Concealment of Suicidal Ideation in Psychotherapy

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Submitted in partial fulfillment of the
requirements for the degree of
Doctor of Philosophy
under the Executive Committee
of the Graduate School of Arts and Sciences

COLUMBIA UNIVERSITY

2017

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ABSTRACT

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Purpose: Assessment and management of suicidal risk often relies on the client's willingness to disclose suicidal thoughts or behaviors. Understanding why clients make the decision to conceal these symptoms is key to improving techniques of assessment. This study directly queried suicide concealers to learn how psychotherapists can better elicit honest disclosure of suicidal material.

Method: A sample of 107 suicide concealers provided both short essay responses and multiple choice responses explaining why they concealed suicidal thoughts from their therapist. In addition, a sub-sample of 64 suicide concealers provided short essay responses describing what they thought their therapist could do differently to help them disclose, and answered multiple-choice questions explaining how they felt about concealment, and whether concealment impacted their therapy. Content analysis was used to identify motives and themes in short essay responses.

Results: Nearly three-fourths of suicide concealers cited fear of practical consequences as the reason they did not disclose. Chief among these fears was involuntary hospitalization, which respondents viewed as the likely outcome of telling a therapist about their suicidal thoughts. Less concrete motives for concealment, such as shame or embarrassment, were significant but secondary concerns. Nearly half of suicide-concealing clients said they would be more honest only if the threat of hospitalization was somehow reduced or controlled. Many asked for some form of assurance or explanations about the chances of being hospitalized as a result of their disclosure. Concealers most commonly felt conflicted about their decision to conceal, with

significant numbers feeling frustrated or guilty as well as safe or in control. While a quarter of concealers believed concealment hurt their progress in therapy, the majority reported no effect. *Limitations*: While responses suggest a range of symptom severity, the sample includes an unknown proportion of mild versus severe suicide risk, reducing generalizability to the general or clinical population. Male and minority clients are under-represented in the sample. *Conclusions*: The concerns expressed by the suicide concealers in this sample suggest that improving techniques of suicide risk assessment may require renewed attention to providing transparent, complete, and easy-to-understand psychoeducation about the triggers for hospitalization and other possible outcomes of disclosure. Clients ultimately control their level of disclosure, and the results of this study suggest they desire sufficient knowledge to make an informed decision.

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Acknowledgements

First and foremost I would like to thank my faculty mentor, Dr. Barry Farber. It was during the anxious first months of my doctoral training that he tasked me with finding out what people lie about in psychotherapy. I wondered how I would ever get respondents to tell me the secrets they would not even tell their therapists. What answers should I hope to find? What hypotheses should I hope to test? His advice was simply: “Ask interesting questions and you’ll get interesting answers.” He could not have been more correct, and I could not have guessed that the questions we asked would result in this project. Dr. Farber made doctoral study possible for me and I cannot thank him enough.

I would also like to thank Melanie Love, my fellow lab-leader and general co-conspirator, whose dedication and organizational talents helped prevent the wheels from flying off this project and several others during our years of collaboration. I also owe tremendous gratitude to my qualitative coding teams, including Alana Morgensen, who made an epic commute to attend our meetings, Mandy Newman, whose enthusiasm was contagious, Veronica Ozog, who never suffered fools gladly, and Bianca Cersosimo, who always brought the Brazilian vibe. Heartfelt thanks go out to all the lab members who pushed this project forward in ways large and small between 2012 and 2016, including Veronika Bailey, Brianne Dickey, Adam Mitchell, Jeff Wong, Katelyn Zmigrodski, Mona Khaled, Laura Curren, Lama Khouri, Kaila Tang, Lauren Grabowski, Matt DeMasi, Kat Wehmeyer, and Catherine Thompson.

Additional thanks to my committee members Dr. Lena Verdeli, Dr. George Gushue, Dr. Christine Cha, and Dr. Andre Ivanoff, and to the incredible generosity and good humor of Eric, Joseph and Emily Tsai, without which the PhD student life would have been much, much harder.

Dedication

This dissertation is dedicated to the 1,345 psychotherapy clients who completed our lengthy research instrument, and especially to the 107 respondents who shared their struggles with suicidal thoughts. I am humbled by their willingness to give so much time and effort to this project.

Concealment of Suicidal Ideation in Psychotherapy

This dissertation is intended to give voice to a hidden population: psychotherapy clients who are actively concealing suicidal ideation from their therapist. By describing the motives, attitudes, and perceived consequences for these clients in their own words, this study aims to provide a deeper understanding of client non-disclosure on this complicated issue, and to offer ideas for how clinicians can better foster the conditions for honest disclosure by clients experiencing suicidal thoughts.

Suicide was the tenth most common cause of death during 2014, claiming 42,773 American lives, or about 117 deaths per day (CDC, 2015). During the same year around 500,000 people were treated in emergency rooms for self-inflicted injuries, about 1.3 million adults reported making a suicide attempt, and suicidal thoughts were experienced by an estimated 9.3 million adults, or 3.9% of the national population (CDC, 2015).

Health care professionals are on the front lines of this crisis. Research suggests that 77% of those who died by suicide had seen a primary care physician in the 12 months before their death, and 30% had received mental health services (Luoma, Martin, & Pearson, 2002). Indeed, it is estimated that 20% of psychologists and over 50% of psychiatrists will lose a patient to suicide during their careers (Alexander, Klein, Gray, Dewar, & Eagles, 2000; Chemtob, Bauer, Hamada, Pelowski, & Muraoka, 1989; Chemtob, Hamada, Bauer, Kinney, & Torigoe, 1988). It is a longstanding hope of those in the suicide prevention community that by training physicians and psychotherapists to identify suicidal patients, thousands of lives could be saved each year (American Foundation for Prevention of Suicide, 2015).

For this reason, considerable research has gone into identifying the predictors of suicide, which include depression, anxiety, and feelings of hopelessness, as well as schizophrenia, bipolar

disorder, borderline personality disorder, substance abuse, chronic health conditions, stressful life events, access to lethal means, a family history of suicide, child abuse, and a previous history of suicide attempts, among others (American Foundation for the Prevention of Suicide, 2015).

There has also been considerable research and scholarship on effective assessment strategies which can identify patients presenting in medical or psychotherapy clinics who may be at risk for suicide (e.g., Jobes, 2006; Joiner, Orden, Witte, & Rudd, 2009; Maltsberger, 1986; Shea, 1999). These strategies generally involve (1) gathering information about baseline and acute risk factors, protective factors, and warning signs of suicide, as well as (2) gathering information about the patient's suicidal ideation, planning, behaviors, desire to die, and intent to commit suicide (Mays, 2004; Welton, 2007).

Unfortunately, the only source for the crucial second category of information is typically the patients themselves, who often decide not to disclose suicidal symptoms to physicians and psychotherapists, even during a structured assessment designed to encourage disclosure of suicidal intent. One study of 355 clients at a college counseling center, for example, found that 13.8% denied suicidal ideation when asked on an intake questionnaire, but admitted it when being given a full suicide assessment by a counselor (Morrison & Downey, 2000). How many more continued to conceal it during assessment, it is impossible to say. Indeed, hiding suicidal ideation is believed to be at least as common as disclosure. Among completed suicides in 16 states, only about 30% of victims were known to have disclosed any intention to take their lives (CDC, 2012). In a sample of 26,000 college undergraduate and graduate students reporting suicidal ideation, 46% had told no one about their thoughts (Drum, Brownson, Burton Denmark, & Smith, 2009).

The population concealing suicidal thoughts, plans, or intentions have been called "hidden ideators" (Morrison & Downey, 2000). If an estimated 9.3 million Americans experienced suicidal ideation at varying levels of severity during 2013 (CDC, 2015), it seems likely the population of hidden ideators in a given year would number in the millions. Only a fraction of ideators will make a suicide attempt (around 14%), and only a tiny fraction will kill themselves (around 0.4%). Yet by definition, all hidden ideators are essentially left alone to deal with their urge to die, one of the hardest possible emotional experiences. Thus, beyond the obvious goal of preventing suicide attempts, we argue that there is an additional goal of reducing psychological suffering among the vast majority of suicidal ideators who may never attempt. The first step to achieving both of these goals is to encourage disclosure.

The literature on suicide assessment describes several possible motives for non-disclosure of suicidal thoughts to health care professionals. These range from fear that the clinician will judge them as crazy or have them hospitalized, to a sense that discussing suicide is taboo or that no one can possibly help (Shea, 2009). Yet very little empirical research exists on the hidden ideator population, their motives for non-disclosure, or their sense for what might help them disclose. This may be because, by definition, they are "hidden" and have not identified themselves in any format where their motives for concealment might be queried by researchers. Rarer still is research on hidden ideators who are in psychotherapy, individuals who have managed to cross every known barrier to treatment, yet are still concealing their most painful thoughts. Orf (2014) notes a dearth of research on concealment of suicidal ideation among psychotherapy clients. He argues that additional research is needed on the factors driving this concealment: "It is critical to identify what factors promote and inhibit disclosure of suicidal ideation so clinicians can support this type of disclosure with their clients" (p. 40).

The purpose of this dissertation is to explore the factors leading to non-disclosure from the perspective of hidden ideators who are in psychotherapy. There is evidence to suggest the therapy population contains many hidden ideators. Blanchard and Farber (2015) found that in a sample of 547 therapy clients, 31% acknowledged having lied to their therapist about suicidal thoughts at some time in the past, and 10% acknowledged having lied about past suicide attempts. This intriguing finding has only been hinted at by previous studies of client dishonesty in psychotherapy (e.g. Baumann & Hill, 2015), which did not ask specifically about suicide. The existence of such a group raises questions about their motives and consequences for non-disclosure, as well as what they feel their psychotherapist could have done to foster greater disclosure. This is important not only for preventing suicide, but for increasing the effectiveness of psychotherapy for those ideators who will never attempt but suffer nonetheless.

Literature Review

Non-Disclosure in Psychotherapy

Although honest disclosure by clients is central to the process of psychotherapy (e.g. Farber, 2006; Stiles, 1995), it is well established that clients are not always honest. They keep secrets (Kelly, 1998; Baumann & Hill, 2015), minimize discussion of personally salient topics (Farber & Sohn, 2007), hide their negative reactions to therapist interventions (Hill, Thompson, Cogar, & Denman, 1993), mislead therapists about the effectiveness of therapy itself (Blanchard & Farber, 2015), and sometimes spin elaborate outright lies (Gediman & Lieberman, 1996).

Predictors of non-disclosure in psychotherapy include a weak therapeutic alliance (Farber, 2003; Hall & Farber, 2001; Kelly & Yuan, 2009), a shorter duration of treatment (Hall & Farber, 2001), and a fear of negative consequences of disclosure (Dew et al., 2007), as well as several measurable individual traits possessed by clients. These include a high tendency toward

self-concealment (Larson & Chastain, 1990), and a lower tendency to disclose distress (Kahn & Hessling, 2001). Such traits are associated with poorer outcomes in psychotherapy (Fedde, 2009; Kahn, Achter & Shambaugh, 2001) as well as with increased problems with overall mental and physical health (Larson & Chastain, 1990; Kelly & Achter, 1995; Smyth, Pennebaker, & Arigo, 2012). Gender is not a predictor of non-disclosure, per se, but a particular gender match (female client with female therapist) has been found to be associated with higher levels of distress being experienced by clients while disclosing (Pattee & Farber, 2008).

When clients report their motives for non-disclosure in therapy, avoiding shame and embarrassment has often topped the list (Baumann & Hill, 2015; Hill, et al., 1993; Kelly & Yuan, 2009). There is good evidence, however, that client motives are contingent on the subject matter being concealed or distorted. For example, Hill et al. (1993) found that when the topic involved not personal secrets, but events happening in therapy, the most common motive for non-disclosure was not shame but the client's desire to avoid feeling overwhelmed by other emotions such as frustration, feeling unsupported, feeling stuck, and worry about hurting the therapist's feelings. In a similar vein, Blanchard and Farber (2015) found that motives for dishonesty about the therapeutic relationship differed substantially from motives for lying on all other topics. Their sample of 106 therapy-related lies reported by clients was motived most commonly by a desire to be polite, and avoid upsetting the therapist. By contrast, 325 lies on all other topics were most commonly motivated by a desire to avoid discomfort and embarrassment. Non-disclosure of suicidal thoughts in therapy, then, may be motived by a set of concerns unique to that topic.

Non-disclosure of Suicidal Thoughts

This literature review is concerned with two related questions: Why do psychotherapy clients lie about suicidality, and how can therapists foster honest disclosure.

Patient factors in concealment of suicidal ideation. Patients may have many reasons for concealing their suicidal ideation that arise from their fears, intentions, character, or view of reality. As noted, very little research exists querying individuals directly and anonymously about why they are concealing suicidal thoughts, and there is only fragmentary evidence for which reasons may predominate over others. As of yet, only one study has looked specifically at reasons for concealment of suicidal ideation in psychotherapy (Orf, 2009), finding that the overall working alliance and a specific method of assessment, based on Joiner's Interpersonal Theory of Suicide, was positively associated with client disclosure of suicidality, while the therapist's having asked "biased or awkward" questions was negatively associated. The usefulness of Orf's study is limited by its dependence on participants to remember back to fairly specific details of their therapist's behavior at unspecified times in the past (e.g. "My therapist asked about the degree to which I felt connected to others"). It did, however, provide support for the idea that therapist behavior is an important predictor of disclosure of suicidal ideation – perhaps more of a factor than the client's own fears of what might happen if they disclose – and so represents an important first look at what reasons for concealment may predominate in a clinical population of hidden ideators.

Outside the context of psychotherapy, sufficient scholarship does exist to develop a list of the possible reasons for hiding suicidal ideation. In this regard, Burton Denmark, Hess, and Becker (2012) analyzed data from 26,451 college students who responded to a national survey by the National Research Consortium of Counseling Centers in Higher Education. From this

sample, 558 students reported they had seriously considered attempting suicide in the previous twelve months and did not tell anyone about their suicidal thoughts. Thematic content analysis of open-text responses to the question "Why did you decide not to tell anyone about your thoughts?" produced nine major reasons why these students concealed: (a) they felt there was low risk of them actually committing suicide (b) they did not want to worry or burden others (c) they saw the topic as too private to share with anyone, (d) they thought it was pointless to ask for help, (e) they feared others' stigmatizing reactions such as rejecting, blaming, and judging, (f) they felt embarrassment or shame feeling that having suicidal thoughts is weak or wrong, (g) they feared tangible repercussions such as forced mental health treatment or removal from school, (h) they did not want outside interference with their decision to commit suicide, and finally, (i) they had no trusted confidant with whom to share their thoughts. No one motive for concealment dominated this list. The most commonly reported motive was (a) perceived low risk of committing suicide, which accounted for 18% of responses, and the least common was (i) lack of confidants, which accounted for 3% of responses. All other reasons each accounted for between 16% and 7% of responses. While Burton Denmark et al. (2012) provide a useful list of relevant motives for suicide concealment generally, it can tell us nothing about the relative salience of these motives for the therapy-using population. Students in the study were reporting why they had not disclosed to "anyone", meaning friends, family, professors, etc., and the study did not report whether respondents were in psychotherapy. Thus, the generalizability of these findings to the psychotherapy population is indeterminate. Motives such as a lack of confidants certainly would not apply to therapy in most cases (the therapist being a built-in confidant), while in contrast, motives such as not wanting to worry or burden others may very well apply to therapy.

Inside the context of psychotherapy, Shea (2009) provides a non-empirical but fairly comprehensive list of possible reasons why patients might conceal suicidal ideation from their therapist. Shea's ten reasons only partially overlap with the motives reported by Burton Denmark et al. (2012), with important areas of divergence (e.g., Shea does not take into account the most common motive found by Burton Denmark, that the client feels he or she is at "low risk" of actually attempting).

- The patient feels that suicide is a sign of weakness and is ashamed to acknowledge it.
- The patient has alexithymia and has trouble describing emotional pain or material.
- The patient does not believe that anyone can help.
- The patient feels that suicide is immoral or a sin.
- The patient feels that discussion of suicide is, literally, taboo.
- The patient is worried that the clinician will perceive him as crazy.
- The patient fears that he will be locked up if suicidal ideation is shared or, if during a crisis call, that the police will appear at his door.
- The patient fears that others will find out about his suicidal thoughts through a break in confidentiality.
- The impulsive patient may lack extensive suicidal ideation before his or her attempt.
- The patient has had marked suicidal ideation and is serious about completing the act but is purposely not relaying suicidal ideation or is withholding the method of choice because he does not want the attempt to be thwarted. (p.18)

Finally, a second study of undergraduates by Hom, Stanley, Podlogar, and Joiner (2017) queried 306 students who reported some lifetime history of suicidal ideation about whether they responded accurately when queried about suicidality by various parties, including family members, friends, teachers, religious leaders, etc. Of this group, 77 participants had been asked about suicide by a psychologist, therapist, or counselor, and 49 had been asked by a psychiatrist. Respondents were significantly more honest with psychiatrists, psychologists, therapists and counselors than they were with family members. The most common reasons for dishonesty differed slightly between psychiatrists and other mental health providers. Embarrassment was the most common reason given for concealment from psychologist/therapists, while fear of being

hospitalized was the most common reason for concealment when probed by a psychiatrist. Other common motives for concealment included “being judged”, “others might find out”, “not being taken seriously” and “being put on medications”.

In all, the literature on concealment of suicidality identifies roughly 12 major reasons why clients might conceal suicidality from their therapist. We will discuss the empirical evidence for each, if available, although not all reasons have empirical backing.

Shame. Shame has been described as an emotional experience resulting from failure to meet internalized social standards, including standards of morality, competence, or aesthetics (Tangney, Wagner, & Gramzow, 1989). While the confidentiality of therapy is designed to minimize shame, it remains a force in the consulting room. In their study investigating client and therapist covert processes, Hill and colleagues (1993) found that about half the instances of patient secret keeping were motivated by shame and embarrassment.

The idea that suicidal thoughts are concealed out of shame is supported by a qualitative study of 34 veterans of the Iraq War who had screened positive for suicidal ideation (Ganzini et al., 2013). These men accepted the need for suicide screening, yet they routinely denied ideation, in part due to experiences of stigmatization in a military culture that sees mental health problems as an embarrassing weakness and thus, as inconsistent with being a good soldier. As one veteran put it, “That’s the heartache…I just try to cover it up and faking it to make it. I know I am hurting, ...physically and mentally, but the thought of trying to get help is a sign of weakness.” (p. 1218)

The concern about appearing weak to others or to oneself has also been noted in a sample of 52 male suicide attempters in Ireland (Cleary, 2005). These men had attempted suicide to deal with general unhappiness, feeling trapped in a situation, a relationship breakup, psychiatric

symptoms, and anger. Two thirds reported never disclosing emotional material to anyone, largely for fear of appearing unmasculine. As one interviewee put it, “Lads can't turn around and talk to their friends. If you turned around and gave a sign of being weak and stuff like that, you'd be ridiculed. There's no way you could show your emotions like that.” (p. 162). Cleary (2005) notes that the constant performative work of projecting a false image of masculine strength had exacerbated their underlying distress, creating a widening gulf between their public self and real self. This resulted in a downward spiral of concealment, denial, and substance abuse. Concealment of distress, then, became a factor contributing to the suicidal act.

In their analysis of survey responses by recently suicidal college students, Burton Denmark et al. (2012) found that only 7% of responses offered shame as reason to conceal suicide, such as “I was ashamed that I would take the easy way out of life” and “I felt guilty because maybe my life isn’t so bad as I think it is sometimes” (p. 89). The authors draw a distinction between shame and “stigma”, arguing that shame refers only to a person’s “personal, internalized negative evaluation of considering suicide” (p. 90), whereas stigma is more akin to a fear of being judged by others (e.g. “I was pretty sure if I told anyone, they would belittle me for considering this as an option, and tell me they expected better of me.”). This is similar to the distinction sometimes made between self-stigma and public stigma (Vogel, Wade, & Haake, 2006), with self-stigma being an internalization of negative public attitudes about conditions such as mental illness. In the samples of common language use collected in qualitative research, however, words like shame, stigma, and embarrassment are often used interchangeably by respondents. Had Burton Denmark et al. (2012) counted shame and stigma together, it would have been the most common motive for concealment, accounting for 20% of reasons given. In the context of psychotherapy, the shame-stigma distinction becomes murkier, as in most therapy

formats, the therapist is the only other person present for the disclosure. Hence, the relevant distinction may be between all species of shame, and the fear of being judged specifically by a therapist.

Fear of being judged by therapist. While fear of stigma is a recognized barrier to seeking mental health care in general (see Hom, Stanley, & Joiner, 2015) and to disclosing suicidality in particular (Burton Denmark et al., 2012), mental health professionals are rarely mentioned as the feared enactors of this stigmatization. Indeed, therapists are trained to provide supportive, non-judgmental venues for disclosure. Nonetheless, research on disclosure in psychotherapy suggests the therapist is an important audience before which the patient fears negative judgment. Of 21 therapy clients interviewed by Farber, Berano, and Capocianco (2004), nine reported that the hardest aspect of disclosure was fear of the therapist's judgmental reaction, offering remarks such as "I don't want people to look at me differently based on what they know about me," and "It's harder to disclose when she [the therapist] makes a mountain out of a molehill" (p. 342). These two quotations capture the sense that therapist judgment can lead both to shame, and to therapist over-reaction. Client disclosure of suicidal ideation may cause the therapist to see the patient as considerably more sick than he or she would like to be seen, and it has the potential to dominate the course of therapy in a way the client would rather avoid. Thus, there may be a second dimension to therapist judgement which is not explored in the literature: that the suicidal disclosure will distort the course of therapy.

Blanchard and Farber's (2015) study of 106 therapy-related lies told by clients found that 42% were motivated by a desire to avoid upsetting the therapist, and 33% by a desire to avoid the therapist's disapproval. These findings are in keeping with Kelly's (2000) argument that clients are strongly inclined to present themselves in a favorable light to their therapist. Thus,

patient concealment of suicidal ideation may be a form of impression management (Goffman, 1959). Consciously or unconsciously, patients may avoid disclosing certain facts if it would threaten the image they have constructed for their therapist.

As mentioned above, disentangling shame from fear of judgement is not easy. Patients prone to projection may be especially likely to convert their experience of shame about a personal secret into an experience of negative judgement by their therapist. It is also the case that some therapists really will have a negative response to a client's disclosure of suicidality, not least because of fear of legal liability should the patient go through with it. It is well established that therapists find it stressful and traumatic when clients make suicidal disclosures or attempts (Farber, 1983; Rodolfa, Kraft, & Reilley, 1988), and patients may pick this up. Hom et al. (2017) found that "being judged" was a salient factor for undergraduates hiding suicidality from psychologists, therapists and counselors.

***Perceived low risk*.** The belief that one does not need treatment is a well-documented reason for not seeking help for suicidal thoughts. Bruffaerts and colleagues (2011) analyzed data from the World Mental Health Survey conducted in 21 countries by the World Health Organization, sampling 1,170 respondents reporting suicidal behavior in the previous year who did not seek treatment. Low perceived need for treatment was the most commonly reported barrier to treatment, reported by 58% of respondents. This was true among those with suicidal ideation only, but also among those who had actually made planned or impulsive suicide attempts! Low perceived need was somewhat less common in high-income countries such as the United States, but was still reported by 45% of respondents. Similar findings appear in a study of US college students by Burton Denmark et al. (2012) who found that perceived low risk for actually killing oneself was the most commonly reported reason for concealment of suicidal

ideation. Statements of perceived low risk such as “I hoped that they [suicidal thoughts] would just go away on their own as they have in the past” (p. 89) accounted for 20% of all reasons given. Respondents either assumed their suicidal thoughts were only temporary, or they lacked seriousness or intensity, or these students felt their moral or religious convictions made suicide unlikely. All three lines of reasoning assume that someone who is not going to actually kill themselves cannot benefit from addressing their suicidal thoughts in therapy – a highly dubious assumption. Finally, Freedenthal and Stiffman’s (2007) thematic content analysis of interviews with American Indian adolescents found that low perceived need for help was again the most commonly cited theme among suicidal respondents who did not seek professional help. Statements such as “Nothing really happened that made me need to go to the hospital to get help” (p. 67) made up 28.8% of reasons given. Interestingly, respondents who professed no need for assistance reported the same severity of emotional problems as those who actually received help.

Inability to self-disclose. As suggested by Cleary (2005), the inability to self-disclose is a key factor in both promoting suicidal ideation and preventing that ideation from being discussed. Apter, Horesh, Gothelf, Graffi, and Lepkifker (2001) found that low levels of self-disclosure (rated on Jourard’s Self-Disclosure Questionnaire) significantly differentiated between four groups: serious attempters, mild attempters, ideators only, and non-suicidal controls. Similarly, Levi et al. (2008) compared 35 serious suicide attempters in an Israeli hospital with 67 non-serious attempters and 71 controls on a wide range of variables having to do with life events, mental pain, depression, self-disclosure, and alexithymia (an impairment in the ability to recognize or symbolize one’s own emotional experiences). Results suggested that while mental pain distinguished between the non-suicidal controls and the two suicide groups, the key

differences between the serious and non-serious attempters had to do with poor self-disclosure, alexithymia, and loneliness. The authors describe an “impossible situation”, in which victims are in unbearable mental pain but unable or unwilling to ask for help (p. 249). The authors conclude that problems with sharing of feelings with others are an important risk factor for near-lethal suicide, over and above the contribution of psychiatric illness and mental pain, including depression and hopelessness. Similar results have been found testing the relationship between high levels of self-concealment and suicidal behaviors in young adults (Friedlander et al., 2012). Indeed, it was originally proposed by Stengel, Cook, and Kreeger (1958) that suicide attempts are themselves communicative acts, a speaking by other means that breaks a cycle of silence and concealment.

Inability to self-disclose is difficult to measure by client self-report. Clients who are unable or disinclined to put their feelings into words may report a variety of motives for concealment, such as privacy, shyness, fear of burdening others, or simply say that suicide is “hard to talk about”.

Belief that disclosure is pointless. Clients may conceal suicidal ideation because they do not believe disclosure will help them, either because they feel entirely beyond help or because they doubt the clinician’s capacity to effectively treat their problems. Burton Denmark et al. (2012) found that the perception that disclosure is pointless made up 13% of reasons given by US college students for not disclosing suicidal ideation to others, offering beliefs such as “I didn’t think anyone would care” and “I didn’t anyone could really help” (p. 89). For some students, these perceptions were based on earlier, unsuccessful efforts to ask for help.

The belief that disclosure is pointless may also be an expression of a more global hopelessness – that one is beyond help. Hopelessness is an obvious contributor to suicidal

behavior itself, measured either as a distinct construct (e.g., Apter et al., 2001) or as a symptom of depression (American Foundation for the Prevention of Suicide, 2015). Hopelessness and pessimism have also been found to inhibit help-seeking behaviors (such as disclosure) through a process that Clark and Fawcett (1992) have termed help-negation, in which individuals suffering acute suicidal ideation reject the available treatment and support. Being in the depths of suicidal ideation appears to debilitate problem-solving skills that might lead one to seek help, as part of an often-noted general loss of perspective that is characteristic of depression (Deane, Wilson, & Ciarrochi, 2001). Giving up all hope is one maladaptive coping strategy seen in those with severe suicidal ideation, and may serve to reduce some aspects of their distress. Thus, the sense of pointlessness characteristic of help-negation may identify individuals who exhibit both the highest risk for suicide completion and the lowest likelihood of actually seeking help (Wilson, 2009).

Belief that suicide is taboo or morally wrong. There is evidence to suggest that disclosure of suicidal ideation differs across racial and ethnic lines, which may be due to differing cultural beliefs about suicide being immoral or taboo (Shea, 2009), or otherwise treated as a subject of public stigma in addition to the individual's personal shame. Two studies of undergraduate students by Morrison and Downey (2000) offer some support. In the first, analysis of 305 case files from a university counseling center found that minority students were disproportionately represented in the group of hidden ideators. In the second, a sample of 60 African American students were significantly more likely to list moral objections to suicide as reasons for living (on the Reasons for Living Inventory, Linehan et al., 1983) than 99 Caucasian classmates. African American suicide rates are the lowest among all ethnic groups in the US,

occurring at a rate of 5.5 per 100,000 deaths compared to whites at 14.7 per 100,000 deaths (National Center for Health Statistics, 2016).

Culture is addressed in the literature on suicide prevention as a potential barrier to help-seeking, of which disclosure to therapist is one type. Research suggests that people from ethnic minority populations experiencing suicidal ideation or attempts had lower rates of service use than their white counterparts; these include Asian Americans, African Americans, and Latinos (Cheung et al., 2009; Chu, Hsieh, & Tokars, 2011; Downs & Eisenberg, 2012). Among American Indians, Gone (2004) found that seeking psychological help was at times seen as little more than "brainwashing" by the white man to foster conformity with white society (p.14). It is unclear whether the ethnic match of therapist and patient is a factor in suicide disclosure, but a review by Goldston et al. (2008) suggests that one barrier to care in general is a concern that providers may not be culturally competent. Sue and Sue (2012) note that once in therapy, clients from non-dominant cultural groups may find their trust in the process undermined by majority clinicians' unwitting racial microaggressions resulting from a lack of cultural competence.

Religion is another potential source of moral taboo around suicide, with groups such as Catholics believing that those who commit suicide will be condemned to hell after death. There is no research on whether such beliefs inhibit the disclosure of suicidal ideation to psychotherapists, but studies such as Burton Denmark et al. (2012) captured college students citing their moral or religious convictions as factors lowering their risk of attempting suicide. That low risk was then cited as a reason for not telling anyone about suicidal thoughts.

When patients have truly internalized a public stigma that contemplating suicide is morally wrong, Shea (2009) observes that the question of whether they choose to disclose their suicidal can be complicated by the ego-defensive forces of denial and repression:

> From a psychodynamic perspective, a curious paradox can arise. If a patient believes that suicide is a sign of weakness or a sin, unconscious defense mechanisms (such as denial, repression, rationalization, or intellectualization) may create the *conscious* belief that the patient's intent is much less than it actually is. When asked directly about his suicidal intent, this patient may provide a gross underestimate of his potential lethality even though he is genuinely trying to answer the question honestly (p.18).

Thus, the client may have motives for non-disclosure of suicidal ideation which are not fully available to consciousness.

***Fear of hospitalization*.** When a patient discloses suicidal thoughts, plans or intentions, the strongest therapist reaction is involuntary hospitalization, which may bring with it a loss of personal freedom, unwanted medications, and removal from critical daily activities such as employment and childcare. Existing research on this reason for concealment is largely focused on the young. One study of 854 high school students in Colorado found that even after a suicide education program, 48% reported that fear of hospitalization would likely prevent them from seeking care should they someday become suicidal (Cigularov, Chen, Thurber, & Stallones, 2008). A similar fear of consequences is reported in two studies of college students (Burton Denmark et al., 2012; Drum et al., 2009), although it was only a minor theme. Only 7% of suicidal ideating students in Burton Denmark et al. (2012) mentioned hospitalization. In Drum et al. (2009), fear of hospitalization was fifth in a list of reasons, after fear of judgment, not wanting to burden others, belief that the problem would pass, and not having a confidant. In a study by Hom et al. (2017), fear of being hospitalized ranked near the top of the list of reasons given by undergraduates who had concealed suicidal ideation from medical doctors, psychiatrists or psychologists/therapists.

There is very little research addressing hospitalization fear among adult ideators. Ganzini et al.'s (2013) qualitative study of 34 veterans undergoing routine suicide screenings found that concern about unwanted hospitalization or medication recommendations was a salient factor in

the decision of whether to be honest. As one participant put it, one never knew if medical staff were “going to try and lock me up in a straight-jacket, I have no idea what the response is going to be if I talk to someone honestly” (p.1219). More salient, however, was the shame and career repercussions that they perceived to be inevitable if they acknowledged suicidal thoughts in the cultural context of the military.

While hospitalization remains the gold standard of care for patients who are at severe and imminent risk for suicide (Bryan & Rudd, 2006), it can be a shocking and frightening experience. Doors are locked. Personal privacy is dramatically reduced. Staff are often brusque and commanding. Patients find themselves mixed in with a very sick population. Hom et al. (2015) speculate that the public may have misconceptions about the level of symptom severity one must reach to trigger hospitalization, and may underestimate the value of inpatient treatment. By contrast, high-risk patients who have previously been hospitalized will know the triggers and, if they’ve had bad experiences, will seek to avoid these triggers through non-disclosure.

Breaks in confidentiality. No study reviewed here mentions a fear that the therapist will break confidentiality as a motive for non-disclosure of suicidal ideation. Yet it is clear that interventions such as hospitalization are likely to result in family, friends, or coworkers learning of the patient’s mental problems. This could lead to fear of stigma, which has long been cited as a barrier to help-seeking, but may be less of a problem than previously believed, as recent major studies suggest only 7-13% of suicide ideators note stigma as a reason not to seek help (Bruffaerts et al., 2011; Burton Denmark et al., 2012). Hom et al. (2015) note that shame and stigma may be more relevant in certain populations (e.g. ethnic minorities) than others. Among undergraduates who report concealing suicidal ideation, Hom et al. (2017) found that “others finding out” was a significant motive for suicide concealer when they were speaking with

psychologists or psychiatrists (reported by around 40% of respondents), but was far more commonly given as a motive for concealing from friends and family (reported by more than 70% of respondents).

Impulsivity. While suicide is often understood as a process that starts with suicidal ideation and moves over time to planning, and then to an attempt (e.g. Thompson et al., 2012), there is evidence that a number of suicides are impulsive. The precise definition of impulsivity is under debate (see Rimkevicienea & De Leo, 2015), but it is generally seen as an unplanned act driven by a moment of crisis or panic. In extremely impulsive suicides, there would be no time for the victim to seek mental health services, and no opportunity for therapist intervention. Such clients may not disclose suicidal ideation in therapy because they are not experiencing it at the time of assessment. For this reason, impulsivity is not discussed here.

Preserving autonomy to commit suicide. Resnick (2002) notes that while mental health professionals would like to imagine themselves as allies in treating depression and suicidality, patients who have decided to die will see them as adversaries: "the psychiatrist and suicidal patient are working toward conflicting goals: preserving and improving quality of life versus ending it altogether" (p. 8). Similarly, Shea (2009) describes a group of ideators who are so committed to ending their lives that they conceal suicidal ideation so that their attempt will not be thwarted. This group may include longtime sufferers who have failed to find relief or severe suicidal ideators whose extreme pessimism causes them to reject assistance. Empirical evidence for these clinical observations includes studies finding that, in various types of samples, between 25% and 75% of suicide completers will have denied suicidal ideation to their clinician (e.g., Busch, Clark, Fawcett, & Kravitz, 1993; Denneson, Basham, & Dickinson, 2011; Robbins, 1981). Those who are determined to die will not disclose their plans to anyone in a position to

intervene. Other clients experiencing suicidality may be less decided, but still want to maintain autonomy and prevent interference.

Avoiding interference and preserving autonomy are obvious reasons to conceal suicidal ideation. Among US college students concealing suicidality, Burton Denmark et al. (2012) found that 7% offered reasons in this category, for example, "I thought they would tell someone or try to talk me out of it. I wanted to be in control of what happened and not have others interfere" (p. 89).

Therapist Behaviors that Affect Concealment of Suicidal Ideation

The second aim of this study is to investigate what therapy clients currently concealing suicidality believe their therapist could do to help them be more honest. As we will see, there is a great deal of scholarship about the most effective methods of suicide assessment (e.g., Jobes, 2006; Rudd, Joiner, & Rajab, 2001; Bongar & Sullivan, 2013), yet it is rare to find studies in which suicidal clients provide feedback, as it were, to the mental health professions who are assessing them. One such study, Ganzini and colleagues' study (2013) of brief suicide screening in US Department of Veterans Affairs medical centers, interviewed 34 Iraq and Afghanistan War veterans about their decision to conceal or reveal suicidal thoughts. Subjected to multiple standardized suicide screenings by different VA staff, some veterans wondered if their answers were being checked for consistency to see if they were lying, and one even wondered if the VA was trying to provoke him to commit suicide! Above all, veterans stressed trust and respect as the keys to fostering honesty about a topic they regarded as intimate and shameful. As one veteran put it: "Those who are nice to me and treat me with respect… they will get all the information they need from me" (p. 1218). Professionals who put aside the standardized screener

to establish interpersonal trust with the veterans were deemed to be safe for disclosure, a finding which challenged the VA's roll out of routine screening for suicidality.

Therapist behaviors that might encourage or discourage disclosure occur against the backdrop of a field which is in flux. Recent advances in suicide assessment and treatment have led to the discarding of ineffective "no suicide contracts" in favor of "suicide safety plans" developed collaboratively with the patient in anticipation of future crises, as well as a new emphasis on intensive outpatient treatment and the teaching of new coping skills that can replace the patient's maladaptive use of suicidality to manage negative affect (Brown et al., 2005; Jobes, 2006; Linehan, 1993; Rudd et al., 2001). Inpatient hospitalization, once the standard treatment for suicidal patients, is increasingly curtailed, both for economic reasons and because its disruptive effects on a patient's personal life and employment can actually make matters worse for many patients (Jobes, 2006). Average lengths of inpatient hospital stay have fallen; for example, between 1990 and 2000 the average length of inpatient psychiatric hospitalization for youths with self-inflicted injuries fell from 3.6 days to 2.7 days (Olfson, Gameroff, Marcus, Greenberg, & Shaffer, 2005).

The recent literature on the role of therapist behaviors is focused on two aspects (1) routinely assessing suicidal risk, and (2) using effective methods to conduct the assessment. Arising from the second aspect is a related concern (3) establishing a trusting relationship with the client.

Failure to assess. The most powerful tool of comprehensive suicide assessment is the face-to-face clinician interview (Bryan & Rudd, 2006, p. 196), yet how often does it actually happen? No reliable numbers exist on the frequency with which therapists and other health professionals assess for suicidal risk, but the perception that they do not do it often enough is

widespread in the literature. Among a sample of clinical psychologists, Sullivan (2004) found that only 77% reported inquiring about suicidal ideation during initial sessions with new clients. Mays (2004) describes a subtle "clinician denial" in which anxious therapists frame questions in such a way as to minimize the likelihood of the client actually making a suicidal disclosure, for example, "You're not suicidal, are you?" (p. 370). A study of outpatient clients of a managed behavioral health care organization seems to some kind of denial or avoidance in action. Among 310 adults reporting on a questionnaire that they "frequently" or "almost always" have thoughts of ending their life, 57% were rated soon after by their treating clinicians as having "no suicidal ideation" (Brown, Jones, Betts, and Wu, 2003). While conceding that discrepancies between questionnaires and face-to-face assessment are normal, the authors conclude the magnitude of the difference was at the very least "somewhat surprising". The failure to ask detailed questions about suicide may be motivated by the high-stakes nature of the situation – losing a patient to suicide may have reputational and legal implications for the clinician. Motto (1989) observes that these pressures can result in therapists denying evident suicidal risk, or regressing to emotional states that compromise their abilities (cited in Bongar & Sullivan, 2013, p. 154).

Style of assessment. When assessment does occur, it may often involve direct questions such as "Do you ever have thoughts about killing yourself?", which may appear on questionnaires or be asked by clinicians without much forewarning. More subtle interview techniques are thought to influence the likelihood of suicidal disclosures. For example, Orf's (2014) study of suicide disclosure in psychotherapy found that the use of questions based on Joiner and colleagues' Interpersonal Theory of Suicide (Joiner, 2005; Joiner, Orden, Witte, & Rudd, 2009) was the strongest predictor of suicide disclosure in a sample of 85 psychotherapy clients. Assessment along these lines includes asking not only about thoughts, but also thwarted

belongingness (isolation and disconnection) and perceived burdensomeness (sense that one is worth more to others dead than alive), as well as whether past risky, self-harming, or violent behavior has allowed the client to develop the necessary capacities for lethal violence against the self. Orf's contention is that the Joiner method not only leads to accurate assessment of risk, but that it results in greater disclosure by the client.

Among books on suicide assessment, Shea's *Practical Art of Suicide Assessment* (1999) offers perhaps the most comprehensive and detailed guidance on every step of the clinical interview with suicidal clients. Among seven "tips for decreasing client reluctance to discuss suicide", Shea suggests listening for slightest hesitation in client responses to questions about suicide, inviting clients to discuss even fleeting ideation, putting down the notebook to engage more completely with the client, as well as making an effort to never appear hurried or uncomfortable with the topic. Shea also recommends clinicians ask themselves "Is there any part of me that doesn't want to hear the truth right now?" in order to identify any countertransference issues that may inhibit client disclosure (p. 122). Shea goes on to describe methods of phrasing, ordering and focusing questions while conducting an assessment, which he calls validity techniques. These include asking about concrete behavioral incidents (rather than general situations), attenuating the client's shame by asking about suicide in the context of the stressors that made suicide seem reasonable to the client, and making gentle assumptions about the client's experience (e.g., "What other ways have you thought of killing yourself?") to signal your acceptance in advance that such behaviors have occurred (p. 132).

Bryan and Rudd (2006) propose a "hierarchical approach" to questioning during suicide assessment. The clinician begins with general questions (e.g., "How have things been going for you recently?") and then moves on to the symptoms of depression (e.g., "From what you've

shared so far, it sounds like you have been feeling depressed. Have you been feeling anxious, nervous, or panicky lately?"), and then to hopelessness (e.g., "It's not uncommon when depressed to feel that things won't improve and won't get any better; do you every feel this way?"), and finally to the specific nature of the patient's suicidal thinking (e.g., "People feeling depressed and hopeless sometimes think about death and dying; do you ever have thoughts about death and dying? Have you ever thought about killing yourself?") (p. 188). By moving gradually, this approach is designed to minimize the patient's anxiety, and thus increase the chances of an honest response. Suicidality is also placed in the context of depressive symptoms, which can have a normalizing effect. If suicidal material does emerge, Bryan and Rudd also recommend asking first about more distant episodes, before moving on to the more emotionally-hot experiences of current suicidality.

Of note here too is Jobes' (2006) Collaborative Assessment and Management of Suicidality (CAMS) approach, a comprehensive framework for assessment and treatment of suicidal patients. Although it is designed for patients already identified as suicidal, it is significant to this discussion for its philosophical stance that the assessing clinician must not be outside "voyeur" to the suicidal wish, but rather a "therapist participant" who expresses genuine empathy for the suicidal desires without endorsing suicide as a solution (p. 37). This stance includes the physical positioning of the clinician in the room: not across from but sitting beside the patient considering suicide.

Another style of assessment involves indirect methods of assessing suicide potential through suicide indices developed for the Minnesota Multiphasic Personality Inventory (MMPI) and Rorschach Inkblot Test. These are outside the scope of the present study.

Establishment of trust. Ideally, suicide assessment occurs in the context of a strong therapeutic alliance (or working alliance), which is among the most studied contributors to overall disclosure in psychotherapy (Farber, 2003; Hall & Farber, 2001; Kelly & Yuan, 2009). Even so, very little research exists on the role of the alliance in the disclosure of suicidal ideation. Orf's (2014) survey of 85 adult psychotherapy patients who had experienced suicidal ideation found that the alliance was a significant predictor of suicidal disclosure. A similar conclusion is suggested by Gazini and colleagues' (2013) interview study with 34 suicidal Iraq War veterans, who reported greater willingness to disclose to clinicians expressing genuine concern, and who knew the patient well and who were trusted (Ganzini et al., 2013). These clinicians asked about suicidal thoughts in the context of the veterans' own goals, such as being present to care of one's children and family. Quickly establishing the patient's trust is almost always mentioned as a goal in suicide assessment (e.g., Jobes, 2006; Bryan & Rudd, 2006).

At the same time, serious ruptures in the therapeutic alliance may be particularly likely in discussions of suicide. The potential for reporting and hospitalization can push the therapist out of the role of ally and closer to the role of adversary (Resnick, 2002) for patients who are either committed to dying or who simply fear losing control over their treatment. This sudden shift can result in what Hendin, Maltsberger, Lipschitz, Haas, and Kyle (2001) refer to as instances of flawed communication, in which therapist techniques actually provoke client concealment. In one case, a young female client announced she would no longer share her suicidal thoughts in therapy. In response, her therapist said she would be forced to hospitalize the patient if she would not be honest about her suicidal intentions. The patient did not respond immediately, but seemed more cheerful in the ensuing weeks and the therapist decided the crisis had passed. Unfortunately the patient killed herself soon after. In an audio-recorded suicide note she cited a sudden loss of

trust brought on by the conflict over suicidal disclosure: “Dr. [X] sort of threatened me. She said that if I didn’t open up to her, she was going to have me put in the hospital… I stopped trusting her and started acting. I started planning then about suicide” (p. 120). Such extreme reactions are rare. More commonly, Shea (2009) argues that patients will make their disclosures in stages, sharing some information, waiting to see how the clinician responds, and then either sharing more information or clamming up as they reevaluate “where this session is going” (p. 18). He argues that allowing the patient to take their time in making difficult disclosures is part of fostering a sense of safety and trust that ultimately leads to full honesty.

Transparency and informed consent. There is some reason to believe that many clients do not fully understand the likely consequences of honestly disclosing suicidal ideation to a mental health professional, and that this uncertainty breeds fear. People fear being incorrectly labeled in a knee-jerk fashion; they suspect medical professionals will make decisions for them based on over-reaction. At the same time, patients tend to appreciate skilled professional attention to their problems, and at times may only drop resistance to disclosure when the clinician has established his or her expertise, concern and sensitivity in assessing them (e.g., Ganzini et al., 2013; Taylor, Hawton, Fortune, & Kapur, 2009). There is, however, strikingly little research and scholarship on this important dynamic of the disclosure dilemma. Shea (1999, 2009) observes that some patients believe the police will appear at their door and cart them off to the hospital if they disclose any level of suicidal ideation. Among US college students, Burton Denmark et al. (2012) found that fear of repercussions were mentioned by 7% of hidden ideators, who believed that they would be forced to leave school or could have their children taken away if they disclosed suicidal ideation. The authors conclude that colleges and universities should consider increasing their transparency about forced leave policies, because students are likely

already acting on a misperception that disclosure will automatically result in a forced medical leave or disciplinary action by the school. Transparency about treatment goals, methods, and the expectations of therapist and patient play a central role in several newer treatment modalities for psychological conditions that involve suicidality, including Dialectical Behavior Therapy (Linehan, 1993), CAMS (Jobes, 2006), and cognitive therapy for the prevention of suicide attempts (Brown et al., 2005). Further, a strong case has been made for a suicide-specific process of informed consent, with the aim of educating patients and their families about the risks and benefits of treatment, as well as the risks of opting out of treatment (see Rudd et al., 2009). Such a process could improve family involvement and crisis management among patients identified as suicidal.

As for patients who are concealing suicidality, the many excellent guides to assessing suicidal ideation have surprisingly little to say about explaining the likely clinical response should patients disclose their suicidality to a clinician. There is little doubt that some percentage of hidden ideators are chiefly concerned with avoiding interventions such as hospitalization. Yet there is no research illuminating whether these yet-to-be-identified suicidal ideators receive sufficient explanation of the likely triggers for hospitalization. Deane, Wilson, and Ciarrochi's (2001) study of young adult attitudes toward help-seeking found that those with higher levels of suicidal ideation reported lower intentions to actually seek help from various sources – with the strongest effect being a resistance to contacting mental health professionals and telephone help lines. The authors speculate that "as actual suicidal ideation increases, individuals become increasingly focused on retaining control over their destiny" (p. 910). Involving mental health professionals presents the risk of further loss of control.

Contextual Factors that Affect Concealment of Suicidal Ideation

While often beyond the control of individual therapists, various contextual factors may also prevent disclosure of suicidal ideation. For example, certain contexts provide more confidentiality and fewer potential penalties for ideators considering disclosure. One study of U.S. National Guard soldiers found that the perceived confidentiality of an assessment changed the rate of disclosure by 57% (Anestis & Green, 2015). Thus, while the specific context of the military suppressed disclosure, enhancing the perceived confidentiality of assessment instruments achieved a higher rate of disclosure. Another context noted for suppressing suicide disclosure is inpatient psychiatric hospitalization. While it is believed that the period immediately after hospitalization is a critical one for suicide risk (e.g., Pope & Vasquez, 2011), no research was found on factors affecting disclosure among inpatients. It is however commonly understood among patients that release from an inpatient unit is contingent on the patient's ability to convincingly deny suicidal intent when staff inquire about it. Thus, some contexts in which therapy occurs can create a silencing effect, discouraging disclosure.

A different effect of context is noted by Mays (2004) who argues that the comforting qualities of individual therapy sessions – even those in which suicidal intent is assessed – may often lead to "affirming effects" by which patients feels listened to and are thus less anxious, more hopeful, and perhaps even feeling more socially connected. During such a session clients may honestly report feeling less suicidal, or decide not to mention suicidal symptoms that in the moment seem to have receded. The clinician may conclude that the crisis has passed, or that no crisis exists. Meanwhile departing clients may sink back into hopelessness at some time after leaving the office, realizing nothing in their life has changed. It is likely that setting of therapy is

a crucial variable in suicide disclosure, particularly hospital inpatient units where denying suicidal intent is required for release.

Would Non-Serious Ideators Benefit from Disclosure?

The literature on suicide disclosure is understandably focused on preventing suicide among the small percentage of ideators who will attempt to end their lives. What about the vast majority who will never attempt? Is there anything to be gained by fostering their honest disclosure of suicidal thoughts? The literature suggests there are benefits, both for the individual and for the effectiveness of therapy. The overall tendency to disclose one's distressing feelings and experiences has been repeatedly associated with psychological well-being (Barry & Mizrahi, 2005; Cramer, 1999; Hook & Andrews, 2005; Ichiyama et al., 1992; Kahn et al., 2002; Pennebaker, 1989, 1997). The opposite tendency, toward self-concealment, has been associated with lower levels of social support, romantic relationship satisfaction, depression, anxiety, negative health behaviors, and of course, suicidality (see Larson, Chastain, Hoyt, & Ayzenberg, 2015 for a review). Self-concealment is also negatively correlated with the therapeutic alliance, known to be a strong predictor of psychotherapy outcome (Fedde, 2009).

To the extent that disclosure in psychotherapy can help individuals practice greater self-disclosure and less self-concealment in general, there would appear to be a major benefit. Indeed, this is why most contemporary therapy models assume that the client's ability to self-disclose about feelings and experiences is an essential aspect of healing (Farber, Berano, & Capobianco, 2004). Findings from three studies demonstrate that psychotherapeutic interventions can decrease an individual's tendency to self-conceal (Brown & Heimberg, 2001; Luoma, Kohlenberg, Hayes, Bunting & Rye, 2008; Wild, 2004).

There has been debate over whether concealing some therapy-relevant secrets may actually help clients by allowing them to present a favorable self-image (Kelly, 2000), but no findings have suggested that this potentially helpful secret-keeping would include suicidal ideation. Clients themselves tend to report that withholding clinically-relevant disclosures negatively affects the process of therapy, and when they do make an intimate disclosure, they tend to be positive about the immediate consequences (Farber et al., 2004). Post-disclosure emotions most commonly reported by clients included not only feeling "vulnerable", but also feeling "relieved," "authentic," and "safe". Thus, an extensive body of psychotherapy research suggests non-serious ideators could benefit from disclosure in the context of psychotherapy, although this is perhaps contingent upon their therapist's responding appropriately.

Limitations of the Existing Research

There are several limitations of the existing literature on what motivates clients in psychotherapy to conceal suicidal ideation and how therapists can help them be more honest. First, no previous qualitative study has queried hidden ideators in psychotherapy about why they choose not to disclose to their therapist. Studies of non-disclosure in psychotherapy have illuminated reasons why clients keep secrets (Kelly, 1998), minimize discussion of certain topics (Farber & Sohn, 2007), hide their negative reactions to therapist interventions (Hill, Thompson, Cogar, & Denman, 1993), mislead therapists about the effectiveness of therapy itself (Blanchard & Farber, 2015), and spin elaborate outright lies (Gediman & Lieberman, 1996). There is reason to believe hidden suicidal ideators conceal for reasons that are distinct from clients who are, for example, dishonest about their sex lives or their opinion of their therapist. As of yet, only one study has looked specifically at client concealment of suicidal ideation in psychotherapy (Orf, 2009), providing some quantitative support for the idea that therapist behavior is an important

predictor of disclosure of suicidal ideation, possibly more of a factor than the client's own fears of repercussions. The only known qualitative study of suicidal individuals deciding whether to disclose to mental health professionals involved 34 US military veterans reacting to the VA's suicide screening and risk assessment process (Ganzini et al., 2013). Missing from the literature is an essential piece of the puzzle: suicidal psychotherapy clients explaining in their own words why they have concealed their suicidality from their therapist. The current study aims to fill this gap.

A second limitation of the current literature is that it provides little sense of the relative importance of various reasons for concealment. Studies of people hiding suicidality in the non-clinical population (Drum et al., 2009; Burton Denmark et al., 2012) and among those questioned by mental health professionals (Ganzini, 2013; Hom et al., 2017) have provided a good sense of the universe of reasons why people hide their suicidal ideation. Twelve of the most prominent reasons are discussed above. Which of these many reasons are most likely to drive concealment in the special context of psychotherapy is unknown.

Third, there is a lack of research on adults. In their comprehensive review of the factors affecting help-seeking among suicidal individuals, Hom et al. (2015) note that the overwhelming majority of studies in this area focus on adolescents and young adults, whose involvement with institutions such as schools and colleges make them relatively easy to study. While suicide is a leading cause of death among young people, middle-aged adults accounted for the largest proportion of suicides (56%) in 2011, and from 1999-2010, the suicide rate among this group increased by nearly 30% (CDC, 2015). Hom et al. call for research to understand the barriers and facilitators to care unique to older adults, writing "it is essential for this research gap to be addressed" (p. 35). This gap, too, can be partially filled by the current study.

Purpose of the Current Study

The current study helps to fill the three gaps in the current literature discussed above by examining reasons for non-disclosure of suicidal thoughts and attempts among adults who are in psychotherapy. This population, by virtue of being in psychotherapy, has overcome every external barrier to help-seeking, yet continues to conceal suicidal ideation from the mental health professionals they are working with. Our goal is to examine patients' own explanation of their motives for concealment, the perceived impacts of concealment, and their sense for what their therapists might have done differently to foster honest disclosure. This study is also designed to gauge the relative importance to concealers of various motives for concealment, and to give a voice to these at-risk clients who feel they cannot share their experiences with suicidality directly.

The current study utilizes data taken from two versions of a large survey of dishonesty by psychotherapy patients (total N = 1345) reporting on a wide range of topics they conceal or lie about in their current therapy. The survey is an online survey instrument comprised of both multiple choice and open-text entry questions, as well as psychometric scales. Version 1 had 547 respondents, and this version provided the data set for Blanchard and Farber (2015). Yet-to-be-analyzed data from this study includes a number of open text and multiple choice questions about the motives and consequences of their non-disclosure. Version 2 is a modification designed to assess levels of honesty or avoidance on a range of therapy-relevant topics, including suicidal thoughts and attempts. This version includes the same set of open-text and multiple-choice questions about motives and consequences for non-disclosure, as well as additional questions designed to explore what respondents think their psychotherapist could have done to

foster greater disclosure. It also included psychometric scales measuring the therapeutic alliance, the tendency to disclose distressing experiences, and overall honesty in therapy.

The present study examines open-text and multiple-choice responses by the subset of respondents from both versions who reported concealing suicidal ideation from their therapist. The motives and reasoning of this smaller subset of suicide concealers have been compared to that of non-suicidal respondents, allowing this study to identify differences in the pattern of motivation that may make suicide concealment unique among topics of dishonesty in therapy. By giving hidden ideators a chance to report on their own reasoning, it is hoped these analyses will advance our understanding of the attitudes and fears that are preventing the disclosure of suicidal ideation among psychotherapy clients.

Research Questions

This study relies primarily on qualitative methodology and deals with a novel and not well-theorized area of inquiry, with previous research on this topic being insufficient to formulate hypotheses. For these reasons, no a priori hypotheses were generated. Instead, a research question approach was used to guide the analysis (Morrow, 2007; Neuendorf, 2002). The following questions arise from the existing literature on suicidality and its concealment in therapy.

Research question 1. What motivates clients experiencing suicidal ideation to conceal this from their psychotherapist, and which motives are the most common? Because previous scholarship suggests that suicidal individuals not in therapy will report a wide range of reasons for non-disclosure with no one reason dominating (e.g., Burton Denmark, 2012), we may see a similar diversity of motivations among hidden ideators who are in psychotherapy. Other research, however, suggests suicide concealers could also skew heavily toward one or two

reasons, as earlier work on dishonesty among psychotherapy clients (Blanchard & Farber, 2015) suggests that motives for concealment from one's therapist can differ substantially according to the nature of the information being concealed. Knowing these motives, as expressed by concealers, will highlight common roadblocks that prevent disclosure and suggest clinical techniques that could help to remove them.

Research question 2. What do suicide concealers believe their therapist could do to help them be more honest? Previous research offers little guidance on what, if anything, dishonest clients feel their therapist could do differently to foster disclosure. When Baumann and Hill (2015) asked clients keeping mostly sex and relationship secrets what could help them disclose, a substantial majority (63.9%) reported that their therapist could foster honesty by asking more direct questions on the topic. Only a tiny minority (6.6%) felt that there were no circumstances under which they would be honest. Clients in the present study are specifically concealing suicidality. The nature of this topic may mean that concealers propose entirely different ideas about what their clinician can do to foster honesty. Knowing these ideas adds the voices of concealers to the ongoing discussions about how to assess and handle suicidal material, and may suggest new approaches.

Research question 3. How do suicide concealers view their own dishonesty on this issue? What feelings do suicide concealers have about their dishonesty? Are they disappointed that they could not be more honest? Or were they satisfied with their level of disclosure? Do they presently foresee being more honest about suicidality with their current therapist, another therapist, or with family and friends? Understanding clients' attitudes toward concealment provides further nuance to our understanding of concealment as seen by concealers, and may

give a sense of the amount or urgency or anguish – or lack thereof – that clients experience when they feel they cannot share suicidal thoughts with their clinician.

Research question 4. How do suicide concealers believe being dishonest about suicidality affects their progress in therapy? Clients may feel that therapy is to some degree ruined when honesty does not seem possible, an attitude that could lead to stalled progress or premature termination. Alternatively, clients may see their concealment as streamlining or refocusing their therapy on what they do want to discuss. Understanding the impact on therapy as seen by concealers provides another previously unseen perspective on the handling of suicide-related material and provides some sense for whether clients who conceal feel there are any costs associated with this decision.

Method

The present study is an analysis of data collected by the Psychotherapy, Technology, and Disclosure Lab of the Department of Counseling and Clinical Psychology at Teachers College, Columbia University. The results analyzed here came from two versions of an online survey about dishonesty in psychotherapy. Data were collected in two waves, the first from January 2014 to February 2015, and the second from June 2015 to March 2016. The survey was administered online in order to collect the largest and most geographically diverse sample possible within resource constraints, and to offer a private, anonymous format in which respondents would feel most comfortable disclosing what they might not say in a face-to-face interview.

Participants

Whole sample of survey respondents. Survey versions 1 and 2 included a total of 1,345 respondents (297 men, 1,029 women, 19 other; age range 18-80 years, M = 35.01, SD = 13.32)

who are currently or were in psychotherapy during the last 12 months. Marital status was reported as single or never married by 824 respondents (61.3%). Participants self-identified as White (75.6%), African-American (5.6%), Asian and Asian-American (5.9%), Hispanic/Latino (4.2%), and Native American (.7%) or Native Hawaiian/Pacific Islander (0.07%); the sample also included 106 respondents who reported being biracial or "other" (7.9%). This was a well-educated sample with 57% reporting a bachelors or higher degree. Median income for this sample was between $30,000-$60,000.

These demographics can be compared to the therapy-using population reported by the National Survey on Drug Use and Health (2012). While the current sample is somewhat younger and contains a greater proportion of college graduates, the two samples are similar in terms of gender and ethnicity. Thus, although the original study used a convenience sampling method, the demographics bear a good overall resemblance to a national therapy-using population.

The median number of therapy sessions for clients in the present sample was 28 with their current or most recent therapist; the median duration of treatment with the current therapist was 12 months, with durations ranging from 1 month to 30 years; 72% of participants were currently (or most recently) working with female therapists, and 28% with male therapists. The theoretical orientation of these therapists, as reported by respondents, included cognitive-behavioral (38.3%), psychodynamic/humanistic (20%), addiction counseling (4%), as well as a range of eclectic, gestalt, and other therapies (8.3%). One quarter of the sample did not know their therapist's orientation. The most commonly reported reasons for these clients entering therapy included depression (64%), anxiety (49%), stress (40%), personal growth (31%), relationship problems (30%), and traumatic experiences (25%), as well as a diversity of other

problems including borderline personality disorder, PTSD, binge eating, bereavement, and emotional problems secondary to medical conditions such as cerebral palsy.

Suicide Concealer sample for research question 1. The present study examines a sub-sample of respondents who reported dishonesty in therapy about having suicidal thoughts or attempts, and subsequently elected to provide answers to a series of open-ended and multiple-choice questions about their motives and feelings relating to being dishonest on this topic. This sub-sample initially numbered 112 respondents. Of that number, five respondents failed to complete a series of suicide-specific follow-up questions and were removed from the analysis. The remaining 107 respondents comprise the Concealer sample analyzed for Research Question 1 about motives for concealment or dishonesty about suicidal ideation in psychotherapy (see Table 1). The average age of the Concealer sample was 31.2 years, (*SD* = 13.04), nearly four years younger than the whole sample median, and ranged from 18 to 67 years. The concealer sample consisted of 86 females, 17 males, and 4 who reported "other" as their gender. Respondents in this group reported their ethnicity as White (73%), African-American (7%), Asian and Asian-American (2%), Hispanic/Latino (7%), and biracial or "other" (12%). Concealers mirrored the education and income distribution of the larger sample, with 51% reporting a bachelors or more advanced degree, and a median household income between $30,000-$60,000. Common reasons for entering therapy among the 107 suicide concealers included depression (74%), anxiety (44%), stress (41%), suicidality (28%), and mood problems (24%). Less common reasons included traumatic experiences (18%), bipolar disorder (9%), personal growth (7%), and substance abuse (4%).

Table 1.

Participant Demographics, Suicide Concealer Sample (N = 107)

	n / mean	% / *SD*
Gender		
Female	86	80%
Male	17	16%
Other	4	4%
Race/ Ethnicity		
African-American	7	7%
Asian/ Asian-American	2	2%
Hispanic/Latino/a	7	7%
White/Caucasian	78	73%
Biracial	8	8%
Other	5	5%
Age	31.2 years	13.04
Education Level		
Grade School	1	1%
High School or GED	23	21%
Some college	22	21%
Associate's Degree	7	7%
Bachelor's Degree	31	29%
Master's Degree	21	20%
PhD / MD / JD	2	2%
Household Income		
$15,000 or less	21	20%
$15,000 - 30,000	18	17%
$30,000 - 60,000	22	21%
$60,000 - 100,000	15	14%
More than $100,000	10	9%
N/A	21	20%
Number of Sessions with Current Therapist		
Average	69.3	92.1
Median	30	--
Reasons for Entering Therapy		
Depression	74	69%
Anxiety	47	44%
Stress	44	41%
Suicidality	30	28%
Mood Problems	26	24%
Traumatic Experiences	19	18%
Bipolar Disorder	10	9%
Personal Growth	7	7%
Substance Abuse	4	4%

Type of Psychotherapy		
CBT	44	41%
Dynamic	21	20%
Other	17	16%
Eclectic or Integrative	4	4%
Humanistic or Existential	3	3%
Addiction Counseling	3	3%
DBT	1	1%
Don't know	14	13%
Satisfaction with Current Therapy	6.6/10	2.5

Suicide Concealer sample for research questions 2 and 3. Because the open-text and multiple choice questions pertaining to research questions 2 and 3 were only offered in version 2 of the survey, the suicide concealer sample used to answer this question was necessarily smaller, numbering 66 respondents. This sub-sample is demographically similar to the larger concealer sample from which it is drawn. The average age was 31 years, (*SD* = 13.46), ranging from 18 to 71 years, and the subsample consisted of 52 females, 12 males, and 2 who reported "other" as their gender. Respondents in this group reported their ethnicity as White (77%), African-American (11%), Hispanic/Latino (6%), and biracial (6%), with 53% reporting a bachelors or more advanced degree, and a median household income between $30,000-$60,000.

Data Collection Procedures

Original data collection. A research proposal and a draft of the survey, including informed documents, were submitted to and approved by the Institutional Review Board of Teachers College, Columbia University on November 14, 2013. The same was done with version 2 of the survey, which was approved by the IRB on March 30, 2015.

Participants were recruited through postings to Craigslist sites serving 13 large metropolitan areas of the United States, as well as 18 more rural areas. The posting message

invited them to participate in a “survey on psychotherapy”, and contained a link to the survey. All respondents were entered into a drawing to win one of six $50 Amazon gift cards. Among respondents to version 1 there were no significant demographic differences in comparing completers of the survey (N = 547) and drop-outs (N = 150), with the exception of gender: the completer group had a higher proportion of women (78.1% female) than did the drop-out group (69% female), chi-square (1, N = 697) = 5.7, $p < .05$. Among respondents to version 2, completers (N = 798) and dropouts (N = 247) showed no statistically-significant differences on gender or any other demographic measure. Identities of respondents were protected by not requiring that respondents share their names. Those who choose to enter the aforementioned random drawing for a $50 gift card were provided a separate survey link in which to enter their email addresses, ensuring their confidentiality and protection of personal information. Personal data was only linked to survey responses in the case of respondents who volunteered for an in-person interview, a later phase of the research project which is not relevant here. This information was kept in password-protected files and de-linked from survey responses after processing by the study team. Subjects taking both versions of the online survey were provided with contact information of the principal investigator/faculty advisor on the study, Dr. Barry Farber, and access to an email address closely monitored by the research team. This information was provided in the consent form for the survey. Subjects who experienced distress while completing the survey were encouraged to contact Dr. Farber or the research team for assistance in finding local counseling services. No respondents contacted the team for this purpose.

Approvals obtains for the current study. Prior to the analysis of the open-text and multiple-choice data, approval by the Institutional Review Board was received on June 15, 2016.

This study was exempted from further review because it uses de-identified data from studies already approved by the board.

Measures

Versions 1 and 2 of the survey consisted of similar assortments of forced choice items, Likert Scale items and sub-items, multiple choice items for which multiple responses could be selected, and open-ended text response items and sub-items in which respondents could type in as much text as desired. Question wording was consistent between the two versions for the open-text items analyzed in this study, but version 2 contained additional questions. Due to these differences, both versions will be described.

Survey version 1. This is an online, self-report instrument, designed with the Qualtrics survey software, incorporating both quantitative and qualitative methodologies. The survey consists of 104 items and the median completion time for the entire survey was 20 minutes. In order to help respondents access memories of dishonesty, the survey part of this instrument provides a list of 58 topics about which they may have been dishonest. The topic list was adapted from the Disclosure to Therapist Inventory IV (DTI-IV; Pattee & Farber, 2008), with items modified or discarded in keeping with the previous literature on lying and concealment. Two rounds of pilot studies were conducted to ensure no major topic areas were missed (i.e., no new topics were suggested by participants). The final version included a wide range of possible topics for dishonesty, such as “my use of drugs or alcohol”, “my desire for revenge”, and “pretending to like my therapist’s comments or suggestions.” The list was designed to include situations previously described as “secrets” as well as “hidden reactions” and “things left unsaid” (Hill et al., 1993). Respondents could quickly browse the list and select topics on which they recalled being dishonest. Further, they had the option to indicate that they had *never* been dishonest with

their therapist, or to volunteer an additional topic not covered in the list. Respondents who selected one or more topics were then presented with the list of topics they had chosen and asked to rate the extent to which they were dishonest about each one on a five-point Likert scale (1 = “a tiny bit”, 5 = “totally or extremely”).

A second section of the survey asked respondents to choose one lie about which they would be willing to answer a series of additional in-depth questions about the circumstances, motivations, and perceived consequences of their dishonesty. This section featured a set of open-ended questions (e.g., “Why did you lie to your therapist about this topic?” “Can you tell us more about it?”) for which respondents could type in answers of any length. This part of the survey also featured a 28-item inventory of possible motives, allowing participants to click multiple options that they felt described their reasons for being dishonest about a specific topic. A preliminary list of such motives was compiled based on previous research suggesting that clients may be dishonest for reasons of impression management (Goffman, 1959), in order to avoid offending the therapist (Rennie, 1994), to control the conversation (Regan & Hill, 1992), to avoid shame (Hill et al., 1993) and to meet the psychological needs of self and other (DePaulo, et al., 1996), as well as for purely practical reasons, such as avoiding legal consequences (Newman & Strauss, 2003). Six graduate research assistants were then asked to record motives for lies they told in therapy over a three-week period, and later, a pilot study collected more motives for dishonesty from a sample of 25 respondents. Following a review by the research team (the two authors and six assistants) of the research literature and the new accumulated data, a total of 28 possible motives were selected to be used in the survey instrument (e.g., “I wanted to avoid shame”; “I wanted to avoid my therapist’s disapproval”; “I was concerned with legal

consequences”). Respondents could also type in additional motivations if they did not see theirs on the list.

Survey version 2. A modification of Survey 1, this is also an online, self-report instrument, designed with the Qualtrics survey software, incorporating both quantitative and qualitative methodologies. The survey included 107 items and the median completion time for the entire survey was 21 minutes. In order to help respondents access memories of dishonesty, a reduced list of 33 topics is presented, adapted from the list used in Survey 1. Respondents are then re-presented those topics which they said they do discuss in therapy and asked to rate their honesty for each topic on a 5-point Likert scale (scale (1 = “not at all honest”, 5 = “completely honest”). Later, respondents are shown the list of topics they said they did not discuss, and asked to provide one of three rationales: “It does not apply to me”, “I would discuss this but it has not come up” and “I purposely avoid this topic”. The software then compiles the list of topics on which the respondent was either not honest (a score of 1 or 2 on the honesty Likert scale) or deliberately avoidant (see Figure 1 for a flowchart of this process). As in version 1, the respondent is then asked to select one topic about which they would be willing to answer a series of additional in-depth questions about the circumstances, motivations, and perceived consequences of their dishonesty. The survey design, while complicated, allowed for the capture of both dishonesty and avoidance, as well as relative levels of honesty, for all 33 topics. Follow-up questions queried the respondent’s motives and perceived consequences for dishonesty, as well as additional open-text and multiple-choice questions designed to elicit their speculations about what might have helped them be more honest about the topic with their therapist.

Items used in this analysis. Respondents who reported dishonesty about suicidal thoughts or behaviors were presented with the option of answering follow-up questions on this

topic (those who answered these follow-up questions constitute the Concealer sample). Respondents first encountered open-text questions. These items included an initial essay box with the prompt "You mentioned that you avoided or were not honest about your suicidal thoughts. Please tell us more: What makes it hard to be honest about this?" This was designed to elicit motives for concealment. Respondents then encountered a second open-ended question, "Can you tell us how not being fully honest affected your therapy?" designed to elicit narratives and feelings about the impact of concealment on therapy. Version 2 of the survey added two additional open-ended questions. These included "If you had told your therapist the truth about this what do you think might have happened?" and "How could your therapist make you feel more comfortable being honest about this?"

Following the open-text items, multiple choice questions were used to provide additional depth to each respondent's story, and to help clarify any vagueness in their open-text answers. Respondents were asked to select one of 6 reasons for not being more honest or select an "other" category. Subsequent multiple-choice questions included "Is this a topic you would ever be more honest about?", "Under what circumstances would you be more honest?", as well as "How did you feel after being dishonest about this?" and "Has not being honest affected your therapy?" Respondents could choose from between 3 and 12 choices for each.

Data Analysis Procedures

As described above, in order to elicit clients' subjective motivations for concealing their suicidality in psychotherapy (research question 1), participants who reported being dishonest about suicidal thoughts or behaviors with their current therapist were asked to respond to the following open-ended question: "You mentioned that you avoided or were not honest about your suicidal thoughts. Please tell us more: What makes it hard to be honest about this?" Participants

could respond by typing an unlimited number of characters into an essay text box provided on screen. Qualitative content analysis was chosen as the appropriate method to identify potential reasons given in these responses and then categorize these reasons according to theme. Content analysis is the systematic, objective, quantitative analysis of message characteristics (Neuendorf, 2002). While content analysis has its modern origins in the study of commercial and political messaging, it can also be used as a scientific method to analyze the nature of a wide range of communicative acts. The idea of a "theme" in qualitative analysis has been variously defined, but in essence it is "a phrase or sentence that identifies what a unit of data is about and/or what it means" (Saldana, 2009). Themes are common in content analysis and may be referred to with terms such as "category" or "domain" (DeSantis & Ugarriza, 2000, cited in Saldana, 2009). In this study a "theme" can be described as a higher-order category of motive that describes a number of respondents' specific and idiosyncratic reasons given for dishonesty. For example, a hypothetical respondent who provides the reason "I'll never go through with it, so why talk about it?" might be categorized under a thematic concept such as "perceived low risk".

Content analysis requires the creation of a sample consisting of individual message units. These units of analysis may be as small as single words or as lengthy as feature films. For this study, the unit of analysis consisted of phrases and/or sentences that describe or convey a motive for dishonesty. Following the content analysis protocol described by Neurendorf (2002), the author examined written responses by all 107 respondents and identified 448 separate statements that appeared to describe potential motives for dishonesty. These 448 message units formed the sample for this analysis. In order to develop the themes, a team consisting of the author and a doctoral student familiar with the research on disclosure in therapy then created the first draft of a codebook, which was then reviewed by the study's faculty sponsor, a published expert in

disclosure and non-disclosure in psychotherapy. This preliminary codebook contained 30 potential themes, all of which emerged directly from participants' responses, as opposed to preconceived categories. The codebook also included categories for "other" and "irrelevant" message units. Along with the codebook, additional documents were prepared, including the coding forms into which decisions would be entered and spreadsheets of the data itself. Three graduate students of clinical psychology (two masters-level, and one doctoral-level) were recruited to be coders for the data set. As laid out by Neuendorf (2002), coder training was an iterative process in which coders were trained on the codebook, attempted to code sample data (at first together and later individually), and offered feedback and revisions to the codebook itself. This preliminary process focused on the training of coders but also involved six revisions of the codebook, with codes being added, and other codes combined.

The final codebook contained 18 codes which were mutually exclusive, in keeping with Krippendorf's (2004) injunction that categories be mutually exclusive. Due to the nature of the data, however, it was also necessary to add three non-exclusive "other or unspecified" categories to capture message units in which the reason given was clearly related to a certain type of motive for concealment (either emotional, practical, or therapy-related) but not detailed enough to match with a precise code. For example, several respondents wrote that they concealed suicidal ideation in therapy because speaking about it "makes me emotional", without specifying whether that emotion was guilt, shame, fear, or sadness. Such a unit would be coded as "other or unspecified emotional impact".

Three-way inter-rater reliability was calculated using Krippendorf's alpha, a statistical measure of agreement that compensates for the possibility of agreement by mere chance. Krippendorf's alpha is considered the most reliable measure for content analysis when

calculating agreement of three or more raters (De Swert, 2012; Hayes & Krippendorf, 2007; Lombard, Snyder-Duch, & Bracken, 2010). Krippendorf's alpha was calculated using the ReCal3 software (Frelon, 2010), an online utility that computes intercoder and interrater reliability coefficients for nominal content analysis by three coders. Following the method described by Neuendorf (2002) both pilot and final reliability estimates were calculated, with the aim of achieving an alpha coefficient of .80. During the training phase described above, coders were trained on subsets of the data, achieving an initial Krippendorf's alpha reliability coefficient of 0.75, which in subsequent rounds rose to 0.83. Final coding took place in ten rounds, each coding roughly 10% of the data, with an average Krippendorf's alpha of .80, meeting the generally-accepted standard for this measure. Each round ended with a meeting of the entire team to review code definitions and make minor corrections to the wording of code descriptions. Disagreements were settled through whole-team discussion and consensus. Finally, the team decided upon four higher-order code groups to which each of the 23 codes logically belong. These higher-order categories were meant to express overarching domains of motives for lying. Code groups included reasons related to practical impacts, reasons related to emotional impacts, reasons specific to therapy or the therapist, and reasons relating to beliefs about self or suicide. Each is described in greater detail below.

Qualitative analysis for research question 2 ("how could your therapist help you be more honest?") was conducted by precisely the same process, with a separate team of three Masters-level clinical psychology students. The data set for question two consisted of 85 message-units produced by 66 participants who answered version 2 of the survey (version 1 did not contain a question on this topic). Just as before, a preliminary codebook was produced with 10 thematic coding categories. During coder training, this was revised down to 8 final codes. Pilot reliability

for this data set was 0.81, and final reliability on the entire coded data set was 0.87, well above the accepted standard for this statistic. As before, the codes for message units on which raters had disagreed were resolved by discussion in meetings of the entire team.

Results

Content Analysis Results for Research Question 1

Structure of the qualitative data. Of the 112 clients who reported having concealed or lied to their psychotherapist about suicidal thoughts or behaviors, 107 clients (95.5%) provided a response to the question: "You mentioned that you avoided or were not honest about your suicidal thoughts. Please tell us more: What makes it hard to be honest about this?" Open-ended responses ranged in length from four to 271 words, and contained between 1 and 22 separate message units, with the median number of message units being three. Once coded, 39% of respondents were found to have provided one motive for dishonesty, 22% had provided two motives, 21% had provided three motives, and the remaining 18% provided between 4 and 6 separate motives for concealment, with just one respondent offering 8 separate motives.

Across 107 responses, 448 message units were coded into one of 22 content categories. These included 19 mutually-exclusive categories and three more general categories capturing other or unspecified emotional, practical, or therapy-related reasons. The number of respondents endorsing each of these 22 motives is presented in Tables 3, 4, 5, and 6. Sample quotations drawn from text entered by respondents is provided for each motive.

Code and code group descriptions. The following sections describe each of the 22 content codes using language provided to coders in the codebook. Major sub-themes are described where present, as are directions for making differential decisions between related codes. Each code is presented along with other codes in its code group, or higher-order category

of motives. There are four code groups: The feared practical outcomes code group contains 7 codes; The reasons specific to therapy code group contains 5 codes; The beliefs about self or suicide code group contains 5 codes; and the feared emotional experiences code group contains 5 codes. I will review the findings for each code along with the other codes in its code group. See Table 2 for the distribution of reported motives across the four higher-order code groups.

Table 2.

General categories of motivation for concealing suicidal thoughts in psychotherapy (N = 107)

Categories	Individuals reporting	Percent of total sample
Concealment to avoid certain **practical outcomes** (e.g. hospitalization, medication, career impacts, etc.; *see Table 3*)	78	73%
Concealment for **reasons specific to therapy** or therapist (e.g. to control course of therapy, because of a bad therapist, fear therapist will judge, etc.; *see Table 4*)	43	40%
Concealment due to **beliefs about self or about suicide** (e.g. "I would never do it", "No one can help me", preference to cope alone; *see Table 5*)	33	31%
Concealment to avoid certain **emotional experiences** (e.g. shame, guilt, to continue denial of the problem, etc.; *see Table 6*)	30	28%

Feared practical outcomes code group. A strong majority of respondents (73%) reported one or more of seven motives for dishonesty relating to the practical, real-world consequences of disclosing suicidal ideation. This group of themes includes forced hospitalization, unwanted medication, family members finding out, impacts on career or schooling, impacts on others (such as children), and in a few cases, the loss of autonomy to commit suicide if they choose to die. This group also includes a general code for other or unspecified practical impacts, where responses were generally worded too vaguely to assign to one of the most specific themes, such as "I did not want serious consequences". All codes in this group reflect the fear that honest disclosure will bring about an immediate break of

confidentiality or intervention by the therapist. These interventions were seen as leading to sometimes dramatic practical consequences for their lives outside of therapy, or for the lives of their loved ones, consequences these respondents believe will make their lives worse, not better. Predicting that their disclosure would set of a chain of events beyond their control, they determined that seeking help from their therapist was not worth the risk. Examples and distributions of response for each of the seven practical outcomes codes are displayed in Table 3.

Hospitalization. When asked why they did not disclose suicidality in therapy, 52% of all respondents spontaneously and specifically mentioned a fear of being involuntarily admitted to a hospital inpatient psychiatric unit. This was by far the most commonly endorsed single reason for concealing suicidal ideation from a therapist. This theme was coded any time the client indicates that avoiding hospitalization is a reason they concealed suicidal ideation; it was not merely visiting the hospital that they seek to avoid, but rather, being involuntarily taken there and held there for an indefinite period of time.

Some respondents said only that they lied because “I didn’t want to get committed” or because “they will lock you up”. Respondents who spoke at greater length generally expressed one of two sub-themes. The first group includes clients who believe that by merely mentioning suicidal thoughts they will be subject to forcible hospitalization. One respondent noted that she never came close to attempting suicide but was “afraid my therapist would commit me so I lied and said I didn’t have thoughts about suicide”. Another client remarked: “Talking about suicide… leads to actions that have to be taken. I feared having to go to a psychiatric hospital.” Some respondents appeared to believe that any discussion of suicidal thoughts is risky. They therefore concealed it from everyone in their lives. As one respondent wrote: “I was scared of telling my therapist, or anyone, the truth. I was scared that would get me placed in some sort of

Table 3.
Practical outcomes avoided by concealing suicidal thoughts (N = 107)

Feared Practical Outcome	Individuals reporting	Percent of sample
Hospitalization "I would be committed to a psych ward." "I would say I wasn't suicidal, even though I was, just to make sure I wasn't hospitalized." "Involuntary commitment is far more traumatic than just dealing with such feelings on my own." "I think they would commit me for treatment and I would be forced into something that would make me feel worse, not better."	56	52%
Medication or medication changes "I do not want to ever be sedated" "I worry the therapist will suggest and push for a medication change. I think my medication is working just fine."	12	11%
Others finding out "I did not want my family to know." "It would out me to my friends, family, and coworkers."	9	8%
Impacts on career or schooling "As a mental health professional, I realize my license is on the line so if I lose that I might as well be dead anyway." "The job was the only thing I enjoyed at the time, and admitting my thoughts of suicide will cause immediate re-assignment." "Saying this could damage future opportunities for myself."	4	4%
Loss of autonomy to commit suicide "I won't be able to follow through with killing myself if I want to." "I believe my fate is my responsibility and that includes suicide. I will not let anyone have the chance to cage me, physically or mentally… nor will I allow interference." "I lied about being suicidal because I did not want to be stopped."	9	8%
Harm or upset to loved ones "I didn't want my mother finding out about my feelings because I wanted to protect her. She wasn't really in all that great an emotional state either."	7	7%
Other or unspecified practical impact "I am afraid to open up and lose everything I have." "It is also scary to not know what the repercussions of giving this information are going to be." "Fear of what will happen if I talk about it."	15	14%

Note. Example quotations taken from survey responses. Sample percentages refer to proportion of 107 suicide concealers who reported each theme.

intensive in-patient therapy." Or as another respondent succinctly explained: "Talking about suicide is never okay." These respondents may have a poor understanding of the actual triggers for hospitalization. Or they may indeed have accurately assessed the anxious climate among clinicians. One respondent's fears were based on the experience of a friend:

> I was terrified that if I talked about just how bad I felt, the topic of suicide would come up, which would lead to me admitting thoughts about killing myself, which for whatever reason makes me think I will be Baker Acted and held against my will in a hospital gown (like my best friend was just over a year ago). And if there is one thing I can't deal with it's losing my control over my circumstances.

A second group of respondents endorsing fear of hospitalization described past experiences with hospitalization, and may represent a more chronically symptomatic population. They appeared to have greater knowledge of the reporting requirements for clinicians and have experienced the consequences of hospitalization first-hand.

> When I was a child, I threatened suicide after experiencing a traumatic sexual event. I was sent to a psychiatric hospital, and that in itself was also a traumatizing experience. The hospital was incredibly unwelcoming, I was very scared the whole time, and a nurse there told me that I should be ashamed of the traumatic sexual experience I'd had. Fearing going back there, since then I've never told anyone when I've felt like suicide was a valid option, and I've definitely thought about it since then.

Several of these respondents with experience of hospitalization articulated a critique of the policy of hospitalization and how it is carried out: "Because if I did [tell the truth] they would put you away, they never listen, the answer to the proplem [sic] is put you away or medicate you to the point you don't know who you are, you can never be honest with them, so you have to lie,

it's an never ending circle…” In a similar vein, another experienced client described concealment of suicidality as really the only good option when dealing with clinicians:

> Everyone I've met with experience in the mental health system knows exactly what to say and how to act around therapists. If you are in the hospital for a suicide attempt- if you admit that you still want to commit suicide, they're never going to let you out. Lying about everything is easier than dealing with med changes, therapist reactions, hospitalizations and ECT treatments.

Another client remarked that even though she knows the rules and procedures for hospitalization, she is made anxious by the uncertainty around how those rules will be applied.

> I am concerned they will force me into a hospital. I am less concerned about this than I first was as I learned that it [suicide] can be discussed to some degree if they realize you are not impulsive and at immediate risk. But, still I don't know how much people know that or what their view of what "immediate risk" means. A week, a month, a year?

A number of respondents expressed the belief that hospitalization – if it did happen – would not help them but actually hurt them, worsening their depression or creating new trauma. One respondent remarked: “I think they would commit me for treatment and I would be forced into something that would make me feel worse, not better.” Or as another wrote: “Involuntary commitment is far more traumatic than just dealing with such feelings on my own.”

Hospitalization was often seen as the proximal outcome – happening right away – that would lead to distal outcomes that happen down the line. Most of the other themes in the practical outcomes code group were frequently mentioned as flowing directly from hospitalization, such as “unwanted medication” or “others finding out”, “harming or upsetting loved ones,” and “loss of autonomy to commit.” Thus, hospitalization occupied a special place in

the logic of the suicide concealers in this sample; it was the primary feared outcome from which other feared outcomes flow.

There is evidence that hospitalization fear was not limited to only those experiencing more severe suicidality. Among the 56 respondents who gave hospitalization as a motive for concealment, 9 also mentioned a belief that they are a low risk for suicide as a reason not to mention it in therapy.

Unwanted medication or medication changes. A less common motive for concealment of suicidal ideation, reported by 11% of respondents, was the desire to avoid psychiatric medications. Fear of medications was far less common than the fear of being "locked up" in a hospital. Indeed, medication was often mentioned as a follow-on effect to hospitalization, for example, "I do not want to ever be sedated", or "I don't want to be hospitalized and get a heavier dose of medication". Clients who had never been on psychiatric medication described a fear of their possible effects:

> I had this idea that if I made my therapist aware that control was slipping rather quickly through my fingertips and that I was fantasizing about the number of ways to kill myself a day, he would put me on medication of some sort. I was afraid he would change the good in me when getting rid of the bad.

Clients already taking psychiatric medication expressed the fear that mentioning suicidal ideation in therapy would cause their therapist to decide that their current medication regimen is not working: "I worry the therapist will suggest and push for a medication change. I think my medication is working just fine."

Others finding out. Another anticipated consequence of disclosure is the violation of confidentiality, with family, friends, or coworkers finding out. This was specifically referenced

by only 8% of all respondents, with remarks such as “my family would know,” or “It would out me to my friends, family and coworkers”. This was coded whenever a client mentioned a break in confidentiality that led to the fact of his or her suicidality being exposed to those outside the mental health system. For those who were young at the time of their suicidal concealment, fear was focused on parents finding out. Older concealers mentioned friends and coworkers. The precise meaning of others finding out for each respondent was often unexplained; in some cases it appeared to be the practical impact leading to the emotional impact of shame.

***Harming or upsetting loved ones*.** This was coded when the client cited the impact on other people (other than the therapist) as a reason for concealing suicidal ideation (e.g. “My mother would be heartbroken”). This is different from others merely learning about the client’s mental illness (others finding out). This code was used when those others would be harmed in some way by the disclosure; it was usually as a distal impact of hospitalization. For example, a female respondent believed that discussing her suicidality with her therapist could ultimately result in losing custody of her children: “I did not want to be forced into an inpatient hospitalization as I had parenting responsibilities that I had no one else to meet and I did not want my child going into foster care”. This was mentioned by 7% of all respondents.

***Impacts on career or schooling*.** This was coded when respondents expressed a fear that honesty about suicidality could do direct or indirect damage to their futures at work or school. That is, the price they feared paying for admitting they were suicidal extended beyond a temporary loss of freedom while hospitalized. They believed it would create long-term setbacks for their key life goals. Only 4% of respondents mentioned this. These included a client who is himself a mental health counselor: “As a mental health professional, I realize my license is on the line so if I lose that I might as well be dead anyway.” Another respondent was in college, and

feared that if he spoke about his suicidal ideation, “they would take it way too seriously and not let me continue my college education.” He was willing to cope with suicidal feelings alone rather than risk being taken out of school. Another respondent explained that he feared hospitalization would entail lost wages, or even a loss of his job: “I cannot financially afford a 72 hour psychiatric hold.”

Loss of autonomy to commit suicide. A minority of suicide concealers (8%) reported concealing suicidal ideation because they wanted to preserve autonomy to commit suicide, (e.g. “If I tell them, I lose the freedom to act”). In some cases, loss of autonomy was described as a distal impact of hospitalization, or of the respondent’s family finding out and then monitoring or restricting their behavior. None of the respondents reporting this motive described imminent threat to their own lives; they described a desire to keep this option open without expressing a clear intention to make a suicide attempt. Respondents were motivated to conceal suicidality because disclosure to a therapist would create a situation in which “I won’t be able to follow through with killing myself if I want to”, or in the words of another respondent, “if I needed to”. One respondent sought to preserve this ability to commit suicide as part of a wider commitment to individual freedom and his ability to make decisions for himself:

> I believe my fate is my responsibility and that includes suicide. I will not let anyone have the chance to cage me, physically or mentally. I understand that temporary problems can lead to this, but my problems are much more deep seated, and if I choose that I've had enough that decision will not be flippant, nor will I allow interference.

Other clients sought to maintain autonomy while acknowledging that suicide was less of a realistic option for them than it was a sort of psychological release valve. Concealment allowed continued engagement with suicidal thinking that offered at least the fantasy of a solution to their

suffering. As one respondent noted: “My suicidal thoughts offer me an option for ending the pain and the hopelessness that often seem to overwhelm me. Thoughts of suicide are always a familiar source of comfort to me, and I have had them for many, many years.”

Other or unspecified practical impact. This general theme was coded when the respondent was clearly worried about real-world consequences of disclosure but examination of both the statement and its context did not provide any indication of precisely what those consequences would be. Examples included: “I am afraid to open up and lose everything I have” and “I was afraid that if I told her it would ruin my life”. In these cases, it is clear the respondents were *not* talking about having a bad emotion or upsetting their therapist. They were talking about some kind of external consequence, apparently a very serious one, but they do not explain. This code was fairly common, with 14% of all respondents making some remark that fit into this category. It is possible that many of these unspecified practical impacts were meant as remarks about hospitalization.

Reasons specific to therapy or therapist code group. The second-most common group of motives for concealment consists of five codes relating to events and persons inside therapy, including a desire to control the direction of therapy, blaming the therapist for concealment, fear of the therapist’s negative judgment, and a fear that revealing suicidal symptoms will make the therapist feel that they have failed as a clinician. Taken together, 40% of all respondents endorsed one of these motives. This group also included a general code for other or unspecified fear of therapist reaction, used where the motive was too vaguely worded to assign to one of the most specific themes, such as “I’m worried the therapist will over-react”. Codes in this group reflect the fear that honest disclosure will have consequences for therapy, the therapeutic

relationship – or that dishonesty arises from errors or failures of the therapist. Examples and distributions of response for each of the five therapy-related motives are displayed in Table 4.

***To control the direction of therapy*.** Responses in this category reflected the client's concern that disclosing suicidal ideation could change the course of therapy in a way that would distract from other topics that are seen as more important, or that he or she feels more ready to deal with. Many in this group believed suicidality was not their major problem, or at least not the main reason why they are in therapy. They fear bringing up suicide would distract the therapist, causing sessions to be hyper-focused on suicidality to the exclusion of all other material. As one respondent noted: "Since I only have 45 minutes a week I unfortunately have to be very selective when it comes to the topics I discuss." Sometimes the concern was that bringing up suicide would distort therapy, causing the therapist to over-focus on suicide crisis management at the expense of underlying problems which are driving the suicidality. Respondents also feared raising suicide would distort the therapist's view of the client's true mental status. Ironically, one respondent felt that lying about suicidality was the only way to create an honest impression of her condition:

> My therapist would feel that they [suicidal thoughts] needed to be front and center in my therapy, and would begin treating me for suicidal ideation instead of giving me the treatment for depression that I'd sought and really needed. I guess it would be accurate to say that I was concerned that honesty would label me, and ultimately that would mean my voice would be discounted. … I didn't want to create a false impression of myself and my issues.

Respondents commonly described a need to control the direction of therapy due to a perception of their therapist as jumpy and over-reactive when it comes to suicidality; they described

Table 4.

Reasons related to therapy or therapist that motivate concealment of suicidal thoughts (N = 107)

Therapy/therapist related motive	Individuals reporting	Percent of sample
To control the direction of therapy "It's really just a distraction from why I'm there." "I think the topics we discuss during therapy would change greatly. I would rather focus on the anxiety" "Since it is my money and time, I want to choose what topic/event/ thoughts/problem we will talk about… suicidal ideation is not one of them."	18	17%
Therapist is blamed for concealment "It seemed he was concerned about his liability more than how I felt." "They are not interested in exploring the topic. It's almost as if they think this reflects poorly on them." "If you mention suicide, they shut down and kind of write you off." "She is a little strange. I'm not that comfortable with her." "He could have asked me about suicidal thinking. During 7 months, he never brought the issue up, despite knowing of the rather pathetic circumstances of my life."	17	16%
Fear of negative judgment by therapist "I can't help but feel judged by my therapist. They usually are condescending." "I have a strange feeling my therapist will judge me or dislike me if I completely divulged my suicidal thoughts." "I did not want to seem weak or pathetic, unable to cope."	9	8%
Fear therapist will feel bad at their job "I don't want to offend her that she can't help with this because it's not her."	1	1%
Other or unspecified therapy-related reason. "I'm worried the therapist will over-react."	11	10%

Note. Example quotations taken from survey responses. Sample percentages refer to proportion of 107 suicide concealers who reported each theme.

managing the therapist's access to the truth so as to obviate any need to manage the therapist's anticipated responses.

> Therapists do not like this kind of patient, immediately label you, and focus very strongly on this one item [suicidality]. Since it is my money and time, I want to choose what topic/event/thoughts/problem we will talk about or that I want help and support on…suicidal ideation is not one of them. The times I have obliquely referred to this, my many therapists have panicked and jumped to conclusions and I have had to spend valuable therapy time calming them down.

Judging by their responses, many respondents who endorsed this reason for concealment were higher-functioning clients for whom hospitalization may seem like a more distant concern. Some reported that they were spending too much money on therapy to allow time to be taken away in discussions of fleeting suicidal thoughts. One respondent was himself a mental health professional. Although he experiences suicidal thoughts, he sought therapy for help with Attention Deficit Hyperactivity Disorder. If he mentioned his recurring suicidality, he believed there would be "resistance to addressing the issues I really need to deal with."

Therapist is blamed for concealment. Responses in the therapist blame category conveyed a belief that actions or qualities of the therapist were to blame for the respondent's not disclosing their suicidal ideation. This theme was present in 17% of responses. It was coded any time respondents expressed distrust, anger, spite, or low opinion of therapist or their techniques – and linked those feelings to their decision not to disclose suicidality. Clients who expressed this motive gave the impression that they *would* have disclosed their suicidality had it not been for something about their therapist. Some responses in this category contained a general discomfort with the therapist, for example, "She is a little strange. I'm not that comfortable with her." Other

respondents offered specific critiques of how their therapist did not measure up to the task of receiving such an important disclosure:

> I was able to get therapy about topics/behaviors that the therapist could easily and confidently handle and understand. Please understand that I feel I had a good therapeutic experience of supportive psychotherapy. If this therapist were smarter, more experienced with the topic, and/or disclosed perhaps a long history of personal suicidal ideation, I might have given her a crack at my "whole self".

Some of the responses in this category contained a harsher view of therapists failing to ask about suicidality, perhaps out of negligence or a desire to avoid the topic.

> He could have asked me about suicidal thinking. During 7 months, he never brought the issue up, despite knowing of the rather pathetic circumstances of my life. … I was absolutely right to keep the secret for 7 months.

Respondents also expressed a belief that when suicide comes up, therapists are afraid for their own legal liability or professional reputation. As one respondent wrote, "It seemed he [the therapist] was concerned about his liability more than how I felt." These respondents were aware that clinicians may face legal or professional repercussions when they lose a client to suicide. Many reported merely sensing the therapist's discomfort with the topic. Others, who were chronically suicidal, wrote about direct experience of being referred to higher levels of care by therapists who, they believe, did not want to deal with them.

> They are not interested in exploring the topic. It's almost as if they think this reflects poorly on them. It is almost as if they don't want to take depressed patients, but if they do, they want them to be on the functional end of the spectrum.....preferably very functional!

> It is a catch-22 situation: You can't get better unless they know you and want to work with you....but if you mention suicide, they shut down and kind of write you off.

Another respondent explained that she had stopped disclosing suicidality to therapists after a range of bad experiences convinced her that therapists simply do not understand depression:

> One therapist suggested that I "toughen up". Another therapist claimed that he could 'cure' depression within 10 sessions of traditional therapy. People, including therapists, really have little idea about the true experiential nature of depression- it steals your life, it sucks the life out of you, every single fucking thing is a burden, from getting out of bed in the morning to going to bed a night.

When a client's frustrations reach this level, there may be global decision that seeking help for suicidal thoughts (here in the context of depression) is not helpful. For this reason, therapist blame may have some conceptual relation to the "pointless" motive code described below.

Fear of negative judgment by therapist. Responses in this category indicated that the clients concealed suicidality because it would cause their therapist to judge them as weak, feel disappointed in them, or be shocked by the depth of their psychopathology or frustrated by their lack of progress. This theme was mentioned by a small minority of respondents (8%). It is distinct from the theme of "embarrassment or shame" in that the client specifically references the relationship with the therapist. This theme sometimes occurred in the context of an apparently *good* therapy relationship that the client was afraid of damaging in some way, and at other times in what sounds like a weaker therapeutic relationship. Examples of this theme include remarks such as "I have a strange feeling my therapist will judge me or dislike me if I completely divulged my suicidal thoughts", and "I can't help but feel judged by my therapist. They usually are condescending."

***Fear therapist will feel bad at their job*.** Responses in this exceedingly rare category express a fear that disclosure of continuing suicidality will make the therapist feel like bad about their own skills or abilities as a therapist. Only one respondent endorsed this idea, writing: “I don't want to offend her that she can't help with this because it's not her.” The client is concealing in order to protect their therapist from experiencing a bad feeling. This may be an expression of the commonly-noted phenomena of suicidal individuals fearing they are a burden to others.

***Other or unspecified therapy-related reason*.** This general code was used for statements in which some event in therapy is mentioned as a reason for suicide concealment, but the precise form this event would take is either vaguely worded or not explained. Ten percent of respondents made remarks that fell into this category. For example, a respondent remarked that “I’m worried the therapist will over-react”. This could indicate a wide range of therapy events from over-focusing on suicidality to judging the client as more seriously ill, or all the way to forcible hospitalization. Because the respondent did not explain, this code was appropriate.

Beliefs about self or suicide code group. The third-most common group of motives for concealment consists of five motives stemming from some belief the respondent holds about themselves or about suicide. These beliefs included the perception that one is a low risk for suicide, that it is better to cope privately, that suicide is hard to talk about, that disclosure is pointless, and that suicide should not be discussed because it is morally wrong. Taken together, 31% of all respondents endorsed one of these motives. Examples and distributions of response for each of the five beliefs about self or suicide codes are displayed in Table 5.

Table 5.

Beliefs about self or about suicide that motivate concealment of suicidal thoughts (N = 107)

Belief about self or suicide	Individuals reporting	Percent of sample
I am a low risk for suicide "There are only a few moments a year when I feel suicidal." "Since I wouldn't really do it, I don't want to talk about it." "I don't have a plan for suicide. I've just never ruled it out as an option."	22	21%
Privacy / I prefer to cope alone "I feel I am fine coping on my own." "I get better more on my own than from the therapist's help." "It's just a tightly held secret that I will never share with anyone."	7	7%
It is hard to speak about suicide "It's just not something I'm comfortable discussing" "I have a hard time bringing up difficult topics." "It's difficult for me to feel like I can explain the full extent of my thoughts."	5	5%
Disclosure is pointless / No one can help me "Discussing it with people has never had any positive effect on my feelings." "Ultimately, I don't believe in a solution for my problems." "It wouldn't have helped."	3	3%
Suicide is morally wrong "It is difficult to open up about a topic that you know is wrong."	1	1%

Note. Example quotations taken from survey responses. Sample percentages refer to proportion of 107 suicide concealers who reported each theme.

I am a low risk for suicide. Responses in the low risk category convey a sense that the client concealed suicidal thoughts in therapy because they are unlikely to ever attempt suicide. For example, this was coded when clients asserted "I'm never going to do it anyway", or when clients noted that "everyone has suicidal thoughts" with the implication being that the suicidal thoughts were not serious and not likely to be acted upon. Mentioned by 21% of the sample, low risk was by far the most common belief about self used to explain the decision to conceal.

Respondents differed in how they assessed their own suicide risk as low. Some reported that the low frequency of their suicidal thoughts indicated low risk. This justified their low motivation to seek help from a therapist. As one respondent explained:

> I'll have a few moments in a year where I feel suicidal; it's usually because I did not meet my current expectations and I tend to think that because I didn't meet those expectations, I will always be a failure…They need to understand that I personally would never act upon fleeting suicidal thoughts and that I am rational enough to realize that whatever horrible situation is going on right now will pass.

Other clients judged themselves as low risk because their suicidality was confined to thoughts. While they may frequently think about killing themselves, they had not reached the stage of planning their deaths. As one respondent wrote: “I have fleeting thoughts of suicide. This seems to be a constant in my life (medicated or not). I don't have a plan for suicide. I've just never ruled it out as an option.”

The perception among these clients that they are “low risk” does not necessarily alleviate fears of serious consequences should they disclose. Indeed, 64% of those mentioning low risk also alluded to possible unwanted practical repercussions affecting their lives such as hospitalization and others finding out. For example, one client doubted if the feelings are “even real,” yet was also silent due to fears intervention:

> Since I wouldn't really do it, I don't want to talk about it. Also, the feelings come and go much, that I can't tell if they are even real. Further, I am worried that it would set off alarms and he would have to tell more people, or would make a big deal out of it.

Many respondents who felt they were not at risk for suicide, worried nonetheless that clinicians would not agree.

Privacy/preference to cope alone. A minority of respondents (7%) cited their sense of being a private person as a reason for concealing suicidal ideation from their therapist. These respondents expressed beliefs about suicidality being a fundamentally private matter. Examples include responses such as "It's a very personal issue," and "It was such a private issue that I never actually revealed to any therapist the depth of my despair." More commonly, respondents expressed a belief about themselves as someone who "can handle it" without therapist help, or with only the non-professional help of family or friends. As Burton Denmark et al. (2012) define this category of motive, it "expresses the respondents sense of him or herself as a fundamentally private and self-sufficient person… the student habitually maintains a self-protective boundary around personal thoughts and feelings…" (p. 89). Respondents in this sample expressed this self-sufficiency with remarks such as "I think these thoughts are just a part of me which I must deal with on my own" and "I don't think it's up to them. It's up to me", as well as, "I get better more on my own than from the therapist's help."

It is hard to speak about suicide. A small number of respondents (5%) noted difficulty speaking about suicide, but provided no clear reason about what precisely made it hard to speak about. Possibilities could include shame, privacy, alexithymia, fear of consequences, etc., but no determination could be made from the response which could place the response in a more specific category. Examples include remarks such as "It's just not something I'm comfortable discussing" and "It's difficult for me to feel like I can explain the full extent of my thoughts". One respondent was more explicit in linking their difficulty speaking about suicide to a broader pattern of shyness and reluctance to disclose: "I might be in a point where I am not benefiting from therapy as much as possible because I have a hard time bringing up difficult topics." More

than half of the respondents who endorsed “hard to speak” also provided remarks that were coded as privacy/preference to cope alone.

Pointless. The pointless category captured responses in which the client did not disclose suicidal ideation because they felt there was no benefit to doing so, perhaps because they perceive that no one can help them. This theme was exceedingly rare in this sample, appearing in only 3% of responses. Responses fitting into this category included “Discussing it with people has never had any positive effect on my feelings” and “Ultimately, I don’t believe in a solution for my problems.”

Morally wrong. Responses coded in the morally wrong category indicated that the respondent conceals suicidal ideation because the act of suicide goes against their religious or moral belief system. While some global religions do view suicide as morally sinful (e.g., Catholicism) only one respondent in this sample briefly mentioned morality as a reason not to discuss suicidal thoughts with their psychotherapist, writing: “It is difficult to open up about a topic that you know is wrong.” This respondent then moved on to focus on other motives, such as fear of practical repercussions.

Feared emotional experiences code group. The least common group of motives for concealment of suicidality in psychotherapy was the desire to avoid feared emotional experiences such as embarrassment, guilt, fear, depression, sadness, or other overwhelming emotions. This group also included dishonesty motivated by denial and willful ignorance, to the extent respondents were able to voice these sometimes unconscious motives. Taken together, 28% of the sample spontaneously reported that their suicide concealment was at least in part motivated by a desire to avoid an uncomfortable emotional experience. Counter to some earlier studies of concealment motives, (e.g., Burton Denmark et al., 2012), we found it was not

possible to reliably distinguish “shame” from “embarrassment” or “stigma” in the set of responses analyzed here. Thus, a combined embarrassment/shame category was used. This group also includes a general code for other or unspecified emotional impacts, where were generally worded too vaguely to assign to one of the most specific themes, such as “It makes me feel emotional”. All codes in this group reflect the fear that honest disclosure will bring about painful emotional experiences for the client, experiences that can worsen their already weakened emotional state. Examples and distributions of response for each of the five emotional experiences codes are displayed in Table 6.

Embarrassment or shame. The most commonly-reported emotion theme was embarrassment/shame, present in 16% of the sample, which was coded any time a respondent mentioned embarrassment as a reason why they concealed suicidal ideation from their therapist. While many authors distinguish shame and embarrassment as different experiences, our coding team was not able to make such a distinction in this sample; many responses could be interpreted as either shame, embarrassment, or an awareness of stigma. Indeed, many respondents mentioned this theme in the briefest possible way, writing only “It’s embarrassing” or “the shame of it”; a brevity that itself may be motivated by embarrassment. Those respondents who elaborated more fully described feeling embarrassed by the simple fact that they want to commit suicide. As unwell as they felt, they were loath to share the depth of their misery so as not to further compromise their dignity. As one client remarked: “It upsets me because I have no control over these thoughts or attempts, so I feel embarrassed that I want to attempt suicide.” Another client identified shame as a possible downstream impact not only of disclosure, but of

Table 6.

Emotional impacts avoided by concealing suicidal thoughts (N = 107)

Feared emotional impact for client	Individuals reporting	Percent of sample
Embarrassment or Shame "I feel embarrassed that I want to attempt suicide." "I know it's supposed to be good for me and protect me from myself, but it adds more shame and self-loathing that just exasperates everything."	17	16%
Guilt "It's hard to be honest about this because I feel a lot of guilt."	2	2%
Sadness "It makes me sad because I know I should be grateful but I'm not." "It's incredibly negative and despairing."	2	2%
Avoidance / Denial "Talking about things makes them more real." "It's hard to be honest because it means admitting that the trauma of the sexual assault had such an impact on me." "I don't want to feel this way nor talk about it with anyone."	8	7%
Other or unspecified emotional impact "It makes me feel emotional."	8	7%

Note. Example quotations taken from survey responses. Sample percentages refer to proportion of 107 suicide concealers who reported each theme.

hospitalization, which he felt would only intensify the shame inherent in his depression:

> In the past I was honest about my thoughts, and I was put into inpatient care. I know it's supposed to be good for me and protect me from myself, but it adds more shame and guilt and self-loathing that just exacerbates everything. It is not safe for me to reveal this to my therapist.

The related emotion of guilt was coded separately but is here reported as a subtheme of embarrassment/shame because it is undeniably in the same family of emotional responses and it

appeared in 2% of respondent's accounts of their motives. Just as with shame and embarrassment, respondents mentioning guilt stated that they avoided discussing their suicidal thoughts in therapy in order to avoid experiencing the sense that they are weak, bad, or a disappointment to others. As one respondent wrote, "It's hard to be honest about this because I feel a lot of guilt." This respondent had become suicidal after completing a course of chemotherapy, and felt selfish for wanting to die, especially considering the efforts others were making to keep him alive.

Avoidance /denial. A number of respondents (7%) admitted concealing suicidal thoughts in order to aid some form of denial, suppression or avoidance. Respondents reported that talking about suicide would force them to fully realize how bad their condition is, to take action to address the problem, or to maybe even carry out a suicide attempt. These respondents were able to articulate that in some sense they are lying to themselves, as well as their therapist, to avoid a confrontation with the reality of their feelings. As one respondent noted, talking about suicide would mean "that you have to accept that these thoughts have crossed your mind. That you would think about causing yourself physical harm." Or as a second respondent put it, "I don't want to feel this way nor talk about it with anyone."

Some respondents argued that denial and avoidance serve a function of keeping suicidality at bay. One respondent, who appeared to have a history of psychosis, feared that sharing his suicidal thoughts would start a process that could lead to him actually attempting suicide.

> Talking about things makes them more real and I may feel I have to do it if I tell anyone… Many things only get worse if I acknowledge them. I have had unusual

> experiences as well that only get worse if I mention them and they [therapists] know what I am thinking.

Another client was the victim of a sexual assault. She said she conceals the full scale of her suicidal thoughts in therapy because to tell the whole truth would force her to face the full impact of the assault. As she explains:

> It's hard to be honest because it means admitting that the trauma of the sexual assault had such an impact on me that now I'm in this scary space where these thoughts even come into my head, and it scares me.

Even so, she later acknowledges that it may be time to end her concealment, writing that "a lack of honesty hinders my progress in healing."

Sadness. Only two respondents (2% of sample) mentioned sadness as an emotional outcome they were trying to avoid by not discussing their suicidality in therapy. Neither respondent provided enough detail to fully understand this motive for concealment. One remarked that being suicidal makes them sad, "because I know I should be grateful but I'm not", which has a tinge of guilt about it. The other respondent stated that they lie about suicidality "because it is incredibly negative and despairing", worsening their mood at a time when they feel vulnerable to depression.

Other or unspecified emotional impact. This general code was used for statements in which some emotional impact is mentioned as a reason for suicide concealment, but the precise nature of this emotion is either vaguely worded or not explained. For example, one respondent notes that "It is painful to talk about this truthfully to anyone - professional or otherwise," suggesting some form of emotional pain, which could be shame, sadness, anger, or some mix of

these emotions. Eight percent of respondents made reference to a non-specific emotional impact of this sort.

Multiple Choice Results Relating to Research Question 1

In addition to the open-text item querying respondent's motives for concealment, version 2 of the survey later asked respondents to complete a multiple-choice item assessing a similar question about their motivation for non-disclosure of suicidality: "*Which of these describes your reason for not being honest?"* The purpose of this item was to corroborate the results of the qualitative content analysis. Of the 66 suicide concealers in version 2, 60 completed this multiple choice item (91%). Some of the multiple-choice categories selected *a priori* cannot be directly compared with the content analytic categories, which arose directly "in vivo" from the respondents' answers in the process of qualitative analysis (see Table 7 for comparable categories). Notably, both methods of inquiry show that practical consequences such as hospitalization were the most common motive for concealment of suicidality in therapy; indeed, equally large percentages of respondents endorsed this motive (73%) in both question formats. Comparison across methods also suggests that respondents were less likely to endorse embarrassment or shame as a motive in the open-text item (where only 17% did so) than in the multiple-choice format (where 62% did so). Other comparable items also showed higher rates of endorsement in the multiple-choice format, where respondents were allowed to click as many choices as they liked.

The multiple-choice item also allows for comparison to be made between common motives for dishonesty about suicide versus non-suicide topics. Table 8 compares multiple-choice responses about motives for dishonesty among the group of 60 suicide concealers from version 2 of the survey with responses from 612 version 2 respondents who reported dishonesty

Table 7.

Comparison of Open-text and Multiple-choice responses to question: "Which of these describes your reason for not being honest?"

Motive for dishonesty	Content Analysis		Multiple-Choice	
	N	Percent	*N*	Percent
Practical consequences (e.g. hospitalization)	78	73%	44	73%
Embarrassment or shame	17	16%	37	62%
I didn't want this to distract from other topics	18*	17%*	14	23%
My therapist would be upset, hurt or disappointed	10**	9%**	11	18%

*Comparison to content analysis category "to control the direction of therapy".
**Comparison to content analysis categories "fear therapist will feel bad at their job" and "fear of negative judgement by therapist".
Note. Content Analysis sample $N = 107$; Multiple-Choice sample $N = 60$; respondents could select multiple answers.

Table 8.

Multiple-choice responses to question: "Which of these describes your reason for not being honest?" with comparison between Suicide and Non-Suicide samples.

Motive for dishonesty	Suicide Concealers		Non-Suicide Sample	
	N	Percent	*N*	Percent
Practical consequences	44	73%	84	14%
Embarrassment or shame	37	62%	374	61%
I didn't want this to distract from other topics	14	23%	165	27%
I doubt my therapist can help or understand	13	22%	148	24%
My therapist would be upset, hurt or disappointed	11	18%	98	16%
It would bring up overwhelming emotions for me	11	18%	109	18%
Other reason	8	13%	105	17%

Note. Suicide Concealers $N = 60$; Non-suicide sample represents all other respondents reporting dishonesty on topics other than suicide, total $N = 612$. Respondents could select multiple answers. Difference between samples is statistically significant, X^2 (6, $N = 672$) = 34.9, $p < .01$.

on thirty other non-suicide topics. Results show that the two groups endorse most of the listed motives for dishonesty at similar rates, the percentage of respondents endorsing each being within 2 to 4 percentage points. There is one important exception, however: While 73% of suicide concealers were motivated by "practical consequences" of disclosure, this motive was only chosen by 14% of all non-suicide respondents. A chi-square test of homogeneity was conducted and found this difference between the two samples is statistically significant (X^2 (6, N = 672) = 34.9, $p < .01$). This result is in keeping with the findings of our qualitative analysis of motives present in open-text responses. It suggests that, compared to all other topics, suicide concealment is far more likely to be linked to fears of practical consequences of disclosure.

Content Analysis Results for Research Question 2

Structure of the qualitative data. Analysis of Research Question 2 was based on those 64 respondents who provided an open-text response to the question: "*How could your therapist make you feel more comfortable being honest about your suicidal thoughts?"* This sample is smaller than the sample for research question 1 only because the question was not originally asked in version 1 of the study but was added for version 2. Of the 66 respondents who saw Research Question 2, 64 clients (96.9%) provided a response to the question. Open-ended responses ranged in length from two to 95 words, and contained between 1 and 4 separate message units, with the median number of message units being 1. Once coded, 45 respondents (70%) were found to have provided one idea for how their therapist could help them be more honest about suicidality, 11 respondents (17%) provided two ideas, and 8 respondents (13%) provided no ideas, saying they did not know.

Across 64 respondents, 84 message units were coded into one of 8 content categories, with one of those categories also being coded for three sub-themes present within the category.

The number of respondents endorsing each of these 8 categories and is presented in Tables 9 and 10.

Code descriptions. The following sections describe each of the 8 content codes using language provided to coders in the codebook. Core themes are described, and sub-themes are described where applicable. The structure of the data for research question 2 did not require the creation of code groups. Results can be seen in Table 9.

Provide assurances about reporting. Close half of respondents (45%) reported that they would feel more comfortable being honest with their therapist about suicidality if they received some form of assurance, explanation, or control over whether the therapist would report their disclosure to others, as well as assurances about the subsequent consequences of that reporting. Many mentioned hospitalization directly, for example, saying they would disclose "if hospitalization wasn't a consequence of talking about suicide". Other wanted assurances from their therapist that other practical impacts would not occur, for example, believing their therapist could make them more honest by "saying they won't take me out of school". Three sub-themes were identified inside this category, which can be described as "promise not to report me", "explain the triggers" and "include me in the decision". The frequency of these three sub-themes are shown in Table 10.

The most common subtheme present in this category was the belief that if the therapist could simply "promise not to report" the respondent's suicidal ideation, then concealment would no longer be necessary. Examples include a respondent who remarked, "If I knew she would not take a greater action after I explained I would have been more open," and another who wrote: "If he reassured me that it would stay between us." Many respondents showed an awareness of mandated reporting laws and in their remarks they allowed that there were cases in which

Table 9.

Themes in Open-Text Responses to "How could your therapist make you feel more comfortable being honest about your suicidal thoughts?" (*N* = 64)

Themes	Individuals reporting	Percent of sample
Provide assurances about reporting my suicidal ideation (*see Table 10*) "If hospitalization wasn't a consequence of talking about suicide" "Saying they won't take me out of school" "Explain what would happen if I talked about my suicidal thoughts" "Allow me to decide if I needed to be hospitalized" "Offering to work with me through my suicidal thoughts without inpatient care."	32	45%
There is nothing my therapist can do "I honestly would not share it with a therapist. As much help that they may be giving me, I trust my friends and family a whole lot more."	13	20%
Ask me direct questions about my suicidal thoughts "If my therapist asked me frankly about it, I think that could make me finally open up about it." "Ask outright." "If she asked about specific time frames for example, I would probably tell her directly."	10	16%
Normalize my suicidal thoughts or validate my experience "If he assured me very clearly… that I am normal for having these feelings, and that they can co-exist with healthier feelings, then I might discuss them."	6	9%
If my therapist and I had a closer, more trusting relationship "I would have to be more comfortable with them." "I guess maybe just over time as I observe if she understands things I say and my general thoughts more."	5	8%
If I had more time in therapy "Considering the costs involved… Maybe if it wasn't so expensive and I had more time to work with."	1	2%
Unspecified change of technique "If his technique/approach was different."	1	2%
Don't know "I honestly don't know."	8	13%

Note. Example quotations taken from survey responses. Sample percentages refer to proportion of 64 suicide concealers who reported each theme.

Table 10.

Sub-themes among 32 individuals who said providing assurances about reporting would help them be more honest about suicidal thoughts and behaviors. (*N* = 64)

Sub-theme*	Individuals reporting	Percent of sample
Promise not to report my suicidal ideation	20	31%
Explain in advance what triggers reporting	8	13%
Include me in decision of whether to report	4	6%

* Subtheme inside overall theme "provide assurances about reporting my suicidal ideation" (*see Table 9*). Sample percentages refer to proportion of 64 suicide concealers who reported each sub-theme.

reporting was a good thing. One respondent, who described herself as unlikely to ever attempt suicide, asked for an exploratory, not legal, approach to suicide:

> If I could trust that it would be approached as exploratory, rather than legally, I suspect it would be tolerable [to disclose]. Having said that, it's impossible to know whether a therapist would take the client at their word that they weren't a threat to themselves/others. I don't think that there is an easy answer for this due to mandatory reporting. While it's certainly necessary in some cases, the very knowledge of this obligation erodes trust/honesty with discussing such topics.

This client's reference to the "impossibility" of knowing whether a therapist will report, reflects a common fear of uncertainty. Other respondent expressed an attitude of resignation, saying they were certain that a promise not to report their suicidality would never be possible due to mandated reporting laws. They appeared to believe their suicidality rises to the level of a trigger for mandated reporting. As another respondent noted, they would share their suicidality in therapy "If I could be sure I wouldn't be hospitalized, but that would never happen".

A second subtheme in the Provide Assurances category is a suggestion that clinicians should “explain the triggers for reporting” so that patients will can know precisely where the line is and then decide for themselves whether to disclose suicidality. As one respondent put it, “They [clinicians] could explain upon asking about the topic that only very serious thoughts or active attempts would be considered grounds for involuntary hospitalization.” These respondents were seeking transparency from their clinician in order to reduce uncertainty about the therapist’s likely response to different levels of suicidality. Before they disclose, they would want to understand both the law, and how their individual therapist interprets that law. One respondent asked that his therapist prove that she understands “the difference between ideations and actual intentions”. Another respondent remarked:

> “I know plenty of people who may have considered suicide but never had a real plan. They may have had fleeting thoughts. I think perhaps this is normal. I would need to know how my therapist felt about this.”

Some were explicit in requesting this explanation be provided at the outset. As another respondent wrote: “Inform me what the protocol is when I am having these feelings, before it occurs, so I can decide how comfortable I am sharing.”

The third sub-theme present in this category was a desire by clients to be included in the decision of whether to report. Such a solution would have therapists essentially sharing decision-making power with clients about the best response when suicidality is on the table. As one respondent wrote, therapists could engender honesty by “allowing me to decide if I needed to be hospitalized”. Another respondent went so far as to propose that their therapist “contract” with them not to over-react to their suicidality.

> I'm afraid of her overreacting and trying to hospitalize me. I know she has professional obligations to report or intervene so I tend to downplay it. She might try to hospitalize me. That would effectively destroy my life. Perhaps "contracting" to clearly define what actions she would take depending on how high the risk is. We talk about it in very abstract terms, but I wouldn't reveal the extent of my plans because I know it would trigger a report.

Some of these respondents have been hospitalized in the past, and described the experience as "traumatic" or causing "major anxiety". They reported that they would be more honest if they could gain some control, or at the very least a thorough and open discussion. As one respondent wrote: "Promise to listen to everything I say and take into consideration my emotional state at this time, and his/her opinion about my overall emotional state. Then see admitting to a hospital as a LAST resort." Other respondents expressed the belief that such conversations seem impossible, believing that therapist's freedom to work with suicidal clients is severely constrained by legal reporting requirements. One respondent reflected on the "scary" experience of disclosing to a therapist who can have her placed on an involuntary psychiatric hold. She would be honest if the therapist showed they were "a person", and not merely a mandated reporter:

> I just need reassurance that the therapist is a person too. Being a mandated reporter is a scary thing if someone has power over you in the form of a 5150. And I think in the system we currently have, it is very hard to foster any open discussion on this issue.

***There is nothing my therapist can do*.** Thirteen respondents (20%) felt there was nothing their therapist could do to encourage greater honesty from them. These respondents had diverse reasons for believing that there was nothing their therapist could do. For some, it reflected a

sense that they themselves, not the therapist, were ultimately responsible for their concealment of suicidality. For example, one respondent wrote, “I don’t think she could [help me be more honest]. It’s nothing about her, it’s more of an issue with myself.” In a similar vein, other respondents saw no place for therapists because they chose to rely on other confidants for support around suicidal feelings, having in a sense given up on the idea of working on suicidality in therapy: “I honestly would not share it with a therapist. As much help that they may be giving me, I trust my friends and family a whole lot more.” The absence of trust in therapists could arise from bad past experiences with disclosure, which provided ample reason for some respondents to doubt that anything could make them disclose more honestly in therapy. As one client noted: “I don’t think anything [can be done differently]. When I had told her in the past, she called 911 on me.” Finally, one client stated her preference for her therapist to avoid the topic altogether; saying in a sense that there nothing the therapist can do and no intervention should be attempted.

***Ask me direct questions about my suicidal thoughts*.** Ten of the sixty-four respondents (16%) spontaneously mentioned that direct inquiry by the therapist would help them honestly disclose their suicidality. These clients would be honest if asked direct, specific questions about suicide. They may have a hard time bringing up the topic but think they could discuss it if the therapist took the lead. For example, one client (previously mentioned) said she was concealing in service of denial. Her suicidal thoughts arise from the traumatic sequelae of a sexual assault, and she did not want to face the full impact of the assault on her life. Yet she wrote: “If my therapist asked me frankly about it, I think that could make me finally open up about it.” Directly inquiry would be enough to overcome her desire to deny and avoid this painful material.

Another respondent stated that she continues to wonder whether suicide is the right option for her. She knows sharing this information could get her hospitalized, yet she predicted her honest nature would override her fears of hospitalization:

> Mostly she [the therapist] is not asking direct questions. I am known for being overly honest and open, in all areas of my life. So if she asked specific time frames for example, I would probably tell her directly, even while concerned if this was "too imminent".

This sample contained suicidal clients, then, who were simply waiting to be asked about their hidden suicidality. Some had actually been asked already, denying it at the time, but felt they would like to be asked again. As one client put it: "I would discuss it if she were to bring it up again. She brought up the issue during our first session but has not mentioned it again."

I don't know. Eight respondents (13%) said they did not know what their therapist could do to foster honesty about the suicidal thoughts they are concealing. Typical responses included "I honestly don't know" and "I really don't know." While these respondents offered no ideas, it is worth considering that some of them may have been essentially expressing feelings in line with another category, "There is nothing my therapist can do", discussed above. Because responses in this category are all very short, however, the coding team had no grounds to make a determination about why these respondents did not know.

Normalize/validate my experience. The responses of six clients (9% of sample) included the idea that they would be more honest if the therapist could help them feel okay about having suicidal thoughts or reassure them that they are not "crazy" for having these thoughts. These respondents expressed a need for some amount of warmth and support from the therapist to get into this difficult topic. Examples included clients wanting "reassurance that my emotions are valid", and for the therapist to "tell of past times people have felt like this." To some extent these

clients were looking for an antidote to the shame or embarrassment they might feel in admitting that they think about killing themselves. One suicidal respondent stated that she was also considering motherhood, and was primarily concerned that her therapist would deem her to be unfit to be a mother if he learned that she was suicidal. She wanted two things: “If he assured me very clearly that he is behind my desire for motherhood no matter what, and that I am normal for having these feelings, and that they can co-exist with healthier feelings, then I might discuss them.”

***If my therapist and I had a closer, more trusting relationship*.** Only five respondents (8% of sample) spontaneously mentioned trust or closeness in the therapeutic relationship as something that could help them be honest about suicide. Here the client wanted their therapist to understand them better, or to get to know them, or to accept them more fully. This category involves relational stances that therapist could take to foster honesty, as opposed to concrete actions. Trust concerns might be seen as implicit in other categories (e.g., those relating to mandated reporting), and the few explicit mentions of trust or closeness in the relationship do appear to be related to those other categories of concern. For example, one respondent acknowledged that she had “stalled” her own therapy by concealing her suicidal thoughts. She feared her therapist would “push for medication or other radical means to address these thoughts, which I doubt would work.” Nonetheless, she believed that a closer relationship would help her believe disclosure will be useful for her. She remarked: “If he actually knew me better, then maybe he'd understand how to help.” Another respondent expressed concern that she did not know much about her therapist’s life, predicting that greater disclosure from the therapist would lead to greater disclosure on her part. The lack of closeness “makes me feel less open and share

less," this client wrote, adding that "ultimately I am scared to bring any more news, resulting in us discussing old irrelevant topics."

The difference between this category and "normalize/validation" is that the latter specifies behaviors the therapist could engage in (e.g. normalizing), whereas this category expresses a sense that somehow the client would need to have a closer or more trusting *overall relationship* with their therapist.

***Miscellaneous responses*.** Two other ideas emerged when respondents were asked to imagine what their therapist might do to foster honesty about their suicidality. Both ideas were espoused by only 1 respondent (1.6% of sample). One respondent noted that their honesty would come if therapy sessions were longer or less expensive, and therefore allowed for more discussion time. He wrote: "Considering the costs involved, I couldn't afford to spend time talking about everything. Maybe if it wasn't so expensive and I had more time to work with." Another respondent called for a "change of technique", but did not specify the change she would like to see.

Multiple Choice Results Relating to Research Question 2

In addition to the open-text item querying respondent's ideas about what their therapist could do to help them honestly disclose their suicidal ideation, version 2 of the survey later asked respondents to complete a multiple-choice item assessing a similar question about what could help them be more honest: *Under what circumstances would you be more honest about your suicidal thoughts?"* The purpose of this item was to corroborate the results of the qualitative content analysis. Of the 66 suicide concealers in version 2, 60 completed this multiple choice item (91%). Results are displayed in Table 11.

Table 11.

Multiple Choice Responses to "Under what circumstances would you be more honest about your suicidal thoughts?" with comparison between Suicide and Non-Suicide samples.

Circumstances for honesty	Suicide Concealers		Non-Suicide Sample	
	N	Percent	*N*	Percent
If I knew my therapist would not over-react	31	52%	138	23%
If my therapist asked me about it directly	32	38%	288	47%
If I felt like this was blocking my progress in therapy	19	32%	199	33%
If I trusted my therapist more	16	27%	152	25%
If I knew my therapist had a similar problem	16	27%	141	23%
Under NO circumstances would I be more honest	11	18%	68	11%
If my therapist was warmer	8	13%	91	15%
If I knew it wouldn't ruin my relationship with my therapist	6	10%	118	19%
If my therapist were more skillful	5	8%	91	15%
If my therapist understood my culture or class	3	5%	73	12%

Note. Suicide Concealers $N = 60$; Non-suicide sample represents all other respondents reporting dishonesty on topics other than suicide, total $N = 612$; respondents could select multiple answers. Difference between the two groups is statistically significant (X^2 (9, $N = 672$) = 24.9, $p < .01$).

Categories for the multiple-choice item were chosen *a priori*, unlike categories determined through content analysis. This makes exact comparison across methods impossible. Nonetheless, some rough comparisons can be made. The most commonly endorsed themes in both the open text and the multiple choice items appear related. While 45% of respondents sought reassurances about mandated reporting in the open-text, 52% chose "If I knew my therapist would not over-react" in the multiple choice. Similarly, while 18% of respondents in the open-text reported that there was nothing their therapist could do to make them more honest, 20% of multiple-choice respondents chose "Under NO circumstances would I be more honest".

All other choices were endorsed by higher percentages in the multiple choice than in the open-text. This is because respondents could select as many choices as they liked on the multiple choice, and thus almost universally reported more themes than in the open-text.

Other comparisons are also possible. Table 11 compares multiple-choice responses among the group of 60 suicide concealers from version 2 of the survey with responses from 607 version 2 respondents who reported dishonesty on 30 other topics not related to suicide. Results show that the two groups endorsed many of the listed conditions that might foster honesty at roughly similar rates, generally within 9 percentage points. Again there was one major exception: Asked what could help them be more honest, suicide concealers were more than twice as likely to report that they would want to know their therapist would not over-react. While 52% of suicide concealers endorsed this item, only 23% of non-suicide concealers did so. A chi-square test of homogeneity was conducted to compare proportions of suicidal and non-suicidal respondents endorsing each of the ten conditions, and was significant, X^2 (9, N = 672) = 24.9, p < .01. This result is in keeping with content analysis findings that suicide concealers believe they would be more honest if they were guaranteed a restrained reaction from their therapist. It suggests that, among all other topics of concealment or dishonesty in therapy, suicide was specifically linked to fears of the therapist's response to the disclosure.

Multiple Choice Results for Research Question 3

Research Question 3, regarding clients' attitudes toward their suicide concealment, was not addressed with content analysis in this study, but instead with two multiple-choice items. The first of these items asked "*How did you feel after being dishonest about your suicidal thoughts?"* Results are shown in Table 12. No one emotional response was dominant, with the most commonly-reported response, "conflicted", being endorsed by 18% of respondents. Other

Table 12.

Multiple choice responses to "How did you feel after being dishonest about your suicidal thoughts?" (*N* = 60)

Feeling about dishonesty	Frequency	Percent
conflicted	11	18%
frustrated	9	15%
in control	9	15%
guilty	8	13%
safe	6	10%
neutral	4	7%
satisfied	3	5%
unconcerned	3	5%
worried	2	3%
regretful	2	3%
true to myself	2	3%
confused	1	2%

Table 13.

Multiple choice responses to "How did you feel after being dishonest?" among respondents in Non-Suicide sample on all other topics of dishonesty in therapy other than suicide. (*N* = 612)

Feeling about dishonesty	Frequency	Percent
conflicted	118	19%
neutral	103	17%
unconcerned	73	12%
guilty	67	11%
frustrated	60	10%
regretful	44	7%
safe	40	7%
in control	37	6%
true to myself	28	5%
worried	19	3%
confused	17	3%
satisfied	6	1%

common responses included “frustrated” (15%), “in control” (15%), “guilty” (13%) and “safe” (10%), a group which mixes positively and negatively-valenced emotions. The same question was also asked of respondents reporting topics *other* than suicidal thoughts, and results are shown in Table 13. Comparison of the two samples suggests broadly similar responses. Statistical comparison with a chi-square test of homogeneity was not possible due to low cell counts; seven of the 12 emotions were endorsed by less than five respondents in the suicide concealer sample.

A second multiple-choice item addressing research question 3 asked respondents *“Is suicidal thoughts a topic you would ever be more honest about?*”. Results are shown in Table 14. While a substantial minority of suicide concealers said they might disclose to their current therapist (23%), the majority (55%) reported that they would probably not honestly disclose about this topic to anyone. The same question was also asked of respondents reporting topics *other* than suicidal thoughts, and results are shown in Table 15. Here the proportion of respondents who would tell their current therapist was higher (34%) and the share of respondents who would never tell anyone lower (33%). A chi-square test of homogeneity found these differences between the two samples were statistically-significant, X^2 (3, N = 672) = 11.6, p < .01, suggesting that suicide concealers believe they are less likely to tell their current therapist, and more likely to anticipate telling no one, when compared with clients concealing information on all other topics captured in the survey (e.g., sex, substance use, feelings about therapy, etc.).

Table 14.

Multiple Choice Responses to "Is suicidal thoughts a topic you would ever be more honest about?" (N = 60)

Response	Frequency	Percent
Yes, but with a different therapist	6	10%
Yes, with my current therapist	14	23%
Yes, but only with family or friends	7	12%
No, probably not with anyone	33	55%

Table 15.

Multiple Choice Responses to "Is this a topic you would ever be more honest about?" among respondents in Non-Suicide sample on all other topics of dishonesty in therapy other than suicide. (N = 612)

Response	Frequency	Percent
Yes, but with a different therapist	109	18%
Yes, with my current therapist	206	34%
Yes, but only with family or friends	94	15%
No, probably not with anyone	203	33%

Note. Differences with Table 14 are statistically significant, X^2 (3, N = 672) = 11.6, p < .01)

Multiple Choice Results for Research Question 4

A multiple-choice item addressing research question 4 asked respondents *"How has not being honest about your suicidal thoughts affected your therapy?"*, to which they could select one of three choices, "It hurt my progress", "It helped my progress" and "no effect". Results are shown in Table 16. Suicide concealers were four times more likely to report that concealment hurt their progress rather than helped it. But by far the most common response was to report that

concealment had no effect progress in therapy. No effect was reported by 65% of the sample. The same question was also asked of respondents reporting topics *other* than suicidal thoughts, and results are shown in Table 17. Comparison of the two samples suggests broadly similar responses. A chi-square test of homogeneity did not find statistically differences between suicide concealers and non-suicide concealers on this item, X^2 (2, N = 672) = 2.4, p = .29. This null finding suggests that in this sample, clients concealing suicidal thoughts were not more likely to perceive a negative or positive impact on their therapy than were clients concealing information about other topics.

Table 16.

Multiple Choice Responses to "How has not being honest about your suicidal thoughts affected your therapy? (N = 60)

Response	Frequency	Percent
No effect	39	65%
It hurt my progress	17	28%
It helped my progress	4	7%

Table 17.

Multiple Choice Responses to "How has not being honest about affected your therapy?" among respondents in Non-Suicide sample on all other topics of dishonesty in therapy other than suicide. (N = 612)

Response	Frequency	Percent
No effect	362	59%
It hurt my progress	226	37%
It helped my progress	24	4%

Discussion

The purpose of this study was to explore the motivations of psychotherapy clients who conceal suicidal ideation from their therapist, giving these "hidden ideators" (Morrison & Downey, 2000) the opportunity to explain the decision to conceal in their own words. A sample of 107 suicide concealers provided both short essay responses and multiple choice responses explaining why they concealed, what they thought their therapist could do differently to help them disclose, how they felt about concealment, and whether concealment negatively impacted their therapy. Since suicide assessment relies almost entirely on the client's willingness to disclose, it is ultimately the client who decides whether an assessment effort succeeds or fails. Understanding how clients make these decisions is key to improving methods of suicide assessment. Finding ways to foster greater honesty from suicide concealers would not only help prevent suicide attempts, it would also improve the quality and usefulness of psychotherapy for the larger number of clients who experience suicidal ideation but will never attempt, clients who currently wrestle with these painful feelings alone. While there is a vast body of research on assessment and management of suicide risk (e.g., baseline and acute risk factors, protective factors, psychological pain, reasons for living, etc.), the voices of suicide concealers are rarely heard. This study directly queried concealers to learn how psychotherapists can better elicit honest and direct disclosure of suicidal material.

Practical Concerns Motivate Most Concealment

The major finding of this study is that psychotherapy clients concealing suicidality from their therapist are most commonly motivated by fear of the practical, real-world consequences of disclosing suicidal ideation. Chief among these feared consequences is involuntary hospitalization, which clients view as a likely outcome should they disclose having had suicidal

thoughts. When asked why they did not disclose, 52% of all respondents spontaneously and specifically mentioned a fear of being involuntarily admitted to a hospital or inpatient psychiatric unit. Many others mentioned related practical fears that generally flow from hospitalization, such as being given unwanted medication, family members finding out, negative impacts on career or schooling, negative impacts on others (such as children the client must care for), and for a small but important minority of respondents, the loss of autonomy to commit suicide if they choose to take their own lives. Taken together, fear of hospitalization and other practical consequences motivated 73% of all suicide concealment in this sample, making it by far the most common factor preventing these clients from disclosing their suicidal thoughts to a clinician. These fears were not limited to clients experiencing severe or imminent suicidality; a substantial proportion of those expressing hospitalization fear also stated that they are a low risk for actually making an attempt.

A related finding is that a large percentage of suicide-concealing clients say they would be more honest only if the threat of hospitalization was somehow reduced or controlled. More than half of respondents reported that they would feel more comfortable being honest with their therapist if they received some form of assurances, explanations, or certainty about the chances of being hospitalized as a result of their disclosure. Some wanted a frank promise not to report the ideation. Others wanted to be educated about the triggers for hospitalization so as to control their disclosure strategically. And still others wanted to be included in a collaborative decision about hospitalization and other treatment interventions. One respondent went so far as to propose that their therapist “contract” with them not to over-react to their disclosure, implying that nervous therapists, rather than patients, were the appropriate focus of a suicide contract! Clients in this sample appear to lack clarity about the triggers for hospitalization; without a clear sense

for where the line is, they stay well back of the border by concealing even mild suicidal symptoms. Sadly, by hiding suicidal thoughts they are concealing precisely the sort of painful emotional material that therapy is designed to help with.

This major finding about hospitalization fear stands in contrast to Burton Denmark, Hess & Becker's (2012) study of college students' motives for concealing suicidality, which found only 7% of respondents were concerned about practical impacts, which they called "repercussions". This difference can be explained by the different targets of disclosure in the two studies. Unlike the study of college students, who were asked why they conceal suicidal thoughts from others in general, respondents in this study were asked why they conceal specifically from their therapist. This suggests that clients may view psychotherapists as distinct from other potential confidants. Specifically, in the current study, therapists were seen as presenting a unique risk of breaking confidentiality to contact police and attempting interventions such as involuntary hospitalization. Therapists were also seen as likely to respond to *any* mention of suicidality with extreme measures.

As predicted by Hom et al. (2005), many clients in this sample seemingly do not understand the triggers for hospitalization and so imagine the worst and take steps to avoid it. Fear of hospitalization was, for many, a fear of the unknown. While a few respondents in our study indicated that they have been hospitalized in the past, the majority of those reporting hospitalization fear did not give indication of having that experience and appear to overestimate the likelihood of hospitalization. Many report that they simply do not know what will happen and do not want to take the chance. Our findings provide support for Ganzini et al. (2013) who found that one reason veterans did not disclose suicidal thinking on routine screenings was a desire to avoid unwanted hospitalization or medication recommendations. Our findings are also echoed in

recent work by Hom, Stanley, Podlogar, and Joiner (2017), who found that two-thirds of college students who reported non-disclosure when probed by psychologists or other therapists about suicidal thoughts were motivated by concerns about being hospitalized.

These findings suggest clear implications for clinical practice. If suicidal clients are actively calculating their chances of triggering unwanted interventions, it is imperative for clinicians to take seriously clients' fears about hospitalization and their confusions about the limits of confidentiality. Surprisingly, this dynamic is rarely mentioned by writers in the field. Many texts about managing suicidal risk (e.g., Jobes, 2006; Maltsberger, 1986) start from the point in time *after* a patient has been identified as a suicide risk, for example, by showing up in an emergency room after a suicide attempt. Texts which address the earlier challenge of how to encourage disclosure, rarely mention the practical concerns raised by clients in this study. Shea's (1999) comprehensive *Practical Art of Suicide Assessment*, contains three insightful chapters about uncovering suicidal ideation, but only contains one brief mention that clients may hold beliefs and fears about being "locked up" for revealing suicidal ideation to a clinician (p. 112). The same is also true of the American Psychiatric Association's (2010) *Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors*, which notes that "simply asking about suicidal ideation does not ensure that accurate or complete information will be received" (p. 10), but makes no mention of any need to provide psychoeducation to patients about the possible consequences for them should they acknowledge having suicidal thoughts, or any other strategy to help patients make an informed decision about disclosure. This is also true of the *VA/DOD Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide* (Department of Veterans Affairs, 2013).

Texts which discuss strategies for interviewing potentially-suicidal clients often portray those clients as primarily concerned with avoiding shame. For example, a comprehensive chapter on suicide assessment by Bongar and Sullivan (2013) discusses the importance of asking the patient direct questions about their suicidality, with an emphasis on "matter-of-factness, clarity, and freedom from implied criticism" (p. 113). In this vein, the authors review approaches to interviewing meant to minimize the patient's anxiety by easing into the subject of suicide in a step-by-step fashion (e.g., the "hierarchical approach"; Bryan & Rudd, 2006). Yet the authors do not discuss the potentially-decisive influence of what the suicidal client believes will happen if he or she does provide a true description of their suicidality. Results of this study suggest that fears about hospitalization and other practical outcomes, not shame, are a major anxiety, perhaps *the* major anxiety, preventing disclosure for clients in psychotherapy. Clients who believe – correctly or incorrectly – that they will be involuntarily hospitalized or experience other unwanted interventions if they disclose suicidal thoughts may feel strongly motivated to conceal no matter what method of assessment is used, and no matter how much clinicians attempt to reduce shame. For this reason, achieving the goal of honest disclosure of suicidality may require finding ways for therapists to psycho-educate about the basic rules of confidentiality, reporting, and hospitalization, in such a way that clients feel some measure of control or predictability. In the vast majority of cases, doing so will likely be alleviating anxieties and unrealistic fears held by the client, and thus will potentially remove this major barrier to disclosure.

Our findings do not provide a clear road map for what this conversation should look like, but they do provide some clues. While many respondents made the unrealistic request that therapists simply "promise not to report" suicidality, others provided more nuanced and realistic ideas. They suggest that clinicians can: (a) explain the law about mandated reporting, (b) explain

the level of suicidality that triggers hospitalization at the facility where the client is being seen, (c) express their personal awareness of the difference between passive and active suicidality, (d) describe what typically happens when suicidality rises to the level of being reported, and (e) acknowledge and validate the anxiety that clients often have about disclosing suicidal thoughts due to fear of unwanted interventions.

Therapists have a major opportunity to provide clarity at the start of therapy through the informed consent process. While clinics often require clients to read and sign consent documents, it is not clear how often clients receive detailed explanations about the triggers for hospitalization in a style and format that they will remember. There are plenty of reasons why therapists might be inclined to quickly gloss over this material. There is evidence (Farber,1983) that among all the stressful behaviors patients might exhibit in session, psychotherapists find suicidal statements to be far and away the most stress-inducing, more so even than aggression and hostility. Therapists who aren't aware of their own anxieties in this regard may shy away from providing detailed explanations of the rules around confidentiality. Explanation may be avoided by clinicians who do not want to alarm new patients, or who are themselves unsure of the specifics, or who perhaps worry that "giving away" the precise triggers for hospitalization might make it easy for suicidal clients to escape detection. The major findings of this study suggest that the opposite strategy is warranted. Clients are already managing their disclosures about suicide to avoid certain outcomes. Careful and slowly-paced explanations of the triggers for hospitalization will bring predictability to discussions of suicide, fostering trust and greater honesty by clients who feel less afraid because they have a measure of control.

These ideas are in keeping with the collaborative approach to suicide risk management favored by recent scholarship in the field. Jobes (2006) urges clinicians to ensure that the

relational dynamic during assessment and treatment "is one of collaboration, where the patient – who is the expert of his or her own experience – is engaged as an active collaborator in clinical care" (p. 41). Similarly, our findings can be seen as an endorsement of some of the 24 "core competencies" in suicide assessment promulgated by the Suicide Prevention Resource Center (2006). Specifically, the third competency calls for clinicians to maintain a collaborative, non-adversarial stance, including "obtaining informed consent to protect client rights and promote client participation in making decisions regarding care and treatment options". Our findings suggest that mastery of this competency, perhaps more than any other, might be valuable for that subset of clients concealing suicidal thoughts out of fear of practical repercussions.

Shame as a Motive for Concealment

Many of the current techniques for eliciting suicidal ideation seek to reduce shame (e.g., Shea's "shame attenuation", 1999), and some studies suggest shame and embarrassment are major drivers of concealment of suicidal thoughts (e.g., Hom et al., 2017). This study of psychotherapy clients provides some nuance to that picture. When given a chance to spontaneously provide reasons for their concealment, only 16% mentioned any type of embarrassment or shame. Respondents were more likely to mention fear of hospitalization, a sense they were low risk for actually attempting suicide, or a desire to control the direction of therapy. Yet when provided with multiple choice options later in the survey, 62% of respondents endorsed "embarrassment or shame", making it the second-most common motive reported in that question format. The data provide no definitive explanation for this pattern of response. It may be that some amount of embarrassment is assumed by clients, such that they did not see fit to mention it. Alternately, respondents may have shied away from volunteering shame as a motive because, after all, acknowledging that one is experiencing shame can feel shameful. Whatever

the case, it does not appear that reducing shame was seen by clients as a way to foster greater honesty. When asked what could help them be more honest, only 9% of respondents mentioned shame-reducing interventions such as normalizing or validating. For suicide concealers in this sample, at least, it appears that efforts to de-stigmatize suicidality would have little effect on their willingness to disclose to a clinician. This is notable because, as discussed above, many approaches to suicide assessment focus on reducing the potential for shame during the interview.

I would never do it anyway

The third-most commonly-reported motive for concealment was the respondent's sense that they would never actually commit suicide. This sense of being "low risk" for suicide was reported by 21% of the sample, a proportion close to that found by Burton-Denmark et al. (2012) in their survey of undergraduates. Some respondents in the low risk group described their suicidality as so fleeting as to not merit a mention. This may indeed be true; clients in therapy necessarily omit much about their daily lives that seems mundane or irrelevant. Thoughts about killing yourself hardly seem irrelevant to psychotherapy, however. So the question can reasonably be asked: If one's suicidality is so fleeting and inconsequential, why bother to hide it from your therapist? These respondents may have other reasons for wanting to avoid the topic. Other respondents in this group described more frequent or intense suicidal ideation, but felt certain they would not act on these urges. For this subgroup, too, we can speculate that a deeper motive for concealment is not being mentioned. Intense or frequent suicidal thoughts are right in the bull's eye of topics to discuss in therapy. Upon close examination, the sense of being low risk for suicide is among the less substantial motives described by participants, and is likely to be undergirded by other motives for concealment which are not being mentioned. These underlying

motives could possibly be anything from the psychological defense of denial, to wanting to avoid a fuss, to fear of practical consequences.

My therapist made me do it

The last two commonly- reported motives for concealing suicidality have their origins in the psychotherapeutic relationship. A significant minority of respondents (17%) said their concealment was motivated by a desire to control the course of therapy. They believed that mentioning suicidal thoughts would distract their therapist and drag the therapy off course and away from issues they want to work on. For this group, editing out suicidal material was characterized as a way to keep anxious therapists from going off track and, by doing so, make the most effective use of precious therapy time. These clients do not trust their therapist to react appropriately to their actual level of suicide risk. A roughly equal number (16%) blamed their therapist's poor technique or flawed character for making it impossible for them to honestly disclose their suicidality. These respondents were often highly critical of their therapists, who they saw as obsessed with their own legal liability. Like the veterans interviewed by Ganzini et al. (2013), clients reporting this motive were concerned with trust and respect, and were attentive to their therapist's reactions. Some had arrived at the conclusion that their therapist did not really care about them.

All of these findings allow us to propose answers to our first two research questions: Therapy patients report a pattern of motivations for concealment which is different both from other populations of concealers and from concealment on other topics. Most suicide concealers believe discussing suicidal thoughts in therapy will result in hospitalization or other practical consequences and seek to avoid these outcomes through non-disclosure. Other motives, such as shame, are significant but secondary. Further, many suicide concealers want explicit assurances

that they will not be reported, to be told up-front what the triggers are for reporting, or to be involved in decisions about hospitalization. Substantial minorities said they would be honest if simply asked a direct question about it, or believe there is nothing their therapist could do.

Concealers are Conflicted Yet Committed

How do suicide concealers view their own dishonesty on this issue? Respondents in this sample were most commonly "conflicted", with significant numbers feeling "frustrated" or "guilty" and others feeling "safe" or "in control". Only 5% reported feeling "satisfied", yet only 3% reported feeling "regretful" about concealment. At first glance these results may seem confusing, but the overall picture supports an interpretation that clients view suicide as a complicated issue about which they would prefer to be honest if they felt honesty was a viable choice. Dishonesty could be described as a double-edged sword, protecting them from unwanted outcomes yet denying them emotional support. Motivated by concerns that seem real to them, they do not regret concealment, yet are not happy about it either. This conflicted feeling was also paramount for those in the comparison sample who reported being dishonest about topics *other* than suicide (e.g., infidelity, substance use, feelings about the therapist), although suicide concealers were somewhat more likely to report being "frustrated" and less likely to report feeling "neutral" about their concealment.

Perhaps the most discouraging finding from this study is that a simple majority of those concealing suicide (55%) said they had no intention to share their experiences with anyone at all, whether inside or outside of therapy. Only a third of respondents anticipated that they would be willing to honestly disclose about suicide to their current therapist or to any other therapist. Perhaps because of the potential consequences, suicide concealers were substantially less likely to see themselves ever disclosing than respondents who reported concealing about other topics.

When asked to get creative and imagine what their therapist could do to help them be more honest, a third of suicide concealers responded that they did not know of anything, or they were certain that there was nothing their therapist could do. When later presented with nine fairly specific conditions that might help them be more honest (e.g. “if I knew my therapist would not over-react”), a substantial minority still insisted that “under no circumstances” would they be more honest. In sum, it appears that while clients are conflicted about concealment, many find it hard to imagine handling this issue in any other way. This suggests that clinicians will have to take the lead in changing the conversation about suicidality, and may face well-entrenched skepticism and reluctance from many concealers.

Most Concealers See Little Impact on Their Therapy

The fourth and final goal of this study was to query suicide concealers about how the concealment affected their therapy: Was being dishonest about this one issue hampering their ability to make progress in therapy overall? Findings on this matter were limited to the results of a single multiple choice question, limiting our ability to draw major conclusions. Nonetheless, a large majority of respondents (65%) reported that concealment had “no effect” on their therapy, neither helping nor hurting their progress. The prevalence of this response suggests that many concealers feel they can still make good use of therapy despite keeping this particular secret. This may help explain why so many do not foresee ever disclosing; they see only risks to disclosure and no real reward. Among those who felt concealment did impact their progress in therapy, respondents were four times more likely to report that it hurt their progress (28%) than that it helped (7%).

Limitations and Future Directions

Several limitations inherent in this study's methodology must be considered alongside the conclusions drawn from our findings. First, it is important to note that the data is drawn from a study that was not primarily about suicide. For this reason, no information was collected on the severity of each respondent's suicidal symptoms. Responses make it evident that the sample includes a wide range of severity and chronicity, however the study did not include measures that could have captured this information for each client. Thus, our sample includes an unknown proportion of mild versus serious ideators, and we cannot conclude that this sample is representative of the symptom severity among the general population of suicidal ideators, or that a given clinician might encounter.

Another limitation arises from the use of online survey techniques. Respondents were invited to participate in the study by the use of advertisements. The absence of random sampling methods means we cannot claim that this sample is representative of the therapy-using population, nor of the population experiencing suicidal thoughts. While the sample has an impressive age range, it is heavily skewed toward females and whites. While this distribution does resemble what is known about the U.S. therapy-using population generally, it means that men and minorities are underrepresented in the sample. Therefore, if there are unique features of the male and/or minority experience around disclosing suicidality, these may not be fully represented by the present analysis. Additionally, the sample that was collected may have been shaped by idiosyncrasies of the study design such as wording choice. For example, terms such as "dishonesty" and "lying" used at different points in the survey may have sounded judgmental to some prospective participants and dissuaded them from continuing. While no significant

demographic differences were noted between completers and non-completers, there was no way to gauge such attitudinal differences.

The use of qualitative coding, conducted in a collaborative manner by teams of coders, can also introduce limitations. Despite the high inter-coder reliability in this study, it is possible that different coding teams would have created different categories of analysis, i.e. codes and code-groups. For example, the coding team separated the motive “Fear of negative judgment by therapist” (reported by 8%) from the motive “Embarrassment or shame” (reported by 16%), and indeed placed them in different code groups. The argument could be made that a client who conceals out of fear of judgment is essentially avoiding shame. Importantly, grouping these two motives together would not have changed the essential findings of this study.

This study would also have benefited from certain analyses which were not conducted. For example, this dissertation does not incorporate potentially illuminating analyses of several measures which were captured in the online data collection. These include measures of social desirability, therapeutic alliance, and total time in therapy. Each of these may have a relationship with motive for concealment, adding considerable nuance to the picture. For example, those with higher therapeutic alliance ratings may have been less likely to experience fear of hospitalization because (we might imagine) they trust their therapist not to overreact to a suicidal disclosure. Future work with this data set may deliver such insights.

Important avenues of future research are suggested by the prevalence of hospitalization fear in this sample. One question is: What do clients actually know about the triggers for hospitalization? There is a strong suggestion in this study that clients overestimate the likelihood of being hospitalized by their therapist. Empirical work is needed to determine whether clients possess accurate knowledge about the limits of confidentiality and the process of reporting. If

such work shows that most clients have very little idea what types of disclosures will trigger a therapist to break confidentiality, it would be important to consider possible adjustments to clinical practice and training. In the same vein, an important question for future research is whether therapists themselves have accurate understandings of the appropriate triggers for hospitalization. While clients who conceal suicidality may be overestimating their therapist's likely reaction, it could also be that clients are *accurately reading* their therapist's anxiety about suicide and their propensity to react with strong measures. Empirical work with a representative sample of psychotherapists could gauge the diversity of attitudes toward hospitalization across the profession, and reveal the need for education campaigns to standardize or otherwise advance practice on this matter. Empirical research is also lacking on the extent to which practicing therapists actually incorporate complete, comprehensible explanations of confidentiality and its limits during the informed consent process.

Finally, we agree with the general point made by Hom et al., (2017), that "further research is needed to better understand how to enhance accuracy of reporting when individuals are probed about thoughts of suicide" (p. 2). Despite many decades of research and clinical publications about suicide assessment, this study suggests there remain situations in which present techniques of suicide assessment are failing. Controlled experiments which can model the disclosure dilemma faced by suicide concealers may be useful in assessing the value of different innovations in assessment technique. Will the transparency about hospitalization triggers actually increase rates of disclosure? Concealers in the present study certainly believed it would. Future research is needed to test that proposition.

Conclusion

By giving a voice to clients who are concealing suicidal ideation from their therapist, the current study contributes to the literature on assessment of suicidal risk. The concerns expressed by the suicide concealers in this sample suggest that improving techniques of suicide risk assessment may require renewed attention to providing transparent, complete, and easy-to-understand psychoeducation about the triggers for hospitalization and other outcomes of disclosure that involve practical impacts on the client's life. Even the most skillful interviewer is not likely to elicit disclosure if the suicidal client believes honesty will result in unacceptable consequences for themselves, their reputation, or their family. Clients ultimately control their level of disclosure, and the results of this study suggest they desire sufficient knowledge to make this an informed decision. These and other findings of the current study provide insight into the motives and perspectives of suicide concealers in psychotherapy and how clinicians can help these clients more fully experience the honest disclosure that is at the core of the psychotherapeutic process.

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APPENDIX A: CONSENT FORM

<u>Please read the form below before beginning the survey.</u>

Honesty and Dishonesty in Psychotherapy Study

You are being asked to take part in a research study about the client experience of psychotherapy. This study will consist of a single survey, which will take about 10-20 minutes to complete. There will also be an opportunity to follow up on the survey with an interview. Please read this form carefully and ask any questions you may have before agreeing to take part in the study.

What this study is about: The purpose of this study is to learn more about what psychotherapy is like for the client and how to improve that experience. Principally, we are interested in what topics clients feel they cannot be open with their therapist about and how that affects therapy.

What we will ask you to do: If you agree to be in this study, you will complete a survey about your psychotherapy experience. The survey will take about 10-20 minutes to complete all parts. This will include demographic questions, questions about your therapist, reasons you entered therapy, and feelings about therapy and your therapist. We will also be asking you whether there are subjects you did not feel comfortable sharing with your therapist. These topics may involve very personal and sensitive information. You are free to skip any question(s) that you do not wish to answer.

Benefits: There are no direct benefits to you. However, your answers will be important in improving the psychotherapy experience and training future clinicians.

Risks/Discomforts: The principal risk involved in this study is that sharing of personal or sensitive information may bring up difficult topics or uncomfortable feelings. Taking part in this study is completely voluntary. You may choose to skip any questions you do not want to answer. If you decide to take part in this study, you are free to withdraw at any time with no penalty to you or loss of benefits to which you are otherwise entitled.

Compensation: As a thank you for your time, we will be offering entry into a lottery. Six survey takers will win a $50 Amazon gift card. At the end of the survey, we will ask for your email address for the lottery. This information will only be used for the lottery and will not be linked to your responses if you are not interested in being contacted for the follow-up interview.

Opportunity for follow-up: We will be conducting follow up research on the major themes of the survey. This will consist of a single in-person interview lasting 30 minutes to an hour about your experience in psychotherapy and the topics you described in your survey that you would like to share more about. If you are interested in being contacted to take part in the follow-up, you will be asked to provide your contact information at the end of the survey. This is voluntary and will not affect your odds of winning in the lottery if you choose not to take part. If you do choose to enter this information, your survey answers are no longer anonymous because they

will be linked to your contact information. However, all personal information will be kept confidential.

Your answers are confidential: Precautions have been taken to keep your information confidential. The records of this study will be kept private. Research records will be kept in a locked file; only the researchers will have access to the records. All identifying information will be removed from any future use of the material in articles or other publications.

How the results will be used: Data from the survey and/or interview may be reported in professional publications and conferences. We plan to report group results, such as, "the most common reasons for lying to one's therapist include..." We will de-identify all quotations in order to protect your confidentiality. By participating in this project, you will be helping to advance knowledge in the field of psychology, particularly in regard to professional training.

If you have questions: If at any point you have questions or concerns regarding this research, you can contact the principal investigator, Barry Farber, at ColumbiaTherapySurvey@gmail.com or by phone at 212-678-3267. This study has been reviewed and cleared by the Teachers College, Columbia University Institutional Review Board (IRB). If you have concerns or questions about your rights as a participant or about the way the study is conducted, you may contact the IRB at (212) 678-4105.

We thank you for your time and consideration. If you are 18 years or older and have ever been in psychotherapy, you may consent and begin the survey on the next page.

Statement of Consent: I have read the above information, and have received answers to any questions I asked. I consent to take part in this study by clicking "Next" and beginning the survey.

With great appreciation,

Dr. Farber's Psychotherapy Lab
Teachers College, Columbia University

APPENDIX B: Codebook for Research Question 1

Code List for Question 1 (Seventh Draft)

Beliefs about Suicide or Self

1 – LOW RISK	**I am a low risk for suicide**
2 – POINTLESS	**It is pointless to disclose; there is no benefit; no one can help me**
3 – HARD TO SPEAK	**It is hard to speak about suicide (not for use if further reason is given)**
4 – MORAL WRONG	**Suicide is morally wrong**
5 – COPE ALONE	**I am a private person; I prefer cope alone or with non-therapist support**

Emotional Outcomes to be Avoided

6 – C-EMBARRASS	**Client embarrassment or shame**
10 – C-SADNESS	**Client depression or sadness**
12 – C-UNSPECIFIED	**Client Unspecified Emotional Discomfort**
13 – C-DENIAL	**Client denial or avoidance of the issue**

Practical Outcomes to be Avoided

15 – HOSPITAL	**Hospitalization**
16 – MEDS	**Unwanted Medication or Change of Meds**
18 – FIND OUT	**Others will find out (e.g. parents, employers) and it will hurt client**
19 – CAREER	**Career Impact**
20 – AUTONOMY	**Preserve Autonomy to Commit Suicide Later**
21 – PRAC OTHER	**Practical Consequences for Client, Other or Unspecified**
22 – HURT OTHERS	**Consequences for others**

Therapy-Related Reasons

14 – DISTRACT/DISTORT	**- Discussing suicide will distract from other topics, dominate or distort therapy; client wants to manage the course of therapy.**
23 – T-FAULT	**Therapist Fault. Client blames non-disclosure on behavior by therapist(s), a lack of caring, lack of skill, failure to understand, or merely their technique.**
24 – T-JUDGMENT	**Client fears therapist will have bad feeling about client; e.g. disappointment**
25 – T-SELF	**Client fears therapist will have negative feeling about themselves or their skills**
27 – T-REACT OTHER	**Therapist reaction, Other or Unspecified**

Other Codes

33 OTHER	**Other reason "33" A reason not accounted for in our codes; please explain**
99 IRRELEVANT	**No Reason/Irrelevant "99" Thought Unit contains no clues about client's reason for concealment**

Codebook for Q1: Why did you conceal?

Instructions:

For this task we are coding individual "thought units" which have been previously demarcated as recommended by Neuendorf (2002). Your job is to code each unit individually, but to code the unit in the context of the entire response given by the individual. For example, the thought unit "I was scared." changes its meaning if the following unit is either "I am frightened of going back to that hospital again" or instead "I can only imagine how my therapist will judge me". So for each client, begin by reading the entire response. Then return to the first thought unit and begin coding.

For each unit, look for evidence of the reason why the person was dishonest. Even if the main thrust of the comment is not about "why", the content of the unit may clearly reveal something that does answer the question of why. Ask yourself for each thought unit: Does it provide insight into why the person lied?

As you make these judgements, try to keep your mind on a reasonable middle ground and allow yourself to make the obvious inferences from the text. Don't get hyper-strict; this is *not* a court proceeding and you do not have to prove your case for a code beyond-a-reasonable-doubt! Instead, you can code based on *your own best guess* as to the subject's intentions. At the same time, don't be lax and just code based on buzzwords you see. For example, every mention of "medications" should not be taken as a reason for concealment. Unless something is truly ambiguous, go ahead and code based on your best assessment. Also be aware that reasons for concealment are different from reasons for not committing suicide. For example, taken out of context, the statement "I have kids to take care of now" could be read either as a reason to live, or as a reason to avoid lengthy hospitalization. You must check the context to make a correct interpretation.

There are 21 reason codes, and 2 extra codes, for a total of 23. We have split up the codes into four code groups. Coding instructions boil down to three simple steps:

Step 1: Read entire response!
Step 2: Code each thought unit individually, but in the context of the entire response. Do not lose the Gestalt of the whole response and end up coding too literally. In the opposite direction, do not make undue inferences; stay as close to the content of the response without blinding yourself to the obvious themes in the response as a whole.
Step 3: When truly confused, use a general code like 21 or 27. It's okay to rely on *your own best guess* as to the subject's intentions based on the whole response. *(See also the Coding Flowchart on last page)*

Beliefs about Suicide or Self

1 - I am a low risk for suicide

(e.g. "I'm never going to do it anyway", or also "suicidal thoughts are normal") Use this code whenever clients assert that they will never go through with it, or also when clients say that everyone has suicidal thoughts, the implication being that suicidal thoughts are not serious and not likely to be acted upon. We will never know for sure if the client is minimizing some serious ideation; we have to take them at their word. Be particularly alert for clients talking about past suicidal ideation. They may talk like low-risk people now because, at the time of the survey, they feel better. However what you're really looking for is why they concealed *at the time* when they were having the thoughts. So be alert for this time-frame distinction.

2 - There is no benefit to disclosing

(e.g. "nothing would change" "they cannot help me") The client may report that they cannot be helped by any therapist, or that they cannot be helped at all. They may say their mood swings are random and talking doesn't help. Unlike many codes which deal with negative outcomes, this code is used when the client is articulating the *absence* of a positive outcome: I am not honest because there's no point. The focus is typically on the client, less than the therapist. For example, you would not code #2 if the client said: "telling this guy won't help because he'll just say something stupid" (this would be #23 Therapist Fault).

3 - It is hard to speak about suicide (e.g. "It's hard to talk about this topic"). This is a pretty vague reason that seems to suggest the person does not have the skills or inclination to talk about it, but there must also be an unstated underlying reason why it is hard: Shame? Shyness? Alexithymia? Fear of consequences? In some sense, this reason is a *non-reason reason*, something that sounds like a reason but does not articulate the actual problem with disclosure. Nonetheless, you must code it if neither the thought unit nor its context gives a clear picture of what makes it hard to speak about suicide. Burton-Denmark made a conceptual link between this as the "Privacy" code.

4 - Suicide is morally wrong (e.g. "It's wrong") This is clearly a distinct reason for not committing suicide, but is it a reason for not disclosing suicide? We could imagine that another reason lies beneath this: For example, saying immoral things is shameful. Thus this is another *non-reason reason*. But sadly we can't make that kind of inference here. The person may have intense spiritual beliefs. They may see practical harm from offending god, etc. We will never know. So we have to use this code.

5 - Privacy/Cope Alone (e.g. "it's none of their business" or "I prefer to cope alone").

Client may state that they "can handle it" without therapist help, or with only the non-professional help of family or friends. Also use this code when the client cites privacy as their reason for concealing suicidal ideation from their therapist. As Burton-Denmark, et al. (2012) define this category: "expresses the respondents sense of him or herself as a fundamentally private and self-sufficient person… the student habitually maintains a self-protective boundary around personal thoughts and feelings…" This can be similar to #1 "Low Risk" because we may often assume that a client who is coping alone is low risk. This is *not always the case*, however. Some clients simply prefer to cope alone, even though they are still pretty high risk. And if the client says they are coping alone because they are low risk, preferentially code Low Risk (#1).

Emotional Outcomes to be Avoided

This group of codes is used when the client anticipates certain emotional impacts of honest disclosure (e.g. "Talking about this is just depressing" or "It's humiliating to admit what's been going on with me"). These are emotional experiences the client seeks to avoid by not disclosing suicidal ideation.

6 - Client embarrassment or shame – client mentions real or potential embarrassment being a reason why they concealed suicidal ideation from their therapist. Client may also mention shame or stigma (which people don't always distinguish from embarrassment). Initially we sought to keep them separate, but respondents appear to use these words interchangeably, thus this combined shame/embarrassment code.

10 - Client depression or sadness - client mentions that disclosure will lead to feelings of sadness, depression, hopelessness or failure.

12 - Client Unspecified Emotional Discomfort – (e.g. "I just can't deal with the emotions") This code is only used when the client cites an emotional experience or discomfort that is not explained, perhaps overwhelming emotions.

13 - Client denial (e.g. "I don't want to face it" or "talking about it makes it real")

Client conceals suicidal thoughts in order to aid some form of denial, suppression or avoidance. The client here is worried about an *internal* audience. They may feel talking about it will force them to take action to address the problem, or to fully realize how bad their condition is, or to maybe even make an attempt. In that sense, it is closely related to codes about client emotional responses. If they talk about it they will have to admit the feelings are real, and they're not ready for that. DO NOT use this code when the client is merely describing how they denied suicidal ideation to others (which is not an actual reason, but rather a #99). Only use this when the client explicitly indicates some amount of lying to themselves or editing their own experience so as to avoid facing the topic.

Practical Outcomes to be Avoided

15 - Hospitalization

(e.g. "They'll lock me up." Or "She might try to hospitalize me") This code is for any time the client indicates that avoiding hospitalization is a reason they concealed suicidal ideation. We can imagine it is not merely visiting the hospital that they seek to avoid, but rather, being involuntarily taken there and held there for an indefinite period of time. This category includes references to "calling the cops" and "being locked up" as well as being "taken away". Key note: Hospitalization is often seen as a proximal outcome – it happens right away – that leads to distal outcomes that happen down the line, such as "friends finding out" or "losing job". There is a process by which a therapist may "report" and the person is "hospitalized" and then the hospitalization causes distal outcomes. Just be alert to the steps of this process, and the distinction between proximal and distal outcomes as you code. Note: This code also includes people who reference bad past experiences in the hospital, as well as those who believe being in the hospital will make their condition worse, not better.

16 - Medication

Code whenever client mentions that disclosure is avoided because it could result in an unwanted prescription of medications, forcible medication, or a change in their current medications.

18 - Others will find out (e.g. parents, friends)

Code whenever client mentions a breach in confidentiality or otherwise say they are afraid that persons in their life (not the therapist) will learn about their suicidal ideation and that this will come back to hurt them (the respondent). Do not confuse this with #22 Consequences for Others, in which others are harmed by a disclosure. This code #18 is mainly about clients fearing repercussions for themselves due to confidentiality breach.

19 - Career Impact

(e.g. "I will lose job" or "I can't afford to be taken out of school") Code this whenever the client links disclosure to negative impacts on their employment, schooling, or future life circumstances generally.

20 - Autonomy to Commit

Clients may conceal suicidal ideation because they want to preserve autonomy to commit suicide, (e.g. "If I tell them, I lose the freedom to act"). Loss of autonomy may happen as a distal impact of hospitalization or of family finding out. Code it whenever the client mentions loss of freedom to kill themselves, if needed, as a reason for concealment.

21 - Practical Consequences, Other or Unspecified

This code is for times when the client is worried about real-world consequences of disclosure but examination of both the statement and its context does not provide any indication of precisely what those consequences would be. Examples might include: "There are implications to saying you're suicidal". In this case, it's fairly clear the respondent is *not* talking about having a bad emotion or upsetting their therapist. They're talking about some kind of external consequence, but they don't say what. You would use this code. You can also use this code for practical consequences which are described but which are outside the scope of the other practical reasons listed above. (This code now includes the old "unwanted intervention" code).

22 - Harming others

Use this code when the client cites the impact on other people (not the therapist) as a reason for concealing suicidal ideation (e.g. "My mother will be heartbroken"). This is different from others merely learning about the client's mental illness (#18). This code is used when those others would be harmed in some way by the information. A borderline case is when someone says: "Who will take care of my kids?" This clearly expresses concern for others (kids) but it is also clearly a reference to either being hospitalized or losing custody. Fear for the children is a distal concern about the proximal event of hospitalization or similar unwanted intervention. Preferentially code #22 in such a case. It is likely that another thought unit nearby will capture the hospital concern.

Therapist Reasons / Reactions

14 - Discussing suicide distracts or distorts therapy Client is worried about changes in the course of therapy caused by disclosing suicidal ideation (e.g. "This would distract" or "It would take away from other things that are more important"). Use this code any time the client cites the idea that suicide will distract or take away time from other topics they feel they could be discussing in therapy, in a sense wasting their time. References to not having enough time, or time being precious, therapy time being expensive, all can properly be coded with this code. This code also covers concerns that bringing up suicide will distort therapy, causing the therapist to over-focus on suicide or misunderstand the client's true mental status.

23 – Therapist Fault

(e.g. "he's just worried about liability") This code is to be used any time therapist actions or qualities are blamed for the client's concealment. You can imagine this being like a Yelp Review; a critique of the therapist or their techniques. Client may have negative feelings about therapist, a lack of trust or some resentment. They may feel the therapist "does not care" or only cares about liability. They

may say that *all* therapists are fools. This code should not be used if the client articulates a specific therapist response (e.g. "he will stupidly blow it out of proportion") but can be coded if the main thrust involves a response but is clearly just expressing low opinion of therapist (e.g. "he will say something stupid"). Specific stupid responses must be coded as a type of therapist response. A borderline case would be "He doesn't seem to care", because you could think of the not caring as a therapist response. However, not caring is not really a response to a disclosure so much as it is a global disinterest in the client. As so you would use this code, capturing distrust, anger, spite or low opinion of therapist or their techniques.

24 - Therapist will have negative judgment of client

(e.g. "I can't stand to disappoint her like that" or "She will judge me"). This code should be used to capture situations in which client fears therapist will judge them, think they are weak, feel disappointed in them, or be shocked by their depth of psychopathology or lack of progress. In contrast to #23, this code often occurs in the context of a *good* therapy relationship that the client is afraid of damaging in some way.

25 - Therapist will have negative feeling about themselves

(e.g. "I don't want to make someone else feel bad at their job") The client worries that admitting suicidality will make the therapist feel bad about their own skills or abilities as a therapist. The client is concealing in order to protect their therapist from experiencing a bad feeling. Note that this is very different from #24, which is when the client fears a negative feeling being directed at them (e.g. disappointment in client). Here the fear is that the therapist will be disappointed in themselves.

27 – Therapy reason, Other or Unspecified

(e.g. "I'm just worried about how she would react") This code is used for statements in which some event in therapy is blamed for concealment, but the precise form of it is not clear. Often this involves a therapist reaction (or over-reaction), but neither the specific unit nor the context gives you a sense for what form this reaction would take. Keep in mind, most therapist reactions are actually coded elsewhere, because these reactions have consequences like hospitalization (#15) or over-focusing on the topic (#14). Code those preferentially if the context informs you of the possible consequences of the therapist reaction. Also, be alert to the distinction between this and the client blaming the therapist for their own non-disclosure, which is code #23. The important thing is that the client is anticipating some consequence affecting therapy, not their lives outside therapy.

Other Codes

33 - Other reason "33"

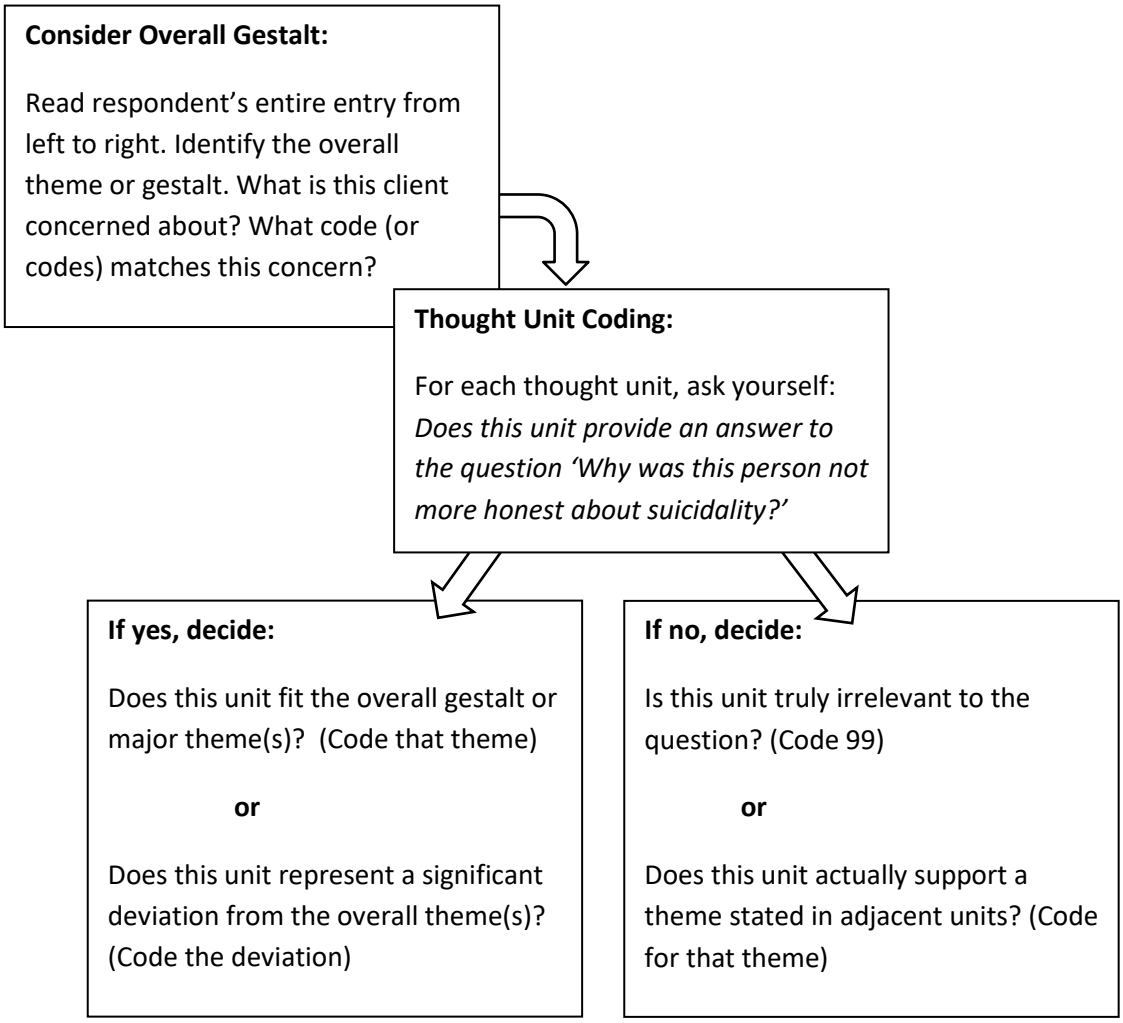
This is used when a reason is found that just cannot be fit into any of the above categories. Use the space to the right of your coding entry to briefly note what you think the reason is.

99 – Not a Reason/Irrelevant "99"

No reason is present in the thought unit. This can happen if a mistake was made in defining thought units, and you find a remark that does not provide any specific reason in response to the first question we are interested in: "Why were you not truthful about this topic?" If a thought-unit does not contain any reason for concealment, don't worry. Code it 99 and use it to inform your understanding of the client's overall motives.

Coding Flowchart

The diagram below provides a way to balance the respondent's overall concerns with specific content of individual thought units.



Distinctions to consider as you code:

1. Are they fearing some *reaction*? (See below) Or do they *cite some belief* about themselves or about the nature of suicide? (see codes 1 – 5)

2. *Whose* reaction does the client fear? (Their own? Their therapist? Their family?)

3. What *type* of reaction do they fear? (Internal to self? Internal to therapy? External in world?)

   Internal to self = emotion codes, (usually codes 6 – 13)
   Internal to therapy = therapy code (usually codes 14, 24, 25, or 27)
   External in world = practical code, usually (codes 15 – 22)

4. Or do they just blame their therapist's poor technique or poor character? (Code 23)

APPENDIX C: Codebook for Research Question 2

Code Book for Question 2 (Third Draft)

1 – Do Not Report
1a – Explain Triggers
1b – Include Me/Give Me Control
3 – Normalize/Validate
4 – Better Relationship
5 – Direct Inquiry
7 – More Time
8 – Unspecified Change of Technique
9 – Nothing Therapist Can Do
10 – I don't know
99 – Not an Answer/Irrelevant

Instructions:
This coding scheme is focused on **actions therapists could take** (or not take) to foster honesty. You can also code *good things* that the therapist is already doing that foster honesty, if that comes up. But our major focus is on what therapists could do differently to help the client disclose (Note that a different coding group is working on reasons why people lie, so don't get distracted by that set of ideas). You might say our goal is to draw out advice and suggestions these client have for their therapists.

1 – Do Not Report – Client would be more honest if they were assured that the therapist would take no action in terms of mandated reporting and/or inpatient hospitalization. Examples would include:

"If hospitalization wasn't a consequence of talking about suicide"
"When I had told her in the past she called 911 on me"
"By keeping this between me and her"

Please note that this code often includes client wish that the therapist would "not over-react". Check the rest of the response to see what *type* of over-reaction the client is precisely afraid of. If the client is afraid of over-reaction involving actions taken outside therapy (reporting, hospitalization), use this code. An ambiguous case would be if the client said: "I need to know if she can tell the difference between thoughts and actual plans". This may be about hospitalization, but check the rest of the response for clues to confirm.

1a – Explain Triggers– Code this any time they want the therapist to explain more about the consequences of suicidal disclosure. Examples include: "explain how they would react if I had these thoughts". This code is labeled "1a" because clients may report a desire for such explanation because they are afraid of being hospitalized, so it is a sub-category of Do Not Report. Client may request psychoeducation. Client may want to know the boundaries of what can be discussed without being reported.

1b – Include Me/Give Me Control – Similar to 1a, except client states that they want the therapist to share decision-making power with the client about their treatment. Example: "Allowing me to decide if I needed to be hospitalized".

3 – Normalize/Validate – Client says they could be more honest if the therapist could help them feel okay about having suicidal thoughts or be reassured that they are not crazy, etc. They may be needing some amount of warmth and support from the therapist to get into this difficult topic. Examples include: "Normalize them" and "Reassurance that my emotions are valid".

4 – Better Relationship - Client wants therapist to understand them better or get to know them or to accept them more fully before they disclose. Client may feel therapist has a distorted or partial view of them or their condition. Examples include: "I would have to trust them more". This involves relational stances that therapist could take to foster honesty, as opposed to concrete actions. The difference between #3 and this code is that #3 specifies behaviors the therapist could engage in (e.g. normalizing), whereas this code expresses a sense that somehow the client would need to have a closer or more trusting *overall relationship* with their therapist.

5 - Direct Inquiry – Client would be honest if asked direct, specific questions about suicide. They may have a hard time bringing up the topic but think they could discuss it if the therapist took the lead. Example: "The topic is hard to talk about so I would be willing to answer more specific questions about it." This is also the code for remarks like "she should challenge me" and also references to being "encouraged" or demonstrations that the therapist "wants to know" about this.

7 - More Time – Client would disclose if they had more time in therapy to do so, longer sessions, or more money to afford therapy, or fewer other issues that they'd rather discuss. Client may reference the cost of therapy and say they didn't want to waste time talking about this. Be careful not to confuse this with #4 Better Relationship. This can happen is a client says they would be honest if they had been in therapy longer and thus, have a closer bond with therapist.

8 – Unspecified Change - Please note this is a *General Category* for when clients say they'd be honest if their therapist made some unspecified change of technique. Do not use this if you can figure out what change in technique is asked for. Look at the entire response and see if the client indicates what kind of change they are hoping for. Only code if they really don't explain.

9 - Nothing – Client says that the therapist is not the problem, or that there is nothing else their therapist could really do. This is usually because the client is satisfied with the therapist; or because the client is resolved not to disclose this under any circumstances to the therapist. Satisfaction with therapist can sound like: "He does make me feel comfortable, so there's really nothing he can do". An example of the client being decided to neve tell their therapist is: "Nothing. This is a secret I will take to my grave". In both cases, clients are saying there is nothing they can think of their therapist could do to foster honesty.

10 – I don't know – Client says they do not know. This may be because the client wrote something like "I don't know" or "N/A".

99 – Not an Answer/Irrelevant – This code is used when a thought unit does not answer question: "How could your therapist help you be more honest?" The thought unit is an extraneous detail or digression. Be aware that some thought units don't give a direct answer to the question, but contribute to an answer given in a subsequent thought unit. For example, the unit "I am very serious about committing suicide" might seem like a 99 unless the next unit is something like "and so there's nothing he can do to make me be honest about this." In this example, both units would be coded #9 "Nothing".