Greater Than "Even Greater" Need?

To the Editor: Eric A. Youngstrom's commentary in the October 2015 issue of the *Journal*[1] highlights the value of assessment standardization demonstrated in Brown and colleagues' excellent article "Detection and Classification of Suicidal Behavior and Nonsuicidal Self-Injury Behavior in Emergency Departments."[2]

The goal of all assessment is to gather reliable and accurate data to guide clinical decisions. Unfortunately, reliability and accuracy of clinician assessment data are reduced by variability in clinician interviewing. Even "calibrated" interviewers using standardized interview guides vary substantially after training and retraining in use of an assessment.[3,4]

Brown et al compared data from "patients' admission notes written in the context of routine clinical care"[2(p1399)] with data collected by "master's- or doctoral-level research staff" using "standardized assessments."[2(p1398)]

Consensus suicide attempt and nonsuicidal self-injury behavior diagnoses were assigned on the basis of the standardized assessments. Overall, the unusually high diagnostic agreement found between unstandardized assessment by clinicians during routine care and standardized assessment by trained research staff interviewers focused on suicidal ideation and behavior (SIB) was attributed to "reliance on clinicians at academic institutions with a culture of excellence in research and evaluation of suicidal ideation and behavior. In the larger context, those findings represent a best-case scenario…."[1(p e1331)]

Still, 18% of patients classified as having made a recent suicide attempt by standardized assessment were not identified as suicide attempters during clinical assessment. In half of these disagreements, clinicians diagnosed nonsuicidal self-injury behavior or other nonattempt behaviors, such as attempt interruption by self or others. In the other half of disagreements, the clinicians missed all suicidal or nonsuicidal self-injury behaviors identified by standardized assessment.

All data in this study on which SIB diagnoses depended were mediated from patients through clinicians or specially trained raters in face-to-face interviews. However, there is another possible medium of communication between patient and clinician. McLuhan's aphorism "The medium is the message" is applicable. Consistent evidence spanning 40 years indicates that standardized patient self-reports identify more suicidal and nonsuicidal self-injury behavior than face-to-face clinician or research staff assessments. Six research groups conducted 7 studies of self-report versus clinician assessment of SIB employing 6 different SIB assessments.[5–11] Three standardized self-report assessments were administered by paper and pencil; 4, by computer interview (3 using text and 1 using interactive voice response). All studies reported greater disclosure of SIB with standardized patient self-report than with clinician face-to-face assessment. This greater sensitivity remained in the 4 studies in which standardized self-report assessment was compared with standardized clinician or research staff assessment.[8–11]

The Catholic confessional has a screen separating priest and penitent. Stigmatized behaviors, sinful or not, are less likely to be disclosed face-to-face than indirectly. *How* patient data are collected matters with regard to sensitive subjects (people and topics). Patients often want clinicians to know about stigmatized thoughts and behaviors that have been completed or, with suicidal ideation and behavior, contemplated, but they have greater difficulty disclosing them directly. Clinicians equipped with standardized patient self-report assessments regarding SIB will provide better care for patients at risk of suicide. Forewarned is forearmed.

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Potential conflicts of interest: **Dr Greist** is a shareholder in Healthcare Technology Systems, Inc, which receives royalties for 1 self-report assessment of suicidal ideation and behavior (the eC-SSRS) studied in 1 published paper referenced in the manuscript; however, this does not seem to be a conflict of interest as the eC-SSRS is only 1 of 6 standardized self-report assessments referenced in publications cited, none of which is specifically recommended in the letter. Further, the eC-SSRS is not mentioned in this letter or in the title of the published article in which it was studied (reference 11).

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