Author’s response to reviews

Title: Broad and narrow personality traits as markers of one-time and repeated suicide attempts: a population-based study

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Author’s response to reviews: see over
Dear Madame or Sir;

We would like to thank you for considering our manuscript for publication in BMC Psychiatry. We also thank the reviewer for his valuable comments. We have revised our original submission, entitled “Broad and Narrow Personality Traits as Markers of One-time and Repeated Suicide Attempts,” in light of the reviewer’s comments. Changes are detailed below.

We look forward to hearing from you. Yours sincerely,

Jelena Brezo

Reviewer Comments

1. PAGE 4 “Qualitative“ differences referred to on page 4 may have many different meanings to different readers and the authors should be more specific about their meaning of this term in the current analyses.

Thank you for calling our attention to this important point. We have now defined more clearly what we meant by ‘qualitative’ and ‘quantitative’ differences in the last paragraph on page 4: “We operationalized qualitative differences as those encompassing traits that are dysregulated in selected subgroups of suicide attempters; Quantitative differences, on the other hand, would pertain to traits that are dysregulated across suicide attempter subgroups although, possibly, to a somewhat different extent.”

2. Page 5, more information about sample loss including the numbers excluded for the various listed reasons. A weighted analysis is done to account for missing data based on SES and gender but the reader is unaware of whether any other characteristics were related to attrition.

More detailed information on sample loss is now available on page 5: “The remainder [of the sample] provided incomplete questionnaire data (n=59); were disabled or died by suicide or from other causes (n=13); could not be (n=12) or were never contacted (n=11); could not be traced (n=99); refused to participate (n=196); lived in a remote area (18); or were missing for unknown reasons (n=498).”

We limited our comparison of the two groups to SES and gender because they were the only baseline variables available for all respondents participating in the study. These findings are consistent with other longitudinal studies that identify male gender and socioeconomic disadvantage as correlates of sample attrition (see, for example, Spoth R, Goldberg C, Redmond C. Engaging families in longitudinal preventive intervention research: discrete-time survival analysis of socioeconomic and social-emotional risk factors. J Consult Clin Psychol. 1999 Feb;67(1):157-63).
2. Given the emphasis on measures of trauma, why hasn’t PTSD included as a psychiatric diagnosis of interest?

This decision was based on our previous research. In an earlier paper,* where we focused on suicide attempters as a group, we found that PTSD had a comparable distribution between suicide attempters and nonattempters. On the other hand, childhood sexual abuse showed marked differences between the two groups.


3. More details are needed to understand the three-level variable definitions of suicide attempt status. Does this variable include self-harm behavior without intent to die? Does the DISC2 have a screening question for depression that may have omitted subjects who are not feeling depressed yet may have suicidal behavior? These details are also needed because of the questionable psychometric properties of the suicidal intent and ideation scales.

The reviewer shares our concern regarding the somewhat low psychometric indices of the suicidal intent and ideation scales. This was in fact one of the reasons behind our decision to assess suicidality using multiple measures, as detailed below and on page 9 of our manuscript. Furthermore, this approach allowed us to assess suicidality also in childhood/adolescence, giving us an opportunity to understand its longitudinal course.

As for the reviewer’s first question, for the most part, i.e., except when we used parental information on suicide attempts in respondents as adolescents, we relied on self-assessed suicide attempts. Unfortunately, we were unable to differentiate self-harm from serious suicide attempts because suicidal intent was assessed only in adulthood. However, we still believe our assessment to be of value given that self-harmful behaviors appear to have higher risk for suicidal behaviors (e.g. Stanley, Winchel, Molcho, Simeon, and Stanley, 1992; Kapur N, Cooper J, King-Hele S, Webb R, Lawlor M, Rodway C, Appleby L, 2006).

In response to the reviewer’s second comment, the DISC2 scale did not allow us to assess suicidality while controlling for depressive symptoms. However, we have overcome this problem by adjusting for the possible confounding of childhood mood diagnosis in our multivariate analyses (Please refer to Tables 2 & 3).

Third, as suggested by the reviewer, we have provided additional information on our response variable. The section now reads (page 9):

Suicide Attempts (Lifetime)
A three-level outcome variable, classifying individuals into non-attempters, one-time and multiple suicide attempters, was created using information extracted from several scales and at two assessment waves:
i) Early Adulthood:
- “Have you already attempted suicide?” (Suicidal Intent Scale)
- “How many attempts have you made prior to the one in question?” (Suicidal Intent Scale)
ii) Midadolescence
The presence and frequency of suicide attempts over lifetime and six-months were assessed using parental and adolescent responses to three questions originating in DISC-2 scales, designed to screen for depressive symptomatology:
- “Have you already attempted suicide?”
- “How many times?”
- “Have you attempted suicide during the last 6 months?”
4. The version of the Barratt Impulsiveness Scale utilized should be included.

We thank the reviewer for pointing out this omission. This information is now provided on page 8, section 4b.

5. Discretionary Revisions: Is the relationship between compulsivity and attempter status explained because this broad trait captures aspects of perfectionism that is known to be related to suicide ideation and behavior?

We agree with the reviewer that perfectionism may be mediating the relationship between compulsive tendencies and repeated suicide attempts. In the discussion, we also suspected the involvement of cognitive rigidity and impaired decision-making, possible correlates of the three types of perfectionism. As the latter were not measured directly by the scales of rejection and compulsivity contributing to the Compulsivity factor, which, furthermore, consists only of their shared variance, disentangling their individual contributions will likely require more research.