

# Agreement Between Self- and Clinician-Rated Suicidal Symptoms in a Clinical Sample of Young Adults: Explaining Discrepancies

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This study compared self- versus clinician-rated suicide assessment among participants referred for suicidal ideation or behavior, with emphasis on understanding self- versus clinician-rated discrepancies. A total of 328 participants in a suicide-treatment project completed baseline measures of symptoms and personality (including self-report and clinician-rated indexes of suicidality), and portions of the sample completed follow-up assessments at 6, 12, and 18 months. A high rate of discrepancy between self- and clinician ratings of suicidality was noted; the nature of this discrepancy was such that clinicians were likely to see patients as high in suicidality, whereas patients were less likely to see themselves as such. Data on future symptoms indicated that patients' self-ratings contained considerable probative value. Variables such as history of previous attempts and histrionic personality style may help explain self-versus clinician-rated discrepancies.

Discrepancies between self- and clinician-rated suicidal symptoms are distressing in that a false negative may result in death and a false positive may result in unwarranted and extreme measures (e.g., involuntary hospitalization), yet relatively little work has been done on this question. We are aware of seven studies on the topic, which have reached conflicting conclusions. M. L. Kaplan, Asnis, Sanderson, and Keswani (1994) reported high agreement between their own self-report suicide measure and clinicians' ratings. (Eddins & Jobes, 1994, reported generally similar findings.) By contrast, in a study of 252 Israeli military personnel who had requested mental health services, Z. Kaplan, Benbenishty, Waysman, and Solomon (1992) found little correspondence between patients' self-report and clinicians' ratings of suicide risk. Similarly, Bancroft (1979) reported substantial discrepancies between clinicians' and patients' views of reasons underlying the patients' suicidal acts. (Hawton, Cole, O'Grady, & Osborn, 1982, reached similar conclusions.) Coombs, Miller, Alarcon, and Herlihy (1992) studied a group of patients who had seen caregivers in the months preceding a suicide attempt. These researchers noted that few clinicians had probed suicidal symptoms, despite the fact that suicidality was directly disclosed by at least half of the patient sample. Jobes, Jacoby, Cimbalic, and Huestead (1997) found that patients' self-ratings regarding suicidality were more prescient

than clinicians' ratings in terms of classifying patients into "acute resolver" and "chronic nonresolver" treatment-outcome groups.

Clearly, the issue needs more study, with regard to the level of correspondence between the two sources of information and especially with regard to explanations for any discrepancies. Regarding such explanations, two studies implicate personality dimensions related to manipulativeness, aggressiveness, and a dramatic interpersonal style. For example, in Hawton et al.'s (1982) study, whereas patients often attributed suicidal acts to relief seeking or to a genuine intent to die, clinicians tended to attribute suicidality to interpersonal manipulation or punitiveness. Bancroft (1979) reported similar findings.

The purpose of the present study was to compare self- versus clinician-rated suicide assessment in a large sample of participants referred for suicidal ideation or behavior. Emphasis is placed on understanding discrepancies. In the case of participants who claimed suicidality that was unconfirmed by clinicians and in the case of participants who denied suicidality but were seen by clinicians as suicidal, personality traits, test-taking styles, and past and future suicidal symptoms were examined as means to understand discrepancies.

## Method

### Participants

Participants included 328 individuals (269 men, 59 women) who were evaluated at intake before entry into a study on the efficacy of a time-limited, problem-solving treatment for suicidal young adults (Rudd, Rajab, et al., 1996). Participants were referred from two outpatient clinics, a 20-bed inpatient facility, and an emergency room, all affiliated with a major U.S. Army medical center. All patients received rigorous treatment, consisting either of the experimental treatment (i.e., the problem-solving treatment) or control treatment (i.e., treatment as usual, often a combination of crisis management, inpatient hospitalization, and antidepressant medications). Various follow-up data are available for portions of the

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sample; for the present study, follow-up data at 6, 12, and 18 months are reported. As discussed below, attrition from the study was substantial, due in large measure to military reassignments and discharges.

Mean age for the total sample was 22 ( $SD = 2.7$ ) years. The gender distribution (82% men) is common in military medical settings. Most participants were Caucasian ( $n = 198$ , or 60%), 25% were African American, 8% were Hispanic, 2% were Native American, 1% were Asian or Pacific Islander, and the remainder were classified as "other." As expected, mood and anxiety disorders were the most common diagnoses.

## Procedures

Testing and diagnostic interviews at intake and at follow-up were conducted by clinical staff (two licensed doctoral-level psychologists, three licensed master's-level professionals, and one advanced-level doctoral student) before entry into the treatment study. All staff were thoroughly trained and carefully monitored (see Rudd, Rajab, et al., 1996, for more information on procedures).

## Measures

Our main focus was on the relation between a clinician-rated measure of suicidality (i.e., the Modified Scale for Suicidal Ideation [MSSI]) and a self-report index of suicidality (i.e., the Suicide Probability Scale [SPS]), as well as on variables that may affect this relation (e.g., personality). Included measures are described next.

**MSSI** (Miller, Norman, Bishop, & Dow, 1986). The MSSI is an 18-item scale that is a modified version of Beck, Kovacs, and Weissman's (1979) Scale for Suicidal Ideation. The MSSI contains 13 items from the original version, plus 5 new items, and is designed as a semistructured interview to be administered by professionals or paraprofessionals. The MSSI assesses suicidal symptoms over the past year. The first 4 items have been designated as screening items to identify those whose suicidal ideation is severe enough to warrant administration of the entire scale. We administered the entire scale to all participants in the present sample, as most were likely to have experienced clinically significant levels of suicidality (thus their referral to the study). Items cover such topics as wish to die; intensity, frequency, and duration of suicidal ideation; suicide plans; and writing about suicide. Past attempt per se is not factored into scoring.

Each MSSI item was rated on a 0–3-point scale; thus, overall scale scores may range from 0 to 54, with a score of 11 or greater indicating clinical significance. Miller et al. (1986) have reported reliability coefficients (e.g., coefficient  $\alpha = .94$ ) and construct validity data (see also Clum & Yang, 1995).

**SPS** (Cull & Gill, 1989). The SPS is a 36-item, self-report measure of suicidal and related symptoms. The scale provides a total score, as well as scores on four subscales: Hopelessness, Negative Self-Evaluation, Hostility, and Suicidal Ideation. For the present purposes, the Suicidal Ideation subscale was deemed most relevant, although it should be emphasized that a virtually identical pattern of results emerged when the total score was used. Suicidal Ideation subscale items cover such topics as wish for death, thoughts of suicide, and not wanting to go on. The total score and the subscale scores have accrued adequate reliability and validity data. Raw scores for the total and subscale scores are converted to  $T$  scores, with scores of 70 or higher indicative of moderate to severe clinical significance.

**Millon Clinical Multiaxial Inventory (MCMI; Millon, 1983).** The original MCMI is a 175-item, true-false inventory designed for use with psychiatric patients. It contains numerous scales that fall into three main categories: basic personality scales, severe personality patterns, and clinical syndromes.

**Diagnoses.** We assigned current diagnoses using a computerized version of the National Institute of Mental Health Diagnostic Interview Schedule (DIS), the *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed., rev.; American Psychiatric Association, 1987) version (see

Blouin, Perez, & Blouin, 1988, for reliability data on the computerized DIS).

**Psychosocial history.** This form assessed basic demographic information as well as individual and family psychiatric background. Of particular interest in the present context, the form included an estimate of the number of previous suicide attempts for the previous 2 years. Consistent with our previous categorization scheme (Rudd, Joiner, & Rajab, 1996), those who indicated no attempt were assigned a 0 on the attempt variable; those who indicated one attempt, a 1; and those who indicated two or more attempts, a 2.

## Results

Using 11 or above as a cutoff for the MSSI and a  $T$  score of 70 or above as a cutoff for the SPS Suicidal Ideation subscale, we established four categories of patients. As depicted in Figure 1, there were two categories of patients for whom self- and clinician ratings corresponded (Cells A and D) and two categories of patients for whom self- and clinician ratings did not correspond (Cells B and C). It is very important to highlight that Figure 1's proportions, as well as all results reported hereinafter, did not vary in any meaningful way when an SPS cutoff of 60 or above (instead of 70 or above) and an MSSI cutoff of 9 or above (instead of 11 or above) were used; consequently, it appears that our findings were not artifactual of the cutoff score selections.

Some features of Figure 1 deserve emphasis. First, remarkably, there were self-report versus clinician-rated discrepancies on more than half of the sample ( $n = 167$ ; see Cells B and D). Second, among these 167 discrepancies, all but 1 involved the clinician rating the patient as more suicidal than the patient rated him- or herself. This is somewhat reassuring. Within the context of a treatment project for suicidal symptoms, it seems natural that clinicians would liberally assign patients to the above-threshold group. And indeed they did. Clinicians assigned 89% of the sample to the above-threshold categories (Cells C and D), whereas patients self-assigned at a much lower rate (39%; Cells B and D). Third, approximately 11% of the sample viewed themselves, and were viewed by clinicians, as below threshold (Cell A)—a small but not

|                       |                     | SPS Self-Report                                                          |                                                                          |
|-----------------------|---------------------|--------------------------------------------------------------------------|--------------------------------------------------------------------------|
|                       |                     | Below Cut-Off                                                            | At or Above Cut-Off                                                      |
| MSSI Clinician-Rating | Below Cut-Off       | <b>A</b><br>N = 35<br>% Row = 97.2<br>% Column = 17.4<br>% Total = 10.7  | <b>B</b><br>N = 1<br>% Row = 2.8<br>% Column = 0.2<br>% Total = 0.3      |
|                       | At or Above Cut-Off | <b>C</b><br>N = 166<br>% Row = 56.8<br>% Column = 82.6<br>% Total = 50.6 | <b>D</b><br>N = 126<br>% Row = 43.2<br>% Column = 99.8<br>% Total = 38.4 |

Figure 1. Proportions of patients assigned to two categories of self-versus clinician-rated agreement (Cells A and D) and two categories of self- versus clinician-rated disagreement (Cells B and C).  $N = 328$ . SPS = Suicide Probability Scale; MSSI = Modified Scale for Suicidal Ideation.

trivial percentage in light of the fact that patients were referred for suicide treatment.

In summary, approximately half of the participants assigned themselves to the below-cutoff group and were assigned by clinicians to the above-cutoff group. How to understand this discrepancy, and is it possible to say who was right, patients or clinicians?

### Who Was Right?

The design of the larger project, which included assessment of past suicidal behavior, as well as prospective follow-up of future suicidal symptoms, allowed an interesting glimpse of the predictive value, retrospectively and prospectively, of the category assignments depicted in Figure 1. The comparison between Cell C (clinicians rate high, patients rate low) and Cell D (clinicians and patients rate high) is of particular interest, because it contrasts clearly suicidal people (Cell D) with those about whom there is disagreement (Cell C). The comparison between Cell C (clinicians rate high, patients rate low) and Cell A (clinicians and patients rate low) is also of interest, because it contrasts clearly nonsuicidal people (Cell A) with those about whom there is disagreement (Cell C).<sup>1</sup>

*Past history of suicide attempt.* For Cells A, C, and D, we examined previous suicide attempts in two ways. First, we examined the proportions of patients in each cell who had previously attempted suicide one or more times. Second, we examined the proportions of patients in each cell who had previously attempted suicide two or more times, in keeping with the view that "multiple attempters" may represent a different category of suicidal person than "no attempters" and "single attempters" (cf. Rudd, Joiner, & Rajab, 1996).

As seen in Table 1, the percentage of people in Cell A (rated by self and clinician as nonsuicidal) who had one or more previous attempts was 40%; the corresponding figures for Cell C (rated by self as nonsuicidal but by clinicians as suicidal) and Cell D (rated by clinician and self as suicidal) were 61% and 63%, respectively. Using the approach described by Hays (1981, pp. 224–226), we computed 95% confidence intervals (CIs) around each proportion (see Table 1). The CIs around the proportions for Cells C and D (61% and 63%, respectively; 95% CI = .55–.67) include the proportions of 61% and 63% but do not include Cell A's proportion of 40%. The CIs around the proportion for Cell A (40%; 95% CI = .25–.56) do not include Cells C and D's proportions of 61% and 63%. It thus seems reasonable to conclude that the proportions in Cells C and D are similar to one another, and both are significantly different from Cell A's proportion ( $p < .05$ ). In the present context, this finding suggests that the clinicians, not the patients, may have been right: All of those rated by clinicians as suicidal (even those who did not view themselves as such [Cells C and D]) were significantly different from clearly nonsuicidal patients (Cell A) with regard to past suicide attempts; patients who rated themselves as nonsuicidal but whom clinicians rated as suicidal (Cell C) were not different from clearly suicidal patients (Cell D). However, as discussed below, it is premature to conclude that the clinicians' ratings are to be preferred over the self-ratings of patients.

Indeed, with regard to multiple-attempt status, a different picture emerged (see Table 1). The CIs around the proportions for Cells A (nonsuicidal; 6%; 95% CI = .02–.19) and C (discrepant;

15%; 95% CI = .11–.21) included the other proportion but did not include Cell D's proportion of 33%. The CIs around the proportion for Cell D (suicidal; 33%; 95% CI = .25–.40) did not include Cells A and C's proportions of 6% and 15%, respectively. With regard to multiple-attempt status, then, patients, not clinicians, may have been right: Patients who self-rated as nonsuicidal but whom clinicians rated as suicidal (Cell C) were more similar to clearly nonsuicidal patients (Cell A) than to clearly suicidal patients (Cell D).

In one case, preference appeared to go to clinicians' ratings, and in another case, to patients' self-ratings. One could argue that, because attempts were self-reported on a questionnaire form, these analyses were biased against clinicians' ratings (e.g., patients in Cell C may have underreported multiple attempts, just as they may have underreported on the SPS; but see contrary results, described later). Or one might argue that multiple-attempt status is most important (Rudd, Joiner, & Rajab, 1996), and therefore patients' ratings should be preferred. Findings on future suicidal symptoms (as rated by clinicians), reported next, address this quandary.

*Suicidal symptoms at follow-ups.* If clinicians' ratings are to be preferred, there should be no difference between patients in Cells C (discrepant) and D (clearly suicidal) on future clinician ratings because all of these exceeded the clinician cutoff score. On the other hand, if patients' ratings are, in a sense, more accurate, one might expect that patients in Cell C (rated by self as nonsuicidal but by clinicians as suicidal) would experience decreased symptoms over time, even as rated by clinicians, as compared with patients in Cell D (clearly suicidal).

This was in fact the case. As can be seen in Table 2, patients in Cell C (discrepant) were rated by clinicians as significantly less suicidal than patients in Cell D (clearly suicidal). This same pattern held up at 12- and 18-month follow-ups (but with nonsignificant differences).<sup>2</sup>

A similar finding emerged when MSSSI cutoff scores at 6 months were examined. Of those who were categorized in Cell C at baseline (i.e., rated by self as nonsuicidal but by clinicians as suicidal), 86% were rated by clinicians as below the MSSSI cutoff at 6 months. Of those categorized in Cell D at baseline (i.e., clearly suicidal), 71% were rated by clinicians as below the MSSSI cutoff at 6 months. The CIs around each proportion did not include the other proportion (95% CI around 71% of .57–.82 did not include 86%; 95% CI around 86% of .76–.92 did not include 71%). Accordingly, it is reasonable to conclude that by 6-month follow-up, patients who had originally rated themselves as nonsuicidal but who were originally rated by clinicians as suicidal were faring significantly better than counterparts who self-rated and whom clinicians rated as suicidal at baseline. Similar analyses at 12

<sup>1</sup> Two ways in which patients in Cells A, C, and D did not differ were with regard to gender and ethnicity.

<sup>2</sup> Interestingly, patients in Cell C were rated by clinicians as no more (perhaps even less) suicidal over time, even compared with patients in Cell A (clearly nonsuicidal). At follow-ups, the MSSSI means for Cells A and C were 2.84 and 2.20 at 6 months, respectively; 1.77 and 1.75 at 12 months, respectively; and 0.00 and 0.00 at 18 months, respectively. Also of interest, 3 patients engaged in suicidal behavior between baseline and 6-month follow-up, 2 of whom were in Cell D's clearly suicidal group and 1 of whom was in Cell C's discrepant group. There were no suicide attempts in the interval between 6- and 18-month follow-ups.

Table 1

*Proportions of Those With No Previous Suicide Attempt, Those With One Previous Attempt, and Those With Multiple Attempts Among Three Categories of Self- Versus Clinician-Rated Suicidality*

| No. of previous suicide attempts | Cell A (n = 35) |    |         | Cell C (n = 166) |    |         | Cell D (n = 126) |    |         |
|----------------------------------|-----------------|----|---------|------------------|----|---------|------------------|----|---------|
|                                  | n               | %  | 95% CI  | n                | %  | 95% CI  | n                | %  | 95% CI  |
| % with no previous attempt       | 21              | 60 |         | 64               | 39 |         | 47               | 37 |         |
| % with one or more attempts      | 14              | 40 | .25-.56 | 102              | 61 | .55-.67 | 79               | 63 | .55-.67 |
| % with one previous attempt      | 12              | 34 |         | 77               | 46 |         | 38               | 30 |         |
| % with multiple attempts         | 2               | 6  | .02-.19 | 25               | 15 | .11-.21 | 41               | 33 | .25-.40 |

Note. Cell A = not suicidal; Cell C = discrepant; Cell D = suicidal; CI = confidence interval.

and 18 months were not conducted because of attrition-related low sample size.

**Attrition.** Although the findings on follow-up symptoms presented in Table 2 may have been influenced by differential attrition rates, they apparently were not. For each follow-up session, higher, though not statistically different, percentages of patients in Figure 1's Cell C (discrepant) returned than did patients in Figure 1's clearly suicidal group in Cell D (e.g., 43% vs. 39% at 6-month follow-up).

### Test-Taking Style and Personality

Taken as a whole, data presented earlier suggest that patients' self-ratings have merit. MCMI data on test-taking style also supported this view. Specifically, 11 participants provided invalid MCMI profiles. Of these, 1 was a member of Figure 1's Cell A (clearly nonsuicidal), 5 of Cell C (discrepant), and 5 of Cell D (clearly suicidal). Thus, the proportion of invalid MCMI profiles in Cell C (discrepant; 3%) was not significantly higher than that in Cell A (clearly nonsuicidal; 3%) or Cell D (clearly suicidal; 4%). Test-taking style does not appear to be an adequate explanation for the pattern of results.

For personality syndromes, we focused on MCMI indicators that might (a) particularly characterize patients in Cell C, whom others (e.g., clinicians) may see as distressed or impaired but who do not see distress or impairment in themselves, and (b) lead an evaluator to overestimate a patient's symptoms. We reasoned that people with histrionic, paranoid, and antisocial traits may worry a clinician, while simultaneously not depicting themselves as impaired or distressed regarding suicide potential.

The histrionic dimension (MCMI Scale 4) was chosen because of the potential for an accentuated and dramatic interpersonal style

that may overdramatize suicide potential on interview but less so on self-report. The paranoid dimension (MCMI Scale P) was selected because of the possibility for a constricted and suspicious interpersonal style, which may concern clinicians, regardless of the actual, underlying nature of suicide potential. The antisocial dimension (MCMI Scale 6) was chosen because of its association with aggression and inability to delay impulses, which understandably would draw the attention of a clinician conducting a suicide assessment. With regard to all three dimensions, note that we predicted that patients in Cell C, who by definition had relatively low scores on one self-report measure (i.e., SPS), would have relatively higher scores on other self-report indexes (i.e., MCMI Scales 4, P, and 6).

As shown in Table 3, our predictions received some support. We conducted a one-way (Cell C [discrepant] vs. Cell D [clearly suicidal]) multivariate analysis of variance (MANOVA), with MCMI Scales 4, P, and 6 as dependent variables, the results of which are reported in terms of Hotelling's  $T^2$  converted to an exact multivariate  $F$  statistic. The MANOVA produced a significant multivariate effect for group,  $F(3, 278) = 5.55, p < .01$ . In the context of the significant multivariate  $F$ , we examined the univariate  $t$ s for MCMI scales separately. Patients in Cell C (discrepant) obtained higher scores than patients in Cell D (clearly suicidal) on MCMI Scale 4,  $t(280) = 3.62, p < .001$ ; Scale P,  $t(280) = 1.81, p = .072$ ; and Scale 6,  $t(280) = 2.83, p < .01$ , although it should be noted that the difference on MCMI Scale P represented a nonsignificant trend.

Also note that MCMI means for Cell C's participants (the discrepant group), although elevated relative to means for Cell D's participants (the clearly suicidal group), were not clinically elevated in an absolute sense. Interestingly, however, regarding the

Table 2

*MSSI Scores at Follow-Ups Between Two Categories of Self- Versus Clinician-Rated Suicidality*

| Follow-up | Cell C |            | Cell D |            | $t$  | $df$ | $p$   |
|-----------|--------|------------|--------|------------|------|------|-------|
|           | n      | MSSI score | n      | MSSI score |      |      |       |
| 6 months  | 71     | 2.20       | 49     | 7.10       | 3.17 | 118  | <.005 |
| 12 months | 44     | 1.75       | 26     | 4.50       | 1.43 | 68   | .158  |
| 18 months | 23     | 0.00       | 14     | 4.21       | 1.78 | 35   | .084  |

Note. MSSI = Modified Scale for Suicidal Ideation; Cell C = discrepant; Cell D = suicidal.

Table 3  
*MCMI Histrionic, Paranoid, and Antisocial T Score Means  
 Between Two Categories of Self- Versus  
 Clinician-Rated Suicidality*

| MCMI subscale | Cell C<br>( <i>n</i> = 161) | Cell D<br>( <i>n</i> = 121) | <i>t</i> (280) | <i>p</i> |
|---------------|-----------------------------|-----------------------------|----------------|----------|
| Histrionic    |                             |                             | 3.62           | <.001    |
| <i>M</i>      | 57.16                       | 46.56                       |                |          |
| <i>SD</i>     | 25.75                       | 22.29                       |                |          |
| Paranoid      |                             |                             | 1.81           | .072     |
| <i>M</i>      | 60.02                       | 56.78                       |                |          |
| <i>SD</i>     | 14.87                       | 15.06                       |                |          |
| Antisocial    |                             |                             | 2.83           | <.01     |
| <i>M</i>      | 60.21                       | 51.62                       |                |          |
| <i>SD</i>     | 24.24                       | 26.54                       |                |          |

*Note.* MCMI = Millon Clinical Multiaxial Inventory; Cell C = discrepant; Cell D = suicidal.

MCMI histrionic dimension (Scale 4), the proportion of patients in Cell C (discrepant) who met or exceeded the MCMI cutoff for clinical significance (i.e., *T* score of 75) was 26% (42 of 161), significantly higher than the proportion of patients in Cell D (clearly suicidal) who met or exceeded the MCMI cutoff for clinical significance (12%; 14 of 121; 95% CIs around proportions did not include the other proportion). There were no similar differences regarding MCMI Scales P (Paranoid) and 6 (Antisocial).

In summary, regarding test-taking style, it appeared that patients who were rated by clinicians as suicidal but viewed themselves as nonsuicidal were no different from counterparts whom everyone saw as suicidal; regarding personality syndromes, patients in the former group (Figure 1's Cell C, or the discrepant group) were somewhat more histrionic, paranoid, and antisocial than patients in the latter group (Figure 1's Cell D, or the clearly suicidal group). MCMI mean scores were not in the clinical range, but the proportion of clinically histrionic patients was significantly higher in the discrepant group than in the clearly suicidal group.

### Discussion

Using standard cutoff scores on self- and clinician-rated suicide measures among young adults referred for treatment of suicidal symptoms, we found a high rate of discrepancy between self- and clinician ratings of suicidality. The nature of this discrepancy was such that clinicians were very likely to see patients as high in suicidality, whereas patients were less likely to see themselves as such, generating a large number of patients who self-rated as relatively low in suicidality but whom clinicians rated as high in symptoms (see Cell C of Figure 1).

This finding is notable in that discrepancies occurred at a remarkably high rate (approximately 50% of the sample). Perhaps more important, we have provided empirically based explanations for the nature of and reasons for the discrepancies. At a general level, the totality of the findings suggests that clinicians overestimated suicidality. That is, they took an understandable, and probably advisable, better-safe-than-sorry approach. The fact that they were, objectively speaking, too safe, was borne out by the results on future suicidality and attrition; participants in Cell C (clinicians

rate high, patients self-rate low) were very similar to clearly nonsuicidal participants (Cell A; see Footnote 2) in terms of future symptoms and were not as symptomatic over time as their clearly suicidal counterparts (Cell D; see Table 2).

What were the stimuli for clinicians' overrating? First, they may have (again understandably) given considerable weight to the existence of a previous suicide attempt. Among those rated as symptomatic by clinicians, almost two thirds had attempted suicide previously, and this percentage was similar whether patients self-rated as suicidal or not (see Table 2). Regarding multiple-attempt status, however, only patients who also self-rated as suicidal (i.e., the clearly suicidal group; Cell D) differed from other patients. Patients whom clinicians rated as at risk but who rated themselves as relatively low in suicidality (Cell C) were not significantly different on multiple-attempt status from patients whom everyone viewed as low risk (Cell A). On this count, patients, more so than clinicians, may have been attuned to the more probative information. Indeed, had clinicians foregone any suicide assessment, including the MSSI, and instead had asked one question about number of past suicide attempts, they would have been better suited to foretell future suicidality. Just as patients in Cell C (discrepant) were very similar to clearly nonsuicidal patients with regard to future symptoms (see Footnote 2), patients with one suicide attempt were very similar to those with no suicide attempts and substantially different from those with two or more attempts. (Multiple attempters' MSSI scores at follow-ups were significantly higher than single and no attempters' scores; single and no attempters' scores did not significantly differ from one another.) This finding is consistent with the view that people with multiple attempts may be categorically different from others, even others with one suicide attempt (Rudd, Joiner, & Rajab, 1996). The finding also is reminiscent of the well-replicated but perhaps underrecognized (among clinicians) finding that basic actuarial indexes (e.g., number of previous attempts) consistently outperform clinicians' intuitions (Dawes, Faust, & Meehl, 1989; Meehl, 1954).

Second, clinicians may have been influenced by some patients' histrionic personality features. A higher proportion of patients in the discrepant category (Cell C) than in other categories exceeded the MCMI clinical cutpoint for significant histrionic symptoms. It is possible that the interpersonal nature of the MSSI interview may be more susceptible to the influence of histrionic personality features than is self-report (e.g., SPS). It is important to elucidate the clinical implications of these findings and, perhaps even more important, to emphasize what the implications are *not*. We are *not* suggesting that clinicians forego suicide assessment in favor of a self-report questionnaire or in favor of one question about number of previous attempts. Clearly, there are people who score relatively low on a suicide inventory who are nonetheless at risk (cf. Footnote 2). Even more clearly, there are people who have never attempted suicide who are nonetheless at risk, as starkly illustrated by completed suicides among those attempting for the first time. Furthermore, we are *not* suggesting that clinicians ignore suicidal symptoms among histrionic patients. Indeed, there is reason to suspect that quick attention to such symptoms among people with personality pathology may prevent their escalation (cf. Linehan, Armstrong, Suarez, Allmon, & Heard, 1991).

However, we are suggesting that clinicians attend to three things. First, at a general level, patients' own self-report deserves

considerable weight. Unless there are clear reasons to the contrary, self-report regarding suicide potential should be the primary data source. Second, clinicians may consider adjustment of the probative value of a single attempt and of multiple attempts. Single attempts may not be as pernicious an indicator as is commonly believed (although we are *not* suggesting they be ignored), and it could be argued that, on contact with a health professional and regardless of current complaint and situational stressors, people with multiple attempts should be automatically and thoroughly assessed for a broad range of suicide risk factors (e.g., substance use and lack of social support; see Rudd & Joiner, 1998; Stoelb & Chiriboga, 1998). Third, clinicians should attend to patients' histrionic personality features and to the possibility that such features may inflate clinicians' views of risk.

In closing, we note some important considerations regarding this study. Data were collected within the context of a large-scale suicide-treatment project in a military setting. Therefore, findings should be viewed with the knowledge that all participants were specifically referred for suicidality and that the gender ratio in our sample (4.6 men to 1 woman) is not representative of the usual mental health setting. Furthermore, regarding data on future suicidality, it should be considered that all participants had received treatment and that attrition from baseline to follow-ups was substantial. Also, dichotomous ratings (suicidal vs. not suicidal) were used. Whereas such ratings—and the cutoff scores we chose—are used in clinical settings, it is also the case that this approach precludes clinicians from assigning differential risk to a patient who scores at the cutoff versus a patient who scores far above the cutoff. In general, then, caution should be exercised in generalizing to other clinical settings and populations. By the same token, the study is fairly representative of the naturalistic situation, in which a suicidal person, because of being in obvious crisis, elicits some form of professional intervention. The structure of the research project, although perhaps detracting somewhat from the fit to naturalistic situations, nonetheless supplies an interesting glimpse into the nature of clinician-patient discrepancies and provides insight into reasons for discrepancies as well as clinical assessment implications.

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