Author’s response to reviews

Title: War-related psychological sequelae among emergency department patients in the former Republic of Yugoslavia

Authors:

Brett D Nelson BA (bnelso1@jhmi.edu)
Dr William G Fernandez MD, MPH (william.fernandez@bmc.org)
Dr Sandro Galea MD, DrPH (sgalea@nyam.org)
Sarah Sisco MPH, MSSW (ssisco@nyam.org)
Kerry Dierberg BS (kdierbe1@jhmi.edu)
Gordana SUBARIC Gorgieva MD, PhD (ssisco@nyam.org)
Arijit K Nandi BS (akn2005@columbia.edu)
Jennifer Ahern MPH (jahern@nyam.org)
Mihajlo Mitrovic[double dagger] MD (bnelso1@jhmi.edu)
Michael VanRooyen MD, MPH (mvanrooy@jhmi.edu)
David Vlahov PhD (dvlahov@nyam.org)

Version: 2 Date: 20 Feb 2004

PDF covering letter
20 February 2004

Dr Christopher Gadd
Assistant Editor, BMC Journals
Middlesex House
34-42 Cleveland Street
LONDON
W1T 4LB
UNITED KINGDOM

Dr. Gadd,

Thank you for the opportunity to have our manuscript considered for publication in your journal. We have reformatted the manuscript to conform with the BMC guidelines, and have also edited the paper as per the reviewers’ comments. A detailed response to each of the reviewers’ comments follow:

Responding to the first reviewer’s comments,

We appreciate Dr. Sondergaard’s editorial comments, and have deleted the wrong use of the term “leading” as well as the duplicate statement “from Kosovo” from the second sentence in the Introduction. It now reads, “…which led to the forced mass expulsion of thousands of ethnic Albanians from Kosovo” (page 3) We have also corrected our statement regarding the number of Serbs that fled the province after the war, to agree with subsequent statistics: “Fearing retaliation from ethnic Albanians, thousands of Kosovar Serbs fled the province…” (page 3)

In terms of the prevalence PTSD symptoms co-existing with depression, we found that 66 (11.9%) of the respondents had both PTSD as well as depression. Due to the fact that the comorbidity between PTSD and depression was so high, the predictors were essentially the same. We have adjusted the results section to reflect this additional data: “Overall, 66 respondents had symptoms of both PTSD and depression (11.9%). Due to the high degree of comorbidity between PTSD and depression, the predictors were extremely similar to that of PTSD alone…… The multivariate predictors of having both disorders were: being a refugee for longer than 30 days (OR = 4.1, 95% CI: 1.6, 10.6) and living in remote Laplje Selo (OR = 6.5, 95% CI: 1.4, 29.9),” (page 10). We have also included a small additional paragraph regarding coexisting PTSD and depression into the discussion section: “We found a high degree of participants with PTSD symptoms that were comorbid with depression. A number of other investigators have found PTSD coexisting with depression in the post-war setting. [50-53] PTSD commonly co-occurs with other psychiatric disorders, particularly with major depression. These co-existing entities are often difficult to distinguish by clinicians, which leads to difficulties in diagnosis, and may be harder to manage than PTSD or depression alone.” [54] (page 12-...
13). The corresponding citations have been included (reference # 50-54). I have also added a sentence to reflect the comorbidity data in the Abstract. (page 2).

Responding to the second reviewer’s comments:

We appreciate Dr. Kozaric-Kovacic’s editorial comments. We agree that the introduction section may have been somewhat lengthy for some readers. To provide the relevant background for readers unfamiliar with the recent conflicts in the Balkans, my colleagues and I attempted to summarize some key events into the first two paragraphs. The third and fourth paragraphs provided the clinical basis for the study (i.e. to answer the “So what?” question). Finally, the fifth paragraph outlines the specific aims of the study. In order to make the paper easier to follow, we will do the following: first, we will subdivide the introduction section into three parts, the **Historical Background** subsection (page 3) will contain the first two paragraphs; the second two paragraphs will be called the **Clinical Relevance** subsection (page 4), and finally the fifth paragraph will be called the **Study Objectives** subsection (page 5).

As described in our **Methods** section (page 5), the study was conducted in two emergency care settings: Belgrade University’s Clinical Center of Serbia, one the leading teaching hospital in Serbia. The other site, Laplje Selo District Hospital, is a small, remote community hospital providing basic medical support for the Serbian enclave in the area. The authors had a particular interest in conduct this study on mental health in a clinical setting. Dr Kozaric-Kovacic is entirely correct in stating that disorders such as PTSD and major depression are not generally viewed as the purview of emergency medicine. However, as is the case in many countries in Europe and North America, a high prevalence of primary mental health problems exist in the medical setting, but are sadly overlooked. People with vague, somatic complaints often will be found to have occult mental health dysfunction. Often, the emergency department setting serves two specific purposes: first, to treat patients that are acutely ill or injured, and second to treat the ailments of those patients with non-acute conditions. Due to a variety of factors, emergency department providers are called upon to evaluate many patients who do not present with what most physicians consider a “real emergency”. A study cited in this manuscript (DL Schriger, et al, Ann Emerg Med 2001 Feb 37(2): 132-40) suggests that up to 42% of patients presenting with “somatic” complaints to an emergency department in Los Angeles, California, were screened with a computerized mental health assessment tool, and had symptoms of a primary mental health disorder. The key point is that many mental health problems are missed—and left untreated—by our contemporaries in the emergency department setting. We feel that there is an important role for screening in the medical care setting, and referral to appropriate mental health treatment. In this study of emergency department patients presenting with “routine” medical complaints, we wanted to assess the prevalence of symptoms consistent with PTSD and major depression in light of the recent conflict.

Dr Kozaric-Kovacic correctly points out that although the Harvard Trauma Questionnaire (HTQ) and the Center for Epidemiologic Studies-Depression (CESD) instruments have
been used extensively, there is rather limited data on their use in this area of the Balkans. Prior to this study, a version of this instrument had been used by investigators at the Centers for Disease Control and Prevention (Lopes Cardozo et al, JAMA 2000, 284(5):569-77) on a population-based study of post-war mental health dysfunction among ethnic Albanians in Kosovo shortly after the end of hostilities. Two years later, we conducted a study (Fernandez et al, Ann Emerg Med. 2004 Feb;43(2):E1-8) using the HTQ to evaluate persistent war-related PTSD symptoms among ethnic Albanian emergency department patients two years after the conflict. Unfortunately, there is a dearth of population-based research at present using the HTQ instrument in Serbia. Also, the CESD instrument has not been used in Serbia until recently. It was developed by researchers at the National Institute of Mental Health in the US as a standardized depression screening instrument in the 1970’s. It has been widely used in North America. It has also been extensively used as a screening device by mental health researchers in the UK, France, Italy, Greece, South America, the Middle East, and in Asia. We have cited the lack of benchmark normative data in Serbia as one of the limitations to our work in the closing paragraphs of the Discussion section just prior to the Conclusion section. To clarify this, we will include the relevant discussion of our shortcomings under a Limitations subsection (page 11).

We apologize for omitting the fact that this study was conducted as a self-reported questionnaire. Consequently, research assistants—trained by the investigators—approached potential participants, obtained informed consent, and then had the participants complete the surveys themselves. It was the same approach we used in our work a year earlier in an emergency department in Pristina, Kosovo (Ann Emerg Med. 2004 Feb;43(2):E1-8). To clarify this, we will add the following to the Study Design subsection (page 5), “This project was designed as a cross-sectional, self-administered questionnaire study…..”. To the Method of Measurement subsection (page 6), we will modify the first sentence to read, “The structured self-administered survey contained questions…..”. Furthermore, we will add the following to the first line of the Selection of Participants subsection (page 6): “After receiving several hours of training in survey-based research techniques and human subjects protection by the investigators, research staff approached stable patients waiting to be seen in the ED”. Also, the statement, “In the case of visual impairment or illiteracy, research staff were instructed to read survey questions aloud, and mark down participants’ answers;” will be added to this subsection (page 6).

In terms of whether the psychopathology reported in the participants arose as a consequence of war-related or other triggers, the questions on the survey instruments themselves asked specifically about war-related mental health sequelae. To clarify matters, we will modify the sentence: “Briefly, respondents are asked to indicate their direct exposure to a list of traumatic experiences (Criteria A)” to read: “Briefly, respondents are asked to indicate their direct exposure to a list of traumatic experiences associated with the 1999 NATO campaign in Serbia (Criteria A)” (page 7).
I should mention two minor changes in the manuscript worth mentioning:

1) Brett Nelson has a Bachelor of Art’s (BA) degree, not a Bachelor of Science (BS) degree. I have changed the manuscript to reflect this (page 1).

2) The article by Fernandez et al (reference #15) can now be cited as:


Thank you again for your careful review. My colleagues and I believe that this manuscript will be a much better article for your editorial efforts.

Best,

William G. Fernandez, MD, MPH
Assistant Professor
Department of Emergency Medicine
Boston Medical Center
One Boston Medical Center Plaza
Dowling 1 South
Boston, MA 02118
U.S.A.
Office: 617.414.4927
Fax: 617.414.7759
Email: William.Fernandez@BMC.org