Suicidality Detection in Therapeutic Settings

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Faculty Introduction

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Everrett Moore has carefully and creatively constructed a research proposal that has an excellent chance to make a difference in the lives of people with suicidal ideation. Understanding that, based on coursework he has pursued, it is quite difficult even for professional psychologists to distinguish truth-telling from deception in therapeutic situations, he has proposed a research study that will address this issue. His proposal, in its first stage, is cogently and effectively designed to determine what communication clues therapists might validly use to distinguish the truth from lying in clients who are discussing whether and to what degree they are having thoughts about committing suicide. It then proposes a training program for therapists that would be based on the findings uncovered in the first stage. Everrett's research is thorough and his writing is clear, concise, and convincing.

Abstract

This prospectus attempts to offer an empirical rationale for the study of deception detection in the process of suicide risk assessment in therapeutic settings. Current practices, scales of measurement, and training programs are discussed, as well as shortcomings of each according to the current literature. A three-phase methodology is proposed that will collect qualitative data and cluster them into items that can be quantitatively assessed in order to make more accurate conclusions and improve positive outcomes for mental health service clients. Potential results and implications are also discussed.

Suicide is a major issue within the mental health professions and represents a constant and prevalent struggle during psychotherapeutic practice, often called one of the most challenging issues that a therapist may encounter. Statistics on suicide are harrowing: suicide was the tenth leading cause of death in 2013; 41,149 suicides occurred in the United States in 2013; suicide was the third leading cause of death among persons aged 10-14; and suicide was the third leading cause of death among persons aged 15-34 (Centers for Disease Control, 2015). In light of such data, research into suicidality is critical.

Despite the field of suicidology being so expansive—far too much so for the purview of this prospectus to properly do the field justice—and presenting many different avenues of inquiry, there is no universal and accurate way to detect suicide risk. Unfortunately, many clinicians opt for one of two extreme approaches: an overly cautious "better safe than sorry approach," which can detract from the clinical experience and distract a patient from his/her immediate goals; or an underestimation of suicidal action that can potentially jeopardize the life of the patient and subjects the clinician to legal complications (Bryan & Rudd, 2006, p.185).

The current work is meant to serve as a prelude to determining more effective and universal methods of suicidal risk assessment. In addition, this work will investigate the role of deception within suicidality. A qualitative methodology will be presented with quantitative follow-ups planned, and expected results and implications will be discussed.

Literature Review

Definitions

Suicidology is a large field, which lends itself to diversity in how terms are interpreted and applied. It is important to have a standard nomenclature to use when discussing the highly complex topic of suicidal risk assessment. Thus, this prospectus will be adhering to the standard suicide terminology first proposed by O'Carroll, Berman, Maris, and Moscicki (1996), outlined below:

- **Suicide**: Death from injury, poisoning, or suffocation where there is evidence that the injury was self-inflicted and that the decedent intended to kill himself/herself. The term completed suicide can be used interchangeably with the term suicide.
- **Suicide attempt with injuries**: An action resulting in a nonfatal injury, poisoning, or suffocation where there is evidence that the injury was self-inflicted and that he/she intended at some level to kill himself/herself.
- **Suicide attempt without injuries**: A potentially self-injurious behavior with a non-fatal outcome, for which there is evidence that he/she intended at some level to kill himself/herself.
- **Instrumental suicide-related behavior**: Potentially self-injurious behavior for which there is evidence that the injury was self-inflicted and that he/she intended at some level to kill himself/herself.
- **Suicide threat**: Any interpersonal action, verbal or nonverbal, stopping short of a directly self-harmful act, that a reasonable person would interpret as communicating or suggesting that a suicidal act or other suicidal behavior might occur in the near future.
- **Suicidal ideation**: Any self-reported thoughts of engaging in suicide-related behavior (O'Carroll et al., 1996, pp.246-247).

By using the above terms, the current project adheres to a discipline standard and will be easy to code the behaviors, communicate to other clinicians, and eliminate the potential for damaging or inaccurate vocabulary. Furthermore, these definitions reflect three important elements of suicidal behavior: (1) outcome, (2) evidence of self-infliction, and (3) evidence of intent to die by suicide (Bryan & Rudd, 2006).

Current Methods of Suicide Risk Assessment

Currently, psychologists are split on the use of suicide risk assessment methodologies (Jobes, Jacoby, Cimbolic, & Hustead, 1997). The majority of clinicians rely on clinical interviews, even as they subscribe to the untested and unknown merits of interview-based methods (Jobes, Eyman, & Yufit, 1995). The following paragraphs provide an overview of a selection of suicide risk assesment methodologies.

Clinical interview/Interview-based questions. The most practiced method of assessing suicide risk is through a clinician's own questions during client therapy (Jobes et al., 1995). Bryan and Rudd (2006) outline a hierarchical approach to questioning that is based on empirically demonstrated areas of suicide risk assessment: predisposition to suicidal behavior; identifiable patient precipitant stressors; the patient's symptomatic presentation; presence of hopelessness; nature of suicidal thinking; previous suicidal behavior; impulsivity and self-control; and protective factors.

Of note, Bryan and Rudd (2006) point out the importance in the distinction between implicit and explicit intent when it comes to suicidality as originally seen in Beck and Lester (1976). Explicit intent is what the patient literally says during the interview (e.g. "even though I've considered suicide, I'm not actually going to do anything about it"). Implicit or objective intent is estimated by the patient's current and past behaviors, as well as his or her expressed understanding of the lethality of the chosen method. This distinction is critical to address, as there are often discrepancies between a patient's explicit intent and implicit intent, which a therapist must investigate via continued questioning (Bryan & Rudd, 2006).

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Scales of Assessment

There are numerous scales for measuring suicidal risk, but only a select few have received empirical attention and support. Brown (2002) offers a substantial review of currently logged scales of assessment that cover interview-based scales, patient self-report scales, and clinician observation scales for suicidal ideation, suicidal behavior, and suicidal risk.

Brown (2002) notes that the heterogeneity of these scales is a problem for the generalization of findings, and that most tests lack predictive validity due, in part, to the low base rate of suicidal incidence. Thus, it is difficult to arrive at conclusions about which scales represent best practice.

Current Training Programs

Pisani, Cross, and Gould (2011) conducted an exhaustive review of training workshops used in English speaking countries that address suicide risk and management through a systematic search of popular and scholarly databases. While an exhaustive list is outside of the purview of this prospectus, the three most popular workshops, as gleaned from the number of instructors trained from 2004 to 2009, were "Unlocking Suicidal Secrets," "Assessing and Managing Suicide Risk (AMSR)," and "Suicide: Understanding and Treating the Self-destructive Processes."

These programs were reviewed on the basis of the domains of competence developed by a Substance Abuse and Mental Health Services Administration (SAMSHA)-sponsored panel (Suicide Prevention Resource Center, 2006). The domains covered were attitudes and approach, understanding suicide, collecting accurate assessment information, formulation of risk, treatment and services planning, management of care, documentation, and legal and regulatory issues.

These programs represent the method by which clinicians who lack formal training learn of suicidality and how to manage it (Bongar & Harmatz, 1991). This is something that this project will hopefully address by proposing a training program that specifically focuses on the detection of deception during suicidal risk assessment.

Lack of Focus on Behavioral Cues in Current Assessment Strategies

When it comes to detecting deception, numerous studies have supported the notion that unassisted accuracy is little better than chance (Bond & DePaulo, 2006; Vrij, 2008). These results were supported, even in regards to individuals who have experience with lie detection, such as police officers and clinical psychologists (Bond & DePaulo, 2006). One study even found that clinicians could only match 27% of what their clients left unsaid after a therapy session. These data indicate that, even if there is deception, therapists are not able to discern the nature of, nor contend with, such deception (Hill, Thompson, Cogar, & Denman, 1993). These are troubling findings

given that clinicians are charged with protecting the lives of their suicidal patients, despite the fact that said patients may deceive as to their intent to commit suicide (Bryan & Rudd, 2006).

Highly skilled deception detectors. Though results may not seem promising for deception detection, there is evidence of highly skilled detectors existing, such as secret service officers (Ekman & O'Sullivan, 1991). Ekman, O'Sullivan, and Frank (1999) later found that clinical psychologists, particularly those with motivation to be better deception detectors, could raise their deception detection rates.

Training effectiveness. Of particular note, Ekman et al. (1999) suggests that the motivation, as demonstrated through willing attendance to a deception detection workshop, was a necessary component to becoming a better deception detector, which implies that people who actively attend training on deception detection will become better at said task. Thus, training is a useful tool for addressing the inability of individuals to detect lies. This theory is corroborated by Frank and Feeley (2003) who found that effective lie detection training programs had six essential components: relevance, high stakes, proper training, proper testing, generalizability across situations, and generalizability over time. Any program that attempts to make a better detector of deception must address these issues. If this is to be applied to detecting deception within suicide risk assessment contexts, a successful program will also match these six domains.

High stakes. The distinction between high-stakes lies and low-stakes lies is critical to the field of deception detection. High-stakes lies are those in which the liar recieves severe consequences or gains based on the detection of the lie (e.g. a person lying about a murder can either be caught and face extreme punishment or get away with the lie and avoid punishment). Low-stakes lies are those in which the consequences of detection are not severe (e.g. telling a stranger that your day has been going well when it really has not, does not present any major consequences). Ekman, O'Sullivan, and Frank (1999) note that the key to successful lie detection is the awareness of deceptive cues, commonly described as leakage, which are involuntary microexpressions that deceivers most often demonstrate in particularly high-stakes deception scenarios due to the increased cognitive load

and associated anxiety. The nature of deception detection testing once relied on low-stakes lies, which limited accurate judgements because of limiting the deciver's leakage (Ekman et al., 1999). When testing with high-stakes, deception detection accuracy increases due to the greater incidence of leakage, which affords the lie detector greater accuracy based on the greater amount of evidence of deception. In the context of suicide risk assessment, it is feasible that clients will demonstrate some form of leakage when attempting to deceive about their suicide risk, which a clinician could be trained to notice.

Statement of the Problem

Though the field of suicidology is large and diverse, little empirical evidence has been given to the potential for deception detection when it comes to assessing suicide risk, particularly the examination of behavioral cues that might indicate deception. The current study proposes a methodology that will investigate research questions with serious clinical, and potentially life-saving, implications:

- **Research Question 1:** Are there cues that professional clinicians can rely on that may indicate when clients lie about suicidal risk?

- **Research Question 2:** Is it possible to implement a training program that can successfully prepare clinicians to detect deception in the assessment of client suicide risk?

The above questions serve as a driving force and, with proper empirical study, may offer a new dimension to consider when it comes to making accurate and predictively valid suicide risk assessments.

Methodology

The proposed study will be conducted in three phases.

Phase 1: Qualitative Interviews With Suicide Assessment Experts

The first phase of the study will focus on gathering qualitative data via practicing clinicians. First, a pre-interview will be conducted with three clinicians who have more than 10 years of experience with work in clinical suicidology, have at least one peer-reviewed article or chapter

published within the field of suicidology, and have participated in at least one suicide training workshop. This pre-interview is to prepare selection criteria for the subsequent qualitative interviews.

After completion of the pre-interviews, qualitative interviews will be conducted with clinicians that meet established selection criteria. The interviews will revolve around clinician-reported deception cues that the patient demonstrated.

1. Questions involving current practices for suicide risk
   (e.g. "How do you currently assess suicide risk within your practice?")
2. Potential failings of former trainings
   (e.g. "Based on training programs you have attended, what are some improvements that you would like future trainings to implement")
3. Perceptions of client deception
   (e.g. "Do you expect clients to deceive you in the therapy session")
4. Current methods of suicide treatment will be presented
   (e.g. "What types of behavior do you pay attention to in order to judge whether a client is at high risk for suicide?"; "Can you recall instances in which a client has attempted to deceive you about their suicidality?").

Once the interviews have been completed, phase two of the study will begin.

Phase 2: Coding of Responses

The qualitative data obtained from the interviews conducted by the primary investigator will be clustered into specific groupings (e.g. verbal cues, nonverbal cues, psychological comorbidity, etc.), which will then be validated by three research assistants trained by the primary investigator. These research assistants will then code the interviewees' responses based on the groupings proposed by the primary investigator. Research assistants' coding must achieve a coder agreement response of at least 80%. If this agreement is not reached, clusters will be reevaluated, and the coders will be asked to code the interviewee responses once again. This follows current methodology of grounded coding, in which underlying themes are allowed to emerge from the documents themselves before they are

clustered (Saldana, 2009). These groupings will then be presented to the interviewees in the form of a training program curriculum for their perusal and revision. After revisions are complete, phase three of the study will begin.

Phase 3: Trial of Training Program Curriculum

Post-revision, a deception detection workshop on the matter of suicide assessment will be conducted with practicing clinicians who are invited to attend. The information will be presented, and participants will be asked to complete a seven point, Likert-type survey that addresses the six domains presented by Frank and Feeley (2003): relevance, high stakes, proper training, proper testing, generalizability across situations, and generalizability over time. Items on participant motivation will be present as well.

A follow-up survey will be conducted after three months in which clients will address their satisfaction with the program, whether or not they feel more capable of detecting deception, and if there are any improvements or suggestions that they might have. All participants will be thanked and debriefed, and the study will conclude.

Methods of quantitative assessment will include an initial ANOVA and follow up t-tests, as necessary, on two different elements of the study: clinician self-reported comfort on detecting deception in regards to client suicidality, and clinician evaluation of the training program for detecting deception in regards to suicidality based on the six dimensions from Frank and Feeley (2003). Interactions between these elements will also be examined as warranted.

Potential Results

As evidenced by Ekman and O'Sullivan (1999), I anticipate that clinicians motivated to learn more about deception detection, especially since it is such a stressful and pressing topic, will increase their ability to detect the deception of their suicidal clients. I also think that, given the high stakes nature of suicide, clients will be more likely to demonstrate leakage, which will further aid in deception detection if clinicians are properly trained.

If this training program is proven effective, it could provide an essential step to improving suicide risk detection by adding another essential dimension to projective factors. Given that the current practical advice for potential deception is to simply keep asking until the clinician is satisfied, these findings offer a greater ability to comfortably and accurately detect deception. This could lead to more benefits for the therapeutic alliance and the general well-being of all involved. ■

Bibliography

Beck, A. T. & Lester, D. (1976). Components of suicidal intent in completed and attempted suicides. *Journal of Psychology: Interdisciplinary and Applied*, 92, 35-38.

Bond, C. F. & DePaulo, B. M. (2006). Accuracy of deception judgments. *Personality and Social Psychology Review*, 10(3), 214-234.

Bongar, B. & Harmatz, M. (1991). Clinical psychology graduate education in the study of suicide: Availability, resources, and importance. *Suicide and Life Threatening Behavior*, 21, 231-244.

Brown, G. K. (2002). A review of suicide assessment measures for intervention research with adults and older adults. *National Institute of Mental Health*.

Bryan, C. J. & Rudd, M.D. (2006). Advances in the assessment of suicide risk. *Journal of Clinical Psychology: In Session*, 62(2), 185-200. doi: 10.1002/jclp.20222.

Centers for Disease Control. (2015). Facts at a glance – 2015. Retrieved from https://www.cdc.gov/violenceprevention/pdf/suicide-datasheet-a.pdf.

Ekman, P. & O'Sullivan, M.O. (1991). Who can catch a liar? *American Psychologist*, 46, 913-920.

Ekman, P. & O'Sullivan, M.O., & Frank, M.G. (1999). A few can catch a liar. *Psychological Science*, 10(3), 263-266.

Frank, M. G. & Feeley, T.H. (2003). To catch a liar: Challenges for research in lie detection training. *Journal of Applied Communication Research*, 31(1), 58-75. doi: 10.1080/00909880305377.

Hill, C., Thompson, B., Cogar, M., & Denman, D. (1993). Beneath the surface of long-term therapy: Therapist and client report of their own and each other's covert processes. *Journal of Counseling Psychology*, (40)3, 278- 287.

Jobes, D. A., Eyman, J. R. & Yufit, R. I. (1995). How clinicians assess suicide risk in adolescents and adults. *Crisis Intervention and Time-Limited Treatment*, 2, 1-12.

Jobes, D. A. Jacoby, A. M., Cimbolic, P. & Hustead, L.A.T. (1997). Assessment and treatment of suicidal clients in a university counseling center. *Journal of Counseling Psychology,* 44(4), 368-377. doi: 10.1037/0022-0167.44.4.368.

O'Carroll, P. W., Berman, A., Maris, R. W., & Moscicki, E. K. (1996). Beyond the Tower of Babel: A nomenclature for suicidology, *Suicide and Life Threatening Behavior*, 26, 237-252.

Pisani, A. R., Cross, W. F., & Gould, M. S. (2011). The assessment and management of suicide risk: State of workshop education. *Suicide Life Threat Behavior*, 41(3), 255-276. doi: 10.1111/j.1943-278X.2011.00026.x.

Saldana, J. (2009). *The Coding Manual for Qualitative Researchers*. London: SAGE Publications.

Vrij, A. (2008). *Detecting Lies and Deceit: Pitfalls and Opportunities* (2nd Edition). England: John Wiley and Sons.

Student Biography

Everrett Moore is a psychology major who finished his undergraduate career at Sam Houston State University in May 2017. He served as president of the Elliot T. Bowers Honors College Ambassadors and as a co-chair for the Undergraduate Research Symposium. Although Everrett worked with the Department of Psychology and Philosophy, he relished opportunities to engage in interdisciplinary learning. This interest prompted him to take up minors in Communication Studies and Creative Writing, the former gave him opportunity to work with Dr. Rick Bello. Under Dr. Bello's tutelage, Everrett was able to combine his future career of clinical psychology with a curiosity for communication studies via this project. Everrett will enter the Clinical Psychology doctoral program at the University of North Texas in the fall of 2017.