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Brief report

Comparison of clinical and research assessments of diagnosis, suicide attempt history and suicidal ideation in major depression

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Abstract

A number of studies have compared clinical diagnostic and suicide assessments to standardized schedules to determine the level of agreement. At best there is only moderate diagnostic agreement, but most often it is fair. There are only a few reports comparing clinical assessments for suicidal behavior with standardized schedules. We present the data from 201 inpatient admissions for major depression that had both clinical diagnostic and suicide evaluations by PGYII resident physicians under supervision from an attending psychiatrist and research evaluations using standardized schedules for diagnosis and suicide by at least masters' level clinicians. There was moderate agreement for diagnosis and suicide attempt history but only fair agreement for the presence of suicidal ideation using Cohen's kappa statistic. In regards to suicide attempt history a cross-tabulation demonstrated that 18.7% of those patients identified by a research schedule as having a past suicide attempt were not identified as such by the clinicians. A cross-tabulation demonstrated that 29.7% of those patients identified by structured interview as having suicidal ideation were not identified as such by the clinician. There was a statistically significant difference in the level of agreement for suicide attempt history between clinical and research assessments for attempts within a year of admission and those beyond a year. These findings suggest the importance of adding a structured diagnostic and suicide assessment to routine clinical care to improve the reliability and validity of clinical evaluations and to inform treatment planning to benefit our patients.

Keywords: Suicidal ideation; Suicide attempt history; Major depression; Clinical assessment; Research assessment; Nosology

1. Objective

Over two decades ago, clinicians were challenged to demonstrate they were not superfluous as diagnosticians (Spitzer, 1983). Since then, reports have compared clinical diagnostic assessments with standardized schedules to determine level of agreement. Studies have focused on children, adolescents and adult outpatients (Basco et al., 2000; Komiti et al., 2001; Kranzler et al., 1995; Shear et al., 2000; Zimmerman and Mattia 1999; Ezpeleta et al., 1997; Jensen and Weisz 2002; Lewczyk et al., 2003; Thienemann 2004), inpatients (Fennig et al., 1996; Kranzler et al., 1995; Miller et al., 2001; Rosenman et al., 1997; Aronen et al., 1993; Steiner et al., 1995), adults transferring from emergency departments to inpatient units (Miller 2001; Taggart et al., 2006) and adult epidemiologic samples (Anthony et al., 1985; Eaton et al., 2000). Studies have assessed psychiatric diagnostic agreement in children and adults from a diagnostic range (Aronen et al., 1993;

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Ezpeleta et al., 1997; Jensen and Weiss 2002; Lewczyk et al., 2003; Steiner et al., 1995; Weinstein et al., 1989; Zimmerman and Mattia 1999), and from restricted number (Basco et al., 2000; Fennig et al., 1996; Komiti et al., 2001; Kranzler et al., 1995; Miller 2001; Miller et al., 2001; Rosenman et al., 1997; Shear et al., 2000; Taggart et al., 2006; Thienemann 2004). Some findings indicate moderate (Anthony et al., 1985; Ezpeleta et al., 1997; Fennig et al., 1996; Komiti et al., 2001; Kranzler et al., 1995; Miller et al., 2001; Taggart et al., 2006), but mostly poor (Aronen et al., 1993; Ezpeleta et al., 1997; Jensen et al., 2002; Komiti et al., 2001; Lewczyk et al., 2003; Miller et al., 2001; Rosenman et al., 1997; Shear et al., 2000) agreement between diagnoses obtained by clinical versus research assessment.

A more critical task is suicide risk assessment. Prospective studies have identified risk factors for suicidal behavior (Oquendo et al., 2006), but no standard clinical suicide assessment exists. Few studies have assessed the utility and accuracy of suicide related rating scales in psychiatric in and outpatients (Beck et al., 1988; Beck et al., 1989; Beck et al., 1979; Brown et al., 2000; Holden and DeLisle 2005; Pinninti et al., 2002; Steer et al., 1993; Steer et al., 1993), and there is sparse literature comparing standardized rating scales for suicidality with clinical assessments. However, clinicians appear to fail to document suicidal behaviors reported by patient self-report or identified by research ratings (Healy et al., 2006; Malone et al., 1995).

Thus, accuracy of clinical diagnostic assessment and suicide risk evaluation, imperative to providing quality and safe care, is sub-par. To address this issue, we determined agreement between clinical and research assessments of diagnosis and suicidal behaviors in inpatients admitted to a research unit. If in fact clinical assessment is less likely to identify high-risk patients or different diagnoses compared to research assessments, then standardized scales in routine care may be useful.

2. Materials and methods

Adult inpatients (N=201) with a major depressive episode (MDE) in the context of major depressive or bipolar disorder based on the Structured Clinical Interview for DSM III-R (Spitzer and Williams 1985) gave written informed consent as approved by the IRB. Postgraduate year II resident physicians (PGYIIs), with attending physician supervision made clinical diagnostic and suicide assessments. Masters or Ph.D. level clinicians performed independent structured diagnostic interviews and suicide assessments within 1–5 days of another. Clinical data were obtained from a retrospective chart review of consecutively admitted patients (October 2002–August 2006).

2.1. Subjects

Women (n=120) and men (n=81) aged 18–72 had a physical examination and routine blood tests, including urine toxicology. Exclusion criteria were current substance or alcohol abuse, or active medical conditions that could confound diagnosis.

2.2. Setting

The inpatient unit is in a tertiary care, university-affiliated medical center. Attending psychiatrists, PGYIIs, nurses, social workers, recreational therapists and mental health therapy aides provide patient care.

2.3. Routine clinical assessment

On admission, patients had a thorough clinical assessment by a PGYII covering chief complaint, history of present illness, current medications, past psychiatric, substance use, physical and sexual abuse, family psychiatric, past medical, family medical, and psychosocial histories, allergies, mental status exam (MSE), multi-axial diagnosis, immediate needs and plan. The standard of care includes an unstructured assessment of current and past suicidal ideation, intent or plan. Attending psychiatrists evaluated patients within 24 h and concurred or amended the PGYIIs' diagnostic and suicide assessment.

Charts were reviewed for documented suicide risk in the "alerts" section. When there was a suicide alert, the MSE was reviewed for current suicidal ideation, intent or plan. If no alert was documented, the chart was not reviewed. Charts were reviewed for admission and discharge diagnoses.

2.4. Research assessment instruments

The International Personality Disorders Examination (Loranger et al., 1994) and SCID-II (Spitzer et al., 1990), the 17-item Hamilton Depression Rating Scale (HDRS-17) (Hamilton 1960), Beck Depression Inventory (BDI) (Beck et al., 1961), and Brief Psychiatric Rating Scale (Overall and Gorham 1962) were used to assess psychopathology. Suicide attempt was defined as a self-destructive act with intent to end one's life. The number, method, and degree of medical damage of suicide attempts were characterized using the