predicted response, rather than randomisation. Bias can then be minimised by propensity score matching\(^2\) (controlling for unmeasured bias between study groups), although this method was not employed by Kessing et al.


Authors’ reply: We certainly agree on the mentioned advantages and disadvantages of observational studies and on the strengths of combining findings from randomised trials with those of observational studies.

Further, we agree on the possibility of the suggested analyses with ‘switch to’ and ‘add on’ as two separate outcomes. We chose the combined outcome measure as using two separate outcome measures (in addition to hospitalisation as an outcome measure) would decrease the statistical power to a low level in some of the analyses. In addition, one of the advantages of using the combined outcome measure is that the results may turn out to be more clear to guide clinical decisions on whether to use lithium or valproate in long-term treatment of bipolar disorder following a number of clinical situations (depression, mania, mixed episode or remission).

Propensity score matching (or other ways of introducing propensity score in the analysis\(^3\)) is a viable alternative to the approach based on multiple Cox regression models used in our paper. However, much experience (e.g. Sturmer et al\(^4\)) suggests that the results thus obtained would not tend to be substantially different. The limiting factor seems to be the available amount of covariate information.


Role of postcards in reducing suicidal behaviour

The article by Hassanian-Moghaddam et al\(^5\) provides useful insights into the potential utility of postcard intervention in reducing suicidal behaviour. The authors by virtue of this study have found that among participants who had self-poisoned, nine postcards sent sequentially over a period of 12 months produced reduction in suicidal ideation and suicide attempts. The study deserves accolades for various reasons, including a large sample from a non-Western population and a randomised control design, ensuring an over 90% retention rate and nearly equal rates of loss to follow-up in both groups. The results of the study are illuminating but their generalisability and applicability in day-to-day clinical practice needs to be analysed against the backdrop of following limitations.

(a) The study provided for assessment of outcomes only at 12 months. It would have been better if the assessments were performed more frequently such as once in 2 or 3 months.

(b) The study at no point assessed suicidal intent among participants.

(c) Instead of employing any standard sampling technique, the participants of the study included consecutive individuals with poisoning, admitted from March to June 2006 in the Loghman-Hakim Poison Hospital.

(d) Baseline assessment did not include a comprehensive psychiatric evaluation that could have ascertained the specific psychiatric diagnosis of the participants and permitted subgrouping of the participants based on psychiatric diagnosis, thereby providing a valuable opportunity to study the differential impact of postcard intervention in reducing suicidal ideation and suicidal attempt among the participants with different psychiatric disorders.

(e) There is no mention in the article of whether the delivery of the postcards was confirmed by the recipients.

(f) The participants were masked to study outcomes but the research psychologist was not masked to allocation, and this could have inadvertently influenced responses at follow-up.

(g) Individuals may have got some clue about the study outcomes from the questions asked of them and this could have influenced the final results of the study.

(h) A small minority of participants withdrew from the postcard intervention but the specific reasons for the same were not assessed.

To make the postcard intervention more acceptable and effective, one needs to ascertain the specific reasons which made the participants withdraw from this intervention.


Authors’ reply: Drs Jhangee & Bhatia have mentioned a number of strengths and limitations, which were specifically addressed in the paper. The other issues that were raised are addressed below.

(a) Postcards are a minimal intervention sustained over 12 months. Optimal assessment is end of treatment and at follow-up, which allows comparison with similar studies.\(^1,2\) Repeated contact and assessment might ‘wash out’ the effect
Corrections

Valproate v. Lithium in the treatment of bipolar disorder in clinical practice: observational nationwide register-based cohort study. *BIP*, 199, 57–63. Table 1 (p.59), final column, row 7: the hazard ratio (95% CI) for Index episode: mixed, with mania/mixed episode as the outcome is 1.59 (1.16–2.18). This typographical error does not affect the findings of the paper.

Psychiatric history and subthreshold symptoms as predictors of the occurrence of depressive or anxiety disorder within 2 years. *BIP*, 194, 206–212. Table 3, p. 209: The values for Social phobia, n (%) should read: No subthreshold anxiety disorder at baseline 31 (3.3), History of social phobia 14 (15.4), History of panic disorder 2 (3.1), History of agoraphobia 5 (9.3), History of GAD 8 (9.2), No history of anxiety 12 (1.7), Subthreshold anxiety at baseline 25 (11.0), History of social phobia 6 (18.2), History of panic disorder 4 (12.1), History of agoraphobia 6 (20.0), History of GAD 4 (9.3), No history of anxiety 12 (9.4), Total 56 (4.8). The values for Generalized anxiety disorder, n (%) should read: No subthreshold anxiety disorder at baseline 22 (2.3), History of social phobia 5 (5.5), History of panic disorder 1 (1.5), History of agoraphobia 2 (3.7), History of GAD 6 (6.9), No history of anxiety 11 (1.5), Subthreshold anxiety at baseline 16 (7.0), History of social phobia 1 (3.0), History of panic disorder 4 (12.1), History of agoraphobia 3 (10.0), History of GAD 2 (4.7), No history of anxiety 8 (6.3), Total 38 (3.3). The erroneous values in the table do not affect other values, including the ones listed in the column Any disorder, n (%), or any of the statistical analyses or conclusions presented in the paper.

Panicked: A study of panic disorder. *BIP*, 198, 204–209. Table 2 (p.206), second column, row 2: the values for Panic disorder, n (%) should read: No history of panic disorder 23 (2.3), History of panic disorder 51 (5.1), History of agoraphobia 12 (2.2), History of anxiety 28 (2.8), Total 130 (13.0). The values for Generalized anxiety disorder, n (%) should read: No history of Generalized anxiety disorder 22 (2.2), History of Generalized anxiety disorder 14 (1.4), History of anxiety 44 (4.4), Total 80 (8.0). The values for Social phobia, n (%) should read: No history of Social phobia 18 (1.8), History of Social phobia 52 (5.2), History of anxiety 30 (3.0), Total 90 (9.0). The values for Subthreshold anxiety disorder, n (%) should read: No history of Social phobia 31 (3.1), History of Social phobia 16 (1.6), History of panic disorder 2 (0.2), History of agoraphobia 6 (2.0), History of anxiety 12 (1.2), Total 51 (5.1). The values for any anxiety disorder, n (%) should read: No history of any anxiety disorder 24 (2.4), History of any anxiety disorder 15 (1.5), History of panic disorder 5 (0.5), History of agoraphobia 9 (0.9), History of anxiety 10 (1.0), Total 54 (5.4). The values for any panic disorder, n (%) should read: No history of any panic disorder 2 (0.2), History of any panic disorder 21 (2.1), History of agoraphobia 3 (0.3), History of anxiety 10 (1.0), Total 35 (3.5). The values for any phobia, n (%) should read: No history of any phobia 21 (2.1), History of any phobia 35 (3.5), History of anxiety 10 (1.0), Total 66 (6.6). The values for any anxiety disorder or panic disorder, n (%) should read: No history of any disorder 34 (3.4), History of any disorder 31 (3.1), History of panic disorder 35 (3.5), History of any phobia 35 (3.5), History of any anxiety disorder or panic disorder 66 (6.6), Total 130 (13.0). The values for any anxiety disorder or panic disorder or any phobia, n (%) should read: No history of any disorder or phobia 34 (3.4), History of any disorder or phobia 96 (9.6), History of any phobia 35 (3.5), History of any anxiety disorder or panic disorder or any phobia 96 (9.6), Total 165 (16.5). The values for any disorder, n (%) should read: No history of any disorder 34 (3.4), History of any disorder 96 (9.6), Total 130 (13.0). The values for baseline panic disorder, n (%) should read: No subthreshold anxiety disorder at baseline 36 (3.6), History of panic disorder at baseline 2 (0.2), Subthreshold anxiety at baseline 14 (1.4), History of anxiety at baseline 24 (2.4), Total 74 (7.4). The values for baseline social phobia, n (%) should read: No subthreshold anxiety disorder at baseline 31 (3.1), History of social phobia at baseline 14 (1.4), Subthreshold anxiety at baseline 10 (1.0), History of anxiety at baseline 28 (2.8), Total 73 (7.3). The values for baseline agoraphobia, n (%) should read: No subthreshold anxiety disorder at baseline 31 (3.1), History of agoraphobia at baseline 15 (1.5), Subthreshold anxiety at baseline 12 (1.2), History of anxiety at baseline 26 (2.6), Total 70 (7.0). The values for baseline anxiety, n (%) should read: No subthreshold anxiety disorder at baseline 36 (3.6), History of anxiety at baseline 24 (2.4), Total 60 (6.0). The values for baseline any disorder, n (%) should read: No subthreshold anxiety disorder at baseline 36 (3.6), History of any disorder at baseline 96 (9.6), Total 132 (13.2).