

Concordance Among Clinician, Patient and Independent Interviewer's Identification of Suicidality in an Adult Outpatient Sample

Ora Nakash, PhD,^{1,2} Maayan Nagar, PhD,¹ and Drew Westen, PhD³

¹ Baruch Ivcher School of Psychology, Interdisciplinary Center (IDC), Herzliya, Israel

² School for Social Work, Smith College, Northampton, Massachusetts, U.S.A.

³ Department of Psychology and Psychiatry, Emory University, Atlanta, Georgia, U.S.A.

ABSTRACT

Background: Accurate identification of suicidal individuals is a complex process among patients seeking mental health services. The purpose of this multi-method multi-informant study was to examine the concordance in identifying the history of suicide attempts and current suicidal ideation among patients, their clinicians and independent interviewers.

Method: A convenience sample of clinicians (N=80) and their adult patients (N=170) who engage in psychotherapy and/or psychopharmacology in community mental health clinics in Israel participated in the study. Patients and clinicians completed a one-item question assessing a lifetime history of suicide attempts (from the Clinical Data Form). Patients also completed the Personality Assessment Inventory to assess current suicidal ideation. An independent interviewer completed a structured diagnostic interview (SCID) including a question assessing current suicidal ideation.

Results: Approximately 18% of patients reported ever attempting suicide, while only 9% were reported by treating clinicians. There were no false positives reported by clinicians. Concordance between treating clinician's and patient's reports on the patient ever attempting suicide revealed a strong positive correlation ($Kappa = .73$). We also found a significantly high correlation between the independent interviewer's and patient's reports of suicidal ideation (Spearman's $r(32) = .66$), indicating moderate to high agreement rates.

Conclusion: Our findings suggest that treating clinicians tend to be conservative in their suicide assessment of their patients. As a result, when they do identify a history of a suicide attempt, they tend to be accurate in their report, yet they also risk under-identification. Clinicians may also fail to ask about this sensitive information and some patients may not reveal information about suicidality to their treating clinicians. Given the complexity of the assessment process for suicidality, triangulating information from multiple sources is recommended. Clinicians should conduct a systematic and explicit suicide risk assessment as well as collect patients' reports using well-validated measures.

INTRODUCTION

Accurate identification of suicidal individuals is a complex process among patients seeking mental health services (1, 2). Patients are not always willing to talk openly about their suicidal ideas or history, and clinicians may not always thoroughly or accurately assess this sensitive topic (3). Other studies have suggested that either the assessment of risk or documentation of the assessment results is not always systematic in mental healthcare settings (4) leading to minimization of risk of suicide (5).

Self-reported measures that include one or more items on suicidal thoughts and/or behaviors and clinical interviews have been the most widely used methods to assess suicidality in clinical practice (4). Using standardized self-report measures and/or structured interview protocols for assessing suicidality result in

more accurate identification of suicidality as they allow for a more complete and systematic assessment of suicidal risk (3, 6). Yet, clinicians usually use the format of unstructured interview to complete suicide assessment (4) that is guided by their clinical experience and intuition, as well as the patient's narrative (4, 7). In the absence of a systematic approach to suicide assessment, clinicians may omit to inquire about specific information related to suicide risk and neglect to identify suicidal ideation and/or behaviors (8, 9).

Despite these limitations, a clinician face-to-face clinical unstructured interview remains the primary standard for assessing suicidal risk in clinical practice. Importantly, little research has been conducted on the concordance between clinician assessment of suicidality and client's self-report. Studies that have been conducted thus far focused on reports of current suicidal ideation and found moderate to high agreement between patients and providers with providers reporting lower rates of suicidal ideation than patients. Suicidal ideation is an enduring vulnerability that is strongly associated with subsequent suicide attempts and suicide death (10). Yigleto et al. (3) conducted secondary analyses of data collected on 68 inpatients treated for mood and anxiety disorders and found that there was 80% agreement between clients' report of current suicidal ideation (based on one item from the Beck Depression Inventory) and clinician assessment of suicidal ideation based on a clinical interview. Similarly, a survey of 125 outpatients attending an anxiety and depression clinic compared endorsement of suicidal ideation in the past week and reported moderate association ($\kappa=.63$) between patient self-report and clinician interview (11). In a different study among outpatients with major depression that compared patient self-report and clinician assessment using structured diagnostic interview, 83.5% agreement rate in current suicidal ideation was documented (12). In a study comparing different forms of interviewing, 30% of inpatients with major depression identified as having current suicidal ideation based on structured research assessment were not recognized when a clinician conducted a clinical interview (6).

Studies conducted in emergency rooms have largely recorded lower concordance rates. In a psychiatric emergency clinic, 62% of patients reported current suicidal ideation on a self-administered questionnaire, while clinicians rated only 37% as suicidal based on clinical interviews (9). Similar lower concordance rates in current suicidal ideation were reported in a study in a Veterans Administration psychiatric emergency clinic

(66% agreement between patient self-report and psychiatrist assessment [13]). We know of no study to date that has examined the patient-clinician concordance in reporting previous suicide attempts. Previous suicide attempt is the single best predictor for future risk and death by suicide (14, 15), and therefore it is an important clinical information to collect.

The purpose of this multi-method multi-informant study was to examine the concordance in identifying a history of suicide attempts between patients and their clinicians in community mental health and outpatient clinics. In addition, we examined the association between patients' report of current suicidal ideation based on a self-report questionnaire and assessment of independent interviewer based on a structured psychiatric interview.

METHOD

PARTICIPANTS

The study was conducted in eight community- and hospital-based mental health clinics located in cities in central Israel and in Jerusalem. All participating clinics offer mental health services (psychotherapy and/or psychopharmacology) to an ethnically and socio-economically diverse adult patient population. A convenience sample of clinicians ($N=80$) and patients ($N=170$) participated in the study. We imposed minimal exclusion criteria for patient participation to maximize generalizability (i.e., actively suicidal and psychotic patients were excluded in compliance with the Ethical Committee recommendation to ensure patient safety). The patients were adult men ($n=69$, 40.6%) and women ($n=101$, 59.4%) over 18 years of age ($M=37.5$, range from 18-70). Patient participants were known reasonably well by the clinician (using a guideline of having a minimum of five clinical contact hours, but less than one year to minimize confounds due to treatment; M months in treatment = 6.0, $SD=4.6$). Participating clinicians ($N=80$) were psychologists ($n=48$), social workers ($n=25$) and psychiatrists ($n=7$) who were licensed clinicians or interns in advanced training (Table 1).

PROCEDURE

We recruited the clinician participants at the clinics through introductory informational meetings. Treating clinicians were encouraged to participate with up to four patients each, maximizing the rate of data collection while maintaining the diversity of the sample ($M=2.13$, $SD=1.27$). Clinicians referred suitable patients. A research coordinator contacted each patient who agreed

Table 1. Sociodemographic and Clinical Information for Patients and Clinicians Participants in the Study

	Patients (n= 170) % (N)	Clinicians (n=80) % (N)
Gender		
Male	40.6% (69)	25.0% (20)
Female	59.4% (101)	75.0% (60)
Age; M(SD)	37.5 (13.7)	41.6 (9.7)
Country of birth		
Israel	75.3% (128)	90.0% (72)
Other	24.1% (41)	8.8% (7)
Relationship status		
Single	43.5% (74)	
With longtime partner, not married	5.3% (9)	
Married	32.9% (56)	
Separated/divorced	15.9% (27)	
Widowed	1.8% (3)	
Education		
Less than 12 years	12.4% (21)	
High school graduate	20.6% (35)	
Certification studies	11.8% (20)	
Some college or technical school	21.8% (37)	
Technical school graduate	4.1% (7)	
College graduate	17.1% (29)	
Some graduate school	4.1% (7)	
Completed graduate school	6.5% (11)	
Currently employed	37.6% (64)	
No	60.0%	
Yes	(102)	
Household income¹		
Primarily student	10.6% (18)	
\$0-1,300	31.2% (53)	
\$1,301-2,600	24.1% (41)	
\$2,601-3,900	15.3% (26)	
\$3,901-5,200	2.9% (5)	
More than \$5,200	7.7% (13)	
Months in treatment with current clinician; M(SD)	6.0 (4.6)	
Number of sessions; M(SD)	16.2 (8.4)	
Discipline		
Psychiatry		8.8% (7)
Psychology		60.0% (48)
Social work		31.3% (25)
Level or expertise		
Licensed		71.3% (57)
Trainee		27.5% (22)
Years of experience post-training; M(SD)		8.7 (10.9)

Note. Numbers do not add up to 100% due to missing data. ¹Mean household income in Israel approximately \$4,000 per month.

clinicians completed informed consent prior to participation. Patient participation included completing a packet of questionnaires assessing demographic, diagnostic and clinical information (including the PAI-SF). Patients were also assessed by an independent interviewer (licensed clinical psychologist) blind to study goals and design. The independent interviewer administered the Structured Clinical Interview for DSM-IV Axis I and Axis II Disorders (SCID-I/P and SOCD-II). Clinician participation was concomitant to patient participation and included completion of measures assessing psychiatric symptoms and clinical information about their patients. Both patients and clinicians were awarded an honorarium of \$50 for their participation. Below we detail the measure included in the current study. For a full description of the study see (16).

MEASURES

Participating clinicians and patients completed the Clinical Data Form (CDF). The CDF includes information on a wide range of demographic, diagnostic and etiological variables. The CDF has been used in multiple studies (17, 18). For the present study, we used questions regarding the patient’s past suicide attempts. Specifically, we used the question: “Has the patient ever attempted suicide?” Response options were “yes” or “no.”

The patient’s suicidal ideation was assessed using the Personality Assessment Inventory-short form (PAI-SF; 19, 20). The complete PAI-SF is composed of 160 items assessing 11 clinical scales and additional treatment and interpersonal scales and subscales which include a scale for current suicidal ideation (SUI) which was used in the current study. The suicidal ideation scale provides assessment of thoughts and ideas related to death and suicide. Items include questions regarding feelings of hopelessness, general and vague thoughts of dying and suicide, and thoughts representing plans for the suicide act. Scores on SUI that range from 60T to 69T suggest a subclinical level of suicidal ideation, i.e., a person who has periodic and transient thoughts about suicide and is pessimistic and unhappy about the future. Scores equal to or greater than 70T represent significant suicidal ideation. The questionnaire also includes three validity scales: infrequency (INF), negative impression (NIM) and positive impression (PIM). Respondents are asked to “Give your own opinion of yourself” by rating every statement on a scale of 0 (not true at all) to 3 (very true). Examples of items include “I’ve recently been thinking about suicide”; “At times I wish I were dead.” Previous

studies have found good psychometric properties to the PAI-SF (19, 21, 22).

We included an additional measure for suicidal ideation as reported by an independent interviewer using the Structured Clinical Interview for DSM-IV Axis I. The SCID (23) is a structured clinical interview designed to assess DSM-IV Axis I and Axis II disorders in psychiatric population studies. The reliability and validity of the procedure are well-established (24, 25). The SCID was conducted by independent expert research interviewers (n=4) who were licensed clinical psychologists. All SCID interviewers were blind to study goals and design. For the current study, we included only information on one item, “recurrent thoughts of death in the previous two weeks” (current suicide ideation) from SCID I (response categories: 1- no, 2 – yes, subclinical level, 3 – yes, symptom exists significantly).

STATISTICAL ANALYSIS

Concordance between raters on categorical variables (suicide attempts as reported by both clinicians and patients) was determined using Cohen’s Kappa statistic. Association between ordinal (SCID assessment of suicidal ideation) and continuous variables (PAI-SF assessment of suicidal ideation) was calculated using Spearman’s rho. We further included measures of sensitivity, specificity and positive predictive value for the associations examined. All analyses were performed using SPSS 25.

RESULTS

Table 2 presents frequencies of suicide attempts and ideation as reported by different informants. Approximately 18% of patients reported ever attempting suicide, while only 9% were reported by treating clinicians. As for suicidal ideation, the independent clinician reported subclinical symptoms for 2.3% (n=4) and significant symptoms existing for 14% (n=24). Suicidal ideation as measured by the patient’s self-report (PAI) was low (mean 2.18 out of 12), with subclinical symptoms reported present for 8.9% (n=10) and significant symptoms for 18.6% (n=21).

Concordance between treating clinician’s and patient’s reports on the patient ever attempting suicide revealed a strong positive correlation ($\kappa = .73$). There were no false positives reported by clinicians (i.e., clinician reporting history of suicide attempts while patients did not report having even attempted suicide), and there was 93.6% agreement between raters (130 patients who did not

Table 2. Patients’ Information Regarding Suicide Ideation and Attempts as Reported by Patients, Treating Clinicians and Independent Clinician

	% (n)
Suicide attempts	
Reported by patient (CDF)	
Yes	17.5% (30)
No	78.4% (134)
Reported by treating clinician (CDF)	
Yes	9.4% (16)
No	85.4% (146)
Suicide ideation	
Reported by patient (PAI-SF SUI);	
mean (SD)	2.18 (3.51)
Range	0 - 12
Subclinical level cut-off; %(n)	8.9% (10)
symptom exists significantly cut-off; %(n)	18.6% (21)
Reported by independent clinician (SCID)¹	
Yes – symptom exists significantly	14.0% (24)
Yes – subclinical level	2.3% (4)
No	15.2% (26)
Was not filled due to irrelevance	60.8% (104)

Note. CDF = Clinical data form; PAI-SF SUI = Personality Assessment Inventory-short form Suicide ideation; SCID = Structured Clinical Interview for DSM-IV Axis I. Numbers do not add up to 100% due to missing data. ¹Question was only filled in for patients screened for major depressive episode by the SCID

attempt suicide, and 16 who did). However, out of the 26 patients who reported ever attempting suicide, 10 were not recognized by their treating clinicians (38.5%).

To further assess the concordance between patients’ reports and clinicians’ reports of patient’s suicide attempts, we examined sensitivity (test how well the clinician identified patients who reported ever attempted suicide), specificity (test how well clinicians identify patients without suicide attempts) and positive predictive value (PPV; probability that patients who were identified by clinicians as ever having attempted suicide self-reported suicide attempts). Sensitivity was 61.5% (95%CI 40.6-79.8%); specificity was 100% (95%CI 97.2-100%); PPV was 100%.

We also examined the association between patient’s reported suicidal ideation (as measured by the PAI SUI scale) and the independent interviewer’s reports of patient’s recurrent thoughts of death. Prior to interpreting PAI results, we inspected missing items (19, 20). According to the manual, if 14 or more items are not answered, the PAI cannot be used. Of note, only 8.8% on the sample had more than 14 or more items not answered. Subsequently, we examined the PAI-A validity scales for elevated scores. According to the PAI manual (19, 20) validity profile of infrequency (INF), negative impression (NIM) and positive impression (PIM) lower than 74T,

83T and 67T, respectively, indicates valid responses for interpretation. Nine participants did not complete the PAI, and an additional six participants had 14 or more missing answers. We excluded an additional 42 participants due to invalidity of PAI profile. All together 57 participants were excluded from analysis when examining suicide ideation. We found significant high correlation between independent clinician's and patient's reporting of current suicide ideation (Spearman's $r(32) = .66, p < .001$) indicating moderate to high agreement rates.

To further assess the concordance between patient's reports of suicidal ideation (as reported by PAI-SF) and interviewer's reports of patient's suicidal ideation (using the SCID), we examined sensitivity (test how well the PAI reports identified cases that were identified by SCID), specificity (test how the PAI identifies patients without suicide ideation) and positive predictive value (PPV; probability that patients who were identified by PAI to have suicide ideation have suicide ideation according to SCID). We first compared the subclinical level of suicidal ideation: sensitivity was 53.3% (95% CI 26.6-78.7%); specificity was 94.1% (95% CI 71.3-99.9%); PPV was 88.9% (95% CI 53.0-98.3%). For significant suicidal ideation, sensitivity was 53.9% (95% CI 25.1-80.8%); specificity was 100% (95% CI 82.4-100%); PPV was 100%.

DISCUSSION

In the current study we examined the concordance in report of previous suicide attempts between patients and their treating clinicians. Our findings show strong correlation between clinicians' and patients' reports of patients' history of suicide attempts. Our findings further show a moderate to high agreement between independent interviewer's assessment of suicidal ideation based on structured diagnostic interview and patient's account based on self-report measure. These findings are consistent with previous studies which documented moderate to high agreement rates in assessment of suicidal ideation between patients and their clinicians (3, 6, 12).

Our findings suggest that clinicians tend to be conservative in their assessment. As a result, when they do identify a history of suicide attempts they tend to be accurate in their report. However, treating clinicians also risk under-identification as manifested in the findings of the current study that document under-reporting of the history of their patients' suicide attempts as compared with the patients' self-report. In our study, clinicians missed more than a third of patients who reported a previ-

ous suicide attempt. The reasons for under-identification should be explored in future research. Clinicians may fail to ask about this sensitive information and some patients may not reveal information about suicidality to their treating clinicians (8, 9). Previous research has documented the importance of clinical judgment in suicide assessment and that it appears to be informed both by concrete risk factors as well as clinicians' emotional responses to suicidal patients (26). These responses can include affiliation, distress and hope (27) and may impact the way the clinician engages or avoids the risk assessment. In addition, patients may feel less comfortable disclosing sensitive information such as suicidality and minimize the frequency and severity of suicidal ideation during clinician ascertained assessment compared to using self-reported questionnaire (12). Some research has documented that patients may feel reluctant to disclose sensitive information regarding suicidal behaviors to their clinicians for fear of being judged (28) as well as perhaps having poor introspective awareness into their implicit suicidality (29).

Overall, our findings are consistent with previous studies demonstrating that clinicians are accurate, yet conservative in reporting significant historical events about their patients such as history of traumatic events (17, 30). Several factors were suggested to explain the gaps in reports of clinical information between patients and clinicians, including avoiding making assumptions without documentation or convincing evidence from the patient; reluctance of patients to expose information they are ashamed of and hesitance of clinicians to inquire about sensitive issues such as suicidality (17).

Our study has several limitations. First, the study included a convenience sample of clinicians and patients. This sampling method may be compromised by selection bias. Second, due to the small number of patients who attempted suicide (either identified by clinicians or self-identified) we could not account for the nested nature of the data. Third, the study included single items assessing previous attempts. Additional research that investigates concordance using more comprehensive risk assessment tools is needed. Fourth, in our study patients were known relatively well by their clinicians. Our study does not address the accuracy of identification of suicidality early in treatment (i.e., intake; 31). Future work should also examine ways in which clinicians can improve the accuracy of self-report measures to assess suicidality (32) as well as ways to increase reliability and validity of self-report measures in clinical settings (1).

CONCLUSION

An important aspect of suicide prevention in mental healthcare settings is an effective suicide risk assessment to guide intervention (33). Suicide risk assessment must consider unique and distinctive patient risk and protective factors for which no evidence base exists. Given the complexity of the assessment process for suicidality, triangulating information from multiple sources is recommended. Clinicians are advised to conduct a systematic assessment of suicidality (including information on suicidal ideation and behaviors). Clinicians should not wait for patients to bring up such information. Instead, they should deliberately and explicitly collect information regarding suicide assessment using structured/semi-structured interviews or well-validated measures (4, 6). Despite its importance, assessment and classification of suicidal ideation and behaviors have been a longtime challenge in clinical practice. The Columbia-Suicide Severity Rating Scale (C-SSRS), which can be used both for screening and in-depth assessment, has received growing support for implementation in the field as it offers improved conceptual uniformity and clinical utility (34, 35). Clinicians' active role in implementing universal suicide screening and continuously monitoring such sensitive clinical information will increase the likelihood of disclosure and reduce the risk of under-reporting and help clinicians to forge the overall safety management and treatment plan for patients at risk for suicide.

Conflict of Interest and Source of Funding

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