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MENTAL HEALTH AMONG SUICIDE ATTEMPT SURVIVORS: THE ROLES OF STIGMA, SELF-DISCLOSURE, AND FAMILY REACTIONS

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MENTAL HEALTH AMONG SUICIDE ATTEMPT SURVIVORS:
THE ROLES OF STIGMA, SELF-DISCLOSURE, AND FAMILY REACTIONS

DISSERTATION

A dissertation submitted in partial fulfillment of the
requirements for the degree of Doctor of Philosophy in the
College of Agriculture, Food, and Environment
at the University of Kentucky

By

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2015

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ABSTRACT OF DISSERTATION

MENTAL HEALTH AMONG SUICIDE ATTEMPT SURVIVORS: THE ROLES OF STIGMA, SELF-DISCLOSURE, AND FAMILY REACTIONS

Although research has shown that mental-health stigma can impact an individual's well-being, little is known about who perpetrates suicide stigma. Moreover, anticipation of stigma could impact whether individuals disclose their suicidal experiences; yet, little is known about suicide disclosure and how family members' reactions play a role in subsequent mental health. To address these gaps, three studies were designed to examine how stigma, suicide disclosure, and family reaction impact subsequent mental health of attempt survivors and those who have experience suicidal ideation.

Individuals who had previously experienced suicidal ideation or a previous suicide attempt ($n = 156$) were recruited through the American Association of Suicidology. Results indicated that attempt survivors were more likely to experience stigma from non-mental health providers and social network members than from mental health providers. A hierarchical standard regression model including both source and type of stigma accounted for more variance ($\Delta R^2 = .08$) in depression symptomology than a model with only type of stigma.

Results from respondents who had experienced a nonfatal suicide attempt in the past 10 years ($n = 74$) indicated that family reaction mediated the relationship between suicide disclosure and depression symptoms ($B = -4.83$, 95% BCa CI [-11.67, -1.33]). Higher rates of disclosure statistically predicted more positive family reactions ($B = 4.81$, $p = .013$) and more positive family reactions statistically predicted less severe depression symptoms ($B = -1.00$, $p = .002$).

Interpretive phenomenological techniques were used to analyze follow-up interviews ($n = 40$) with attempt survivors. Individuals' reactions to suicide disclosure offered insight for attempt survivors' regarding their place in society. More specifically, reactions impacted the degrees to which attempt survivors felt that they belonged within their social group and whether they were a burden to their loved ones.

Given these results, the potential contributions of family scientists to the field of suicidology are examined. Specifically, researchers have primarily examined suicide as an individual phenomenon; family scientists are ideally suited for examining the family's role after an attempt occurs. However, family science must also make the transition to viewing suicide as a family experience.

KEYWORDS: Attempt Survivor, Family Communication, Interpretive Phenomenology
Self-Disclosure, Suicide Stigma

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Chapter One

Introduction

As a researcher and clinician, I have witnessed the isolation individuals often experience when depressed and considering suicide. This is an all-too-common experience; the World Health Organization (2014) estimates that nearly one million people die by suicide each year and that the rate of suicide has increased by 60% in some counties over the past 45 years. Among family members, distress and panic at the fear of losing a loved one can limit one's ability to respond compassionately to the individual struggling with suicidal ideation and behavior, thereby further exacerbating the sense of isolation. However, the majority of researchers studying suicide and clinicians working with family systems that include a suicidal individual view this phenomenon as solely an individual issue.

With the evolution of family systems theory and family therapy, family scholars have advocated for examining the family's role in a variety of mental health issues, such as depression (Keitner & Miller, 1990) and anxiety disorders (Bögels & Brechman-Toussaint, 2006). However, most of the research on suicide continues to focus solely on the role of individual risk factors (see Van Orden et al., 2010). For example, much research focuses on the impact of mental illness (Moskos, Olson, Halbern, Keller, & Gray, 2005; Nock, Hwang, Sampson, & Kessler, 2010), substance use (Harris & Barraclough, 1997), prior suicide attempts (Beautrais, 2002; Pompili et al., 2009), or history of incarceration (Binswanger et al., 2007; Karimina et al., 2007). This framework limits the treatment options for professionals working with children and adults struggling with suicidal ideation by omitting family members who can play a role in treatment.

This gap in the literature is addressed herein by examining family experiences associated with suicide among attempt survivors and those with lived experiences (i.e., individuals who have experienced suicidal ideation). First, in this chapter, I outline existing theoretical orientations toward suicide and present family theories that can augment our understanding of suicide experiences. The next three chapters are comprised of three studies that examine how attempt survivors and those with lived experiences experience stigma, suicide disclosure, and family reaction. Finally, I conclude with a chapter that provides strategies for how family scientists can contribute to the field of suicidology.

Theoretical Contextualization

Suicide theories primarily focus on explaining the cause for suicide, although most theorists have recognized that suicide is caused by multiple risk factors (Van Orden et al., 2010). Family theories can offer a new perspective for conceptualizing suicide experience by understanding family reactions to a member's suicidal behavior and subsequently providing recommendations for how best to facilitate the treatment process among families. To emphasize this point, I will review (a) how current suicide theories address the topic of family, and (b) what family theories can add to our understanding of suicide.

Role of Family in Current Suicide Theories

Durkheim's social regulation theory. Durkheim (1897/1951) conceptualized suicide as an individual state that occurs as a result of two primary components of societal regulation: *social integration*, the way in which people feel they are contributing to and accepted by society, and *moral regulation*, the rules that guide how individuals

should behave or interact with others. In this interpretation, marriage and parenthood are two central family contexts through which social integration occurs (Durkheim); family members ideally provide a sense of acceptance while also guiding young individuals toward socially appropriate behavior (Frey & Cerel, 2013).

Durkheim (1897/1951) also posited that four categories of dysregulation contribute to suicide: (a) *egoism*, when the individual ego dominates over the social ego; (b) *altruism*, when social ego dominates over the individual ego to the point that individual interests do not exist; (c) *anomie*, when there is a breakdown of moral regulation (or social norms); and (d) *fatalism*, when excessive control over an individual occurs, preventing that person from acting on passions or goals for the future. If the family is viewed as a governing body for integration and regulation, one can apply these categories to how individuals might relate to the larger family system in an unhealthy way. For example, individuals who solely identify with their own interests or exclusively with the family interests may be more likely to develop suicide ideation. However, a limitation of this theory is that the four categories are difficult to separate, and the process for applying these categories to an individual's behavior is a subjective process (Dohrenwend, 1959). Nonetheless, using these categories to conceptualize an individual's relationship to the family has merit.

Shneidman's psychache perspective. Although not a concise theory, Shneidman's psychache perspective has had a large impact on the field of suicidology. He coined the term *psychache* to refer to the emotional pain experienced when one's individual needs are not met (Shneidman, 1993). His list of psychological needs includes many items related to interpersonal communication or social comparisons, such as

abasement, deference, nurturance, rejection, and understanding (Shneidman, 1996).

These needs could be unmet due to more global aspirations; however, many needs are assessed based on interactions with those in one's immediate proximity, such as family members (Frey & Cerel, 2013). Therefore, Shneidman's work provides a perspective for examining suicide as a result of how family members meet the psychological and emotional needs of one another.

In the preface to his book, *The Suicidal Mind*, Shneidman (1996) wrote that "the keys to understanding suicide are made of plain language . . . the ordinary everyday words" of people who attempt suicide (p. viii). He emphasizes that all people, trained professionals and lay people alike, play a role in suicide prevention. In fact, suicide prevention efforts have emphasized the need for family members, and more often friends, to recognize suicide risk factors in their loved ones. For example, many universities have offered Question-Persuade-Respond (QPR) trainings, which teach individuals to question, persuade, and respond to individuals who may be considering suicide (QPR Institute, 2011). However, these trainings do not reach community members not affiliated with universities, and family members who experience a loved one's suicide attempt often do not receive training regarding how to respond if suicide risk reoccurs in the future. Suicidal individuals often have an impulse to talk about their suicidal thinking, even though this communication may occur in a disguised or coded manner (Shneidman, 1996). Clinicians have been trained to recognize communication both prospectively (signaling an impending suicide attempt) and retrospectively (suicidal communication that is only recognized as such in hindsight after a suicide death, often during a psychological autopsy). However, untrained family members generally do not know what

to look for even though they are most likely the ones with whom these types of communications will occur. Shneidman's philosophy of suicide suggests that everyone has a role in suicide prevention, but more work needs to be done to disseminate that perspective and the requisite skills to lay audiences.

Joiner's interpersonal theory of suicide. Currently, the most prominent suicide theory is the interpersonal theory of suicide (Joiner, 2005; Van Orden et al., 2010), which is the first suicide theory to emerge in over a century. The theory's primary components center around interpersonal relationships—the degrees to which individuals feel as though they belong and that they are a burden to others—which make it the suicide theory most clearly applicable to family relationships. Figure 1.1 provides a Venn diagram of the theory's three primary components. *Thwarted belongingness* refers to a feeling of isolation that occurs when an individual's inherent need to belong is not met (Van Orden et al.). *Perceived burdensomeness* refers to the feeling that one is a burden to loved ones. The interpersonal theory of suicide posits that the desire to die occurs when both thwarted belongingness and perceived burdensomeness occur simultaneously (Van Orden et al.). A strength of this theory is that it provides clear descriptions of how these components may exhibit in an individual. For example, thwarted belongingness can appear as loneliness or the absence of reciprocal care, while perceived burdensomeness can exhibit as self-hate or the belief that one is a liability to loved ones. These operationalizations provide explicit goals for professionals to target when working with suicidal individuals.

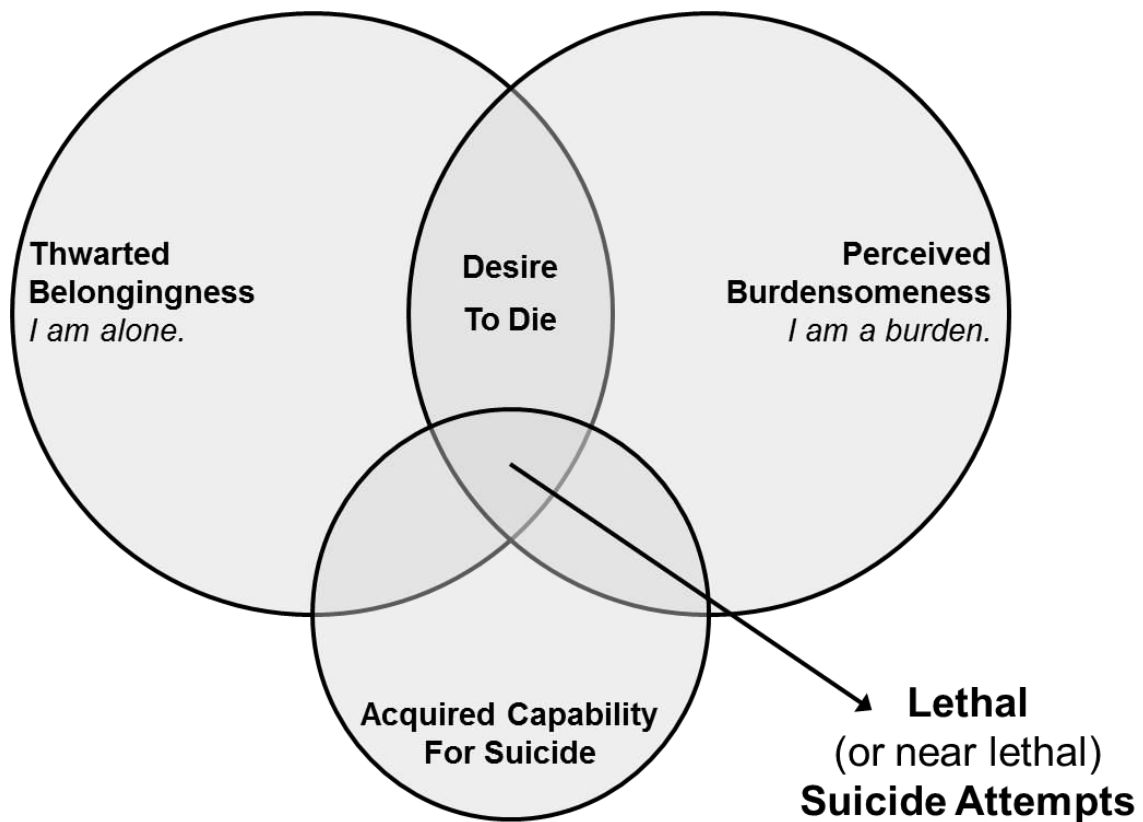


Figure 1.1. Model of the Interpersonal Theory of Suicide. Desire to die occurs when both thwarted belongingness and perceived burdensomeness are present. When these two components are combined with the acquired capability for suicide, individuals are at risk for lethal or nearly lethal suicide attempts.

Potential of Family Theories for Understanding Suicide

Previous theories about suicide have focused solely on preventing lethal behavior both by (a) illuminating factors that may cause suicidal ideation to prevent the desire to die at the onset, and (b) by determining risk factors that warrant immediate intervention to stop ideation from leading to suicidal behavior. However, these theories do not address what happens after a nonlethal attempt occurs. In fact, a previous nonfatal suicide attempt is one of the most reliable predictors of future suicidal behavior (Joiner, 2005). Therefore, the time period immediately following an attempt can be crucial for rebuilding interpersonal relationships and establishing trust between attempt survivors and their family members or friends. Theories utilized by family scientists provide frameworks for understanding the family's role in this process.

Human ecological theory. Human ecological theory provides a framework for understanding how societal stigma impacts family and individual behaviors. The theory uses the term *ecosystem* to refer to a system in which an individual interacts with his or her environment (Bubolz & Sontag, 2009). As the main proponent of human ecological theory, Bronfenbrenner (1979, 2001/2005) continued to revise and develop the theory over his lifetime (Tudge, Mokrova, Hatfield, & Karnik, 2009). The most mature version of his theory included a Process-Person-Context-Time (PPCT) model (see Figure 1.2), which examines the changes in development that occur as a result of process, person, context, and time (Bronfenbrenner & Morris, 1998), and can be used to examine the family's role in perpetrating suicide stigma.

Process. As a crucial component of human development, *processes* explain the connection between an individual and the context in which he or she exists

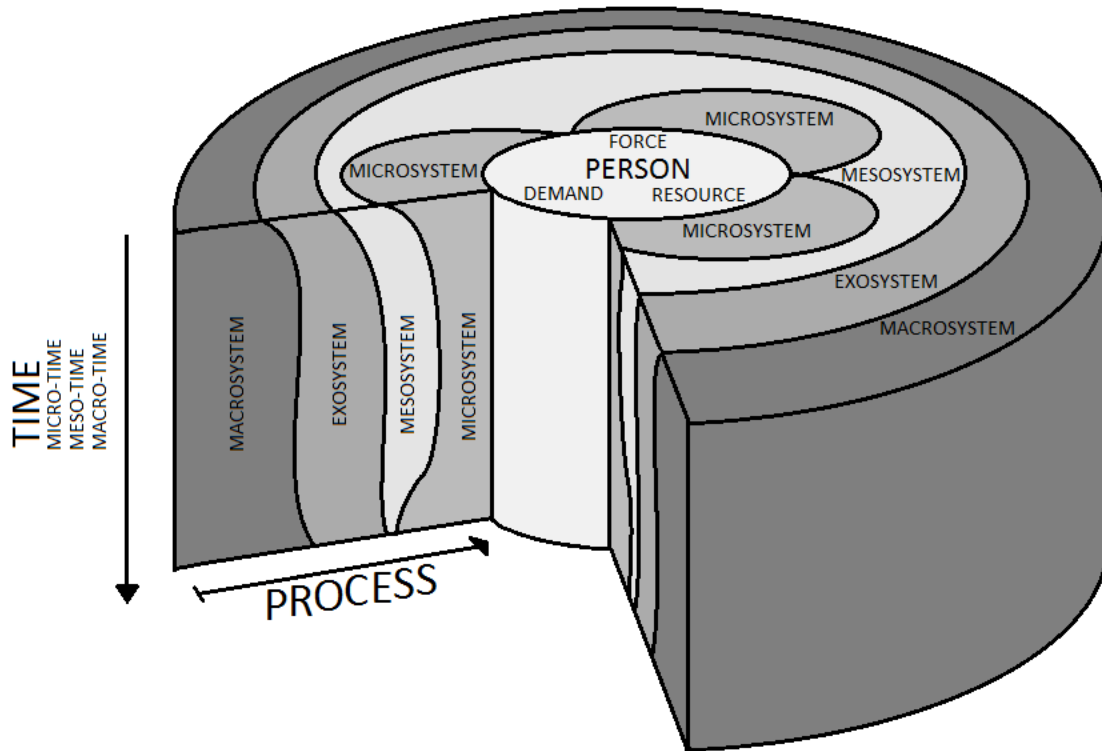


Figure 1.2. Bronfenbrenner's Process-Person-Context-Time (PPCT) Model. This model depicts the person in the center of the multiple contextual levels (i.e., microsystem, mesosystem, exosystem, and macrosystem) as they move downward through time. Process is represented as a slice that cuts through all three components: Demand, resource, and force characteristics of an attempt survivor interact with multiple contexts (i.e., microsystem, mesosystem, exosystem, and macrosystem) over time as a process, which provide multiple opportunities for stigmatizing experiences.

(Bronfenbrenner, 1988). Processes are reciprocal interchanges that occur between an evolving person and the objects, persons, or symbols that exist in the external environment. The term *proximal processes*, the key factor in human development, refers to processes that occur frequently in the immediate environment and endure over extended periods of time (Bronfenbrenner & Morris, 1998). How processes occur as well as the outcome that occurs as a result are impacted by the developing person, the environment, the developmental outcome being observed, and social changes over time (Bronfenbrenner & Morris). The process component does not occur separately from person, context, and time; rather, it describes the reciprocal relationships between these additional components.

Person. Bronfenbrenner criticized his own earlier work for focusing too much on context and failing to include the person's role in his or her own development (Bronfenbrenner, 1989). In his later work, he emphasized personal qualities that interact with the environment (Bronfenbrenner, 2001/2005), classifying them into three types of characteristics. *Demand characteristics* are those that provide immediate stimuli when interacting with another person, such as gender, age, ethnicity, or physical appearance. For example, gender could have an immediate impact on whether stigma is experienced by attempt survivors and those with lived experiences (i.e., past experiences of suicide ideation; hereafter referenced together with the term attempt survivor). One common myth is that suicidal behavior disclosure occurs solely to garner attention (Joiner, 2010). That myth coupled with the common practice of devaluing women as being too emotional (Goldenberg & Roberts, 2004) suggests that females may experience more stigma when reporting suicidal behavior than men experience. In contrast, *resource*

characteristics are mental and emotional resources (e.g., past experiences, intelligence) as well as social and material resources (e.g., access to food and housing, caring parents) that are implicit rather than immediately apparent (Tudge et al., 2009). For attempt survivors, individuals with multiple past attempts may illicit more stigma than individuals who have not previously attempted suicide. Finally, *force characteristics* are personal characteristics that relate to temperament, persistence, and motivation. These characteristics are often referenced in clinical work with regard to how motivated an individual is for treatment. A suicidal individual may experience less stigma if he or she is perceived as motivated for psychiatric treatment compared to those perceived as less motivated.

Context. Bronfenbrenner (1979) originally conceptualized the ecosystem as being comprised of multiple nested, interdependent structures or smaller systems, which were later integrated as the context component of the PPCT model (Tudge et al., 2009). The *microsystem* refers to the immediate environments experienced by an individual, such as work, school, family, and church. For attempt survivors and those experiencing suicidal ideation, another important microsystem is the treatment environment, including outpatient or inpatient psychiatric care. The *mesosystem* is comprised of the interactions among microsystems, such as when family members participate in treatment alongside attempt survivors. The *exosystem* refers to effects from microsystems that are not directly experienced by the individual, such as when a family member's interaction with another environment indirectly affects the individual experiencing suicidal behavior. In this system, the individual does not have direct interaction with the environment but rather is indirectly effected by the effect that environment had on the family member. For

example, a parent may attend religious services that reinforce stigmatizing beliefs that suicide is a sin, which could in turn negatively impact how the parent interacts with a child who is an attempt survivor. The *macrosystem* refers to the cultural environment, such as customs, attitudes, values, or ideologies that are held by the society within which one lives.

Time. The *time* component of the PPCT model represents how processes, persons, and contexts develop and change over time, and consists of three dimensions of time (Bronfenbrenner & Morris, 1998). *Micro-time* refers to how process, person, and context change over the course of a specific activity or interaction. For example, the level of stigma one perceives over the course of a conversation may help to determine the extent to which suicidal behavior is disclosed. In contrast, *meso-time* refers to the level of consistency in interactions through a person's environment. This period of time could be experienced as consistency across interactions with one person over time (i.e., repeated conversations about suicide with a parent) or as consistency across interactions with several people (i.e., separate conversations about suicide with multiple family members). Finally, *macro-time*, which is what Bronfenbrenner (1986) originally referred to as the *chronosystem*, refers to the historical period or context within which a process is experienced. For example, the etiology and treatment of mental health has changed in a way that has reduced stigma toward suicide over the past century. Similarly, public opinion often shifts when a prominent case has been covered in the media, such as when a celebrity's suicide prompts intense emotional reactions that are either stigmatizing (McMorris, 2014) or used to prompt positive social change (Dokoupil, 2014).

The nested structure of human ecological theory is valuable for understanding how stigma emerges and how stigmatizing societal attitudes may lead to stigmatizing behaviors within a family. Although Bronfenbrenner's model does not provide a clear trajectory for relational processes or human development, it conceptualizes how extrafamilial factors impact intrafamilial dynamics (Bubolz & Sontag, 2009). One way to stop the suicide stigma cycle is by reframing suicidal behavior and improving attitudes toward suicide within each system. For example, there may be some utility in framing the behavioral act of suicide as a symptom of, rather than distinct from, the mental illness that leads to suicide ideation. Maine, Shute, and Martin (2001) took this approach by differentiating between attitudes about suicide and attitudes toward those who die by suicide in order to promote positive interventions with those experiencing suicidal ideation. However, this conceptualization risks perpetrating the idea that suicide is a chosen behavior rather than a symptom of mental illness. In viewing suicide as a symptom of mental illness, the family microsystem could serve as a barrier by preventing macrosystem stigma from reaching the individual. Thus, psychoeducation is needed at the individual, family, and societal levels to stop stigmatizing behaviors from occurring within the meso- and exosystems.

Family systems theory. Adopted from general systems theory, family systems theory proposes that the family is a system of interrelated and interdependent individuals (Bowen, 1978). Proponents of this theory believe that individuals should not be examined in isolation but rather as part of the larger system in which they reside. The systems concepts of interdependence and mutual influence (von Bertalanffy, 1975) have been used in the suicide bereavement literature to explain how one family member's suicide

impacts the entire family system. Conversely, family systems theory can also explain how the family environment affects the experience of suicide before and after an attempt (Frey & Cerel, 2013). A central component of this theory posits that pathology does not occur at the individual level; rather, the family system's interpersonal dynamics, such as inadequate communication styles and low cohesion, are viewed as the culprits of dysfunction (Montgomery & Fewer, 1988). Accordingly, some scholars have hypothesized that suicide is associated with dysfunctional family systems (Richman, 1986; Sabbath, 1969); however, this perspective has yet to gain traction among suicide scholars.

Boundaries define subsystems within the larger system and boundary permeability regulates the flow of information between subsystems. More or less permeable boundaries could lead, respectively, to more or less awareness among family members concerning suicidal behavior in a family member. Little information flows through a closed boundary, which prevents family members from knowing about suicidal behavior, and therefore, from helping a member who is struggling with suicidal thoughts. However, classifying boundaries is rather subjective and relative to one's interpersonal relationship experiences and judgment (Whitchurch & Constantine, 2009). Consequently, one family member may perceive a relational boundary as open and therefore rely on disclosure without provocation while the other perceives the boundary being more closed and therefore does not disclose, resulting in the former being unwittingly unaware of the latter attempt survivor's diminished mental health. Similarly, family members may trust that important information will be openly and readily disclosed, and consequently miss pertinent but concealed information concerning a family member's suicidal behavior.

In a similar manner, the systems concept of feedback loops offers a new perspective on the circular nature of suicide disclosure and family reaction. In general systems theory, a feedback loop refers to a pattern of feedback from one system to another. When extrapolated to family systems, feedback loops refer to a pattern of behavior in which behavior by one individual influences the behavior of another, and vice versa. For example, a mother who hears her adolescent son flippantly comment that the family would be better off if he was not alive might not take the comment seriously and therefore disregard it and walk away without further inquiry. This interaction represents a negative feedback loop because it attempts to restore equilibrium to the system (Whitchurch & Constantine, 2009). More explicitly, the son's statement that he is a liability represents an attempt to disrupt the family's status quo, but by not engaging the comment the mother prevents disruption to the system by (perhaps unconsciously) discouraging the son from expressing additional thoughts that might disrupt the homeostasis of the system.

Contrasting the concept of negative feedback loops, suicide disclosure and reaction could also occur in the form of a positive feedback loop. In a systems context, positive feedback loops are cycles of behavior that promote change, regardless of whether that change is good or bad (Whitchurch & Constantine, 2009). The study detailed in Chapter 3 found that reaction mediated the impact of suicide disclosure on subsequent depression. However, the findings were not able to indicate whether this relationship was circular; that is, whether higher rates of disclosure elicit helpful reactions to suicide disclosure, which in turn elicit continual disclosures. Proponents of family systems theory refer to this as a positive feedback loop (Whitchurch &

Constantine, 2009) because the response suggests that the family is receptive and potentially adaptive to disclosure and thereby invites continued disclosure (see Figure 1.3), which has the potential to disrupt the family system in a helpful way by improving communication and remedying suicidal behavior.

Equifinality—the ability to reach the same outcome through a variety of means (von Bertalanffy, 1968)—affords clinicians the liberty to determine the extent to which family members should be involved in treatment to maximize positive growth. Some family members could be involved extensively, such as participating in therapy sessions in which family members share their experiences of the suicide attempt while also modifying their behavior to provide a more supportive environment that strengthens the attempt survivor’s interpersonal relationships in order to alleviate suicide symptoms. In contrast, other family members may need to be less involved initially, perhaps because positive communication seems unachievable and close family involvement is therefore contraindicated. Less involvement, for example, may mean that a parent provides rides to therapy in order to show support for the treatment process without direct involvement. Clinicians often facilitate an open discussion concerning the degree and nature of family involvement during therapy, and positive growth can be achieved in cases where either more or less family involvement is deemed ideal. However, identifying the optimal level of family involvement for mitigating future suicide risk is an exploratory process at this point; neither empirical, clinical, nor theoretical evidence currently provides clear guidance for making valid assessments in this regard.

Social exchange theory. Exchange theories borrow from behavioral psychology and economic theories by considering the rewards, costs, and resources in interpersonal

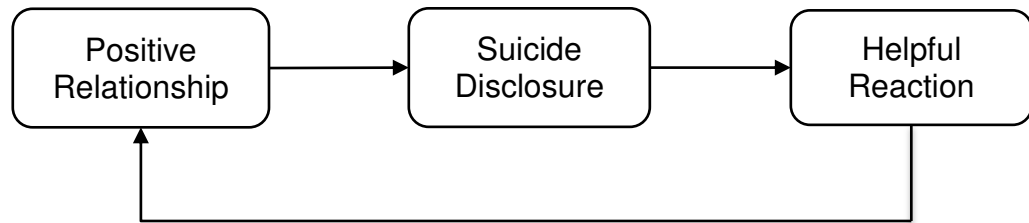


Figure 1.3. Positive Feedback Loop Between Disclosure and Reaction. A positive relationship theoretically leads to an increase in suicide disclosure, which in turn leads to a more helpful reaction, which then leads to a more positive relationship, and so on.

relationships (Sabatelli & Shehan, 2009). Their basic premise suggests that individuals are rational beings who seek to maximize rewards and minimize costs in relationships, and that decision-making can be understood in the context of these fundamental motivations. This framework can be used to examine at least two aspects of the attempt survivor experience: the decision-making process for disclosure, and the role of family relationships post-attempt.

Although scant research has focused on suicide disclosure among attempt survivors, an exchange perspective suggests that disclosure decisions occur based on the anticipated costs and rewards of disclosure. Previous interactions with family members undoubtedly play a role in that calculation. For example, attempt survivors may avoid disclosure of a suicide attempt if they have heard a family member make a negative remark about a celebrity's suicide. Chapter 4 describes how some attempt survivors who experienced a family member's panic or negative reaction to their suicide disclosure chose to maintain the relationship while simultaneously concealing suicidal behavior. Alternatively, individuals may feel comfortable disclosing suicidal behavior if they have experienced compassionate, supportive responses from a family member in the past concerning unrelated issues.

Exchange theory posits that the criteria used to evaluate rewards and costs varies among people and over time (Sabatelli & Shehan, 2009). Individuals assess potential rewards and costs based on the subject matter or situational context. For example, a negative initial reaction may be viewed by some as an indicator that subsequent disclosures are not an option, and others may interpret the same negative initial reaction as an indication that the appropriate time for disclosure has not yet arrived. In the latter

case, the interpersonal environment may be continually assessed with the intention of eventually disclosing once the potential rewards for disclosure are perceived to be greater than the potential costs of disclosure. Until one anticipates that the rewards of disclosure exceed the costs, however, exchange theory indicates that attempt survivors will conceal information.

In addition to explaining the decision-making process for disclosure on the basis of anticipated costs and rewards, social exchange theory also assumes that social exchanges are regulated by rules of reciprocity and fairness (Sabatelli & Shehan, 2009). This perspective mirrors the interpersonal theory of suicide's concept of burdensomeness that occurs when reciprocal care is absent (Van Orden et al., 2010). Relationships with those who are perceived to be liabilities or who do not reciprocate positive benefits within a relationship may be dissolved. For example, the emotional liability of a suicidal family member may be too great, prompting a family member to cut off the relationship.

These assumptions of reciprocity and fairness occur through maintaining trust (Blau, 1964; McDonald, 1981), commitment, and dependence (Sabatelli & Shehan, 2009), all of which would be impacted when a family member makes a nonfatal suicide attempt. Figure 1.4 depicts how reciprocity, fairness, trust, commitment, and dependence are interrelated for attempt survivors. First, trust implies that others "will not exploit or take unfair advantage" of the relationship (Sabatelli & Shehan, p. 404), which means long-term outcomes can be sought while being less concerned or calculating about immediate decisions and circumstances (Burns, 1973; Scanzoni, 1979). To the extent that family and friends feel that this implicit contract was violated and therefore lose trust in the attempt survivor, exchange-based calculations of the relationship will change. Many

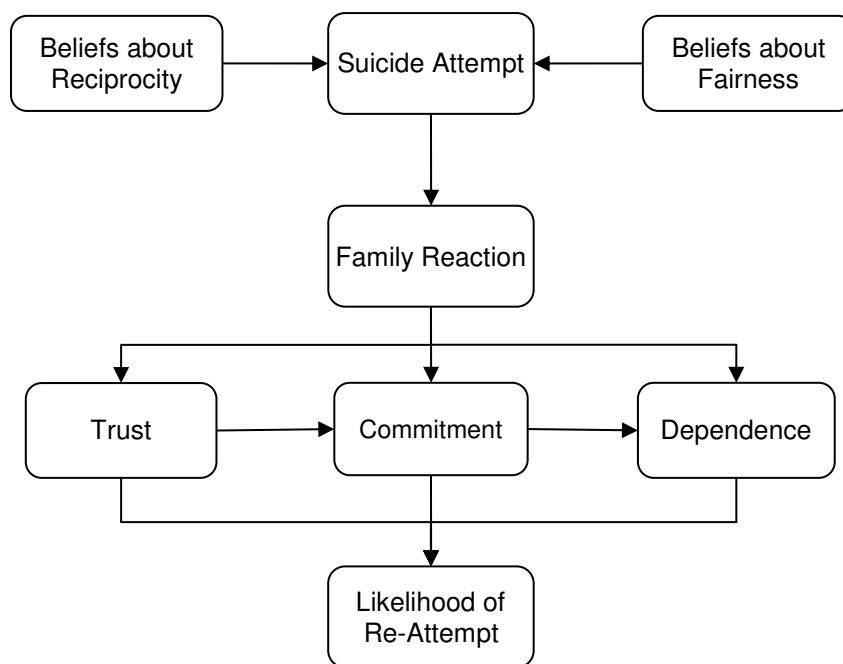


Figure 1.4. Principles of Social Exchange Theory in Attempt Survivors. Conceptual model displaying (a) how norms of reciprocity and fairness can contribute to whether a suicide attempt occurs, (b) how the attempt leads to family members' reactions, and (c) how their reaction contributes to trust, commitment, and dependence, which in turn could predict whether an additional suicide attempt occurs.

people believe mental illness and suicidal behavior are choices (McMorris, 2014; Tadros & Jolley, 2001), which may compound the negative effects of the perceived trust violation and further erode one's willingness to continue investing in the relationship. When combined with social exchange theory's tenets of maximizing rewards and minimizing costs, it becomes apparent why some family or friends will cut off their relationship with an attempt survivor: Maintaining the relationship represents too much of a risk because they cannot trust the attempt survivor, and family members therefore end the relationship to protect themselves. Similarly, attempt survivors' trust in their family members may dissolve once a family member reacts in a hurtful way, and that loss of trust will inhibit future disclosures (see Chapter 4).

A breakdown of trust would have a direct impact on individuals' commitment to the relationship, commitment being that which occurs when individuals are willing to participate in and work toward maintaining a relationship over a long period of time (Sabatelli & Shehan, 2009). According to exchange theory, a loss of trust would lead one to rescind his or her commitment to the ongoing relationship; it could also be that family members are committed to making decisions that promote not only their own personal well-being but also the well-being of other family members and the family system as a whole. However, when trust is lost, an individual no longer believes that both parties are committed to maintaining or improving the relationship. In other words, family members may interpret an individual's suicide attempt as a sign that he or she is not committed to the rest of the family. Similarly, attempt survivors may see the breakdown of trust and commitment as validation of their beliefs about their place in the world (see Chapter 4),

which could in turn increase suicidality through the perceived absence of family member concern about their personal well-being.

Relational stability occurs as trust and commitment increases interdependence in the relationship, and the loss of trust and commitment therefore results in the withdrawal of interdependence (Sabatelli & Shehan, 2009). Once an interaction occurs that reinforces disconnection and burdensomeness (and subsequently dissolves trust and commitment), attempt survivors may feel they can no longer depend on the relationship as a source of support or, alternatively, that preexisting concerns of this nature are validated. Consequently, attempt survivors may seek alternatives to disclosure, which often turns out to be an additional suicide attempt (Shneidman, 1996).

Chapter Two

Perpetrating Suicide Stigma:

How Do Social Networks and Treatment Providers Compare?

Stigma surrounding suicide has been pervasive and persistent (Tadros & Jolley, 2001). Stigma refers to negative or inaccurate stereotypes about a specific group of people that stems from “poorly justified knowledge structures that lead to discrimination” (Corrigan & Penn, 1999, p. 766). For the broader category of mental illness, these knowledge structures and the stigmatizing behaviors they illicit are widespread (Pescosolido et al., 2010), often connoting beliefs that individuals with mental illness are (a) dangerous and should be feared, (b) irresponsible and should not be allowed to make their own decisions, or (c) childlike and need to be under the guidance of others (Brockington, Hall, Levings, & Murphy, 1993).

Stigma specifically toward suicide can occur in the form of social disapproval, isolation, or shunning (Scocco, Castriotta, Toffol, & Preti, 2012). Two studies conducted decades apart both found that stigmatizing attitudes were more pronounced toward suicide than toward ethnic and religious groups (Kalish, 1966; Lester, 1992-1993). Numerous other studies have identified specific expressions of stigma. For example, roughly half of American university students said they would not date someone who had attempted suicide in the past year (Lester & Walker, 2006). Adjectives used to describe people who die by suicide also reveal stigmatizing beliefs; those adjectives include arrogant, attention-seeking, pathetic, selfish, and weak (Batterham, Calear, & Christensen, 2013).

Beyond identifying stigma toward suicide, these examples also exemplify how existing suicide stigma research, although valuable, primarily examines the stigmatizing attitudes that non-attempters have toward attempters (Batterham et al., 2013; Scocco et al., 2012) or that family members who have had a relative die by suicide experience (see Sudak, Maxim, & Carpenter, 2008). Reports of stigma encountered by attempt survivors and those with past experiences of suicidal ideation (hereafter referenced together with the term *attempt survivor*) can be a valuable learning resource that has thus far gone largely untapped by suicide researchers (Lester & Walker, 2006). Furthermore, the few studies (e.g., Cerel, Currier, & Conwell, 2006; Emul et al., 2011) that have examined the experiences of individuals with suicidal behavior fail to examine stigma perpetrated by non-professionals, such as family and friends. Therefore, the current study examines stigma experienced by attempt survivors from both treatment providers and individuals in one's social and family networks. Before detailing the method employed in this study, the existing literature regarding sources of stigma and how these sources relate to stigma types will be reviewed.

Review of Relevant Literature

Sources of Stigma

Suicide stigma has been perpetuated from a religious and legal standpoint for centuries (Tadros & Jolley, 2001); yet few studies have specifically examined the source of suicide stigma (i.e., the individual or group from which another person perceives stigma). Some researchers have explored stigma perceived through interactions with treatment providers. One study in Turkey found that up to 80% of medical students displayed socially distant attitudes toward attempt survivors (Emul et al., 2011). Another

study found that over half of patients with suicidal behavior who presented at an emergency department in the United States did not feel that the staff listened to them, explained the nature of treatments, or took their injury seriously (Cerel et al., 2006). Moreover, more than half also felt that the emergency department staff directly punished or stigmatized them. Although valuable, these studies only examined emergency department providers and medical students. No other studies to date have examined the extent to which attempters feel stigmatized by other treatment providers or have compared rates of stigma by mental health versus non-mental health providers (e.g., emergency department personnel, family physicians, pharmacists, etc.).

Mental health providers are specifically trained to work with individuals struggling with mental illness. Licensing boards for marriage and family therapists (American Association of Marriage and Family Therapy, 2014), psychologists (American Psychological Association, 2014), psychiatrists (American Psychiatric Association, 2014), and social workers (National Association of Social Workers, 2014) require professionals to have training in the epidemiology, symptoms, and treatment of mental health problems. This requirement does not exist for non-mental health providers. Therefore, we hypothesized the following:

H₁: Attempt survivors experience a higher prevalence of stigmatizing experiences with non-mental health treatment providers than with mental health providers.

In addition to interactions with treatment providers, attempt survivors may also interact with friends or family members following suicidal behavior. However, research on suicide stigma has often failed to consider the role of the family environment in perpetuating or assuaging stigma among individuals contemplating suicide (e.g., Gould,

2001). Consequently, little is known about suicide stigma from treatment providers relative to suicide stigma from one's social network. One study compared social network stigma and perceived stigma from mental health treatment providers experienced by individuals struggling with general mental health concerns: Stigma from mental health providers was reported more often than from employers and friends, but less often than from coworkers, family, and the general community (Wahl, 1999). However, the study did not account for whether the individuals disclosed suicide information to all of these individuals. Certain individuals may be more likely to know about a history of suicidal behavior and thus have more opportunity to exhibit stigma. For example, family members may be more likely to discover evidence of suicidal behavior compared to friends or employers with whom one does not reside. Therefore, the following should be true:

H₂: Stigmatizing experiences are more likely to be experienced from interactions with social network members than with treatment providers.

Types of Stigma

Recent stigma research has indicated that stigma has multiple dimensions. The two dimensions most commonly referenced in the literature are public stigma, which refers to the awareness of stereotypes held by the general public (Link, 1987), and anticipated self-stigma, which occurs when an individual adopts those stereotypes in their beliefs about themselves and often results in disempowerment and devaluation of self (Corrigan, 2002). Although these two forms of stigma frequently co-occur, individuals are capable of recognizing stereotypes without agreeing with them (Jussim, Nelson, Manis, & Soffin, 1995), and these two forms of stigma can produce different effects on attitudes about treatment (Pattyn, Verhaeghe, Sercu, & Bracke, 2014) and treatment-

seeking behaviors (Corrigan & Rüsch, 2002). For example, Pattyn et al. found that individuals struggling with mental illness who experienced higher levels of self-stigma viewed professional treatment as less important than did their counterparts who experienced lower levels of self-stigma, and those with higher levels of public-stigma were more likely to view informal help-seeking as less important than did their counterparts who experienced lower levels of public-stigma.

Published research has examined the effects of stigma type, but no published studies have addressed whether and how those effects vary according to source of stigma. Because suicidal ideation often stems from interpersonal components of feeling that one does not belong and is a burden to others, attempt survivors may be more likely to value the opinions of individuals in their social network (i.e., friends, family, etc.) than the opinions of professionals (e.g., treatment providers). In other words, an attempt survivor who hears a loved one explicitly state that the survivor is loved and valued might be able to rid oneself of thoughts that he or she is a burden to others. In contrast, stigmatizing interactions that reinforce previously-held ideas of burdensomeness and a lack of connection might be more likely to agree with those thoughts as well. Therefore, we hypothesized

H₃: Perceived stigma from mental health or non-mental health treatment providers has a larger effect on perceived public stigma than on forms of self-stigma.

H₄: Perceived stigma from social network members has a larger effect on self-stigma than perceived public stigma.

Effect of Stigma on Mental Health

Previous research has indicated that experiencing mental-health stigma is linked to lower self-esteem (Link, Struening, Neese-Todd, Asmussen, & Phelan, 2001), poorer life satisfaction (Rosenfield, 1997), and a smaller social network (Link, Cullen, Stuenkel, Shrout, & Dohrenwend, 1989) in individuals coping with mental health issues. The impact may be cyclic for attempt survivors because these factors also increase the likelihood of another suicide attempt (see Van Orden et al., 2010). However, no published studies to date have examined whether distinguishing among sources of stigma increases the ability to predict an attempt survivor's mental health, and specifically depression, which is experienced by most individuals who attempt suicide (Joiner, 2005). Given the negative impact of stigma on those who have general mental health issues and research showing the importance of interpersonal relationships for suicide risk (Van Orden et al.), the following hypothesis should be true:

H₅: Models that include type and source of stigma have better predictive ability for depression symptom severity in attempt survivors than do models that include only type of stigma.

Method

Sampling Procedures & Characteristics

Invitations to participate in an online survey were distributed using listservs maintained by the American Association of Suicidology (AAS). To participate, respondents must have been at least 18 years of age and experienced suicidal ideation or attempted suicide. Eligible individuals were invited to complete the survey via an online link. Listserv members also distributed the invitation through various suicide-support

organizations, such as Suicide Anonymous and the Suicide Prevention Resource Center (SPRC.org).

These sampling procedures yielded 156 participants, ages 18-77 ($M = 38.6$, $SD = 13.0$). The majority were female (79%) and Caucasian (90%); no other ethnicities exceeded 4% of the sample. Roughly 42% were single and had never married, 33% were married, 16% were divorced, 9% were separated, and 1% were widowed. Roughly 42% of participants described themselves as not religious. Among those who identified with a specific religion, 38% described themselves as strongly religious, 28% as somewhat strongly religious, 25% as somewhat weakly religious, and 10% as very weakly religious.

Measures

Suicide history. Suicide behavior severity was measured by asking respondents “Which of the following describe your past experiences with suicide?” Respondents were instructed to select all that apply from six response options ranging from *I have thought about hurting or wanting to kill myself* (1) to *I have attempted to kill myself, and I wanted to die* (6), and responses were later condensed to provide a response corresponding to the highest lifetime severity of suicidal behavior in which the respondent had engaged. Respondents were also asked “How have you hurt yourself in the past?” and “How many times have you attempted suicide?” Finally, respondents were asked to provide the year in which their last suicide behavior occurred, which was used in conjunction with the respondent’s reported age to calculate time since attempt and age at attempt.

Stigma source. Respondents were asked whether they came into contact with and experienced stigma from different types of treatment providers or social networks following their suicidal behavior. First, respondents were asked whether they had no

contact, non-stigmatizing contact, or stigmatizing contact with each individual. Responses were then combined and mean scores were calculated by summing the total number of stigmatizing experiences divided by the number of individuals contacted. A mean score represented the level of stigma experienced from each group: mental health providers (i.e., counselor or therapist, telephone counseling service, psychiatrist); non-mental health treatment providers (i.e., family physician, pharmacist, psychiatrist, naturopath/herbalist, clergy or minister); and social network (i.e., coworker, friend, romantic partner, or family member). Higher values represent higher prevalence of stigma perpetrated by the members in each respective group.

Stigma type. Two subscales from the *Individual-Level Abortion Stigma Scale* (Cockrill, Upadhyay, Turan, & Foster, 2013) were adapted to measure levels of perceived public stigma and self-stigma about the suicide attempt. The original scale consists of four subscales measuring separate types of stigma experienced by women who have experienced an abortion. Wording in the instructions and individual items was changed to reference suicidal behavior rather than abortion. The 7-item *worry about judgment* subscale (e.g., “People would gossip about me”; subscale range: 7-28) was used to measure perceived public stigma. Response options ranged from *not worried* (1) to *extremely worried* (4), and responses to all items were summed with higher scores indicating higher levels of perceived public stigma. Cronbach’s α for the worry about judgment subscale was .90.

The 5-item *self-judgment* subscale (e.g., “I felt like a bad person”; subscale range: 5-25) was used to measure self-stigma. Response options ranged from *strongly disagree* (1) to *strongly agree* (5). Reliability for the self-judgment scale was initially low

(Cronbach's $\alpha = .67$) so procedures were implemented to determine whether reliability could be improved by removing an item; consequently, "I felt confident I had made the right decision" was removed, which increased Cronbach's alpha to .83. Responses to all remaining items were summed, with higher scores indicating higher levels of self-stigma.

Depression symptomology. The 9-item *Patient Health Questionnaire-9* (PHQ; Spitzer et al., 1994) was used to measure respondents' depression symptomology. The scale assesses how often the respondent experienced symptoms of major depressive disorder (e.g., "Little to no interest or pleasure in doing things") over the preceding two weeks. Response options ranged from *not at all* (0) to *nearly every day* (3). Scores for all items were summed for a possible range of 0-27, with higher scores representing higher depression symptomology. Cronbach's α for the PHQ was .93.

Analytic Procedures

Descriptive information was calculated for all suicide and prevalence of stigma variables. To test H₁ and H₂, a repeated measures one-way ANOVA was conducted to compare prevalence of stigma perpetrated by mental health providers, non-mental health providers, and social network members. Then, two multiple linear regression models were used to test H₃ and H₄ to determine whether source of stigma could statistically predict levels of perceived public stigma and self-stigma. Finally, to test H₅, a hierarchical multiple regression model was created to examine whether including source and type of stigma could improve the prediction of depression symptomology in attempt survivors compared to a model with only stigma type. Perceived public stigma and self-stigma were entered in Step 1, and sources of stigma—mental health provider stigma, non-mental health provider stigma, and social network stigma—were added in Step 2.

Results

Descriptive Information

Suicide variables. Individuals were asked to report the most serious suicidal behavior in which they had engaged over their lifetime. Over half of respondents (58%) had attempted suicide with the intent to die, 14% had attempted suicide without the intent to die, 8% bought materials to attempt but did not follow through, 7% communicated ideation to others with the intent to die, 6% communicated intent to others but did not really want to die, and 6% had experience ideation but had not communicated these thoughts to others. Number of attempts ranged from 1-26 ($M = 3.9$, $SD = 5.2$), and time since most recent attempt ranged from 0-42 years ($M = 8.2$, $SD = 10.3$).

Prevalence of stigma variables. The most common treatment providers utilized following suicidal behavior were counselors, psychiatrists, and emergency department personnel (see Table 2.1). Among those who used specific providers, the most common stigmatizing experiences occurred with emergency department personnel and clergy/ministers. Within social networks, more participants disclosed to a close friend or family member than to a romantic partner or coworker, and participants were most likely to experience stigma from family or a coworker.

Hypotheses Testing

Table 2.2 displays means, standard deviations, and intercorrelations for all variables. Mental health provider stigma was moderately and positively correlated with non-mental health provider stigma, and results showed a small-to-medium correlation between social network stigma and both mental health provider stigma and non-mental health provider stigma. The two types of stigma—perceived public stigma and self-

Table 2.1

Percentage of Respondents Who had Contact with Providers or Social Network and the Percentage Who Experienced Stigma with that Individual

Type of individual	Percentage contacted	Percentage stigma ^a
Mental-health provider		
Counselor or therapist	83.6	20.5
Psychiatrist	67.8	22.3
Telephone counseling service	23.0	22.9
Non-mental health provider		
Emergency department doctor or nurse	56.6	60.5
Family physician	48.0	27.4
Clergy or minister	28.3	34.9
Pharmacist	25.0	21.0
Naturopath or herbalist	5.9	22.2
Social network		
Close friend	79.5	28.2
Close family member	73.7	57.1
Romantic partner	63.8	41.2
Coworker	35.5	51.9

^a Refers to percent of individuals who experienced stigma out of all the participants who contacted the individual source.

Table 2.2

Means, Standard Deviations, and Intercorrelations for Independent and Dependent Variables

Variable	<i>M</i>	<i>SD</i>	1	2	3	4	5
1. Mental health provider stigma	0.21	0.35	–				
2. Non-mental health provider stigma	0.41	0.40	.31**	–			
3. Social network stigma	0.42	0.37	.22*	.22*	–		
4. Perceived public stigma	18.55	6.22	.03	-.07	.10	–	
5. Self-stigma	16.00	4.30	.13	-.06	.14	.47***	–
6. Depression	21.69	8.17	.07	.08	.23**	.23**	.20*

* $p < .05$. ** $p < .01$. *** $p < .001$.

stigma—were moderately and positively correlated. Social network stigma, perceived public stigma, and self-stigma were slightly and positively correlated with depression. The ANOVA results indicated the prevalence of stigma experienced was affected by the type of individual perpetrating it, $F(2) = 16.55$, $p < .001$, partial $\eta^2 = .13$. Pairwise comparisons supported H_1 : The prevalence of reported stigma from non-mental health providers ($M = 0.41$, $SD = 0.40$) was substantially higher than the prevalence of reported stigma from mental health providers ($M = 0.21$, $SD = 0.35$), $p < .001$, $d = 0.86$. In contrast, these data only partially supported H_2 : The prevalence of reported social network stigma ($M = 0.42$, $SD = 0.37$) was substantially higher than the prevalence of reported mental health provider stigma, $p < .001$, $d = 0.97$, but only a small and non-statistical difference was detected between social network stigma and non-mental health provider stigma, $p = .300$, $d = 0.17$.

Multiple linear regression analyses examining the relationship between source of stigma and type of stigma were conducted to test H_3 and H_4 (see Table 2.3). The data did not support these hypotheses. Rather, all three sources of stigma had larger effects on self-stigma than on perceived public stigma for participants in our sample, although none were statistically significant. The point estimate with these data for the effect of mental health provider stigma on self-stigma indicated that a meaningful effect likely exists ($\beta = .19$), but the precision of the point estimate was not sufficiently precise with these data to rule out the possibility that this observed effect reflects sampling error.

The full hierarchical multiple regression model (see Table 2.4) including source of stigma explained 14% of the variance in depression symptomology, $F(5, 104) = 3.27$, $p = .009$. Beyond type of stigma, source of stigma accounted for a statistical increase

Table 2.3

Regression Analysis for Sources of Stigma Predicting Stigma Types

Predictor variable	Perceived public stigma					
	<i>B</i>	<i>SE</i>	95% CI	β	<i>t</i>	<i>p</i>
Mental health provider stigma	0.75	1.86	[-2.94, 4.45]	.04	0.40	.688
Non-mental health provider stigma	-1.60	1.65	[-4.87, 1.67]	-.10	-0.97	.334
Social network stigma	2.03	1.74	[-1.42, 5.49]	.12	1.17	.246
Predictor variable	Self-stigma					
	<i>B</i>	<i>SE</i>	95% CI	β	<i>t</i>	<i>p</i>
Mental health provider stigma						
Non-mental health provider stigma	2.33	1.27	[-0.19, 4.84]	.19	1.84	.069
Social network stigma	-1.66	1.12	[-3.89, 0.56]	-.15	-1.48	.141

Note. CI = Confidence intervals for *B*.

Table 2.4
Hierarchical Multiple Regression Analysis for Predicting Depression

Step and predictor variables	R^2	ΔR^2	B	SE B	95% CI	β	t	p
Step 1: Type of stigma	.06	.06						.046
Perceived public stigma			0.29	0.14	[0.02, 0.56]	.22	2.10	.038
Self-stigma			0.06	0.20	[-0.34, 0.45]	.03	0.29	.771
Step 2: Source of stigma	.14	.08						.009
Mental health provider stigma			-0.65	2.35	[-5.31, 4.00]	-.03	-0.48	.781
Non-mental health provider stigma			1.53	2.07	[-2.57, 5.63]	.07	0.74	.461
Social network stigma			6.16	2.18	[1.83, 10.48]	.27	2.82	.006

Note. CI = confidence interval for B .

(8%) in the variance explained, F change (3, 104) = 3.21, $p = .026$, which supported H₅. Increases in perceived public stigma statistically predicted increases in depression symptomology ($\beta = .22$, $p = .038$). Stigma from social network was the only stigma source that statistically predicted changes in depression symptomology: Increases in social network stigma predicted increases in depression symptoms ($\beta = .27$, $p = .006$).

Discussion

This study examined the prevalence of suicide stigma perpetrated by treatment providers and social network members as well as how stigma source predicts stigma type and depression symptomology in individuals with a history of suicidal behavior. The findings indicate that suicide stigma was more likely to be experienced from social network members and non-mental health providers than from mental health providers after accounting for whether an individual disclosed to each source. In addition, source of suicide stigma statistically enhanced the ability to predict depression symptomology in individuals with a lifetime history of suicide behavior. More specifically, stigma perpetrated by social network members was the best predictor of depression symptom severity.

The findings that stigma from social network members and non-mental health providers was most commonly experienced is problematic because these sources may be the first point of contact for many individuals experiencing suicidal behavior. For example, attempt survivors are often either found by a family member during an attempt or taken to a medical facility (e.g., emergency department) to address any harm from the attempt method. In these cases, contact with a mental health professional, such as a counselor or therapist, is often delayed. If individuals experience suicide stigma at the

first point of contact, they may be less likely to subsequently contact a mental health provider. Moreover, individuals who are forced into mental health treatment (e.g., emergency hospitalization at a psychiatric facility) may not continue with recommended outpatient treatment voluntarily. This finding highlights the need for additional psychoeducation for social network members and non-medical professionals regarding the etiology of suicidal behavior and the negative effect of stigma.

In addition to findings regarding the prevalence of stigma, the finding that social network stigma was the best predictor for depression symptomology (see Chapter 2) is especially poignant in light of the limited research on suicide disclosure and the subsequent social network reaction. A limitation of this finding is that this study focused solely on perceptions of stigma, and questions were not included that focused on what types of specific interactions were stigmatizing. What remains unclear is how social network members reacted to suicide disclosure and whether particular interactions were more harmful than others. For example, the old adage “if you cannot say anything nice, do not say anything at all” may influence some social network members to avoid asking questions about suicide. Similarly, individuals who feel nervous asking questions for fear they will exacerbate suicidal behavior by asking questions might avoid broaching the topic. Intuitively, no interaction may be less harmful than explicit negative responses to suicidal behavior. In contrast, avoiding the topic of suicide or, more extremely, refusing to talk about suicide may substantiate or intensify feelings of isolation among attempt survivors, and consequently perpetuate suicidal behavior in a similar manner as explicit negative comments. Overall, these findings highlight the gap in our knowledge concerning family reaction to the disclosure of suicidal ideation or behaviors.

Finally, the finding that source of stigma was not a predictor of perceived public stigma was surprising given that this distinction has been found with stigma not related to suicide. Individuals with suicidal ideation often interpret interpersonal interactions as indications that they either do not belong or that they are a burden to others (Van Orden et al., 2010). The effect of stigma experiences may be an example of this behavior, in that suicidal individuals may not be able to separate stigma as a public attitude but rather an indication of their value and place in the public world. If this interpretation is true, future studies may find that suicidal individuals report higher levels of self-stigma due to internalizing outside opinions as truths about themselves. Our findings partially support this hypothesis, but more research is needed to examine the idea further.

Conclusion

Previous researchers have often failed to examine the role of stigma source for understanding the stigmatizing experiences of individuals with a lifetime history of suicidal behavior. The current study highlights how the type of individual perpetrating suicide stigma can be an important predictor for subsequent depression symptomology in this population. Suicide is a pervasive, global problem, yet research has been remiss to not fully examine all likely factors that affect mental health, especially in attempt survivors and those who have experienced suicidal ideation. Findings from this study suggest that stigma source may play an important role in suicide prevention.

Chapter Three

Suicide Attempt Disclosure and Depression:

The Moderating and Mediating Effects of Family Reaction

Suicide prevention is typically aimed at individuals who are currently experiencing suicidal ideation or individuals who have previously attempted suicide and are at risk for attempting again (Fialko et al., 2006; Kessler, Borges, & Walters, 1999). However, these treatment efforts are often dependent on the willingness of individuals to disclose current or previous experiences of suicide. Revealing personal information, such as secrets, has been linked to positive health benefits (see Frattaroli, 2006, for a meta-analysis), and disclosure of a concealable, stigmatized identity, such as a history of suicidal behavior, can improve psychological adjustment (Beals, Peplau, & Gable, 2009; Talley & Bettencourt, 2011). More specifically, the disclosure of traumatizing and potentially stigmatizing information to an empathic individual can result in more successful coping (Harvey, Orbuch, Chwalisz, & Garwood, 1991).

Although researchers have identified many risk factors for suicide (see Van Orden et al., 2010), little has been done to engage with attempt survivors to learn from their experiences of being suicidal and not dying (Lester & Walker, 2006; Cerel et al., 2006). These individuals could provide insight into how and when they choose to reveal current or past suicidal experiences and how that disclosure influenced their ability to manage their symptoms. Additionally, research on suicide has often failed to consider the role of the family environment in perpetuating or assuaging the negative reactions (or stigma) experienced by individuals contemplating suicide (e.g., Gould, 2001, cf. Frey & Cerel, 2013). Rather, the focus of suicide stigma research has primarily been on the negative

reactions experienced by family members who have had a relative die by suicide (see Sudak, Maxim, & Carpenter, 2008). For these reasons, the experiences of attempt survivors were examined to assess the interaction of one's disclosure of past suicidal behavior (hereafter referred to as suicide disclosure), family reaction to that disclosure, and current mental health status. Before describing the method and results, the existing literature that informs this study will be reviewed.

Background Literature

The interpersonal theory of suicide (Joiner, 2005; Van Orden et al., 2010) is a relatively new approach for predicting suicide ideation and risk for suicidal behavior. However, the theory does not account for the possible effects of disclosure. Stigma associated with suicide may inhibit attempt survivors and those who have experienced suicide ideation (i.e., often referred to as individuals with lived experiences) from disclosing their suicidal behavior, or limit disclosure to a few trusted individuals while hiding their history from other family members and friends. Indeed, refusing to talk about a stigmatized issue is one method of coping with stigma (Dageid & Duckert, 2008). However, disclosure of past suicide behavior may serve as a coping mechanism or as a form of treatment by countering feelings of isolation following an attempt. Although focused on sexual orientation rather than suicide, research has found that risk for psychological distress is lower among those who disclose stigmatized information about themselves than among their counterparts who conceal that information (Talley & Bettencourt, 2011). This finding can be extrapolated to predict similar results when attempt survivors and those with lived experiences disclose their suicide history with close friends or family members (Frey & Cerel, 2013). Although the research described

here suggests that disclosure should generally improve mental health among attempt survivors, this is an empirical question that research has yet to directly assess with regard to suicide attempters and those with lived experiences.

Another aspect that warrants further research is the impact of family members' reactions following disclosure of a suicide attempt or suicidal ideation. Although disclosure in itself may help improve attempt survivors' mental health following suicidal behavior, the reaction of loved ones following disclosure may also have important implications for subsequent mental health. For example, sharing one's suicidal ideation with loved ones and receiving a supportive response could increase feelings of belongingness, encourage the monitoring of health and safety, and facilitate the attempt survivor's willingness to seek treatment. Moreover, suicide disclosure has the potential to decrease perceived burden—a risk factor for suicide (Van Orden et al., 2010)—on the individual if the response is positive, such as if family members are supportive or offer encouragement that reinforces the patient's importance within the family. Alternatively, an unsupportive response from family members upon suicide disclosure may exacerbate the individual's feelings of isolation, thereby increasing one's risk for suicide. Some studies indicate that disclosure does not necessarily have positive effects (e.g., Caughlin & Patronio, 2004), such as when a negative reaction to the disclosure occurs. For example, one study found that the positive relationship between disclosure of sexual orientation and mental health was contingent upon having strong social support (Ulrich, Lutgendorf, & Stapleton, 2003). In any case, research is needed that examines the factors that impact the likelihood of self-disclosing suicidal behavior and how reaction to that disclosure subsequently affects mental health. Therefore, this study examined the

relationship between suicide disclosure to a family member and subsequent depression symptomology, as well as whether that relationship is moderated or mediated by the family member's reaction to that disclosure.

Method

Participants

Invitations to participate were distributed through listservs maintained by the American Association of Suicidology (AAS) and various suicide-support organizations, such as Suicide Anonymous and the Suicide Prevention Resource Center (SPRC.org). Researchers and clinicians were encouraged to share the study invitation with eligible participants. Inclusion criteria required that respondents were at least 18 years of age and had attempted suicide in the past 10 years. These recruitment procedures resulted in 144 respondents. However, for this study, only respondents with complete data (no missing values) were included in the analyses.

These procedures yielded 74 respondents with ages ranging from 18 to 62 ($M = 36.5$, $SD = 12.2$), and who were primarily female (71%) and Caucasian (89%). Complete descriptive statistics for ethnicity, parental status, and relationship status are presented in Table 3.1. Number of suicide attempts ranged from 1 to 25 ($M = 3.7$, $SD = 4.3$) and time since attempt ranged from 0 to 10 years ($M = 3.2$, $SD = 2.9$). The most common method used in previous attempts was cutting or stabbing ($n = 65$); 58 ingested drugs, 22 used suffocation or hanging, 10 ingested toxic substances other than drugs, 8 used firearms, 7 used carbon monoxide poisoning, 4 attempted drowning, and 4 jumped from a high place.

Table 3.1

Demographic Characteristics of Participants

Characteristic	<i>n</i>	%
Sex		
Male	21	28.8
Female	52	71.2
Parenthood		
Children	32	43.2
No children	42	56.8
Relationship status		
Never married	34	45.9
Married	18	24.3
No longer married ^a	22	29.7
Ethnicity		
Caucasian	66	89.2
African-American	2	2.7
Hispanic/Latino	2	2.7
Asian American	2	2.7
Middle Eastern	1	1.4
Other	1	1.4

^aThe “no longer married” group included participants who were divorced ($n = 13$), separated ($n = 8$), and widowed ($n = 1$).

Measures

Suicide disclosure. No measure of suicide disclosure currently exists in the literature. Previous attempts at measurement are limited to single items that categorize disclosure based on whether it occurred (Beck, Schuyler, & Herman, 1974) or query the number of individuals to whom the respondent has disclosed (e.g., Talley & Bettencourt, 2013). However, experiences of suicide vary in both severity and symptomology (ideation vs. behavior), and degree of disclosure is varied too. Therefore, the *Self-Harm and Suicide Disclosure Scale* (see Appendix A) was developed for this study to measure the degree to which respondents disclosed their past self-harming or suicidal behavior. Respondents were first asked to select a family member with whom they talk the most about life's challenges. Then, respondents were asked to indicate whether they had shared each of ten possible topics with the target family member, such as "when I am thinking about hurting myself on purpose," or "the reason why I attempted suicide." Response options were *no* (0) and *yes* (1). Mean scores ranging from 0 to 1 were calculated for each respondent on the ten items, with higher scores indicating higher levels of suicide disclosure.

Family reaction. The *Family Quality Reaction Scale* (see Appendix B) was also created for this study to measure how the target family member's reaction to suicide disclosure was perceived. Respondents were asked the degree to which they agree with five statements regarding the target family member's reaction to their suicide disclosure, such as "I felt more comfortable with this person after I told him or her." Response options ranged from *strongly disagree* (1) to *strongly agree* (4), and total scores were

summed with higher scores indicating more positive reactions to suicide disclosure. Internal reliability of this scale yielded a Cronbach's alpha of .87.

Depression symptomology. The 9-item depression subscale from the *Patient Health Questionnaire* (PHQ-9; Spitzer et al., 1994) was used to measure respondents' severity of depressive symptoms at the time of participation in the current study. The subscale assesses how often over the previous two weeks the respondent had experienced symptoms of major depressive disorder, such as "little interest or pleasure in doing things," and including one symptom related to suicide: "thoughts that you would be better off dead, or of hurting yourself in some way." Response options ranged from *not at all* (0) to *nearly every day* (3). Scores for all nine items were summed, with possible total scores ranging from 0 to 27 and higher scores representing higher depression symptomology.

Analytic Approach

Preliminary analyses were conducted to determine whether participant demographics affected the extent of disclosure, quality of reaction, and depression-symptom severity. Independent samples *t*-tests were used to assess the effects of sex (male vs. female), parenthood status (parent vs. non-parent), and ethnicity (white vs. non-white), and one-way ANOVAs were used to assess the effects of relationship status (never married vs. married vs. no-longer married). Next, moderation analysis and mediational analysis utilizing bootstrapping techniques were conducted using Hayes' (2013) PROCESS macro to assess whether family reaction moderates or mediates the relationship between suicide disclosure and subsequent depression symptoms when controlling for time (in years) since participants' most recent attempt.

Previous studies have shown that bootstrapping is a powerful and accurate method for testing mediation effects (MacKinnon, Lockwood, & Williams, 2004; Williams & MacKinnon, 2008). Another benefit of bootstrapping over other approaches to mediation analysis (e.g., Sobel test, empirical M -test) is that bootstrapping does not assume normality in the sampling distribution (Hayes, 2009). In this analysis, the data would support the mediational role of family reaction on disclosure if the bias corrected and accelerated bootstrapped confidence intervals for B , which were set at 95% from 1,000 bootstrap samples, did not contain zero.

Results

Roughly 89% of respondents had deliberately disclosed their suicidal behavior to someone after it happened; 60% of those who had deliberately disclosed to a friend, 42% to their spouse or romantic partner, and 30% to their mother. Other disclosure targets included sisters (19%), fathers (13%), brothers (13%), grandmothers (2%), and a grandfather (1%). When asked to identify a target family member for the *Family Quality Reaction Scale*, responses were varied but the most common were mother (32%), sister (20%), spouse (11%), brother (9%), adult child (9%), father (8%), and grandmother (4%).

Independent samples t -tests indicated no statistical differences in reports of suicide disclosure, family reaction, and depression symptomology between males and females, parents and non-parents, and whites and non-whites. One-way ANOVAs were performed to test for differences on predictor and outcome variables according to relationship status (see Table 3.2). Results indicated that relationship status had a meaningful effect ($\omega = .35$) on levels of suicide disclosure according to Kirk's (1996) benchmarks for interpreting omega, which suggest that $\omega \geq .24$ is a medium effect and

Table 3.2

Means, Standard Deviations, and One-Way Analyses of Variance for the Effects of Relationship Status on Dependent Variables

Variable	Never married		Married		No longer married		$F(2, 71)$	p	ω
	M	SD	M	SD	M	SD			
Disclosure	0.39	0.37	0.76	0.24	0.54	0.30	4.74	.017	.35
Reaction	12.71	3.74	16.44	3.43	13.93	5.18	1.14	.116	.25
Depression	25.29	7.99	21.61	8.82	23.95	8.63	2.28	.327	.16

Results of Planned Contrasts for Effect of Relationship Status on Disclosure

Contrast	Value Contrast	SE	t	p	d
Not married vs. married	0.58	0.22	2.61	.012	0.85
Never married vs. no longer married	-0.15	0.11	-1.47	.149	0.42

$\omega \geq .37$). Planned contrasts revealed that married participants ($M = 0.76, SD = 0.27$) statistically disclosed more suicide-related information than non-married individuals—that is, than both never married participants ($M = 0.39, SD = 0.37$) and no-longer married participants ($M = 0.54, SD = 0.30$). The magnitude of this difference ($d = 0.85$) means that the married individual will report disclosing more in 73% of randomly paired married and non-married individuals. No statistical difference was detected between disclosure rates of never married and no-longer married participants. Additionally, relationship status did not have a statistical effect on perceptions of family reaction or depression symptoms.

A moderation model (see Figure 3.1A) was tested to examine the moderating effect of family reaction on the relationship between disclosure and subsequent depression while controlling for time since attempt, $F(4, 69) = 10.94, p < .001, R^2 = .56$. Family reaction ($B = -1.09, p = .030$) and time since attempt ($B = -1.51, p < .001$) statistically enhanced the prediction of depression—more positive reactions and more time predicted lower depression symptom severity. However, disclosure did not statistically predict depression symptom severity, nor did reaction moderate that relationship.

Next, a mediation model was tested to assess the indirect effect of suicide disclosure on depression symptoms through family reaction when controlling for time since most recent attempt (see Figure 3.1B). The overall model accounted for 56% of the variance in depression symptoms, $F(3, 70) = 14.97, p < .001$. Higher rates of disclosure statistically predicted more positive family reactions ($B = 4.79, p = .020$), and more positive family reactions ($B = -0.99, p < .001$) and an increase in time since the most

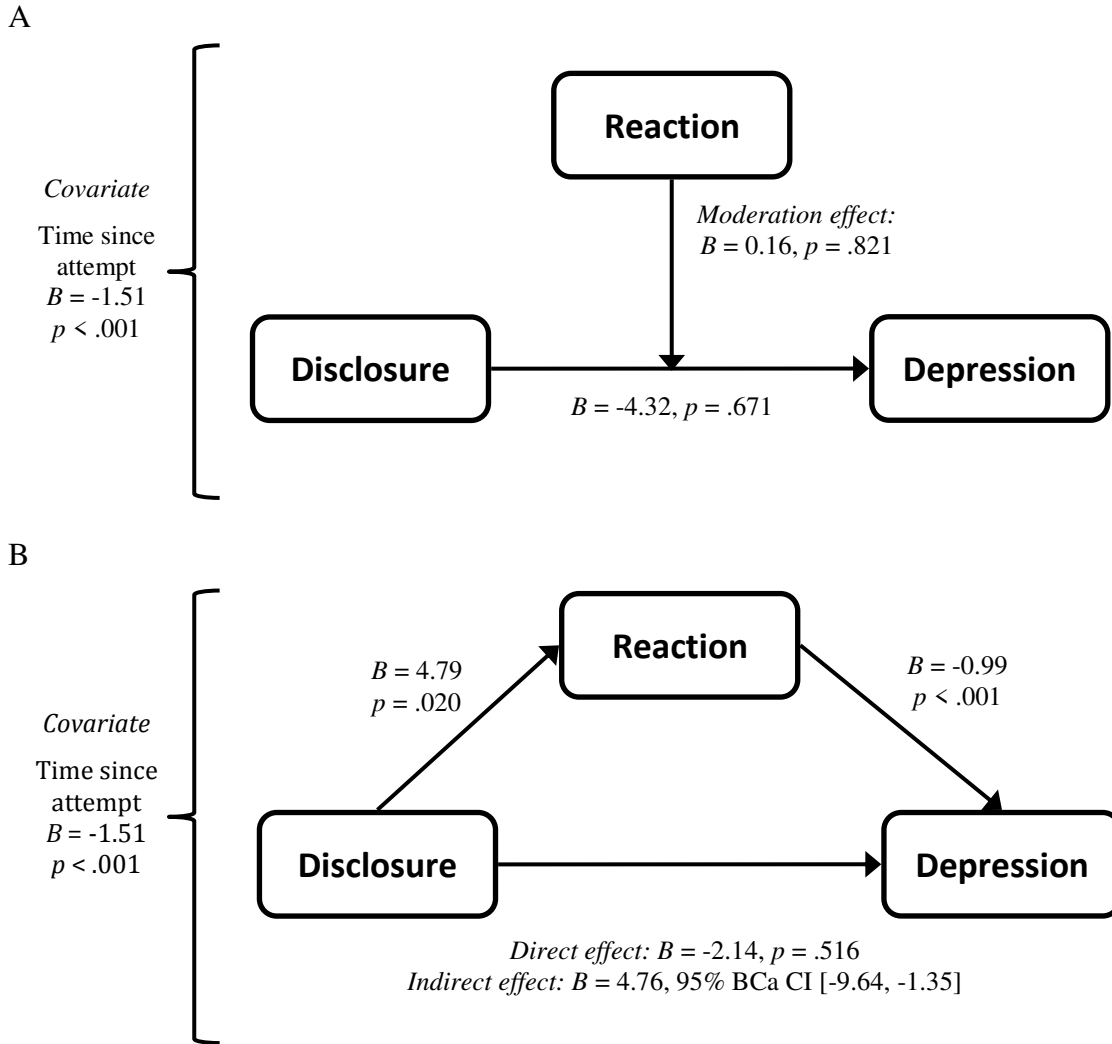


Figure 3.1. Tested Moderation and Mediation Models. (A) Conceptual moderation model indicating family reaction did not moderate the effect of disclosure on depression symptoms when controlling for time since attempt; (B) Statistical mediation model supporting reaction as mediator for the effect of suicide disclosure on depression symptomatology when controlling for time since attempt using bootstrapping techniques (Preacher & Hayes, 2008).

recent attempt ($B = -1.51, p < .001$) statistically predicted less severe depression symptoms. Although there was no direct effect of disclosure on depression ($B = -2.14, p = .516$), the indirect effect ($B = -4.76, 95\% \text{ BCa CI } [-10.44, -1.74]$) was different from zero, indicating that quality of reaction mediated the relationship between disclosure and depression symptomology.

Discussion

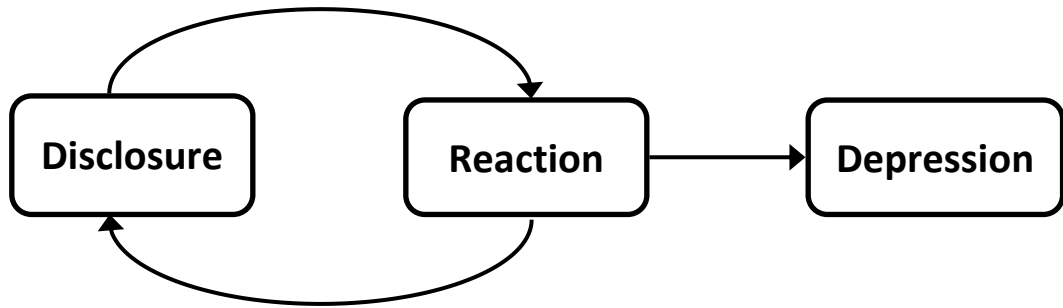
A mediational analysis was conducted using a bootstrapping approach to test the relationship between suicide disclosure and depression symptoms, as well as the role of family reaction in mediating that relationship after controlling for time since most recent attempt. Higher degrees of disclosure predicted (or elicited) more positive family reactions which, in turn, predicted less severe depression symptoms. Family reaction mediated the effect of suicide disclosure on depression symptoms, supporting the idea that family reaction is an important component for understanding the role suicide disclosure plays in mitigating depression sequela among attempt survivors.

The link between disclosure and reaction, indicating that more disclosure is associated with more positive family member reactions, raises additional questions about the direction of the relationship. One explanation—that disclosing more information leads to more positive reactions—suggests that family members are more capable of responding in a helpful manner when they receive a higher degree of disclosure, and therefore, a more accurate picture of the attempt survivor's experience. For example, some family members who learn an attempt happened without their knowledge may respond with panic that another attempt could happen in the immediate future, whereas members who receive more information regarding events that precipitated past attempts

and whether there is a current risk may feel they can respond more confidently (Figure 3.2A). However, an alternative explanation suggests a positive feedback loop (Broderick & Smith, 1979): A family member's positive and helpful reaction after learning about suicidal behavior could motivate the attempt survivor to share more information in a way that facilitates the recovery process. This conceptualization suggests that more positive responses to initial disclosure elicit not only more disclosure but also lead to less severe depression symptoms. Thus, the relationship between disclosure and less severe depression symptoms would be spurious—that is, rather than a direct relationship between disclosure and symptoms, both are affected by the response to disclosure (see Figure 3.2B). Additional research, with possibly a longitudinal component, is needed to empirically evaluate these competing explanations.

The finding that an increase in disclosure is indirectly linked to less severe depression symptoms augments previous research highlighting a link between disclosure of a stigmatized identity, such as suicide, and mental health (e.g., Talley & Bettencourt, 2011; Ulrich et al., 2003). Now that there is support for the effect in an attempt survivor population, more research is needed to establish validated and reliable measures that can be used to further examine the phenomenon. A limitation of this study is that it only measures whether specific information about suicide behavior was ever communicated. It does not measure whether the information was discussed at great length or merely mentioned briefly. Additionally, the *Self-Harm and Suicide Disclosure Scale* does not ask questions regarding the decision-making process for disclosure. For example, some individuals may disclose information voluntarily with the intent to include a family member in the treatment process whereas other family members may become aware of

A



B

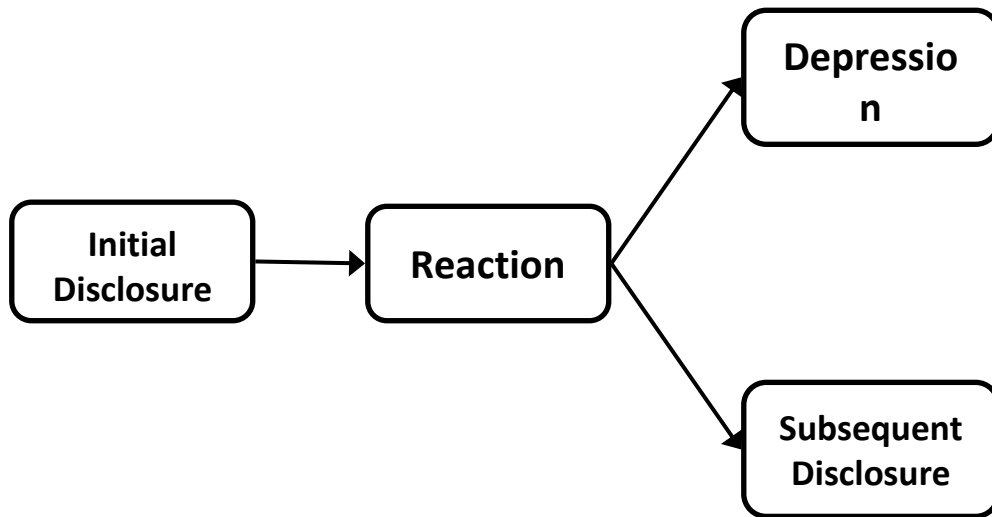


Figure 3.2. Hypothesized Models for Future Research. Conceptual models depicting (A) how a positive feedback loop between disclosure and reaction, in which disclosure elicits a reaction which in turn effects whether disclosure increases or stops, may affect depression, and (B) a spurious relationship between disclosure and depression in which both are effect by reaction.

suicidal behavior without the attempter's permission, such as finding the person in the process of an attempt or by learning about the behavior from other family members. Moreover, family members of individuals who experience a severe suicide attempt that resulted in hospitalization may learn this information from hospital staff who might contact next of kin following the admission. How an attempt survivor decides to disclose information and whether that information was disclosed voluntarily are important questions that have not yet been examined in the suicide literature and are necessary given the findings of the current study.

The indirect effect of disclosure on mental health through family reaction highlights the pressing need for assessing attempt survivors' levels of social support. The scale developed for this study, although reliable, measured perceived quality of the reaction. In other words, the *Family Quality Reaction Scale* measured whether the attempt survivor perceived the reaction as positive or negative. What remains unclear is what behaviors family members specifically employed that were either helpful or harmful. This study suggests a need for qualitative research with attempt survivors to obtain rich understandings of not only the variety of reactions experienced but also what components of those reactions improved their experience of suicide recovery as well as increased the likelihood that they would disclose again in the future. These qualitative interviews should also attempt to garner insight concerning behaviors that should be avoided in order to prevent the exacerbation of thwarted belongingness and increased burdensomeness (Van Orden et al., 2010). More generally, future research should provide clear implications for working with family members of suicide attempters and those with

lived experiences either as part of treatment or to create a more helpful recovery environment at home.

Findings of the current study indicate that family members play an essential role in mediating the effect of disclosure on subsequent depression symptomology, although little is known about how the combination of disclosure to multiple people who respond in a variety of ways affects mental health. Findings from this study are limited in that participants reported on disclosure and reaction specific to one self-selected target person. Reactions across one's family and social networks are probably varied; some individuals may experience a positive reaction from some family members or friends while simultaneously experiencing stigma and negative reactions from other family members or friends. More research is needed to determine how the collective mix of reactions across individuals within one's family and social networks impact the broader experience of suicide disclosure and subsequent mental health.

Conclusion

Previous studies have highlighted the role of disclosure in improving the mental health of individuals with concealable and stigmatizing identities. This study augmented existing literature by indicating that increased disclosure is associated with more positive family reactions which, in turn, is associated with less depression symptomology in attempt survivors. The findings presented here lay the groundwork for future research that may improve the treatment experience for attempt survivors and lead to interventions that include family members in the treatment process in helpful ways. Suicide in a family member can be a terrifying process for family members, and providing a way for them to

contribute to treatment has the potential to improve the experience for attempt survivors and their family and social networks.

Chapter Four

An Interpretive Phenomenological Inquiry of Family Reaction to Suicide Disclosure

Suicide is the second leading cause of death for individuals aged 15-34 in the United States (Center for Disease Control and Prevention, National Center for Injury Prevention and Control, 2011) where, among all age groups, over 100 suicide deaths and nearly 3,000 nonfatal suicide attempts occur daily (Drapeau & McIntosh, 2014). Although difficult to assess because of underreporting, professionals estimate that roughly 25 attempts occur for every death by suicide (Drapeau & McIntosh), which suggests that social networks are more likely to include an individual who has experienced a nonfatal suicide attempt (hereafter referred to as *attempt survivor*) than to experience a member's death by suicide. Despite the prevalence of nonfatal suicide attempts, little is known about the experiences of attempt survivors. Moreover, researchers have not examined how family members and friends react to a loved one's suicidal ideation or behavior. Therefore, this study examined the meanings attempt survivors derived from the reactions of family and friends to the attempt survivors' disclosure.

Background Literature

Research has repeatedly indicated that a non-lethal suicide attempt is the most reliable predictor for future suicidal behavior (e.g., Beautrais, 2002; Gibb, Beautrais, & Fergusson, 2005). The interpersonal theory of suicide (IPTS; Joiner, 2005; Van Orden et al., 2010) posits that attempt survivors have an elevated risk for subsequent suicidal behavior because they have a higher acquired capability for the behavior relative to those who have not crossed the attempt threshold. Theoretically, non-lethal suicide attempts

desensitize individuals to high levels of pain and the fear associated with dying, thereby increasing the likelihood that attempt survivors will attempt again if the factors contributing to suicidal ideation are not resolved. Indeed, acquired capability for suicide is positively correlated with number of previous suicide attempts (Van Orden, Witte, Gordon, Bender, & Joiner, 2008), although more research is needed to determine the causal direction and to examine plausible spurious relationships.

A limitation of IPTS is that it does not integrate experiences specific to attempt survivors beyond acquired capability. That is, although the theory posits that thwarted belongingness and perceived burdensomeness are needed for a desire to die to occur, proponents of IPTS have clearly articulated how interpersonal factors contribute to these two factors. Limited social support (Cacioppo et al., 2006) and family conflict (Bastia & Kar, 2009; Cetin, 2001; Hawton, Fagg, & Simkin, 1996) can lead to loneliness and the absence of reciprocal care (i.e., when individuals perceive they have no one to whom to turn and offer no support to others; Van Orden et al., 2010) which are two forms of thwarted belongingness. Perceived burdensomeness can occur when individuals feel they are expendable or unwanted (Sabbath, 1969; Woznica & Shapiro, 1990) and when they have high levels of self-blame and shame (Chatard, Selimbegovi, & Konan, 2009). Because these contribute to suicidal ideation, treatment methods post-attempt should aim to remedy experiences associated with thwarted belongingness and perceived burdensomeness to decrease the likelihood of an individual repeating suicidal behavior. However, stigma associated with suicide often results in individuals concealing their stigmatized identity or attempt survivors feeling shunned and isolated (Scocco et al.,

2012), both of which could decrease feelings of belongingness and increase feelings of burdensomeness.

Research on family members' and friends' reactions following a suicide attempt is limited. Only one study has looked at how suicide disclosure and family reaction interact to impact depression symptomology: Increased disclosure was linked to more positive family reactions; moreover, family reaction mediated the relationship between disclosure and depression symptomology so that increased disclosure was linked indirectly to less severe depression symptoms (see Chapter 3). However, this study only measured whether respondents perceived the reactions to be helpful and did not address which specific types of reactions or behaviors constituted a helpful or harmful reaction. Furthermore, research has not yet addressed how these reactions are interpreted by attempt survivors and the types of meanings they associate with the disclosure and reaction experience. Therefore, the current study was designed to gain a rich description of family member reactions to suicidal behavior and to better understand how attempt survivors interpret those reactions.

Present Study

The purpose of this study was to describe family members' reactions to suicide disclosure and the meanings associated with these interactions from the viewpoint of individuals who have attempted suicide. Phenomenological research aims to describe the *essence*, or common aspects that describe how all individuals experience a specific phenomenon (van Manen, 1990) by detailing not only what is experienced but also how the individuals experienced it (Moustakas, 1994). Phenomenological research typically follows either a descriptive or interpretive methodology. The interpretive

phenomenological approach (also referred to as a hermeneutic approach) taken with this study differs from descriptive methods in that in addition to describing the core concepts associated with phenomena, meanings associated with experiences are extracted (Lopez & Willis, 2004). In other words, the interpretative approach examines not only what individuals know but also what they experience (Solomon, 1987) in a way that makes hidden meanings associated with the experience more explicit.

The interpretive and descriptive approaches to phenomenology also differ in their perspectives on individual freedom in decision making. The descriptive approach follows the philosophy of *radical autonomy* (Husserl, 1954/1970), which suggests that individuals are free agents responsible for making their own choices and does not consider the impact of one's social environment on those choices. The interpretive approach follows the philosophy of *situated freedom* (Heidegger, 1962/2008), which also suggests that individuals are free agents responsible for making their own choices but, in contrast, stipulates that the choices available to an individual are constrained by the specific cultural and political contexts of their time and place. Heidegger referred to this tenet as one's *lifeworld*, and he described the inability to extract oneself from this world as *being-in-this-world*. These philosophies imply that interpretive phenomenological approaches should describe the meanings that result from an "individual's being-in-this-world" and how this relationship impacts one's experiences (Lopez & Willis, 2004, p. 729). This contextual approach is important for understanding suicide attempt survivors' experiences with reactions because those experiences are embedded within and influenced by societal attitudes about suicide, and these experiences therefore cannot be

fully understood without understanding the stigma context associated with being an attempt survivor.

Although bracketing is often viewed as contradictory to interpretive approaches (LeVasseur, 2003), scholars have encouraged researchers to be explicit about their preconceptions toward the research topic and how these preconceptions are used in the research (Geanellos, 2000; Lopez & Willis, 2004). As a clinician, I have extensive experience working in an inpatient, psychiatric hospital. This work primarily entails assessing causes and risk for ongoing suicidal behavior while simultaneously navigating family dynamics with family members present during the assessment as well as expectations concerning how the suicidal behavior will affect family members who were not present. These experiences have shaped my belief that family communication can be an important tool in suicide prevention, but it is often nullified by the family members' lack of knowledge about suicide and the needs of suicidal individuals. Misunderstanding the causes, consequences, and needs associated with suicidal behavior limits family members' ability to respond in helpful ways. The interpretive phenomenological approach allows me to conscientiously utilize these beliefs when interpreting the meanings extracted from participant interviews through *co-constitutionality*. Koch (1995) originally used this term to refer to the mutual influence between a person and his or her environment, an idea which Lopez and Willis extended by suggesting that interpretations are a result of meanings derived from both participant and researcher experiences. Thus, I interpreted the findings of this study through my perspective on the family dynamics at play to create informed, best-practice recommendations for family and social network members.

Method

Recruitment & Sample Characteristics

Participants were recruited through a survey posted on the American Association of Suicidology listserv open to individuals who had experienced suicidal ideation or had previously attempted suicide. Survey respondents ($N = 156$) who reported disclosing suicidal behavior to another individual were asked to volunteer to be contacted for an in-depth discussion about their experience with suicide and their interactions with other individuals post-attempt. Those who volunteered a phone number or an email address ($n = 67$) were contacted to schedule a confidential interview. Two follow-up emails or phone calls were attempted for each participant who did not respond to the initial contact.

These procedures resulted in 40 completed interviews with primarily female (70%) and Caucasian (90%) participants whose ages ranged between 28 and 62 years ($M = 45.8$, $SD = 9.8$). The highest number of reported previous suicide attempts was 25 ($M = 4.0$, $SD = 5.2$), and time in since most recent attempt ranged from less than 1 to 41 years ($M = 11.0$, $SD = 12.4$). The most common methods attempted were drug ingestion ($n = 30$) and cutting/stabbing self ($n = 22$). Individuals were asked to report the types of individuals to whom they disclosed information about their suicide attempt: The most common individuals identified were a friend ($n = 21$), a spouse or romantic partner ($n = 21$), and a medical or mental health professional ($n = 17$). See Table 4.1 for additional descriptive information about the sample.

Procedures

Semi-structured audio-only telephone interviews were conducted and digitally recorded with each participant. Audio-only interviews did not allow the transmission of

Table 4.1
Descriptive Characteristics

Characteristic	<i>n</i>	%
Sex ^a		
Female	28	71.8
Male	11	28.2
Ethnicity		
Caucasian	36	90.0
Latino/Hispanic	3	7.5
Asian	1	2.5
Marital status		
Married	15	37.5
Single, never married	11	27.5
Divorced	11	27.5
Separated	3	7.5
Attempt method		
Drug ingestion	30	75.0
Cutting/stabbing	22	55.0
Hanging	7	17.5
Suffocation	7	17.5
Ingestion of other toxic substance	5	12.5
Firearm	5	12.5
Traffic accident	2	5.0
Jumping	1	2.5
Drowning	1	2.5
Disclosure target		
Friend	23	57.5
Spouse/romantic partner	21	53.5
Professional	17	42.5
Mother	10	25.0
Sister	6	15.0
Father	5	12.5
Grandparent	3	7.5
Brother	2	5.0
Written/discussed online	2	5.0
Children	2	5.0

^aOne participant identified as transgender.

nonverbal communication (Creswell, 2013; Hanna, 2012) but, relative to face-to-face interviews, telephone interviews reduced time and transportation costs for participants and provided them more power to terminate the interview at their discretion (Bertrand & Bourdeau, 2010). Prior to beginning the interview protocol, polite but brief conversation was engaged in to build rapport and trust, then the purpose of the study was described and participants were assured that the information they shared would be confidential. Rapport and trust can be more difficult to establish in audio-only interviews than in face-to-face interviews (Hanna, 2012). Therefore, additional methods that were used during the interviews included verbal nods (e.g., “uh huh”), empathetic statements, maintaining awareness of a neutral voice to avoid inflections that imply judgment, and making assuring statements of neutrality (e.g., “I’m hearing that the experience was very difficult for you”).

The interview protocol included questions related to experiences with suicide, family response to suicide or suicidal ideation, and idealized notions about a family’s role in such circumstances. Example prompts and questions (see Appendix C for full interview protocol) included “What was the individual’s reaction following the suicide attempt(s)?,” “What was helpful or not helpful about how the individual reacted?,” and “What do you wish could be different about people’s reaction following the suicide attempt(s)?” These questions guided the initial interviews, but the interview protocol evolved as more interviews were conducted. For the purposes of this study, only questions regarding reactions by friends and family members were analyzed, and responses regarding health care professional reactions were omitted.

Data Analysis

The audio-recorded interviews were conducted in accordance with Ricoeur's philosophy (1976, 1986/1991) of a phenomenological hermeneutical approach, which posits that individuals develop self-understanding through interpreting the objects (or in this case, interactions with people) around them. Then the interviews were transcribed by paid assistants, and data analysis occurred in three steps after all interviews were completed. The first phase entailed a naïve reading of each transcript to reflect upon the ideas presented in the interviews and to develop initial directions for the structural analysis. The second stage consisted of a structural analysis of the interviews by (a) identifying one or more sentences that reflect individual meaning units, (b) condensing each meaning unit into a shorter form, (c) organizing shortened meaning units to develop subthemes, (d) examining the subthemes to recognize new themes that are central to the interviews, and (e) comparing interviews to each other to ensure that the common experiences had been identified. The third stage included a review of all transcripts and researcher preconceptions to develop a comprehensive understanding of the material.

Ricoeur (1976, 1986/1991) describes the data analysis process as a spiral movement alternating between these three phases with the purpose of understanding and developing explanations of the material. This process was further validated by reporting findings using rich, thick descriptions, which entails using strong action verbs and quotations as well as interconnecting details in the final contextual explanation (Stake, 2010). Additionally, my dissertation committee reviewed the proposed study and reported findings to encourage rigor and to validate the findings.

Results

The overarching meaning exhibited by participants was that reactions to suicide disclosure provide important cues to attempt survivors regarding their place in the world. This meaning was exhibited through three main themes: (a) Reactions from family members or friends that lead attempt survivors to believe they do not belong and are a burden to their loved ones. (b) Reactions from family members and friends that implied attempt survivors could belong or not be a burden if they concealed their suicidal behavior, and (3) Reactions from family members and friends that conveyed to attempt survivors that people want to help and that their existence is valued by others. Each individual theme is described below in more detail.

I Do Not Belong, and I Am a Burden

Negative experiences were those which were described as a contributing effect to ongoing feelings of worthlessness and self-blame, and every participant reported having a negative experience with at least one person after disclosing suicidal behavior. Many of the negative experiences were explicitly stigmatizing statements, such as name-calling or blaming the attempt survivor with directly hurting other people. Attempt survivors described family members “screaming at me,” “telling me I was weak,” and “laying into me and yelling at me” once their family learned about the attempt. Statements by family members that reinforced negative opinions that attempt survivors held about themselves included “how could you do this to your family?,” “you’re putting your family through pain,” “you’re always selfish,” “only selfish people die by suicide,” and “you’re going to Hell because God does not want you to kill yourself.”

One woman referred to both friends and family members when she described a negative reaction she experienced: “They were saying stuff like, “How can you do that? You’re selfish. It’s a selfish act. Can’t you just think about your children?” She described how her attempt “was used as a weapon” against her. She described how these reactions reinforced feelings that she did not belong and was a burden to her family: “I felt even more misunderstood. . . . They put the blame on me, and that even gives me more validation to end my life. It just doesn’t help. It validates those negative points on how I feel about myself.”

Another way in which reactions to suicide disclosure were perceived as negative was when the focus was initially on the impact of the behavior on friends and family members rather than a desire to understand or help the attempt survivor. Several participants described how others reacted by focusing on what the attempt survivors were doing to them, which further exacerbated attempt survivors’ feelings of being a burden to their loved ones. These survivors often clarified that they recognized the potential for emotional pain their suicidal behavior could cause, but they described how family members overreacted and became angry about the attempt. Participants reported family members who would indicate that learning about the suicide “was affecting them negatively.” One participant’s family member explicitly stated his feelings, “he told me he was angry,” and another participant was asked “how can you do this to me?” Another woman stated one of her friends “was angry that I didn’t tell her sooner” and “felt like we weren’t as close as she thought we were.”

One woman exemplified this experience by stating

The biggest thing that gets to me about people around suicide is that they think it's all about them, and people totally forget that people attempt suicide because they are in too much pain. And when people try to understand it, it's all about, "Well, why didn't you talk to me? Me, me, me?" There is no connection between "you did this because you were in so much pain." . . . I understand they have to process it themselves, but it was still no real connection and compassion for why this happens. It's still the judgment.

She continued to describe the stigmatizing difference between mental illness and physical ailments, "You don't get blamed for having cancer, but you get blamed if you end up dying by suicide because you just couldn't deal with it anymore, and to me, that is very unfair."

Other participants described negative reactions that perpetuated stigmatizing attitudes about attempt survivors while simultaneously ostracizing attempters by setting them apart from non-attempters. Participants described how they were "not allowed to see my children," "removed from the church," and "immediately put on leave [from work] without pay." A male attempt survivor described being removed from an organization that was valuable to him: "After I tried to commit suicide, I was no longer an elder in the church. As the pastor put it, 'we can't have somebody emotionally unstable in a leadership position in the church.'" He described this reaction as a punishment that increased thwarted belongingness by making him feel not accepted. He stated, "Suddenly, all these people and all these business relationships I had, the water was poisoned. I was persona non grata." As this example indicates, individuals who distanced attempt survivors from meaningful social, spiritual, and professional roles

further exacerbated perceived burdensomeness by denying opportunities for attempt survivors to reconnect with community members in ways that could reinforce their value and positive contributions to others. Rather, the stigmatization and corresponding isolation both validated and intensified feelings of perceived burdensomeness and lack of belongingness.

I Can Belong and Not Be a Burden if I Hide This Part of Myself

Many participants reported hurtful reactions from friends and family members that were negative to the attempt survivor experience but did not directly contribute to feelings of burdensomeness or thwarted belongingness. The meanings derived from these interactions suggested that a positive relationship between the attempt survivor and the individual could continue provided suicide disclosure no longer took place within the relationship. Other participants described similar experiences of suppressed disclosure due to the limited capacity of a friend or family member to respond constructively. Unhelpful responses included “freaking out,” “overreacting,” or “going into automatic problem-solving mode.” Participants also reported how family members would ask the wrong questions: “how do we stop this behavior” rather than a “bigger understanding of what was driving it.”

Additional examples of unhelpful reactions included family members who avoided or did not want to talk about the attempt in a way that led attempt survivors to believe they could not emotionally handle the information. One participant described how “my dad got up and walked out. . . . He couldn’t handle it.” Other participants described how “people quit asking about it,” “people avoided me,” “kept their distance from me,” and “didn’t call me or check on me.” One female attempt survivor explained how her

mother said, “If you’re going to be this way, I don’t want to know about it. Just don’t be that way with me, you can be that way with anybody you want, but don’t be that way with me.” Another participant interpreted family members’ avoidance as meaning that she was a burden unless she hid her suicidal behavior: “People want to go out and be around people that are fun to be around, but as a survivor, you’re not fun to be around. People get tired of hearing about it.”

One female described how some individuals were too overwhelmed by the information yet others were open and willing to discuss it:

I knew that they really didn’t want to talk about it, about the details. And I personally find that sharing it with someone is a really helpful thing, but I didn’t want to push them. I think it would have been more helpful for me if I could talk about it.

She described how this impacted whether or not she could talk to family members about her suicide in the future by saying, “when I had a few depressive episodes after that and I had suicidal thoughts, I thought, ‘Oh my gosh, I can’t tell them. They’ll really freak out because they know I have attempted.’” She further clarified by saying that people were the most helpful when they were “not afraid to talk about it.”

Extensive monitoring—that is, hypersensitivity to the possibility of suicidal behavior, often at the expense of attempt survivors’ independence and personal freedom—also inhibited suicide disclosure while simultaneously maintaining a positive relationship with friends and family members. Many attempt survivors interpreted extensive monitoring as an expression of concern, yet they also believed that the concern

was rooted in a fundamental misunderstanding of the situation and the support needed, as conveyed in the following statement:

He just called me every day for a week, threatening to call the police on me if I didn't talk to him every day. . . It wasn't really helpful because I felt there was this barrier between us because, if I say the wrong thing, he's going to call the police on me. So it just put this invisible space between us and it shut me down so that I couldn't really talk about what I was feeling. . . That cut the relationship, because as much as I knew that he cared about me—and he was being very caring and trying to be supportive—he didn't really do it in a way that I was looking for.

Attempt survivors often reported hiding information to avoid extensive monitoring, primarily as a way to limit the burden on friends and family members. This interpretation highlights how extensive monitoring, although often motivated by a desire to help the attempt survivor, can actually lead attempt survivors who experience this reaction to experience heightened feelings of burdensomeness, and perhaps avoid subsequent disclosures.

I Belong, and I Am Not a Burden

Although each participant had experienced at least one negative reaction to suicide disclosure, many participants also reported positive reactions that reinforced feelings of worthiness. Many family members want to provide helpful responses but lack the understanding or knowledge needed to do so. Therefore, all positive reactions described by these participants are presented in Table 4.2, with at least one quotation from a participant to describe each reaction type. From these codes, three primary

Table 4.2
Helpful Reactions that Emerged During Coding, Number of Participants that Reported Them, and Sample Items

Reactions	<i>n</i>	Sample item
Validation	37	Say something like, “Wow. That’s hard.” or some people would say something like “Everyone has dark times.” I got a lot of praise for coming forward and asking for help. People acknowledged how hard it is to come forward and say I’m having these thoughts
Non-judgment	36	She didn’t make it about me being crazy or being wrong. Don’t think they’re bluffing or that they’re seeking attention
Reinforce connection	25	To say that you love me and that there would be a big hole in their life if I wasn’t there. I would like to know how much they need me to be in their life, how much I matter to them. When someone says, “You’re a really important part of my life,” that changes my whole thinking about myself.
Letting me talk about it	25	Letting me know that I didn’t have to hold it in. I think that is the most help is to be able to talk about it, being able to process it.
Ask questions	25	I think the ideal reaction would be to ask people what it is you need from me to support your recovery process, just asking “What is it that you need me to do to support you? What is it that I can do to show you that I’m with you through this process?”
Saying you’re available	14	Just saying we love you, we’re here if you want to talk about it. Expressing that the other person wants to help is uplifting
Projecting strength	11	Just knowing she was there and was not going to freak out if I called her.
Offer empowerment	5	She affirmed my ability to be resilient and overcome these experiences. I was basically getting nothing but negative messages, but she believed in my ability to overcome adversity and voiced that to me.
Brainstorming	5	After listening for a little bit or talking through with me, asking why things are going the way they are to develop a really basic step for going forward. It doesn’t have to be a long, extensive safety-plan, just an idea of what can help right now.
Being clear about limits	5	I think people I’ve become close to have been very good at saying, “What do you need? How can we be supportive” and holding their own to be able to say, “I actually need a break” when they do. That’s been helpful.
Physical contact	4	He is a quiet, thoughtful guy so he didn’t say a whole lot. He just hugged me.
Follow-up	4	One of my friends would follow up. We came up with a rainbow-colored scale, and she’d ask me, “What color are you today?” That’s the biggest thing is people who are willing to ask me about it are the people I feel safest with.
Tangible support	3	Having some family members around, just because I was in a scary place both mentally and in a hospital I’ve never been in. It was very helpful to have them around just to do practical things like feed my cat or help me grocery shop.
Advocate for patient	3	My dad got up and walked out. He couldn’t handle it because he thought it was bullshit. At the break, my mother went to him, and it’s the first time my mother ever stood up for me about anything. My mother went to him and said, “You will be in that room, and you will listen, and we will do whatever is necessary to help her.” That was life changing for me.

subthemes were commonly repeated by the majority of participants: seeking to understand by asking questions, being present, and projecting strength and stability.

Seeking to understand by asking questions. When asked about helpful reactions or the ideal way to respond to suicide disclosure, many participants reported the need for open-ended non-judgmental questions, as opposed to closed-ended and blaming or condescending questions. One respondent succinctly captured this sentiment:

For someone to say, “Wow, what’s happening for you in your life right now?” not “What’s wrong with you? How can we diagnose you?” but “What’s happening in your life? What makes you feel like it’s not worth living?” Just open, curious questions. An attitude of curiosity rather fear, I think is a big piece of it.

Additional examples of helpful questions included, “How were you feeling?,” “What do you think about when you’re suicidal?,” “What do you think would help you?,” “Is there anything I can do,” “What’s going on?,” or “Do you want to talk about it? Tell me what happened.”

These examples of questions highlight the need for attempt survivors to perceive a genuine desire by family and friends to understand the attempt experience and to determine the ways in which the loved ones could be the most helpful. Participants did not convey an expectation that people not be afraid when talking about suicide, but they did articulate a wish that curiosity, compassion, and the desire to help be stronger than the fear of having a conversation about the circumstances and their experiences.

Being present. This subtheme referred to individuals who projected not only the curiosity to ask questions but also the willingness and desire to hear honest answers to those questions. This type of reaction was directly related to increasing feelings of

belongingness, in that it allowed attempt survivors the opportunity to explain their experience so that non-attempters could begin to understand their world rather than be judgmental about it. Participants described helpful reactions in which someone “really listened,” “did not interrupt or judge me,” “didn’t have to say anything, just was there,” “was very calm and present,” “was supportive, heard me out,” and “stayed to listen to me and talk to me.” These helpful reactions occurred when family members remained available for open communication and continued to be engaged with the attempt survivor during the disclosure process.

A participant described an ideal reaction in which someone would be present without trying to fix the situation: “[for my family] to be willing to stand there and listen to what I have to say and realize and know that you are actually not the person who has to fix it.” He described a desire to be able

to just turn to somebody and say, “Could you just be there for me for a moment?” Just that I’m struggling at the moment and as I lose track of reality, to just have them stand there and just look concerned and actually not get distracted, just to be there until I can gather myself together and move forward or move on or move to whatever it is that I need to do next to get myself to a safe situation.

In moments such as the one in this example, participants described individuals reacting in a way that provided compassion and support without an expectation that the individual would always know the right way to respond. As one participant explained about her husband, “He listens to what I have to say without being judgmental or criticizing, and he says that he loves me and doesn’t want anything bad to happen to me.” These types of reactions convey a desire to help and re-establish a personal connection

that reinforces feelings of belongingness for the attempt survivor without placing blame or minimizing the experience.

Projecting strength and stability. Participants commonly reiterated a desire to avoid burdening friends and family members by disclosing their suicidal ideation. Many expressed appreciation for those individuals in their lives who were capable of hearing about suicidal behavior without becoming overwhelmed by it. For example, a participant referred to the strength of her husband as one of the helpful reactions she experienced:

He was very strong, and very supportive, and very loving, and since then our relationship has just improved. Emotionally and mentally, I feel stronger. . . He made me feel like he was big enough, and he was strong enough, to handle the truth.

The strength conveyed during these types of interactions reassured attempt survivors that their behavior was not a burden to their family members and friends. Some participants described implicit or nonverbal communication that implied stability (e.g., attentive listening, initiating conversations) while others referenced the need for explicit acknowledgements of personal boundaries. For example, one participant referenced helpful reactions in which family members “acknowledged how much they didn’t know” or were “able to say, ‘I actually need a break’ when they did.”

Many individuals also acknowledged that suicide disclosure can be overwhelming, especially when it occurs unexpectedly. These participants conveyed that family members should be able to express their concerns, albeit in a compassionate and non-blaming manner. That said, one participant indicated a preference that family members withhold their own concerns or struggles until the attempt survivor is

emotionally stable: “Even if it’s fake, project some sort of strength and desire to discuss your reactions or difficulties with it at a later time when the suicidal person is more emotionally stable. I think that would be a huge help.” Reactions portraying strength and stability established trust between the two parties by reassuring attempt survivor that they could disclose suicidal information and the recipient’s response would be both compassionate and delicate.

Discussion

An interpretive phenomenological analysis of in-depth interviews with suicide attempt survivors was conducted to understand the meanings attributed to family and friends’ reactions upon disclosure of suicidal behavior. Findings indicated that attempt survivors interpret reactions to determine how they should relate interpersonally with others. Negative experiences and suppression of disclosure result from hurtful reactions and helpful reactions lead to positive experiences that reinforce feelings of belongingness for attempt survivors. These findings have important implications for the social networks of attempt survivors, as well as for clinicians and researchers working with suicide attempt survivors.

Stigmatizing reactions, such as condescension and ostracization, can convey the message that individuals do not belong and are a burden to others, which contradicts the belief that suicide stigma is a deterrent for suicidal behavior (Gould, 2001). Maine et al. (2001) attempted to remedy suicide stigma by separating an attitude about the *behavior* from attitudes about the *people* who engage in the behavior. However, this interpretation perpetuates the idea that suicide is a choice rather than a symptom of mental illness. The opinion that reprimanding statements regarding suicide could be helpful discourages

individuals from talking about suicide and punishes individuals who have already engaged in suicidal behavior. The current study provides evidence that suicide attempt survivors felt further isolated due to stigmatizing responses from others. The findings suggest that family members and friends should focus on the factors or feelings that led to the desire to die (e.g., open questions, being present for the answers) rather than a focus on the behavior itself (e.g., extensive monitoring).

The negative impact of extensive monitoring is surprising given previous indications that monitoring can facilitate suicide prevention. The removal of means (i.e., removing medications, securing weapons, blocking access to heights) is one of the primary methods for preventing suicide (Mann et al., 2005), and monitoring serves as one method of ensuring that suicidal individuals do not gain access to new means. This recommendation is inconsistent with participant reports in the current study, who indicated that extensive monitoring sometimes prevented them from disclosing suicidal ideation. This prompts additional questions concerning the possible curvilinear utility of monitoring; it seems likely from these findings that excessive monitoring generates a harmful cycle whereby increased monitoring elicits avoidance behaviors, which subsequently lead to additional monitoring, and so on. It may be that the utility of monitoring varies by person or context. For example, perhaps monitoring is most effective with impulsive individuals who experience rapid changes in mood or when individuals are undergoing changes in medication. Similarly, intensive monitoring may be advisable immediately after an attempt or when suicidal ideation is present, and best avoided the ideation subsides. In any case, the implication of this finding is that conversations involving all parties should establish clear expectations for when

monitoring should and should not be employed, so that family members feel they can trust attempt survivors around harmful materials while also ensuring that attempters feel safe to initiate a conversation about suicide without losing independence and freedom.

The factors that prevent family members and friends from offering helpful reactions also remain unclear. Although this study was conducted with the preconception that family members are limited by their lack of knowledge and understanding of suicide, there is limited research to support this interpretation (e.g., Maine et al., 2001) beyond personal experiences. Another explanation for unhelpful responses could be emotional flooding, whereby individuals become overwhelmed by their own emotions in a way that inhibits their ability to respond rationally (Orbach, Mikulincer, Sirota, & Gilboa-Schechtman, 2003). Family and friends could feel fear, anxiety, disappointment, or even betrayal after hearing about another's suicidal behavior; yet, the findings of the current study suggest that attempt survivors need individuals to set those emotions aside—or at least be mindful of them in a way that allows an empathic response. This interpretation points toward the need for additional research with family members who have experienced a loved one's suicide attempt to learn more about their experiences immediately following disclosure and the factors that facilitated or prevented a compassionate response.

Conclusion

This study extends our understanding of the meanings attempt survivors intuit from the reactions of family and friends following their disclosure of suicidal behavior. Findings from this study indicate that reactions following disclosure have a profound impact on whether attempt survivors feel they belong with social network members and

whether they feel that they are a burden to those around them. Suicide is prevalent on national and global levels, and this study provides valuable insight into how friends and family members can facilitate the recovery process following a loved one's suicide attempt.

Chapter Five

Conclusion

This dissertation project examined the role of stigma, self-disclosure, and family reactions experienced by suicide attempt survivors. The first study found that a model including the source of stigma (i.e., the type of individual from whom stigma was perceived) and type of stigma was a better predictor of depression symptoms in attempt survivors than a model that only accounted for type of stigma. More specifically, stigma from social network members (e.g., family, friends, coworkers, romantic partners) was the only stigma source that statistically predicted changes in depression symptomology, with increases in social network stigma predicting increases in depression symptoms. Findings from the second study indicated that family reaction mediated the relationship between suicide disclosure and depression symptoms: Higher rates of disclosure statistically predicted positive family reactions, and more positive family reactions statistically predicted less severe depression symptoms. Finally, the third study found that family member reactions' to suicide disclosure influenced attempt survivors' perceptions about whether they belonged or were a burden to others. The findings elucidated from this dissertation project lay the groundwork for future research and clinical work.

This study highlights the need for new interventions that not only treat severe mental illness but also facilitate and improve family communication. The therapeutic approaches currently available to clinicians often target only one of these issues, which may severely limit their efficacy. Very little is known about family's role in treatment for suicide, which makes it difficult to suggest new approaches. Future research should examine how family members facilitate or exacerbate risk factors for suicide to determine

which interventions are needed. For example, findings described in Chapter 4 highlight the need for an intervention that facilitates open communication about monitoring.

Family members may need to establish rules about what types of monitoring is needed to maintain safety while also preserving the attempt survivor's independence.

Although not a prominent finding in the qualitative study presented in Chapter 4, the coded responses suggest that there may be distinct difference in family reactions to suicide attempts based on whether the attempter was an adolescent or an adult. Some participants indicated involuntary disclosure when they attempted as an adolescent, in that family members informed extended family members or family friends about the attempt without the attempter's permission. This behavior was not commonly reported among attempters who attempted as adults. Moreover, those who attempted as an adolescent more often reported that family members exhibited panic or emotionally intense reactions compared to those who attempted as adults, whereas adult attempters more often reported blaming reactions from family members compared to those who attempted as adolescent. It is unclear whether family members are more likely to interpret suicidal behavior in adults as irresponsible compared to the same behavior in adolescents. For example, families could feel that adults should "know better" than to engage in suicidal behavior. This phenomenon warrants further investigation using a lifespan framework, in which disclosure and subsequent reactions are examined according to the developmental lifespan stage of the attempter.

What Can Family Scientists Contribute to the Field of Suicidology?

The results reported in this dissertation underscore the important role that family members have on mental health following suicide disclosure, and perhaps on subsequent

suicide risk. Family and relational issues have an important impact on both the development and treatment of suicidal behavior within the individual, and suicide can profoundly impact surviving family members and the family system as well. Clearly then, family scientists are ideally suited for examining suicide, yet suicide has not been a topic of study within family science and family has not been a topic of study among those who study suicide attempt survivors.

Tangible steps can be taken to remedy the near absence of family in current perspectives on suicide. One strategy is by prioritizing the family system as the first point of response for recognizing symptoms or risk factors and encouraging individuals to seek treatment for suicide. Family life educators, researchers, and clinicians need to be educated on the role and benefits of family involvement so they, in turn, can educate family members on suicidal risk factors and symptoms of suicidal behavior. Parents, spouses, and siblings can play a key role in recognizing changes in mental health that occur over time, but most family members are not sufficiently prepared to recognize risk factors, tell-tale signs of suicide ideation, or to intervene and pursue treatment options when suicide risk is high. Therefore, education is a key strategy for shifting away from the current emphasis on individual illness toward a view that suicide is a family, relational, and social phenomenon for which family is best situated to prevent.

A second strategy for involving family in suicide prevention and intervention is to advocate for suicidal individuals by decreasing family communication and behaviors that stigmatize suicide. Individuals with past suicide attempts, as well as the family and friends of those who attempted or completed suicide, are often plagued by stigma. Research on stigma in the context of suicide has often examined the impact of stigma on

suicide survivors' bereavement, not the stigma associated with suicidal ideation and behavior. Some fear that reducing the stigma of suicide itself would normalize suicide as a reasonable and acceptable option when faced with difficult life circumstances (Cialdini, 2003; Gould, Jamieson, & Romer, 2003). In contrast to this argument, stigma often prevents individuals from seeking professional help and telling others about their state of mind (Conner et al., 2010; Schomerus, Matschinger, & Angermeyer, 2009). If one feels free to be open and honest about suicidal thoughts, then family members and friends can play an essential role in facilitating conversation and encouraging an individual to seek treatment. Moreover, research on other stigmatized topics (e.g., sexual orientation) has found that disclosure of a stigmatized personal experience or characteristic decreases risk for psychological distress (Talley & Bettencourt, 2011). Similarly, the study detailed in Chapter 2 indicates that social network stigma toward suicide is the best predictor for depression symptom severity compared to stigma perpetrated by treatment providers. However, more research is needed to determine the best way to reduce harmful negative family communication regarding suicide.

Another step toward reconceptualizing suicide as a family phenomenon is to prepare the family environment following the admission of suicidal ideation or behavior. Although family scholars know that the family environment plays a pivotal role in mental health treatment, knowledge of how the family environment contributes to treatment following a suicide attempt in particular is limited. Family scholars have found that negative family interactions during treatment exacerbate feelings of burdensomeness, which could increase suicide risk (Sun, Long, Huang, & Huang, 2008). Similarly, the study outlined in Chapter 4 indicates that family reactions to suicide disclosure can

reinforce feelings of burdensomeness and thwarted belongingness. However, it remains unclear how a family's response to the suicidal ideation impacts subsequent suicidal behaviors.

Finally, family scholars should expand research on the intersection of family and suicide to advance our understanding of how the family environment interacts and changes following the admission of suicidal ideation or a suicide attempt. For example, only one published article has explored the family environment following a patient's hospitalization due to a suicidal attempt (Sun et al., 2008), and this study merely proposed directions for future studies. Moreover, one study found that over a third of family members who accompanied family members to emergency rooms following an attempt were actually with the patient when the attempt occurred (Cerel et al., 2006), but no research has examined family members' role in trying to intervene or respond to a suicide attempt, or the impact of this experience on future family relationships. This information is necessary to inform evidence-based interventions with families destabilized by a suicidal member; otherwise, family life educators and therapists will be ill-equipped to help families adapt during this tumultuous time.

Although suicidal behavior is an individual action, it disrupts the entire family system. The family system likely also plays a role in the development of the suicidal behavior. While much of the suicide prevention research has focused on individual factors, the role of family and its contribution to the development and treatment of suicide has been largely ignored. In order to understand how to help individuals struggling with suicide, researchers and clinicians must understand not only the

individual factors but also family context. In doing so, suicide prevention advocacy efforts will be enhanced and lives will be saved.

Appendix A

Self-Harm and Suicide Disclosure Scale

Some people choose to share information about their past self-harming or suicidal behavior with others. The following questions ask about how much information you have shared with a family member and a friend or romantic partner.

Before completing the scale below, please think of a family member with whom you have shared the most about this information. If you have not shared information a family member, please select the family member to whom you tell most things.

- A. Mother
- B. Father
- C. Sister
- D. Brother
- E. Grandmother
- F. Grandfather
- G. Aunt
- H. Uncle
- I. Cousin
- J. Spouse
- K. Other Please fill in: _____

	Target Family Member		Not Applicable
	Yes	No	
1. when I am thinking about hurting myself on purpose			
2. that I have hurt myself on purpose without the intent to die (cutting, burning, biting, picking, etc.)			
3. how often I hurt myself on purpose without the intent to die			
4. the method used to hurt myself on purpose without the intent to die			
5. the reasons why I hurt myself on purpose without the intent to die			
6. that I have attempted suicide			
7. how many times I have attempted suicide			
8. the method I used to attempt suicide			
9. where I was at when I attempted suicide			
10. the reasons why I attempted suicide			

Appendix B

Family Quality Reaction Scale

The following statements refer to what happened when you told your family and non-family member that you were thinking about hurting yourself or that you had hurt yourself. Please select the degree to which you agree with the following statements.

	Target Family Member			
	Strongly disagree	Somewhat Disagree	Somewhat Agree	Strongly Agree
1. This person's reaction was helpful.	1	2	3	4
2. This person's reaction made me regret telling him or her.	1	2	3	4
3. I felt more comfortable with this person after I told him or her.	1	2	3	4
4. This person's reaction made me feel uncomfortable.	1	2	3	4
5. Since telling him or her about hurting myself or thinking about hurting myself, I now share more information with him or her.	1	2	3	4

Appendix C

Interview Protocol

Project: Phenomenological Exploration of Family Role after Suicide Attempt

Date:

Date of most recent suicide attempt:

Questions:

1. Tell me the story of your (first) suicide attempt.
 - a. What were the events that led up to the attempt?
 - b. What type of treatment did you receive following the attempt?
2. What was your family's role in the experience?
 - a. Who have you told about your experiences?
 - i. Are there people who found out without you telling them?
 - b. How did your family/friends find out about the attempt?
 - c. Are there people you chose not to tell? Why or why not?
 - d. Is there information you chose not to share? Why or why not?
 - e. What was their reaction to the attempt?
 - f. After someone initially had a negative reaction, did you ever try talking to them about it again?
 - i. If so, how did you make the decision to try again?
 - ii. What did you do differently?
 - g. What was your family's role in treatment following the attempt?
 - h. Did your attempt change your relationships with family members? How so?
3. What do you wish could be different about your family's role in the experience?
 - a. Describe your ideal experience for when you family found out about your attempt.
 - b. What did your family do that was helpful following the attempt?
 - c. What did you family do that was not helpful following the attempt?
 - d. Extra Notes:

Distress Interview Prompts:

1. What was it like for you to participate in this interview? Helpful? Uncomfortable?
2. What was challenging?
 - a. Was it challenging to tell your story?
3. What was helpful?
 - a. Was it helpful to tell your story? (Was there anything helpful about telling your story?)
 - b. Do you see any benefit from telling your story?
4. Would you recommend for other attempt survivors to tell their story? Why or why not?

After research is done, is it okay to contact again for follow-up questions?

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PROFESSIONAL POSITIONS HELD

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Student Committee to the Board, American Association of Suicidology, 2013-Present

SCHOLASTIC AND PROFESSIONAL HONORS

Morton M. Silverman Student Award, American Association of Suicidology, 2015

Emerging Scholars Fellowship, Active Minds, 2015

Alice P. Killpatrick Fellowship, University of Kentucky, 2013-2015

Outstanding Student Award, National Council on Family Relations, 2014

Outstanding Graduate Student Paper Award, National Council on Family Relations
Affiliate Council, 2014

Doctoral Student of Excellence, Department of Family Sciences, 2014

Distinguished Student of Excellence, School of Human and Environmental Sciences,
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Alda Henning Graduate Scholarship, 2011-2012

Master's Student of Excellence, Department of Family Studies, 2011

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PROFESSIONAL PUBLICATIONS

Ashurst, K., Smith, L. W., Little, C. A., Frey, L. M., Werner-Wilson, T. A., Stephenson, L., & Werner-Wilson, R. J. (2014). Perceived outcomes of military-extension adventure camps for military personnel & their teenage children. *American Journal of Family Therapy, 42*, 175-189. doi:10.1080/01926187.2013.799975

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