Author's response to reviews

Title: Particular difficulties faced by GPs with Young adults who will attempt suicide. A cross-sectional study.

Authors:

Nadia Younes (nyounes@ch-versailles.fr)
Christine Chan Chee (c.chan-chee@invs.sante.fr)
Clement Turbelin (turbelin@u707.jussieu.fr)
Thomas Hanslik (hanslikt@gmail.com)
Christine Passerieux (cpasserieux@ch-versailles.fr)
Maria Melchior (maria.melchior@inserm.fr)

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Author's response to reviews: see over
1. The major concern I have with this paper are the definitions of “young adult” and “older adult”. In the second paragraph of the background section, the authors have appropriately alluded to the fact that different commentators define “young” in different ways. However the concern I have is that the authors have biased their writing towards supporting the commentators who would define the upper age of “young adult” as aged 35. For example in the US census data the following age bands are used:

- Under aged 18 • 18-29 years
- 30-44 years
- 45-64 years
- 65 years and over

In Erik Erikson’s widely cited life model young adult is defined as aged 20-40. It is my understanding that the DSM-IV manual revised the upper age limit of “young adult” upwards to aged 45. I cite these examples to encourage the authors to consider internationally how “young adult” is defined and to consider re-categorising and reanalysing the data according to such age bands.

Indeed have the French Sentinel Surveillance database from which the authors retrieved the data categorised the data into aged bands? If so it would appear the most credible option would be to analyse the data according to such categories? Alternatively a credible option could be to use the definitions and age bands used in the French Population Census.

If re-analysing the data is not feasible then I would suggest the authors highlight whether they wrote a research protocol prior to data retrieval. If this was the case then they could reasonably defend themselves against criticism of data dredging. If a research protocol was not written a priori then the authors must report that they have undertaken a post-hoc analysis of the data and consider applying a more rigorous statistical test of significance (eg. Bonferroni corrections).

We thank the reviewer for this comment which helps us precise a central point and agree that the age bands are problematic since there is no consensus (in both upper and topper age limits).

The French Population Census is not useful as it distinguishes the following groups: >20 years, 20-59 years and >60 years.

As suggested by the reviewer, we decided to use Erik Erikson’s life models, to consider young adulthood in a developmental perspective (Erikson E: Childhood and Society. New York; 1950). The upper limit of 39 years old was also used by Daniel Levinson’s life model (Levinson D, Darrow CN, Klein EB, Levinson, M.: Seasons of a Man's Life. New York; 1978). This age band was also consistent with the previous Finish paper comparing adolescents, young adult and older suicide attempters (Suominen K, Isometsa E, Martunnen M, Ostamo A, Lonnqvist J. Health care contacts before and after attempted suicide among adolescent and young adult versus older suicide attempters. Psychol Med. 2004 Feb;34(2):313-21).

We conducted new statistical analyses with following age bands: 18-39 years and 40 and above. The results were consistent with those we originally reported with the age band ranging from 18 to 34 years, which were constructed prior to our statistical analyses.

We introduced the following changes in the manuscript:

- In the Introduction section, we added an explanation of Erikson’s and Levinson’s models to justify our choice of age bands:

  In the present investigation, we considered young adults ages 18 to 39, following Erik Erikson’s widely cited life model and Daniel Levinson’s model, to consider young adulthood in a developmental perspective [14] [15]

- All presentations of the age bands and results were modified in the manuscript (Abstract, Background, Analysis, Results, Table 1)
2. On page 10 the authors conclude that their findings contradict those of a large study of suicide attempters in Finland. The authors need to report whether the Finnish researchers used different definitions of "young adult" and "older adult" since the obvious explanation for the contradiction is a difference in case definition.

Our new age bands now meet those chosen by the Finnish study: 15-24, 25-39, 40 and above. Thus, case definition does not explain the difference between our findings and the Finnish study. In the revised version of our manuscript, we detail the Finnish study to explain this inconsistency (p 10).

"This finding is contradictory with that of a large study in Finland conducted among suicide attempters treated in general hospitals, which found no major differences between the three age-groups (15-24, 25-39 or 40 and above) before the attempt in treatment contacts (without data on contacts with private health care providers) [13]. The difference in the settings (our data considered primary care suicide attempters) can explain the discrepancies between the two studies."

Reviewer 2:

1. The main query I would have with the data is that the reason for attending the GP is not documented. This may affect the results, in that consultations for mental health are more likely to lead to disclosure of psychological distress than those for, eg, urti or contraception.

   We agree that this is a real limitation of the study. Unfortunately, this information was not collected from GPs, we note it for the next change to the Sentinelle report). For the moment, we add this limitation at the end of our discussion section with the following sentence (p 9):

   "We were also not able to consider the reason for attending the GP which may have affected the results: consultations for mental health are more likely to lead to disclosure of psychological distress than those for a somatic reason."

2. This study uses GP reports that are collected after the suicide attempt and are self-reported by the GP. This could lead to bias in the results as the GP will have knowledge of the suicide attempt at the time of documentation.

   We totally agree with this comment. We discussed this limitation in the previous version (“Information provided by GPs may have been biased by their awareness of their patient’s recent suicide attempt”). In the revised version, we replace our expression by the reviewer’s as it seems clearer (p 9).

   "Information provided by GPs may have been biased as the GP had knowledge of the suicide attempt at the time of documentation."

3. The conclusion that GP’s are less active when diagnosing & treating depression in young adults is overstated. The data collects treatment data within the past 3 months, however for young adults, a significant proportion were not seen in the previous 6 months to the suicide attempt. This suggests that young adults do not consult for mental health problems or that the suicidal attempts are more opportunistic compared to older adults. The longer gap between being seen by the GP and attempting suicide may mean that the patient was not depressed, or as severely depressed at the time of seeing the GP, making risk of suicide difficult to detect.

   We thank the reviewer for helpful comments.

   - First, we changed our conclusion section to be more nuanced about results and to highlight the main results: fewer consultations in the preceding 6 months, less identification of depressive symptoms in the preceding year and less active management in the preceding three months.

   With young adults who subsequently attempt suicide, GPs face particular difficulties compared to older adults: a significant proportion of young adults were not seen in primary care in the previous 6 months, GPs identified less depressions in the preceding year and were less active in managing in the preceding three months. Suicidal attempts could also be more opportunistic than in older adults. On the other hand, medical training, continuing medical education and collaborative care should include better instruction about challenges in identifying and addressing the mental health needs of young adults, which has been considered as "a new frontier in the health and social policy of the 21st century" [54]. Future research on this specific population in primary care should be conducted.

   - Second, in the limitation section, we insisted on information collected at different times (p 9):

   "Finally, the interpretation of results should take into account that information was collected at different times as GP were instructed to report data about the last consultation (time and suicidal ideas expression) (even if it was more than 6 months before), about their recognition of depression or psychological difficulties in the last year and about their management in the three months preceding the suicide attempt."
- Finally, we changed the title of the article to match our results:

"PARTICULAR DIFFICULTIES FACED BY GPS WITH YOUNG ADULTS WHO WILL ATTEMPT SUICIDE. A CROSS-SECTIONAL STUDY".

4. The second sentence in the conclusions states that GP's identified fewer psychological difficulties in younger adults but this is not shown in the results. They authors state that there was no significant difference between recognition of psychological distress, but there was in diagnosis of depression.

   Our first conclusion about results regarding the identification of psychological difficulties and depression was wrong (results and discussion were corrected accordingly). We changed our conclusion in this way, as indicated above.

   « With young adults who subsequently attempt suicide, GPs face particular difficulties compared to older adults, as a significant proportion of young adults were not seen in the previous 6 months, as GPs identify less depression in the preceding year ……». 