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Zane Hensel
Minnesota State University, Mankato

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The Effects of Therapist Expertise and Concerns of Involuntary Hospitalization on the
Disclosure of Suicidal Ideations and Behavior

By
Zane Hensel

A Thesis Submitted in Partial Fulfillment of the
Requirements for the Degree of
Master of Arts
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Clinical Psychology

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The Effects of Therapist Expertise and Concerns of Involuntary Hospitalization on the Disclosure of Suicidal Ideations and Behavior

Zane Hensel

This thesis has been examined and approved by the following members of the student's committee.

Dr. Eric Sprankle, Advisor

Dr. Kristie Campana, Committee Member

Dr. Jeffrey Buchanan, Committee Member

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Table of Contents

Abstract.....	iv
Introduction	1-12
College Students.....	2-3
Disclosure of Suicidality.....	3-8
Therapist Expertise.....	8-12
Aim of Study.....	12
Method.....	12-16
Participants.....	12-14
Materials.....	14-15
Procedure.....	15-16
Results.....	16-26
Discussion.....	26-33
Conclusion.....	33
References.....	34-37
Appendix A Disclosure of Involuntary Hospitalization Practices	38
Appendix B Therapist Vignettes.....	39-40
Appendix C Suicide Disclosure Survey.....	41

Abstract

Suicide continues to grow as a complex and multi-faceted problem in prevention and treatment, particularly for college students with an increased predictor of risk of suicidal behaviors.

Previous research has indicated that one of the largest concerns for suicide disclosure is a fear of involuntary hospitalization. Over 200 college students participated in examining therapist expertise and understanding information on involuntary hospitalization on their rate of suicide disclosure. A 2x2 MANOVA, a 2x2x2 MANOVA that included gender, and a factor analysis were performed on an ad-hoc 11-question survey assessing suicidal ideation and suicidal behavior disclosure. The results indicated that there was an interaction effect between therapist expertise and information on involuntary hospitalization, such that standard therapists discussing in-depth involuntary hospitalization information had increased rates of suicide disclosure compared to standard therapists using standard disclosure and confidentiality protocols. Increased rates of suicide disclosure were also seen with expert therapists using standard disclosure and confidentiality protocols compared to expert therapists discussing in-depth involuntary hospitalization information. Furthermore, women were more likely than men to disclose on questions of suicidality. These findings imply a potential shift in how therapists approach discussing suicidality with clients.

The Effects of Therapist Expertise and Concerns of Involuntary Hospitalization on the Disclosure of Suicidal Ideations and Behavior

Suicide is a complex and multi-faceted problem that exists in every society across the world. The act of suicide permeates through various cultures with varying prevalence rates, as well as through several age groups, from children to the elderly (Kokkevi et al., 2012). In the United States (US), suicide is the 10th leading cause of death for the population at large (Center for Disease Control, 2017). This can be particularly impactful during life transitions and development cycles, such as the transition from adolescence to adulthood or adults transitioning into their first stages of life. When examining this population more closely, suicide accounts for the second leading cause of death for individuals aged 15-24 (Center for Disease Control, 2017).

While more attention and scrutiny has begun to focus on the issues of suicide, such as education, prevention, and treatment, the efforts have not materialized with reducing suicide rates (Hedegaard et al., 2018). In contrast, suicide rates have seen a steady rate of incline (Hedegaard et al., 2018). From 2000 to 2016 in the US, the age-adjusted suicide rate has seen a 30% increase from 10.4% to 13.5% per 100,000 individuals with an increase on average about 1% per year from 2000 to 2006, and roughly 2% on average from 2006 to 2016 (Hedegaard et al., 2018). What this indicates is that the crisis of suicide is accelerating, with suicide rates increasing at a faster rate in comparison to just the previous decade (Hedegaard et al., 2018). The concern for the accelerating rate for suicide attempts, as well as for implementing or crafting a potential treatment intervention, is complicated by the age of the individual, rates of disclosure and non-disclosure, as well as understanding the parameters and reasons why an individual may or may not disclose their suicidality and to whom. These factors are exacerbated particularly so

in college students, and therefore, require a more in-depth examination focusing on suicidality and the unique risk factors at play.

College Students

College students serve a unique risk when dealing with suicidality. Students are at a time of several stressors, such as entering adulthood if they are a traditional student, the possibility of moving away from home and loss of support networks, demands of collegiate workloads as well as job responsibilities to stay financially afloat (Mortier et al., 2017). These stressors can create environmental conditions that can potentially increase the potential risk regarding suicidal ideations and behaviors (Mortier et al., 2017).

When examining suicidal ideation, students across 72 US universities and campuses had a rate of suicidal ideation at 3.3% to 13.4% (Ketchen et al., 2015). More broadly, Mortier et al. (2017) found suicidal ideation that ranged from broad ideation to seriously considering suicide to have yearly prevalence estimates between 5-35% for college students. This is alarming considering that the rate seen here for college students exceeded the general rate of suicidal ideation for the general population, which hovers around 3.9% (Center for Disease Control, 2015).

For suicidal behaviors, college students were found to have yearly prevalence of suicide attempts to range from 0.6-11% (Mortier et al., 2017). This large range shows not only the volatility of suicidality, but also the upper bounds of the suicide attempt range are high for a given population. Given the concern for suicidal ideations and behaviors among college students, various college and university institutions have tried to implement primary prevention interventions for suicidality; however, not only are high-risk students undiagnosed and ultimately untreated, but a meta-analysis revealed that the primary prevention interventions were shown to

be either ineffective or have limited evidence demonstrating their effectiveness on suicidal behavior (Harrod et al., 2014).

College students are becoming an increasing group of people at risk for suicidal ideations and behaviors (Mortier et al., 2017). Furthermore, for students entering college, the first onset of suicidal thoughts and behaviors within the first year of college is 4.8-6.4% (Mortier et al., 2017). With students who do have their first onset of suicidal ideations and behaviors in college, 50.7-65.7% of these individuals had suicidal thoughts and behaviors that were concentrated within the top 10% of the highest predicted risk within a model created by Mortier et al. (2017).

Accordingly, the risk factors that were shown to be predictors for the first-onset of suicidal thoughts and behaviors across bivariate and multivariate models included trauma prior to age 17, dating violence prior to age 17, betrayal (whether it from a partner cheating or close friend/family), or being at risk for a mental disorder (Mortier et al., 2017). With such a high-risk population and the volatility in the development and severity of suicidality, more attention needs to be given to understanding how to assess and ultimately treat this population. The first step to assessing and treating suicidality in college students lies in the ability for a student to feel comfortable in disclosing their suicidality to an individual with authority.

Rates of Disclosure

Suicidal ideations and behaviors can be private events or they can be disclosed to another person. These private events can include ideations that are not disclosed or through behaviors done in secret. Disclosure can take the form of divulging suicidal ideations to another person, performing a suicidal gesture, or even a suicide attempt in front of another person. The mode of communication for disclosing suicidality is also varied. For instance, disclosing suicidality can happen in person, through a delayed messaging system such as through a suicide note or a social

media post, or through a live communication that is not done in person, such as through a telephone call or video call. Suicide disclosure can also be impacted by whom it is being disclosed to (Hom et al., 2017; Husky et al., 2016).

Within the context of the greater population and without considering issues of style of disclosure or to whom an individual discloses, Merelle et al. (2018) performed a cross-sectional study in the Netherlands and found that 48% of individuals who had suicidal ideations did not disclose them to anyone. These results are similar to a cross-sectional study from France that showed that 48.7% of individuals with suicidal ideation did not report their ideation to anyone (Husky et al., 2016). Thus, as a template, almost half of individuals with suicidal ideations do not disclose to anyone, which is problematic from a clinical perspective. However, when examining Austrian and Turkish university students, these students reported a history of suicidal thoughts at 29.9% and 45.9% respectively, while those same Austrian and Turkish university students reported a disclosure rate of suicidal thoughts at 33.8% and 40.0% respectively (Eskin et al., 2015). While this can begin to generate discussion on the difference in age and potential concerns a younger individual may have with disclosing suicidal thoughts and behaviors, this nonetheless demonstrates that suicide disclosure as a whole is comparatively low with regards to the total occurrence of suicidal thoughts and behaviors. In particular, as Eskin et al. (2015) showed, university students can experience a high rate of suicidal thoughts but ultimately have low rates of disclosure, thus limiting potential relief and treatment from the distress these thoughts may create, whether the disclosure occurs to close friends and associates or to therapists.

When examining to whom individuals disclosed their suicidal ideations and behaviors, discrepancies emerged. While less than half of individuals with suicidal ideation did not report

their ideation to anyone, those that did share their ideation disclosed only to their family or friends 38.4% of the time, to just a health professional 12.2% of the time, and to both family and friends along with a health professional 20.5% of the time (Husky et al., 2016). This leads credence to the idea that family and friends are viewed as a safer place to confide in and disclose their suicidal actions in comparison to health professionals.

This has several complications for individuals in the health and mental health professions, such that the need to understand the barriers to disclosure here is paramount in the first step to addressing suicidal ideations and behaviors. For instance, in a meta-analysis of 36 studies assessing over 14,000 suicides, suicide disclosure was found to occur in roughly half of individuals who die by suicide (Pompili et al., 2016). To extrapolate further, while half of these individuals who did not disclose died by suicide, the other half of individuals did disclose their suicidal intentions to someone. Thus, while the disclosure rate is only at roughly half, what can be shown with reference to Husky et al. (2016), with disclosure being more far more prominent to family and friends in comparison to health professionals, is that when disclosure occurs it happens at a much lower rate to health professionals.

Therapists, however, face more issues than having individuals not disclosing their suicidal ideation and that is having a client speak truthfully about what they are facing. For instance, 31% of individuals who had thoughts of suicide lied to their therapist about having them while 39% percent of individuals lied about the severity of their symptoms, as in they minimized the severity of their suicidality to their therapist (Blanchard & Farber, 2016). Here, even when clients or patients are willing to disclose, they may minimize the severity of their symptomology, thereby trying to reduce the risk in the eyes of the therapist. This, however, leads

to the question of what barriers exist in preventing individuals in disclosing their suicidality to their therapists.

Reasons for Non-Disclosure

The reasons to disclose suicidality to another party is multi-faceted, often predicating on the expectations of the individual and to whom they are disclosing their suicidality (Hom et al., 2017). Disclosing suicidality to another can be beneficial, risky, or neutral in tone. For instance, disclosing suicidality can be beneficial for expanding social support, combating stigma, ending the secrecy, strengthening coping skills, and gaining personal safety (Sheehan et al., 2019). However, while the beneficial side of disclosure can be promoted as a means to increase the rate of disclosure in pertaining to suicide, it is often the risks and perceived negative consequences of disclosing suicidal ideation and behaviors that needs to be addressed.

The various reasons to not disclose one's suicidality will be predicated on an individual's environment and circumstances (Sheehan et al., 2019). Some of the reasons to not disclose suicidality to another party includes stigma, overreactions from the told individual (such as persistent check-ups or immediate removal of any perceived dangerous objects), a sense of being a burden, and being emotionally difficult to process or to disclose to another (Sheehan et al., 2019). Within the purview of stigma, another reason that exists is the belief that the suicidal behaviors or ideations would be perceived as attention-seeking, which limits disclosure (Maple et al., 2019). While there are a variety of other categories of reasons on why individuals do not disclose their suicidality, there is however one reason that stands out in comparison – fear of involuntary hospitalization.

The concern or fear of involuntary hospitalization stems from the idea that disclosing any suicidal ideation or behavior will, in turn, have the individual committed against their will to a

hospital or psychiatric facility, whether that be by a therapist or law enforcement. The fear of involuntary hospitalization is often ranked as either the quintessential reason why individuals do not disclose their suicidality or one of the top, particularly to therapists. Ganzini et al. (2013) performed semi-structured interviews with veterans and found that a fear of involuntary hospitalization was a barrier to suicidal disclosure. Furthermore, 52% of participants reported concerns of involuntary hospitalization as a reason for concealment of their suicidality, which was the highest rated item for a reason for concealment (Blanchard & Farber, 2018). This relates to early adulthood as well, such that in college students who had a history of suicidal ideation, one of the top reasons for inaccurately disclosing or not disclosing this information to various individuals was due to fear of hospitalization (Hom et al., 2017). This rate of minimizing symptoms to various individuals, such that they would either deny their suicidality or minimize its intensity, was the highest for medical doctors at 73.3%, psychiatrists at 61.1%, and psychologists/therapists/counselors at 66.7% (Hom et al., 2017). To note, the top reason for psychologists/therapists/counselors at 71.4% was a sense of embarrassment; however, as mentioned fear of hospitalization as close behind at 66.7% (Hom et al., 2017). When looking at family or friends, fear of hospitalization dropped to roughly 35%, with the largest categories being that it might worry the individual (family or friend) or a sense of embarrassment (Hom et al., 2017).

This disparity in disclosure rates and reasons for non-disclosure between therapists and family/friends showcases a reality where individuals with suicidal ideations and behaviors have different thought processes and rationale when or if they disclose their suicidality. In particular, while family and/or friends may be able to give a warm and considerate environment that an individual may feel comfortable to share in, a therapist creates a different perception, such that

perception stems from a therapist's power. While a therapist could create a warm and inviting environment that would facilitate and nurture the therapeutic alliance and help foster the trust necessary for an individual to wish to disclose their suicidality, the reality is that a power dynamic exists, such that the therapist does have the legal authority to impose involuntary hospitalization against the client's will. Thus, a potential remedy for therapists may include examining if the level of expertise a therapist has may affect the therapeutic relationship and by extension, disclosure.

Therapist Expertise

Therapist expertise can be viewed as “the manifestation of the highest levels of ability, skill, professional competence, and effectiveness” (Hill et al., 2017, pg. 9). Therapist expertise as research has focused more on client outcomes being correlated with therapist expertise, with not as much focus being on what clients are seeking in a therapist. Nonetheless, an examination of therapist expertise, in relation to the therapeutic alliance and disclosure are in order.

Research examining therapist expertise has been difficult, due to the disagreements and uncertainty with how to define and ultimately assess a therapist's level of expertise (Locati et al., 2019). One way to examine therapist expertise could be viewed through performance expertise, specifically breaking down the category into relational and technical expertise (Locati et al., 2019). Relational expertise is based on the therapist's relation with a client, such as being able to provide an empathetic and caring environment with positive regard as from a Rogerian standpoint (Locati et al., 2019). While alone this may not be enough to produce therapeutic change, it is still a vital component and related to a client's outcome (Locati et al., 2019). Technical expertise refers to the appropriate and skillful application of specific and necessary interventions and techniques during the course of therapy, within the parameters of having

established a strong, therapeutic alliance (Locati et al. ,2019). From this, there could be considered a relation between a relational expertise and a technical expertise, or rather, a consideration of the therapeutic relationship with their client and their technical ability to implement specific interventions.

When considering therapist expertise through more the lens of technical expertise, Gulliksen and company (2012) examined patients with Anorexia Nervosa and found that therapist expertise was one of the top-rated factors with regards to client satisfaction of treatment. Also, therapist expertise reduced shame about themselves as individuals with Anorexia Nervosa and their symptoms (Gulliksen et al., 2012). Within the context of an eating disorder, therapist expertise here was found to improve client satisfaction about the treatment as well as a reduction in a negative symptom (shame); thus, while this is still primarily outcome focused, it showcases how therapist expertise can improve client satisfaction about an upcoming treatment and can be viewed as an in-session dynamic. When examining the traditional patient outcome markers however, a systematic review of various therapist characteristics (in this case expertise) found the results for therapist expertise to be weak regarding patient outcomes, though one study had shown some positive effect for patient satisfaction (Sanchez-Bahillo et al., 2014). Therefore, within the context of just therapist expertise as viewed through technical expertise, there is the potential to improve client satisfaction throughout the therapeutic process with limited scope in client outcomes. From this, technical expertise can be examined in conjunction with relational expertise, or more commonly viewed as therapist expertise in relation to the therapeutic alliance.

The therapeutic alliance, also known as the working alliance, can be construed as the relationship and trust developed between the therapist and client, including establishing the goals

of therapy, the client's commitment, and an agreement on the overall strategies of therapy (Patterson et al., 2008). Therapist expertise can be examined in relation to the therapeutic alliance as a whole; however, the aspect of a therapist's training and overall experience has shown mixed results with regards to its relation to the therapeutic alliance (Locati et al., 2019). Overall, results have shown either no relation between therapist expertise and the strength of the therapeutic alliance to only partial support for the alliance (Locati et al., 2019). Nonetheless, the therapeutic alliance is a multi-faceted component of the overall therapeutic process, which includes the implementation of technical interventions and techniques, which falls more under the purview of technical expertise. What needs to be established is the relation of the therapeutic alliance to disclosure.

Hall and Farber (2001) found that the length of therapy and the therapeutic alliance were the most important with regards to rate of disclosure; however, this study found the least discussed topic to be sexual in nature (pornography interests, sexual interests, masturbatory habits, etc.) without a notion of suicidality. While an existentialism category existed, such as a fear of growing older and a fear of death or dying, those are tangentially related to the core of suicidality. Even so, topics revolving something sexual in nature have often been difficult for clients to disclose to therapists, including even lying to their therapist about their sexual history or fantasies (Blanchard & Farber, 2016). From this, a relation between therapeutic alliance and disclosure with regards to sensitive topics could be construed.

Overall, a working conceptualization here could examine the complete relation with therapist expertise, the therapeutic alliance, disclosure, and sensitive topics. For instance, Lovgren et al. (2019) interviewed adolescents with depression and asked them about their experiences in therapy and what was helpful or not during therapy. What was found was that one

of the beneficial factors was having a trustworthy and experience therapist, such that it aided in therapeutic improvement and the therapeutic process, and overall was found to support the therapeutic relationship between the adolescent and their therapist (Lovgren et al., 2019). Since an experienced therapist was found beneficial in therapeutic improvement and the process, along with supporting the therapeutic relationship, this could, in turn, help improve disclosure rates surrounding sensitive topics, as in suicidal ideations and behaviors. This conceptualization can serve as a template for understanding the role that therapist expertise might have on disclosure.

Theoretical Literature

From a theoretical standpoint, there is some literature and credence that exists that supports the notion of therapist expertise shaping the course of a therapy session, such as the social power theory. The framework for social power theory resides in the ability for the therapist to influence outcomes within the therapy office, and as such, that therapist's abilities are determined by their sense of credibility and attraction (Hollander-Goldfein et al., 1989). The sense of credibility stems from a client's knowledge about a therapist's field or discipline and their credentials (Hollander-Goldfein et al., 1989). Furthermore, the sense of credibility can be shaped by the client's perception of their therapist, as in if the therapist is relaxed, seemingly interested in them, confident, responsive, and organized (Hollander-Goldfein et al., 1989). What can be shown here then is a combination between previous knowledge of a therapist, such as a client's knowledge about their therapist and understanding their credentials, as well as in-session therapy dynamics. While the in-session therapy dynamics is variable, as in it will change from therapist to therapist and the therapist's ability to create a therapeutic alliance with their client, the perception of expertise stemming from their field and credentials has a role in shaping therapy outcomes.

Another potential theoretical orientation to ascribe to would be following opinion-change research. Opinion-change research follows the idea that a therapist would try to influence the client, such that it would allow an easier attainment of the goals of therapy (Strong, 1968). The theoretical orientation of opinion-change research flows from cognitive dissonance theory, such that the idea is that there is a disconnect between a therapist's opinions and conceptions and a client's opinions and conceptions, and as such can create dissonance within the client (Strong, 1968). In essence, one of the avenues for opinion-change and dealing with the potential dissonance is that the perceived expertise given to a therapist can shape how a therapist's discrepant communications can be interpreted and will lead more to opinion change rather than disparagement of the therapist (Strong, 1968). Within a suicide framework, the perception of expertise could help alleviate the idea of dissonance that a client might have and therefore may increase the odds that a client may be willing to disclose.

Aims of the Study

This study will examine the effects that therapist expertise and information regarding involuntary hospitalization has on the rates of suicide disclosure in college students. The issue of involuntary hospitalization and the concern for disclosure has been addressed as a potential area for future research that needs to be conducted (Blanchard & Farber, 2018). The hypothesis is that an expert therapist and having additional information on involuntary hospitalization will increase the rate of suicide disclosure.

Methods

Participants

Participants included 248 college students from the Minnesota State University, Mankato who initiated the online survey, and 210 individuals completed enough of the survey to be

included in the analysis. Participants were removed from consideration if they did not answer if they were at least 18 years old ($n = 9$), did not consent to the premise of the survey and exited out ($n = 3$), or did not correctly answer the two-question manipulation check ($n = 26$). Of the 210 participants, the majority of participants were straight ($n = 196$, 93.3%), white ($n = 163$, 77.6%), and women ($n = 160$; 76.2%). The age of the participants ranged from 18 to 44 ($M = 20.89$, $SD = 3.65$). A full description of the participants' demographics is listed in Table 1.

Table 1

Participant Demographics

Characteristics	<i>n</i>	%
Race		
Other/Bi-Racial/Multi-Racial	7	3.3
Asian	13	6.2
Latino/Hispanic	13	6.2
Black	14	6.7
White	163	77.6
Gender**		
Men	49	23.4
Women	160	76.2
Sexual Orientation		
Other*	2	1.0
Bisexual	6	2.9
Gay	6	2.9
Straight	196	93.3
Year		
Other	1	0.5
Grad Student	5	2.4
Sophomore	22	10.5
Junior	48	22.9
Senior	64	30.5
Freshman	70	33.3
Have Received Psychological Services		
Yes	104	49.8

No	105	50.2
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* Includes demisexual, pansexual, asexual, and other orientations

**Gender was asked and only cis-gendered people responded

****n* may not sum to 210 due to participants leaving fields blank

Materials

Disclosure of Involuntary Hospitalization Practices

Two different forms of disclosing information were used in this study. The first form was a standard release form that described the reasons that a therapist might break confidentiality, such as concerns of suicide and homicide, abuse or neglect of certain populations, and responding to a court order. The second form gave in detail more about the specific parameters that an individual may be involuntarily hospitalized regarding concerns of suicide. The two disclosure forms can be found in Appendix A.

Therapist Vignettes

Two therapist vignettes were created for this study. Both vignettes followed a hypothetical psychologist named Dr. Alex Jensen; this name was used to decrease potential gender and racial biases. The first vignette is a half-page form that describes Dr. Jensen's work history, number of years of practice and number of clients seen, and Dr. Jensen's abilities, such as being able to see a wide range of client issues such as grief, trauma, major depressive disorder, and more. The second vignette added on top of the first vignette a description of Dr. Jensen's specialization with working with individuals with varying suicidality, as well as giving workshops and conference seminars on suicidality. The two vignettes can be found in Appendix B.

Ad-hoc Suicide Disclosure Survey

An 11-question survey was created for this study, with some items adapted from questions in Firestone (2011) and Beck et al. (1979). This survey addressed an individual's

willingness to disclose information on suicidal thoughts, intents, behaviors, and severity.

Following reading the vignette on the therapist (Dr. Alex Jensen), participants would rate their likelihood of disclosing any of the questions to Dr. Alex Jensen on a 1 (*very unlikely*) to 4 (*very likely*) scale. The Self-Disclosure Scale was developed to examine adolescent's willingness to self-disclose in areas of friendship, family, and body image (Shulman, 1993). The Self-Disclosure Scale was modified by Horesh et al. (2004) to include items on depression and thoughts of death. However, due to the items asked on the Self-Disclosure Scale and the modified version of the Self-Disclosure Scale being either unrelated and unnecessary, such as disclosure to friends, family, and body image, or tangentially related, such as markers based on depression or merely thoughts of death itself, a new survey had to be created for the purposes of this study. While following a similar pattern of disclosure, such as from a 4-point scale of disclosure, the content material needed to be changed to suit the purpose of the study. Sample questions for this survey include, "Attempted suicide," and, "Thoughts of a plan to commit suicide (when, how, where)." The full survey can be located in Appendix C.

Procedure

Participants were recruited from psychology courses from a medium-sized Midwestern university. These participants were given an online Qualtrics link to begin the survey. The survey started with an informed consent form that described the purpose and details of the survey, specifically discussing the study assessing an individual's willingness to disclose suicidality to a therapist based on a therapist's level of expertise and having information regarding involuntary hospitalization. The participants would be removed from the survey if they indicated they were less than 18 years old.

The participants were randomly assigned to the two sets of conditions: therapist expertise level and information regarding involuntary hospitalization. The therapist expertise factor had two levels: the first level described a typical practicing clinician while the second level described a clinician that had experience working with individuals suffering from suicidal thoughts and behaviors. The involuntary hospitalization factor had two levels as well: the first level being a standard disclosure form that described why a clinician may break confidentiality (suicide, homicide, abuse, court order), while the second level described the parameters of involuntary hospitalization in detail, including when and how a person may be involuntarily hospitalized and that merely describing suicidal thoughts and behaviors does not automatically start the process of involuntary hospitalization. Therefore, the participants were randomly assigned to four groups from the two described factors. Once the participants read their respective vignettes and information on disclosure, all participants answered the 11-question Suicide Disclosure Survey.

Results

2x2 MANOVA & ANOVA

A 2x2 MANOVA was performed on therapist expertise and involuntary hospitalization using the 11 items from the Suicide Disclosure Survey. A series of Pearson's correlations were performed on the dependent variables to examine multicollinearity. Those results are in Table 2 and were shown to exhibit no multicollinearity. One item from the Suicide Disclosure Survey was removed from the MANOVA analysis due to being insufficiently correlated with the other items. This item was the "Would you truthfully report the severity or intensity of any of your ideations or behavior?" question. The analysis showed that the interaction of therapist expertise and involuntary hospitalization was significant for disclosure rates, $F(1, 203) = 2.13, p = 0.024$, Wilk's Lambda = 0.90, $\eta^2 = 0.10$. Next, a series of 2x2 ANOVAs was performed using therapist

expertise and involuntary hospitalization to ascertain where the significant difference existed between the dependent variables. An analysis of variance showed that the interaction of therapist expertise and involuntary hospitalization was significant for the item “Thoughts of being a burden”, $F(1, 200) = 4.52, p = 0.03, \eta^2 = 0.02$. These results are presented in Figure 1. An analysis of variance showed that the interaction of therapist expertise and involuntary hospitalization was significant for thoughts and feelings of a passive suicidal desire, $F(1, 200) = 4.25, p = 0.04, \eta^2 = 0.02$. These results are presented in Figure 2.

Table 2

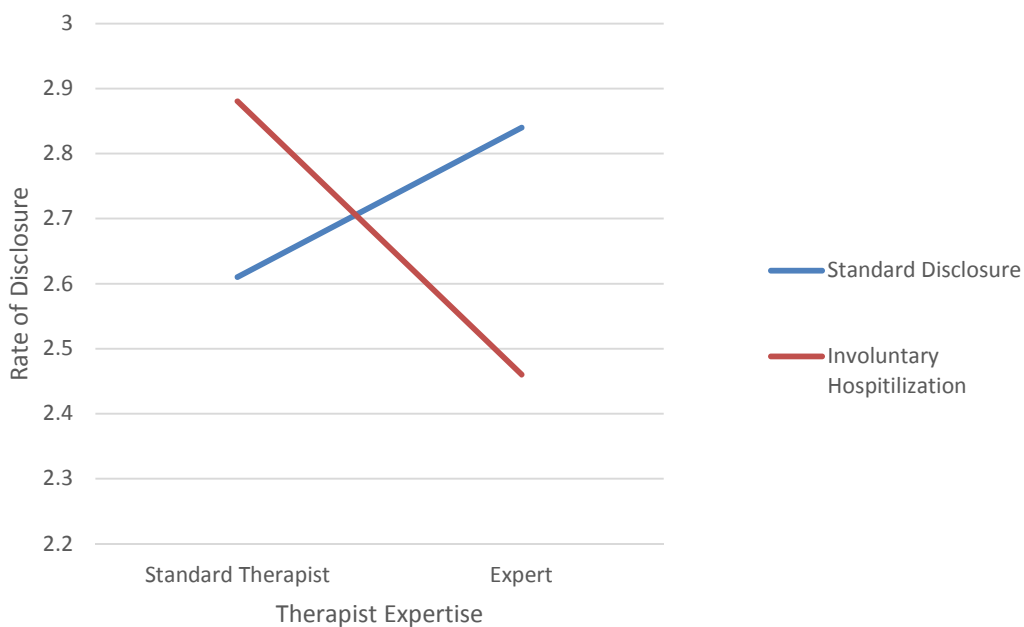
Pearson's Correlations

	Sig.										
	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.
1. TBB	1										
2. TAS	0.68**	1									
3. FOH	0.72**	0.57**	1								
4. TPSD	0.68**	0.66**	0.63**	1							
5. AS	0.65**	0.72**	0.51**	0.61**	1						
6. CSS	0.58**	0.69**	0.51**	0.63**	0.73**	1					
7. PS	0.51**	0.69**	0.31**	0.54**	0.65**	0.62**	1				
8. NT	0.48**	0.67**	0.36**	0.52**	0.70**	0.63**	0.71**	1			
9. SDB	0.66**	0.58**	0.67**	0.66**	0.53**	0.54**	0.47**	0.48**	1		
10. FSH	0.74**	0.72**	0.73**	0.72**	0.62**	0.64**	0.54**	0.52**	0.68**	1	
11. TRS	0.23**	0.23**	0.15*	0.18**	0.22**	0.19**	0.25**	0.22**	0.19**	0.23**	1

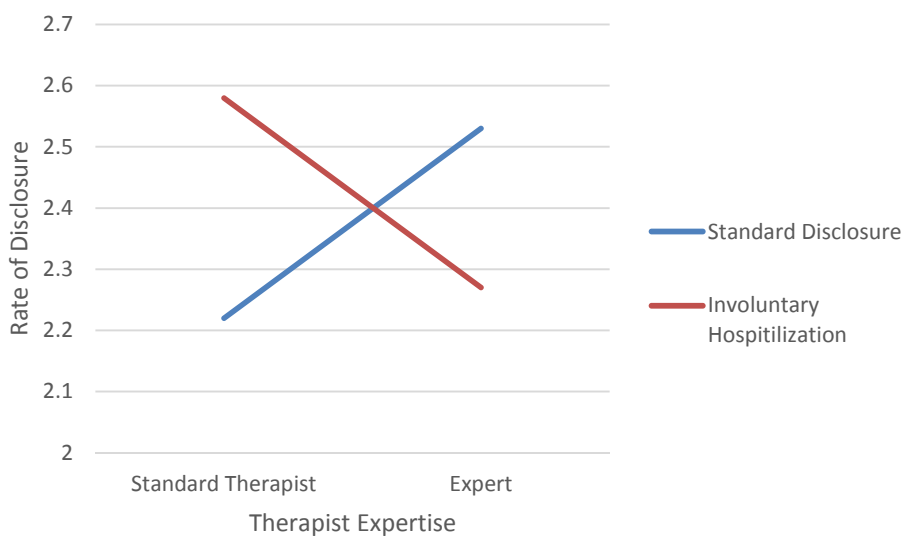
* $p < 0.05$, 2-tailed; ** $p < 0.01$, 2-tailed; TBB, Thoughts of being a burden; TAS, Thoughts of attempting suicide; FOH, Feelings of hopelessness; TPSD, Thoughts of passive suicidal desire; AS, Attempted suicide; CSS, About to commit suicide but stopped; PS, Thoughts of a plan to commit suicide; NT, Acquired necessary tools for suicide, SDB, Engaging in self-destructive behavior, FSH, Extreme feelings of self-hatred, TRS, Would you truthfully report the severity of your symptoms.

Figure 1

Expertise and Involuntary Hospitalization on Thoughts of Being a Burden

**Figure 2**

Expertise and Involuntary Hospitalization on Passive Suicidal Desire



As shown in Figure 1, there is an interaction for therapist expertise and involuntary hospitalization for the item “Thoughts of being a burden”, such that a standard therapist

discussing in-depth involuntary hospitalization has higher rates of disclosure in comparison to an expert therapist discussing in-depth involuntary hospitalization. Furthermore, this holds true for an expert therapist using a typical release form (such as reasons for breaches in confidentiality) in that this yields higher rate of suicidal disclosure in comparison to an expert talking in-depth about involuntary hospitalization. Similar to Figure 1, Figure 2 showcases a similar interaction for therapist expertise and involuntary hospitalization for thoughts and feelings of passive suicidal desire.

A 2x2 ANOVA was performed using therapist expertise and involuntary hospitalization on the item removed from the MANOVA; the item pertaining to truthfully reporting severity of symptoms. An analysis of variance showed that therapist expertise was significant for the item pertaining to truthfully reporting the severity of their symptom, $F(1, 203) = 4.24, p = 0.04, \eta^2 = 0.02$, thus indicating that individuals are more willing to truthfully report the severity of their symptoms to an expert therapist ($M = 2.75, SD = 0.99$) compared to a standard therapist ($M = 2.48, SD = 0.89$).

Factor Analysis

A principal component analysis was performed on the 11-item Suicide Disclosure Survey with orthogonal rotation. With an eigenvalue greater than 1, the results indicated that there were two factors that best fit the data, accounting for 70.13% of the variance. The results of this principal component analysis are presented in Table 3. With a load score of at least 0.60, 10 of the 11 items from the Suicide Disclosure Survey loaded onto two factors.

Table 3

Principle Component Analysis of Suicide Disclosure Survey

Items	Factors	
	1	2

1. TBB	0.81	0.33
2. TAS	0.59	0.65
3. FOH	0.90	0.08
4. TPSD	0.75	0.39
5. AS	0.49	0.71
6. CSS	0.52	0.65
7. PS	0.28	0.83
8. NT	0.28	0.83
9. SDB	0.79	0.26
10. FSH	0.81	0.37
11. TRS	0.04	0.42

TBB, Thoughts of being a burden; TAS, Thoughts of attempting suicide; FOH, Feelings of hopelessness; TPSD, Thoughts of passive suicidal desire; AS, Attempted suicide; CSS, About to commit suicide but stopped; PS; Thoughts of a plan to commit suicide; NT, Acquired necessary tools for suicide, SDB, Engaging in self-destructive behavior, FSH, Extreme feelings of self-hatred, TRS, Would you truthfully report the severity of your symptoms.

Factor 1 contains items pertaining to thoughts and feelings of depressive considerations, passive suicidal desire, and even self-destructive behaviors that aren't specifically suicide as a direct outcome. Therefore, Factor 1 will be referred to as the "Depression" subscale. Factor 2 contains items that pertain to thoughts and behaviors specifically revolving around suicide itself, such as attempting suicide, acquiring items to commit suicide, thoughts of attempting suicide, planning behaviors, and stopping an attempt midway through. Therefore, Factor 2 will be referred to as the "Suicide" subscale. The final item on the Suicide Disclosure Survey that examines truthfully reporting the severity of symptoms did not load on any of the two factors. The Depression subscale had a Cronbach Alpha of 0.92, and the Suicide subscale had a Cronbach Alpha of 0.91.

2x2 ANOVAs with Subscales

A set of 2x2 ANOVAs were performed examining therapist expertise and involuntary hospitalization on the Depression subscale and the Suicide subscale. The 2x2 ANOVA for the Depression subscale and its results are presented in Table 4. The 2x2 ANOVA for the Suicide subscale and its results are presented in Table 5.

Table 4

2x2 ANOVA of Therapist Expertise and Involuntary Hospitalization on Depression

	Sum of Squares	df	Mean Square	F	Sig.
Expertise	0.06	1	0.06	0.07	0.79
IH	0.24	1	0.24	0.28	0.60
Expertise * IH	0.07	1	0.07	0.08	0.77
Total	175.16	207	1.23		

IH = Involuntary Hospitalization

Table 5

2x2 ANOVA of Therapist Expertise and Involuntary Hospitalization on Suicide

	Sum of Squares	df	Mean Square	F	Sig.
Expertise	0.01	1	0.01	0.01	0.93
IH	0.00	1	0.00	0.00	0.97
Expertise * IH	2.19	1	2.19	2.51	0.12
Total	180.45	207	3.07		

IH = Involuntary Hospitalization

2x2x2 MANOVA and ANOVA

A set of exploratory analyses were performed incorporating gender that was not included in the main MANOVA and ANOVA analysis. This was done due to the sample size discrepancy, such that women were over 76% of the sample. A 2x2x2 MANOVA was performed on therapist expertise, involuntary hospitalization, and gender using the 11 items from the Suicide Disclosure Survey. Gender is comprised of two levels: males and females. A series of Pearson's correlations were performed on the dependent variables to examine multicollinearity. Those results are in Table 2 and were shown to exhibit no multicollinearity. One item from the Suicide Disclosure Survey was removed from the MANOVA analysis due to being insufficiently correlated with the other items. This item was the "Would you truthfully report the severity or intensity of any of your ideations or behavior?" question. The results for the 2x2x2 MANOVA are presented in Table 6.

Table 6

2x2x2 MANOVA of Therapist Expertise, IH, and Gender

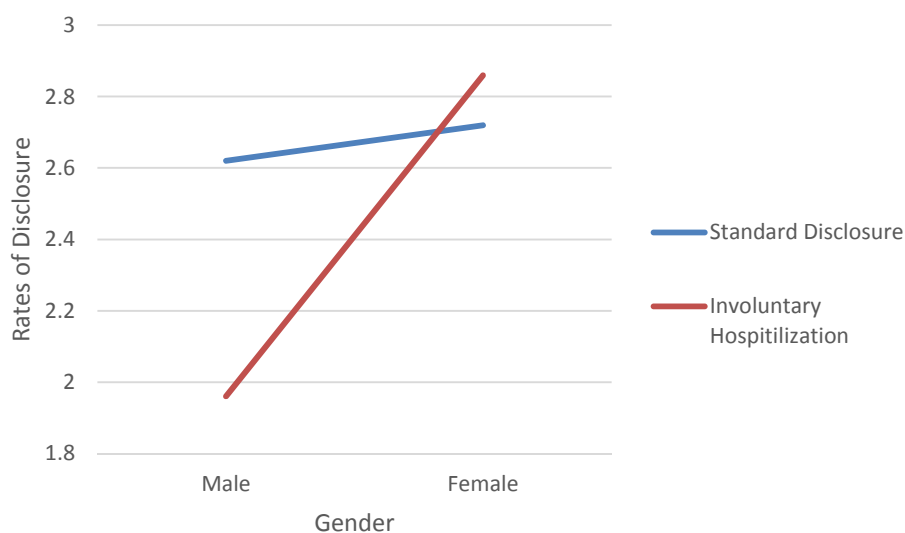
	df	Wilks	F	Sig.	η^2
Gender	2	0.82	1.92	0.01*	0.09
Expertise	1	0.96	0.80	0.63	0.04
IH	1	0.93	1.38	0.19	0.07
Gender * Expertise	1	0.95	1.02	0.42	0.05
Gender * IH	1	0.90	1.98	0.04*	0.10
Expertise * IH	1	0.90	1.97	0.04*	0.10
Gender * Expertise * IH	1	0.96	0.84	0.59	0.04

* $p < 0.05$; IH = Involuntary Hospitalization

Next, a series of 2x2x2 ANOVA's were performed using therapist expertise, involuntary hospitalization, and gender to ascertain where the significant difference existed between the dependent variables. An analysis of variance indicated that gender was a significant factor in the rates of disclosure for the "Thoughts of being a burden" item, $F(2, 203) = 4.62, p = 0.01, \eta^2 = 0.04$, thus showing that women ($M = 2.79, SD = 1.04$) are more likely to disclose the thought of being a burden compared to men ($M = 2.31, SD = 1.19$). An analysis of variance showed an interaction between gender and involuntary hospitalization for the "Thoughts of being a burden" item, $F(1, 203) = 4.98, p = 0.03, \eta^2 = 0.03$. Those results are presented in Figure 3. As shown in Figure 3, there is an interaction for gender and involuntary hospitalization for the item "Thoughts of being a burden", such that while the standard disclosure information does not relatively change the difference between men and women disclosure rates, having information on involuntary hospitalization has women have higher rates of suicidality disclosure whereas for men having information on involuntary disclosure reduces disclosure rates.

Figure 3

Gender and Involuntary Hospitalization on Thoughts of Being a Burden



An analysis of variance indicated that gender was a significant factor in the rates of disclosure for the “Feelings of hopelessness” item, $F(2, 203) = 5.33, p < 0.01, \eta^2 = 0.05$, thus showing that women ($M = 3.11, SD = 1.02$) are more likely to disclose feelings of hopelessness compared to men ($M = 2.54, SD = 1.20$). An analysis of variance indicated that gender was a significant factor in rates of disclosure for the “Thoughts of passive suicidal desire” item, $F(2, 203) = 3.14, p = 0.04, \eta^2 = 0.03$, thus showing that women ($M = 2.49, SD = 1.05$) are more likely to disclose passive suicidality compared to men ($M = 2.08, SD = 1.13$).

An analysis of variance showed that gender was a significant factor in the rates of disclosure for the “Attempted suicide” item, $F(2, 203) = 6.97, p < 0.01, \eta^2 = 0.05$, thus showing that women ($M = 2.37, SD = 1.15$) are more likely to disclose attempted suicide compared to men ($M = 1.76, SD = 1.01$). An analysis of variance indicated that gender was a significant factor in the rates of disclosure for the “About to commit suicide but stopped” item, $F(2, 203) = 3.79, p = 0.02, \eta^2 = 0.03$, thus showing that women ($M = 2.49, SD = 1.11$) are more likely to disclose stopped suicide attempts compared to men ($M = 2.04, SD = 1.10$). Furthermore, an analysis of variance showed that gender was a significant factor in the rates of disclosure for the “Extreme feelings of self-hatred” item, $F(2, 203) = 5.05, p < 0.01, \eta^2 = 0.03$, thus showing that women ($M = 2.72, SD = 1.04$) are more likely to disclose feelings of self-hatred compared to men ($M = 2.24, SD = 1.20$). Finally, a 2x2x2 ANOVA was performed on the removed item from the MANOVA, the item dealing with reporting the truth of the severity of symptoms. Those results are reported in Table 7.

Table 7

2x2x2 ANOVA of Therapist Expertise, IH, and Gender on Reporting Severity

	Sum of Squares	df	Mean Square	F	Sig.
Gender	1.32	1	1.32	1.47	0.23
Expertise	3.46	1	3.46	3.85	0.05
IH	0.32	1	0.32	0.36	0.55
Gender*Expertise	1.28	1	1.28	1.43	0.23
Gender*IH	0.00	1	0.00	0.00	0.95
Expertise*IH	0.46	1	0.46	0.52	0.47
Gender*Expertise*IH	0.12	1	0.12	0.13	0.72
Total	184.92	205	7.86		

* $p < 0.05$; IH = Involuntary Hospitalization

2x2x2 ANOVA for Subscales

A set of 2x2x2 ANOVAs were performed on therapist expertise, involuntary hospitalization, and gender on the two created subscales – Depression and Suicide. An analysis of variance showed that gender was a significant factor in the rates of disclosure for the Suicide subscale, $F(1, 206) = 8.06, p < 0.01, \eta^2 = 0.04$, thus showing that women ($M = 2.72, SD = 0.88$) are more likely to disclose within the Suicide subscale compared to men ($M = 2.29, SD = 1.04$). Finally, an analysis of variance showed that gender played a significant role in the rates of disclosure for the Depression subscale, $F(1, 206) = 4.08, p < 0.04, \eta^2 = 0.02$, thus showing that women ($M = 2.2, SD = 0.92$) are more likely to disclose within the Suicide subscale compared to men ($M = 1.91, SD = 0.91$).

Discussion

This study examined the effects of therapist expertise, involuntary hospitalization, and gender on rates of disclosure pertaining to suicidality. To start, the interaction effects for the 2x2

MANOVA examining therapist expertise and involuntary hospitalization yielded results counter to the original hypothesis. The original hypothesis stated that having information on involuntary hospitalization and having an expert therapist would create an environment that would yield higher rates of disclosure; however, the results here are not in line with the hypothesis. For two of the 10 items, particularly the “Thoughts of being a burden” and “Thoughts of passive suicidal desire” both had the interaction effect of therapist expertise and involuntary hospitalization. The interaction effect and direction was the same for both items, in that having information on involuntary hospitalization and a standard therapist gave to higher rates of suicide disclosure than having information on involuntary hospitalization and an expert therapist. Furthermore, this was also true if a client had an expert therapist but shared only a standard release form; in essence, the data initially suggests that expert therapists should utilize standard release forms and typical therapists should share more information regarding involuntary hospitalization.

The potential reasoning for the results of this interaction may lead back to client perception. To clarify, if a client sees a therapist who is considered an expert in suicidality, there may be undue anxiety on the part of the client if they are suddenly informed about in-depth information regarding involuntary hospitalization. This could be due to the perception that the expert therapist versed in suicidality and their motives for sharing this information on involuntary hospitalization may be construed by the client as priming the client or “setting up” the client to share their suicidality, and that the expert therapist would be more sensitive to pick up their statements of suicidality. This is in contrast when an expert therapist utilizes a standard release form, such that since the client is knowledgeable about the therapist’s expertise on suicide, the client may not require further information from the therapist such that the authority and expertise may be enough to satisfy the client. Furthermore, when examining a standard

therapist and the in-depth information on involuntary hospitalization, since a standard therapist would not be considered an expert in the field of suicide, having additional information on involuntary hospitalization could add in the required component that could put a client at ease and be more likely to disclose issues of suicidality. Therefore, this leads to a tentative conclusion that depending upon the expertise of the therapist, that additional information on involuntary hospitalization may be beneficial in providing higher rates of suicidal disclosure from clients. However, only two out of the 10 items from the Suicide Disclosure Survey were found to be significant within the 2x2 MANOVA. These two items are focused more on depressive ideations and passive desire, compared to attempts or behaviors such as preparatory behaviors of acquiring tools or stopping an attempt.

The final item from the Suicide Disclosure Survey focused on a different theme compared to the other items, such that of dealing with truthfully reporting symptom severity. Here, therapist expertise was found to be a significant factor, such that expert therapists were more likely to have clients truthfully report the severity of their symptoms in comparison to a standard therapist. As Hall and Farber (2001) shown, the therapeutic alliance can increase disclosure in clients. Furthermore, therapist expertise has been shown to help improve the therapeutic process (Lovgren et al., 2019). Therefore, the perceived level of expertise of the therapist can have a beneficial effect in truthfully reporting the severity of symptoms. This is important, particularly with suicidality, such that it was previously shown that 39% of clients reported lying about the severity of their symptoms (Blanchard & Farber, 2016). The disclosure of suicidality is in two parts – the symptoms themselves, such as ideations and behaviors, and their severity. Understanding the full extent of the severity of symptoms is a crucial difference between the ideation of planning suicide compared to physical behaviors of planning a suicide.

Within the Suicide Disclosure Survey itself, the results indicated two factors that yielded high reliability from the Cronbach Alpha analysis. These two factors centered around depressive ideations and constructs, whereas the other factor focused more on suicidal ideations and behaviors. While the two subscales were found to not be significant for therapist expertise and involuntary hospitalization, the subscales provide a template for future research to utilize.

Another set of analyses were performed including gender as a factor with therapist expertise and involuntary hospitalization. These results, however, are more exploratory and should be viewed with caution due to the low number of men that participated in this survey. Nonetheless, this initial analysis can provide a foundational template for future research and inquiry when examining therapist expertise and involuntary hospitalization for suicide disclosure. To start, the initial 2x2x2 MANOVA had gender, the interaction of gender and involuntary hospitalization, and therapist expertise and involuntary hospitalization to be significant. Within the main effect for gender, what was seen across several of the significant items was that women would be more likely to disclose than men, including items pertaining to depressive ideation, suicidal ideation, and even suicidal attempts. A meta-analysis of over 200 studies has shown that women are more likely to disclose than men in social settings (Hall & Farber, 2001). However, within a clinician's office, it was found that gender did not play a significant role in the rate of disclosure to a therapist (Farber & Hall, 2002). Nonetheless, within these results, men are less likely to report suicidality than women, and this serves as a concerning warning regarding this population. Men are more likely to use more lethal means for suicide attempts which leads to a higher rate of suicide completions in comparison to women who are more likely to use less-lethal means for suicide attempts but less completions (Lim et al., 2014). This creates a dangerous discrepancy between women who are more likely to disclose their

suicidality and be more likely to engage in less-lethal suicide attempts in comparison to men who are less likely to disclose their suicidality and be more likely to engage in more-lethal suicide attempts and ultimately completions.

Gender also had an interaction with involuntary hospitalization and that it yielded unexpected results. When men were presented with information on involuntary hospitalization, they were less likely to disclose in comparison to the standard release form; women, on the other hand, were more likely to disclose when given information about involuntary hospitalization in comparison to the standard release form. While this interaction existed for just one item, specifically the “Thoughts of being a burden” item, it demonstrated a difference in how information regarding involuntary hospitalization was perceived different between men and women. A potential rationale for this discrepancy is that giving men additional information on involuntary hospitalization could potentially induce anxiety whereas for women it could alleviate anxiety with regards to what happens to anything that they disclose. However, due to the small sample of men in this study, any in-depth examination of these results are meant to be taken with caution.

There was a significant interaction effect for therapist expertise and involuntary hospitalization for the 2x2x2 MANOVA; however, there were no significant interactions reported when examining the 10 items from the Suicide Disclosure Survey within the ANOVAs. Therefore, while the 2x2x2 MANOVA indicates that some combination of therapist expertise and involuntary hospitalization has an effect on the rates of suicide disclosure, the current amount of data available is thus insufficient to draw any significant conclusions with regards to the 10 items used from the Suicide Disclosure Survey.

Finally, the addition of analyzing the subscales of Depression and Suicide within the context of a 2x2x2 MANVOA examining gender, therapist expertise, and involuntary hospitalization yielded similar results, such that gender was a significant factor in both the Depression and Suicide subscale. Specifically, women were more likely than men to disclose in both the Depression and Suicide subscale. The results of these subscales are similar to the previous results found and shows not only the validity of the subscales, but that again there is a discrepancy between men and women disclosing their suicidality and related components, such as depressive ideation.

Implications

The results of this study may serve as an impetus that changes the initial discussion of suicidality with clients and may help better serve how clients and therapists interact in therapy settings to the client's benefit. For generalist practitioners working with clients seeking mental health services, these results indicate that clients may be best served by discussing in a more in-depth fashion the details of involuntary hospitalization such that they may allow a client to be more willing to disclose pieces of suicidality to their therapist. In addition, an expert therapist may not be better suited discussing involuntary hospitalization and instead should use a standard disclosure and confidentiality protocol with their clients. Furthermore, women clients may be more willing to disclose information regarding suicidality compared to men. For researchers, the ad-hoc Suicide Disclosure Survey produced two factors with a high Cronbach Alpha and can serve as a template for further research within the realm of suicide disclosure.

Limitations and Future Directions

However, these implications need to be understood within the context of the methodological limitations of the study. To begin, in examining college students, this study

examined one particular institution (Minnesota State University, Mankato) as well as one particular subset within that institution – Psychology students. To create better generalizability, multiple institutions across the country or even worldwide would be needed. Within the sample, the sample skewed heavily towards white women, thus creating underrepresentation issues with men and people of color. Furthermore, the skewed sample had no representation with regards to sexual and gender identity, as in there were no transgender or non-binary participants, as well as having small representation within the lesbian, gay, and bisexual community.

Another consideration is that this sample is not a clinical sample, and participants may not have currently or previously experienced suicidal ideations or behaviors. Therefore, different results could be found working with students who are currently experiencing suicidal ideations and behaviors in comparison to asking students to rate their potential disclosure of this information from a hypothetical experience of suicidality. However, since almost half of the sample had received psychological services at some point in their history, this is still relatable since individuals would have experienced a clinician's office and potentially wrestled with what to disclose or keep to themselves. While the participants may have sought psychological services for issues other than suicidality, it still presents itself as working with a sample that has experience and a history in therapy settings.

Future directions for this study would be to expand the population to include other institutions outside of a Midwest university and to collect a more diverse, college sample. Specifically, within the context of this study's results, equalizing the number of men within the study can help serve to expound on the initial results found here regarding gender's effect on suicide disclosure. Additionally, future studies can look at specific populations (such as the LGBT population) and could focus on more clinical samples. Furthermore, future analyses could

examine differences in disclosure between those who have received psychological services and those who have not.

With future research utilizing the ad-hoc Suicide Disclosure Survey, this tool could include qualitative items that could assess more clearly the reasons and motivation to disclose or withhold disclosure. While Fulginiti and Frey (2019) examined qualitative reasons why individuals disclose or withhold suicidality disclosure, the addition of qualitative items assessing reasons and motivation for disclosure within the Suicide Disclosure Survey could add insight within a specific item, such as understanding motivation for disclosure for attempted suicide compared to passive suicidal desire. In the realm of reasons why individuals do not disclose suicidality, Blanchard and Farber (2018) had discussed the issue of the fear of hospitalization and had offered assessing this fear as a potential future direction. This study offers an initial analysis into this fear and can serve as a springboard for future research to analyze this phenomenon.

Conclusion

In conclusion, this research found that therapist expertise and information regarding involuntary hospitalization can have an impact on the rates of disclosure of suicidality. Furthermore, the ad-hoc Suicide Disclosure Survey can serve as a template for future research examining this particular phenomenon, along with further examining the validity of the two subscales. While the results analyzing gender showed certain trends for disclosure rates, these results would need to be replicated in larger samples of men to verify their results. Future research and analysis in this area of suicide can serve as a foundation in how researchers understand suicide disclosure and how clinicians may move forward with how to best assist clients in feeling comfortable disclosing suicidality.

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Appendix A

Disclosure of Involuntary Hospitalization Practices

A.1

In some specific situations, therapists can share information without your permission. Common exceptions to confidentiality are:

- 1) To protect you or the public from serious harm (suicide or homicide).
- 2) To report abuse or neglect of children, the elderly or people with disabilities.
- 3) To respond to an order from a court.

A.2

Important Disclosure Information Regarding Suicide

The concerns of disclosing information relating to suicide has prompted clients to wonder how much they can disclose without being involuntarily committed to a hospital. While the main goal of a therapist is the safety of their client, the following information should give clients a better understanding of the process of disclosing suicidal information and the potential effects.

To start, it's common for therapists to ask about suicide and factors that increase the risk of suicide with clients during therapy sessions.

However, some clients may not wish to disclose any information because of the fear that it may be used to involuntarily commit them to a hospital. **The important point is that disclosing thoughts, emotions/feelings, or actions of suicidal behavior does not automatically start the process of involuntarily committing someone.**

For example, disclosing thoughts that you want to commit suicide, that you believe you would be better off dead, or that you feel hopeless in the future, does not automatically require involuntary hospitalization.

However, if the therapist believes that the client is in immediate danger, as well as the client believes that they cannot keep themselves safe, then involuntary hospitalization may result as a last resort.

But the act of involuntarily committing a client is more collaborative than typically believed. For example, if a client states that they are going to go home after the session and commit suicide, the therapist must assess the risk and likelihood of that happening. Then, they work with the client to see if the client can keep themselves safe (as in, will they go through with the suicidal act or what resources does the client have [such as friends] they can rely on in case the urge becomes too strong). If the therapist believes the potential risk is high, as well as the client believing that they can't keep themselves safe, then the process of keeping the client safe through involuntarily hospitalization can begin.

Appendix B

Therapist Vignettes

B.1

Dr. Alex Jensen

Education:

Ph.D., Clinical Psychology, University of North Carolina, Greensboro, Greensboro, North Carolina, August 2000.

Experience:

Has been in private clinical practice for over 15 years with over 1,000 clients seen.

Works with children, families, and adults with a history of diverse backgrounds through individual or group sessions.

Has experience working with a wide range of psychological concerns and issues such as grief, trauma, major depression disorder, anxiety disorders, conduct disorders, and personality disorders.

B.2

Dr. Alex Jensen

Education:

Ph.D., Clinical Psychology, University of North Carolina, Greensboro, Greensboro, North Carolina, August 2000.

Experience:

Has been in private clinical practice for over 15 years with over 1,000 clients seen.

Works with children, families, and adults with a history of diverse backgrounds through individual or group sessions.

Has experience working with a wide range of psychological concerns and issues such as grief, trauma, major depression disorder, anxiety disorders, conduct disorders, and personality disorders.

Specializes in assessing and treating adolescents and adults with varying degrees of suicidal thoughts and intents

- Has given workshops and conference seminars dealing with suicide prevention and interacting with individuals with suicidal ideation.

Appendix C

Suicide Disclosure Survey

C.1 The following questions will pertain to thoughts, feelings, and actions relating to suicide. For each question, rate the likelihood that you would inform or disclose to Dr. Alex Jensen (from the previous page) these thoughts/feelings/actions on a scale from 1 (very unlikely) to 4 (very likely).

For these questions, it does not matter if you have or have not personally experienced anything in the question. Please answer the question as if you are experiencing the thought, feeling, or action, and answer according to the likelihood you would tell Dr. Alex Jensen about them.

	Likelihood of telling Dr. Alex Jensen			
	1 (very unlikely)	2	3	4 (very likely)
1. Thoughts that you are a burden, that you would be better off dead or everyone would be better off without you				
2. Thoughts of attempting/committing suicide				
3. Feelings of hopelessness about your future				
4. Thoughts/feelings of a passive suicidal desire (such as wouldn't move to save your life if a car was coming)				
5. Attempted suicide				
6. Was about to commit suicide but stopped yourself (such as you held a gun to your head and then put it down)				
7. Thoughts of a plan to commit suicide (when, how, where)				
8. Acquired the tools necessary and with the purpose to attempt suicide (purchased a gun)				
9. Increasingly engaging in more-and-more self-destructive behaviors without regard to consequences (drinking, drug use, high-risk situations such as drinking and driving)				
10. Extreme feelings of self-hatred "I don't deserve to live"				
11. Would you truthfully report the severity or intensity of any of your ideations or behavior?				