Letters to the Editor

Predictors of Suicide Attempt in Early-Onset Psychosis: Methodological Issues and Concerns

To the Editor: With reference to the recent article by Sanchez-Gistau et al,1 we wish to discuss a few methodological issues and concerns not previously discussed regarding the study limitations.

Our first issue regards the suitability of some instruments (Positive and Negative Syndrome Scale [PANSS], Hamilton Depression Rating Scale [HDRS]) for the study sample (aged 9–17 years) in view of their questionable or unknown validity in child and adolescent populations. The authors have not commented on this; however, the cross-referenced parent study indicates that adult scales were used for adolescent patients to act as a baseline on this; however, the cross-referenced parent study indicates that adult scales were used for adolescent patients to act as a baseline in their longitudinal cohort study.2 However, in the absence of validity, their use in a younger population at least for the purpose of present study does not seem to be justifiable. Instead, the assessments might have been done using the Kiddie-PANSS3 for psychotic symptoms, Children’s Depression Rating Scale4 for depressive symptoms, or other age-appropriate instruments. An additional limitation is that the Schedule for Affective Disorders and Schizophrenia for School-Age Children-Present and Lifetime Version (K-SADS-PL) was simply translated into Spanish and not validated further for use.

Second, there were only 3 assessments in total, viz, baseline, 1-year, and 2-year (T0, T1, and T2), which appear to be too infrequent for a study with suicidality as a primary outcome. The intervening 1-year period was accounted for by only a single question (“Have you attempted suicide since the last visit?”). The use of repeated measures (eg, 3- or 6-monthly) and corroboration from family members or clinical records might have increased the robustness. Third, more than 80% of the sample was recruited from hospitalized patients, which indicates a sample that has a higher severity of illness at baseline, thereby influencing the generalizability of results.

Fourth, the reported scores on the Hollingshead-Redlich Scale (2.6 ± 1.2; see Table 1 in the article) appear to be inexplicable, as the minimum possible score on this scale is 11: both factors of this scale are assessed on a Likert scale from 1 to 7 and then their weighted values (×7 for “occupation” and ×4 for “education”) are summed, giving a possible range from 11 to 77.5 This standard scoring has been widely used in other scientific studies.6

From a statistical perspective, a few points need to be mentioned. The confidence intervals for each of the 3 variables for which logistic regression analysis showed significant differences (see Table 2 in the article) are quite wide, pointing to a large standard error. In the multivariate model, there is no mention of correction of P values, which could have been adjusted using Bonferroni or Šidák correction. Finally, there were too few positive observations (n = 10) in the dichotomous dependent variable; hence, the findings of regression analysis should be treated as exploratory and need replication in future studies.

Indeed, the study adds to the limited literature on suicidality in early-onset psychosis, and the findings are of clinical and public health significance. However, these findings should be interpreted in the light of the methodological limitations summarized above.

References


Vaibhav Patil, MD
Raman Deep Pattanayak, MD
ddrmandeep@gmail.com
Ashwani Kumar Mishra, PhD

Author affiliations: Department of Psychiatry and National Drug Dependence Treatment Centre, All India Institute of Medical Sciences (AIIMS), New Delhi, India. Potential conflicts of interest: None reported. Funding/support: None reported.

© 2013 Copyright Physicians Postgraduate Press, Inc. Not for distribution, display, or commercial purposes.