Letters from readers are welcome. They will be published at the editor's discretion as space permits and will be subject to editing. They should not exceed 500 words with no more than three authors and five references and should include the writer's e-mail address. Letters related to material published in *Psychiatric Services*, which will be sent to the authors for possible reply, should be sent to Howard H. Goldman, M.D., Ph.D., Editor, *Psychiatric Services*, at psjournal@psych.org. Letters reporting the results of research should be submitted online for peer review (mc.manuscriptcentral.com/appi-ps).

Seeking Safety Therapy: Clarification of Results

To the Editor: Our study of Seeking Safety therapy was published in the September issue (1). We would like to correct two omissions, which may help clarify outcomes for Seeking Safety and the comparison condition (enhanced residential services). In the article we addressed outcomes over a one-year time frame. However, we did not present outcomes at six months, which was the end of the Seeking Safety intervention. Second, we failed to identify the full extent and asymmetry of the data loss that characterized the study after the end of treatment.

At six months, two significant differences favored Seeking Safety over the comparison condition after Bonferroni correction: avoidant behavior and social support. Two additional variables that favored Seeking Safety were not significant after Bonferroni correction: the PTSD Checklist and days worked. On eight variables, both Seeking Safety and the comparison condition showed significant improvements over baseline, with no difference between conditions: days of drug use, days of alcohol use, the 30-item Symptom Checklist Revised, self-esteem, the psychiatric composite of the Addiction Severity Index (ASI), the medical measure on the 12-Item Short-Form Survey (SF-12), hypervigilant behavior, and days homeless. Two additional variables (ASI drug and alcohol subscales) had a similar pattern; although the difference from baseline was a non-significant trend for the Seeking Safety condition, this likely reflects the greater statistical power in the much larger comparison condition. Finally, only two variables, intrusive thoughts and the medical measure of the SF-12, did not show significant improvements from baseline for either condition.

Sample sizes decreased substantially over time. At three months, about 80% of participants in both conditions completed the assessment, and at six months the rate for both was about 63%. However, at nine months only 40% of Seeking Safety participants and 56% of comparison participants were available, and at 12 months the proportions dropped to 27% and 53%, respectively. It is thus difficult to draw conclusions about the later time points, and we suggest caution in interpreting the one-year outcomes reported in the paper.

In that spirit, we also note that an interaction analysis of condition-by-time showed that participants in both conditions improved on number of days of drug use during the first six months, but that during the second six months participants in the Seeking Safety intervention experienced an increase. The latter may reflect, however, selective dropout from the study. Thus the statement in the abstract that "the Seeking Safety cohort was significantly more likely to have used drugs within the past 30 days" reflected only a small sample during the follow-up period after Seeking Safety had ended, and this finding should be interpreted with caution.

We believe that these additions clarify and elaborate on the results of this project. In sum, at the end of treatment, participants in both Seeking Safety and the comparison condition evidenced consistent and positive outcomes on substance use and related areas. On two of 12 outcomes, differences between conditions favored the Seeking Safety intervention. Later time points (nine and 12 months) were a follow-up period for Seeking Safety, and sample attrition was substantial (the majority of the Seeking Safety sample was not assessed).

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CATIE Findings Revisited

To the Editor: We applaud the special section in the May 2008 issue with commentaries interpreting findings from the landmark Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) study (1,2). The introduction stated that "the literature suggests little evidence that, with the exception of clozapine, second-generation antipsychotics confer superior efficacy in ameliorating positive and negative symptoms and improving cognition or that they are more tolerable." Our meta-analysis (3) is one of ten published reports cited at the end of this statement.

For the record, like the animals in *Animal Farm,* some second-generation antipsychotics—olanzapine, risperidone, and amisulpride—were shown in our analysis to be superior to first-generation antipsychotics. In addition, the report by Lieberman and colleagues (4) of results from phase I of CATIE showed that olanzapine was superior in efficacy to the first-generation antipsychotic perphenazine. We agree that clozapine is more effective than first-generation antipsychotics and that given the data currently available, the other second-generation antipsychotics—quetiapine, ziprasidone, and aripiprazole—have not been shown to have better efficacy than first-generation agents.

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Health Care Use by Victims of Charcoal-Burning Suicide in Taiwan

To the Editor: Burning barbecue charcoal in an enclosed space to create carbon monoxide intoxication has become a popular method of suicide in some Asian countries, particularly in Hong Kong and Taiwan (1,2). Since 2002 suicide by charcoal burning has become the second most commonly used method of suicide in Taiwan, accounting for more than 30% of all suicide deaths (3). However, little is known about the patterns of health care use in this suicide subgroup.

We linked mortality data classified as *ICD-9* code E952 (N=2,192), E953 (N=4,814), and E950 (N=2,797) from 2000 through 2004 to National Health Insurance data files. Chi square tests were used to compare health care use in the past year and history of psychiatric or medical contacts between persons who completed suicide by charcoal burning (E952), hanging (E953), and solid or liquid poisoning (E950).

We found that compared with persons who committed suicide by hanging and solid or liquid poisoning, charcoal-burning suicide victims had fewer health care contacts. Only 18% (N=396) of victims of charcoal-burning suicide had visited a psychiatrist in the year before suicide; this percentage was significantly lower than for victims of hanging (25%, N=1,216) and solid or liquid poisoning (23%, N=650) ($p<.001$). Recorded psychiatric diagnoses were less frequent among victims of suicide by charcoal burning than among those who used the other methods (40% [N=906] of the charcoal-burning suicide victims compared with 57% [N=2,765] of hanging victims and 59% [N=1,639] of poisoning victims) ($p<.001$ for both comparisons).

The presuicide physical condition of the charcoal-burning victims was better than the condition of victims in the hanging and poisoning suicide subgroups, as reflected by the lower likelihood of hospital admission in the past year (18%, 35%, and 58%, respectively) ($p<.001$ for both comparisons). Even when the analysis controlled for age, the lower rate of health care use among victims of charcoal-burning suicide was observed.

Our results corroborate findings from Hong Kong that victims of charcoal-burning suicide were less likely to have pre-existing mental or physical illness (1,4,5). Our results further indicate that this suicide subgroup was significantly less likely to make contact with the health care system. Therefore, the traditional suicide prevention strategy that focuses on recognition and treatment of high-risk groups may not be able to reach this population. Our results support the point previously raised by researchers from Hong Kong that this new method may have attracted individuals who would otherwise not have considered suicide (2,5). Acute stress, particularly economic difficulty, rather than mental disorders may be the major precipitating factor of suicide in this suicide subgroup (2,5). Population-based prevention strategies to prevent charcoal-burning suicide that might be considered include efforts to destigmatize mental illness to enhance appropriate help-seeking behaviors, restrictions on access to charcoal (for example, by removing charcoal from open shelves and making it necessary for the customer to request it from a shop assistant), and guidance for the media on how to report on suicide events.

This study was limited by the difficulty of determining the reliability and validity of the claim data. Furthermore, not all deaths classified under *ICD-9* code E952 were from charcoal burning; some deaths may have resulted from other types of carbon monoxide poisoning.

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