychological Association. (2010). *Ethical Principles of Psychologists and Code of Conduct*, 2010 Amendments. General Principles.
<http://www.apa.org/ethics/code/index.aspx>. Retrieved 3/5/2012.
- American Psychological Association. (2010). *Ethical Principles of Psychologists and Code of Conduct*, 2010 Amendments. Privacy and Confidentiality.
<http://www.apa.org/ethics/code/index.aspx?item=7>. Retrieved 3/5/2012.
- Anchor, K.N., & Sandler, H.M. (1973). Psychotherapy sabotage and avoidance of self-disclosure. *Proceedings Of The Annual Convention Of The American Psychological Association*, 485-486.
- Apter, A., Horesh, N., Gothelf, D., Graffi, H., & Lepkifker, E. (2001).

- Relationship between self-disclosure and serious suicidal behavior. *Comprehensive Psychiatry*, 42, 70-75. doi:10.1053/comp.2001.19748
- Arsenault-Lapierre, G., Kim, C., & Turecki, G. (2004). Psychiatric diagnoses in 3275 suicides: a meta-analysis. *BMC Psychiatry*, 4, 37.
- Brent D.A., Perper, J.A., Allman C.J., Moritz, G.M., Wartella, M.E., & Zelenak, J.P. (1991). The presence and accessibility of firearms in the homes of adolescent suicides: a case-control study. *Journal of the American Medical Association*, 266, 2989-2995.
- Brezo, J., Paris, J., & Turecki, G. (2006). Personality traits as correlates of suicidal ideation, suicide attempts, and suicide completions: a systematic review. *Acta Psychiatrica Scandinavica*, 113, 180-206.
- Castonguay, L.G., Constantino, M.J., & Holtforth, M. (2006). The working alliance: Where are we and where should we go?. *Psychotherapy: Theory, Research, Practice, Training*, 43(3), 271-279. doi:10.1037/0033-3204.43.3.271
- Centers for Disease Control and Prevention. (2010). *Suicide: Risk and protective factors*. Retrieved from:
<http://www.cdc.gov/ViolencePrevention/suicide/riskprotectivefactors.html>
- Center for Disease Control and Prevention. (2009). *Suicide: Facts at a Glance*. Retrieved from:
www.cdc.gov/violenceprevention/pdf/Suicide-DataSheet-a.pdf
- Chapman, A.L., Specht, M.W., & Cellucci, T. (2005). Factors associated with suicide attempts in female inmates: The hegemony of hopelessness. *Suicide & Life-Threatening Behavior*, 35, 558-569.
- Chemtob, C.M., Hamada, R.S., Bauer, G.B., Kinney, B., & Torigoe, R.Y. (1988). Patients'

- suicides: Frequency and impact on psychiatrists. *The American Journal of Psychiatry*, 145, 224–228.
- Chemtob, C.M., Hamada, R.R., Bauer, G., Torigoe, R.Y., & Kinney, B., (1988). Patient suicide: Frequency and impact on psychologists. *Professional Psychology: Research and Practice*, 19, 416-420
- Cheng, A.A., Chen, T.H., Chen, C., & Jenkins, R. (2000). Psychosocial and psychiatric risk factors for suicide: Case-control psychological autopsy study. *British Journal Of Psychiatry*, 177360-365. doi:10.1192/bjp.177.4.360
- Cherpitel, C.J., Borges, G.L.G., & Wilcox, H.C. (2004). Acute alcohol use and suicidal behavior: A review of the literature. *Alcoholism: Clinical & Experimental Research*, 28, 18S-28S.
- Cohen, J. (1992). A power primer. *Psychological Bulletin*, 112, 155-159.
- Costa, P.T., McCrae, R.R. (1992). Normal personality assessment in clinical practice: The NEO Personality Inventory. *Psychological Assessment*, 4, 5-13.
- de Wilde, E.J., Kienhorst, I.C., Diekstra, R.F., & Wolters, W.H. (1992). The relationship between adolescent suicidal behavior and life events in childhood and adolescence. *American Journal of Psychiatry*, 149, 45-51.
- Dew, K., Morgan, S., Dowell, A., McLeod, D., Bushnell, J., & Collings, S. (2007). 'It puts things out of your control?': Fear of consequences as a barrier to patient disclosure of mental health issues to general practitioners. *Sociology Of Health & Illness*, 29, 1059-1074.
- Dindia, K., & Allen, M. (1992). Sex differences in self-disclosure: A meta-analysis. *Psychological Bulletin*, 112, 106-124. doi:10.1037/0033-2909.112.1.106
- Elliott, J.L., & Frude, N. (2001). Stress, coping styles, and hopelessness in self-poisoners. *Crisis*:

- Journal of Crisis Intervention & Suicide Prevention*, 22, 20-26.
- Eisenberg, M.E., & Resnick, M.D. (2006). Suicidality among gay, lesbian and bisexual youth: the role of protective factors. *Journal of Adolescent Health*, 39, 662-668.
- Fagiolini, A., Kupfer, D.J., Rucci, P., Scott, J.A., Novick, D.M., & Frank, E. (2004). Suicide attempts and ideation in patients with bipolar I disorder. *Journal Of Clinical Psychiatry*, 65, 509-514. doi:10.4088/JCP.v65n0409
- Farber, B.A. (2003). Patient self-disclosure: A review of the research. *Journal of Clinical Psychology*, 59, 589-600.
- Farber, B.A., & Hall, D. (2002). Disclosure to therapists: What is and is not discussed in psychotherapy. *Journal of Clinical Psychology*, 58, 359-370. doi:10.1002/jclp.1148
- Farber, B.A., & Sohn, A. (2001). The relationship of patient disclosure to therapy outcome. Paper presented at the annual conference of the Society for Psychotherapy Research. Monte-video, Uruguay.
- Hall, D.A., & Farber, B.A. (2001). Patterns of patient disclosure in psychotherapy. *Journal Of The American Academy Of Psychoanalysis*, 29, 213-230. doi:10.1521/jaap.29.2.213.17262
- Hatcher, R.L., & Gillaspay, J.A. (2006). Development and validation of a revised short version of the Working Alliance Inventory. *Psychotherapy Research*, 16, 12-25.
- Hendin, H., Lipschitz, A., Maltzberger, J.T., Haas, A.P., & Wynecoop, S. (2000). Therapists' reactions to patients' suicides. *The American Journal of Psychiatry*, 157, 2022-2027.
- Hill, C.E., Thompson, B.J., Cogar, M.C., & Denman, D.W. (1993). Beneath the surface of long-term therapy: Therapist and client report of their own and each other's covert

- processes. *Journal of Counseling Psychology*, 40, 278-287.
- Hirsch, J.K., Duberstein, P.R., Conner, K.R., Heisel, M.J., Beckman, A., Franus, N., & Conwell, Y. (2006). Future Orientation and Suicide Ideation and Attempts in Depressed Adults Ages 50 and Over. *American Journal of Geriatric Psychiatry*, 14, 752-757.
- Hook, A. & Andrews, B. (2005). The relationship of non-disclosure in therapy to shame and depression. *British Journal of Clinical Psychology*, 44, 425-438.
doi:10.1348/014466505X34165
- Horesh, N., & Apter, A. (2006). Self-disclosure, depression, anxiety, and suicidal behavior in adolescent psychiatric inpatients. *Crisis: The Journal Of Crisis Intervention And Suicide Prevention*, 27, 66-71. doi:10.1027/0227-5910.27.2.66
- Horvath, A.O., & Greenberg, L.S. (1989). Development and validation of the Working Alliance Inventory. *Journal of Counseling Psychology*, 36, 223-233.
- Jinying, L. & Huichang, C. (2003). Self-disclosure and its Relationships with Personality Traits, Loneliness, and Mental Health in College Students. *Chinese Mental Health Journal*, 17, 666-668.
- Joiner, T. (2005). *Why people die by suicide*. Cambridge, MA US: Harvard University Press.
- Joiner, T. (2011). *Lonely at the top: The high cost of men's success*. New York, NY: Palgrave Macmillan.
- Joiner, T., Orden, K., Witte, T. K., & Rudd, M. (2009). Risk assessment. In T. r. Joiner, K. A. Van Orden, T. K. Witte, M. Rudd (Eds.), *The interpersonal theory of suicide: Guidance for working with suicidal clients*.
- Joiner, T., Walker, R.L., Rudd, M., & Jobes, D.A. (1999). Scientizing and routinizing the

- assessment of suicidality in outpatient practice. *Professional Psychology: Research And Practice*, 30, 447-453. doi:10.1037/0735-7028.30.5.447
- Jourard, S.M. (1971). *Self-disclosure: An experimental analysis of the transparent self*. New York: Wiley.
- Jourard, S.M. (1968). *Disclosing man to himself* Princeton, NJ: D. Van Nostrand.
- Kahn, J.H., Achter, J.A., & Shambaugh, E.J. (2001). Client distress disclosure, characteristics at intake, and outcome in brief counselling. *Journal of Counseling Psychology*, 48, 203–211.
- Kelly, A.E. (1998). Client's secret keeping in out-patient therapy. *Journal of Counseling Psychology*, 45, 50–57.
- Kelly, T.M., Soloff, P.H., Lynch, K.G., Haas, G.L., & Mann, J.J. (2000). Recent life events, social adjustment, and suicide attempts in patients with major depression and borderline personality disorder. *Journal of Personality Disorders*, 14, 316-326. Doi: 10.1521/pedi.2000.14.4.316
- Kelly, A.E., & Yuan, K. (2009). Clients' secret keeping and the working alliance in adult outpatient therapy. *Psychotherapy: Theory, Research, Practice, Training*, 46, 193-202. doi:10.1037/a0016084
- Kidd, S., Henrich, C.C., Brookmeyer, K.A., Davidson, L., King, R.A., & Shahar, G. (2006). The social context of adolescent suicide attempts: Interactive effects of parent, peer, and school social relations. *Suicide & Life-Threatening Behavior*, 36, 386-395.
- Leenaars, A. (Ed.). (1999). *Lives and deaths: Selections from the works of Edwin S. Shneidman*. Philadelphia: Brunner/Mazel.
- Leenaars, A.A. (2010). Review: Edwin S. Shneidman on Suicide. *Suicidology Online*, 1, 5-18.

- Lindeman, S., Laara, E., Hakko, H., & Lonnqvist, J. (1996). A systematic review on gender-specific suicide mortality in medical doctors. *British Journal of Psychiatry*, *168*, 274-279.
- Linehan, M.M., Goodstein, J.L., Nielsen, S.L., & Chiles, J.A. (1983). Reasons for staying alive when you are thinking of killing yourself: The Reasons for Living Inventory. *Journal Of Consulting And Clinical Psychology*, *51*(2), 276-286. doi:10.1037/0022-006X.51.2.276
- Lorant, V., Kunst, A.E., Huisman, M., Bopp, M., & Mackenbach, J. (2005). A European comparative study of marital status and socio-economic inequalities in suicide. *Social Science & Medicine*, *60*, 2431-2441.
- Malone, K.M., Oquendo, M.A., Haas, G.L., Ellis, S.P., Li, S., & Mann, J.J. (2000). Protective factors against suicidal acts in major depression: reasons for living. *American Journal of Psychiatry*, *157*, 1084-1088.
- Masango, S.M., Rataemane, S.T., Motojesi, A.A. (2008). Suicide and suicide risk factors: A Literature review. *South African Family Practice*, *50*, 25-29.
- McAdams, C.R. & Foster, V.A. (2000). Client suicide: Its frequency and impact on counselors. *Journal of Mental Health Counseling*, *22*, 107-121.
- McLean, J., Maxwell, M., Platt, S., Harris, F., & Jepson, R. (2008). *Risk and protective factors for suicide and suicidal behavior: a literature review*. Edinburgh: The Scottish Government: Social Research.
- Meadows, L.A., Kaslow, N.J., Thompson, M.P., & Jurkovic, G.J. (2005). Protective factors against suicide attempt risk among African-American women experiencing intimate partner violence. *American Journal of Community Psychology*, *36*, 109-121.
- Menniner, W.W. (1991). Patient suicide and its impact on the psychotherapist.

- Bulletin of the Menninger Clinic*, 55, 216-227.
- Moscicki, E.K. (1997). Identification of suicide risk factors using epidemiologic studies. *Psychiatric Clinics of North America*, 20, 499-517.
- Neeleman, J. (2001). A continuum of premature death. Meta-analysis of competing mortality in the psychosocially vulnerable. *International Journal of Epidemiology*, 30(1), 154-162.
- Nisbet, P.A. (1996). Protective factors for suicidal black females. *Suicide & Life-Threatening Behavior*, 26, 325-341.
- Palmer, B.A., Pankratz, V.S., & Bostwick, J.M. (2005). The lifetime risk of suicide in schizophrenia: a reexamination. *Archives of General Psychiatry*, 62, 247-253.
- Peruzzi, N. & Bongar, B. (1999). Assessing risk for completed suicide in patients with major depression: Psychologists' view of critical factors. *Professional Psychology: Research and Practice*, 30, 576-580.
- Pharris, M.D., Resnick, M.D., & Blum, R.W. (1997). Protecting against hopelessness and suicidality in sexually abused American Indian adolescents. *Journal of Adolescent Health*, 21, 400-406.
- Platt, S., & Hawton, K. (2000). Suicidal Behaviour and the Labour Market. In K. Hawton, & K. van Heeringen (Eds.), *The International Handbook of Suicide and Attempted Suicide* (pp.309-384). Chichester: John Wiley & Sons.
- Plutchik, R., & Van Praag, H.M. (1994). Suicide risk: Amplifiers and attenuators. In M. Hillbrand & N.J. Pollone (Eds.), *The psychobiology of aggression*. Binghamton, NY: Haworth Press.
- Pompili, M., Girardi, P., Ruberto, A., & Tatarelli, R. (2005a). Suicide in the epilepsies: a meta-analytic investigation of 29 cohorts. *Epilepsy & Behavior*, 7, 305-310.

- Pompili, M., Girardi, P., Ruberto, A., & Tatarelli, R. (2005b). Suicide in borderline personality disorder: A meta- analysis. *Nordic Journal of Psychiatry*, *59*, 319-324.
- Pompili, M., Girardi, P., Tatarelli, G., Ruberto, A., & Tatarelli, R. (2006). Suicide and attempted suicide in eating disorders, obesity and weight-image concern. *Eating Behaviors*, *7*, 384-394.
- Psych Central. (2012). Frequently Asked Questions about Suicide. *Psych Central*. Retrieved on July 16, 2012, from <http://psychcentral.com/lib/2007/frequently-asked-questions-about-suicide/>
- Qin, P., Agerbo, E., Westergård-Nielsen, N., Eriksson, T., & Mortenson, P. (2000). Gender differences in risk factors for suicide in Denmark. *British Journal Of Psychiatry*, *177*, 546-550. doi:10.1192/bjp.177.6.546
- Regan, A.M., & Hill, C.E. (1992). Investigation of what clients and counselors do not say in therapy. *Journal of Counseling Psychology*, *39*, 168-174.
- Rehkopf, D.H., & Buka, S.L. (2006). The association between suicide and the socio-economic characteristics of geographical areas: A systematic review. *Psychological Medicine*, *36*, 145-157.
- Rihmer, Z., & Kiss, K. (2002). Bipolar disorders and suicidal behavior. *Bipolar Disorders*, *4*, 21-25.
- Saypol, E., & Farber, B.A. (2010). Attachment style and patient disclosure in psychotherapy. *Psychotherapy Research*, *20*, 462-471. doi:10.1080/10503301003796821
- Shneidman, E. (1973). Suicide. *Encyclopedia Britannica* (Vol. 21, 383-385). Chicago: William Benton.
- Shneidman, E. (1985). *Definition of suicide*. (pp. 202- 213.) New York: John Wiley & Sons.

- Shea, S.C. (2002). *The Practical Art of Suicide Assessment: A Guide for Mental Health Professionals and Substance Abuse Counselors*. Hoboken, N.J.: John Wiley & Sons, Inc.
- Swan, S., & Andrews, B. (2003). The relationship between shame, eating disorders and disclosure in treatment. *British Journal Of Clinical Psychology, 42*, 367-378.
doi:10.1348/014466503322528919.
- Strassberg, D.S., Anchor, K.N., Gabel, H. & Cohen, B. (1978). Client self-disclosure in short-term psychotherapy. *Psychotherapy: Theory, Research & Practice, 15*, 153-157.
- Stiles, W.B. (1984). Client disclosure and psychotherapy session evaluations. *British Journal of Clinical Psychology, 23*, 311-312.
- Stiles, W.B. & Shapiro, D.A. (1994). Disabuse of the drug metaphor: Psychotherapy process-outcome correlations. *Journal of Consulting and Clinical Psychology, 62*, 942-948.
- Tracey, T.J., & Kokotovic, A.M. (1989). Factor structure of the Working Alliance Inventory. *Psychological Assessment, 1*, 207-210.
- Trull, T.J., Widiger, T.A., Ueda, J.D., Holcomb, J., Doan, B.T. Axelrod, S.R. Stern, B.L. & Gershuny, B.S. (1998). A structured interview for the assessment of the five-factor model of personality. *Psychological Assessment, 10*, 229-240.
- Tryon, G.S. & Kane, A.S. (1990). The helping alliance and premature termination. *Counseling Psychology Quarterly, 3*, 233-238.
- Wagner, B.M. (1997). Family risk factors for child and adolescent suicidal behavior. *Psychological Bulletin, 121*, 246-298.
- Weiner, M.F., & Schuman, D.W. (1984). What patients don't tell their therapists. *Integrative Psychiatry, 2*, 28-32.
- Wilcox, H.C., Conner, K.R., & Caine, E.D. (2004). Association of alcohol and drug use disorders

and completed suicide: An empirical review of cohort studies. *Drug & Alcohol Dependence*, 76(SUPPL.), 11-19

Wright, K.B. (2005), Researching Internet-Based Populations: Advantages and Disadvantages of Online Survey Research, Online Questionnaire Authoring Software Packages, and Web Survey Services. *Journal of Computer-Mediated Communication*, 10: 00. doi: 10.1111/j.1083-6101.2005.tb00259.x

Yang, B. & Clum, G.A. (1996). Effects of early negative life experiences on cognitive functioning and risk for suicide: A review. *Clinical Psychology Review*, 16, 177-195.

Appendix A

Survey Description as Seen on Socialsci.com

This survey is about talking about thoughts of suicide in counseling. We hope to learn more about what makes it easier or harder for people in counseling to talk about thoughts of suicide. The results of the survey may help develop better counseling practices for people with suicidal thoughts.

Appendix B

Pre-survey Screening Questions

- 1) Are you currently involved in counseling/psychotherapy?
Yes
No

- 2) If yes, have you had thoughts of suicide during your current treatment? Your answer will be strictly confidential.
Yes
No

Appendix C

Informed Consent

Robert Orf, M.S., a doctoral student at Antioch University New England, is inviting you to fill out a survey about talking about thoughts of suicide in counseling. We hope to learn more about what makes it easier or harder for people in counseling to talk about thoughts of suicide. The results of the survey may help develop better counseling practices for people with suicidal thoughts. To participate in this survey you must be currently attending counseling/therapy, have had thoughts of suicide during the period of counseling/therapy, and be at least 18 years old.

This survey includes questions about

- your feelings about your therapist
- your comfort in discussing suicidal thoughts with your therapist,
- what kinds of questions your therapist asked you about suicidal thoughts
- suicide attempts and hospitalization history
- demographic information

We estimate that it will take about 15 minutes to complete the survey.

Risks and Benefits of Participation.

This survey asks about difficult experiences in your life; thinking about those experiences may be uncomfortable for you. If you think it will be too uncomfortable for you, you should not participate in this study. If you discover while taking the survey that it is too uncomfortable, you should just stop at any time.

The benefits of participation include receiving points from socialsci.com, which can go towards an Amazon.com gift card or a donation to scientific research. Participating in this study may prompt you to experience some insights about yourself and your therapy.

Your Privacy.

No identifying information will be collected as part of this survey – your responses will be anonymous.

If you have any questions about the study:

You may contact Robert Orf, at telephone # 603-359-9787 or email at rorf@antioch.edu. You may also contact Robert Orf's research adviser, George Tremblay, PhD., at telephone # 603-283-2190 or email at gtremblay@antioch.edu.

If you have any questions about your rights as a research participant:

You may contact Katherine M. Clarke, PhD., Chair of the Antioch University New England IRB, at telephone # 603-283-2162 or email at kclarke@antioch.edu. You may also contact Stephen Neun, PhD., Vice President of Academic Affairs at Antioch University New England at telephone # 603-283-2150 or email at sneun@antioch.edu.

Appendix D

Demographic Information Questionnaire

The following brief survey will ask for demographic information. You are free to refuse answering any question and to stop participating at any time.

1. Please select the gender with which you identify:

Female Male Transgender Intersex Other (please specify) _____

2. Please select the ethnicity or race with which you identify:

Caucasian African-American Hispanic/Latino/a Asian American Native American Multiracial
Other

3. Please select the sexual orientation with which you identify:

Heterosexual Homosexual Bisexual Asexual Other

4. How old are you? _____

5. How many years and months have you been in or where you in your most recent outpatient psychotherapy/counseling experience?

Years _____

Months _____

6. Are you currently involved in outpatient counseling/psychotherapy?

Yes

No

7. How many years and months have you been in outpatient psychotherapy/counseling throughout your life?

Years _____

Months _____

8. How many different outpatient psychotherapists/counselors have you seen in your lifetime? _____

9. How many times have you been admitted in inpatient or hospitalization treatment throughout your life? _____

10. If known, what diagnosis have you received?

Primary _____

Secondary _____

Appendix E

Suicidal Ideation in Psychotherapy Questionnaire

The questions in this section concern behaviors and attitudes related to the therapeutic process and suicidal ideation. Suicidal ideation is defined as having serious thoughts of suicide or ending one's life. This questionnaire will ask about what makes it harder to talk about and what makes it easier to talk about. Please answer each question as it relates to your current therapeutic experience. You are free to refuse answering any question and to stop participating at any time. Please select the number that best describes your experience with each question.

	Strongly Disagree	Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Agree	Strongly Agree
1. During the time of my therapy, I was having serious thoughts of suicide.	1	2	3	4	5	6	7
2. I feel my therapist was fully aware of my suicidal thoughts and plans.	1	2	3	4	5	6	7
3. I talked about this topic fully during treatment.	1	2	3	4	5	6	7
4. My therapist and I often discussed this difficulty.	1	2	3	4	5	6	7
5. I did not tell my therapist the whole truth about my suicidal thoughts.	1	2	3	4	5	6	7
6. I told my therapist I was not having suicidal thoughts, when this was not true	1	2	3	4	5	6	7
7. My therapist asked me about suicidal thoughts.	1	2	3	4	5	6	7
8. During the period of my treatment, I felt disconnected from family and friends.	1	2	3	4	5	6	7
9. During the period of my treatment, I felt I was a burden to others.	1	2	3	4	5	6	7
10. During the period of my treatment, I was participating in self-harm behavior or hurting myself intentionally (e.g. cutting)	1	2	3	4	5	6	7
11. During the period of my treatment, I was participating in risk taking behavior (e.g. excessive substance use, dangerous driving).	1	2	3	4	5	6	7
12. My therapist asked about the degree to which I felt connected to others.	1	2	3	4	5	6	7
13. My therapist asked about the degree to which I felt as though I was a burden to others.	1	2	3	4	5	6	7
14. My therapist asked about self-harm behavior or dangerous behavior (e.g. cutting, excessive substance use).	1	2	3	4	5	6	7
15. My therapist asked about past suicide attempts.	1	2	3	4	5	6	7

It is hard for me to be completely honest or open about my thoughts of suicide with my therapist because:	Strongly Disagree	Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Agree	Strongly Agree
16. It is something I feel ashamed or embarrassed about.	1	2	3	4	5	6	7
17. I do not feel my therapist can handle it.	1	2	3	4	5	6	7
18. I do not want my therapist to feel sad or worried.							
19. I do not feel my therapist was qualified to help this.	1	2	3	4	5	6	7
20. My therapist asked about it in a leading way. Ex: "You're not thinking about suicide are you?"	1	2	3	4	5	6	7

	Strongly Disagree	Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Agree	Strongly Agree
21. My therapist asked about it in an awkward way.	1	2	3	4	5	6	7
22. I do not especially want to work on this issue.	1	2	3	4	5	6	7
23. Talking about this topic or thinking about it makes me feel uncomfortable.	1	2	3	4	5	6	7
24. I generally have a hard time talking about my problems.	1	2	3	4	5	6	7
25. I do not want to be seen as crazy.	1	2	3	4	5	6	7
26. It is sinful or wrong to have these thoughts.	1	2	3	4	5	6	7
27. I am afraid that I will receive negative consequences or punishments if I do.	1	2	3	4	5	6	7
28. I am concerned the law enforcement authorities will be called.	1	2	3	4	5	6	7
29. I am worried I will be hospitalized or "locked up."	1	2	3	4	5	6	7
30. I am concerned that I may lose custody of my children.	1	2	3	4	5	6	7
31. I do not think I could be helped with this issue.	1	2	3	4	5	6	7
32. I do not want to be helped with this issue.	1	2	3	4	5	6	7

It is easier for me to be completely honest or open about my thoughts of suicide with my therapist because:							
	Strongly Disagree	Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Agree	Strongly Agree
33. It is something I do not feel ashamed or embarrassed about	1	2	3	4	5	6	7
34. My therapist asked about it in an open and sincere way.	1	2	3	4	5	6	7
35. My therapist asked about it in a direct way.	1	2	3	4	5	6	7
36. I believe that many people sometimes have these thoughts.	1	2	3	4	5	6	7
37. I want to work on this issue.	1	2	3	4	5	6	7
38. It is generally not difficult for me to talk about my problems.	1	2	3	4	5	6	7
39. I am comfortable that I will not experience negative consequences if I do talk about it.	1	2	3	4	5	6	7
40. My therapist discussed the limits of confidentiality with me and I felt comfortable with this understanding.	1	2	3	4	5	6	7
41. I feel that in talking about it, I can work on this problem and make meaningful change.	1	2	3	4	5	6	7
42. My therapist provides me with a questionnaire form, which makes it easier to share.	1	2	3	4	5	6	7
43. I feel that my therapist can handle this topic.	1	2	3	4	5	6	7
44. I am not concerned with my therapist's feelings.	1	2	3	4	5	6	7
45. I feel that my therapist was qualified to help me with this.	1	2	3	4	5	6	7
46. My therapist has told me that many people have had thoughts of suicide during their lifetime.	1	2	3	4	5	6	7

	Strongly Disagree	Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Agree	Strongly Agree
General Attitudes							
47. This topic is important for people in general to talk about during therapy.	1	2	3	4	5	6	7
48. This topic is important for me to talk about in therapy.	1	2	3	4	5	6	7
49. I wanted to be involved in my most recent therapy experience.	1	2	3	4	5	6	7
50. I wanted to work on or change my suicidal thoughts.	1	2	3	4	5	6	7
51. I feel satisfied with my most recent psychological treatment.	1	2	3	4	5	6	7
52. I feel that my therapist was qualified and able to help me.	1	2	3	4	5	6	7

Final Questions

53. In your entire life, how many times have you attempted suicide? _____

54. In your entire life, how many times have you been hospitalized after a suicide attempt or for having thoughts of suicide? _____

55. During your current therapy experience, how many times have you attempted suicide? _____

56. During your current therapy experience, how many times have you been hospitalized after a suicide attempt or for having thoughts of suicide? _____

