

11.8 in the control group (Mayou *et al*, 2000). This may indicate that the trauma of meeting a debriefer for 1 hour was comparable to the trauma of the traffic accident itself.

If the findings of Mayou *et al* are valid, it shows a tremendous potential for psychological intervention. However, we are still not convinced that a 1-hour psychological intervention unintentionally can do so much harm.

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Ø. Ekeberg, E. Hem Department of Behavioural Sciences in Medicine, University of Oslo, PO Box 1111 Blindern, N-0317 Oslo, Norway

Diazepam in the treatment of GHB dependence

We read with great interest the recent case reported by Price (2000) concerning the utility of diazepam in suppressing gamma-hydroxybutyrate (GHB) dependence and related withdrawal symptoms. Before describing the case Price states, “I believe this to be the first reported case of in-patient detoxification”. However, the first report on the utility of the same doses of diazepam in treating GHB withdrawal syndrome was published a year earlier by our group in a patient taking about 181 g/day GHB for 4 months, for its euphoric and anxiolytic effects (Addolorato *et al*, 1999). On discontinuation of GHB, the patient showed a withdrawal syndrome consisting of high anxiety levels, tremor, sweating, tachycardia and nausea. Complete disappearance of drug withdrawal symptoms was achieved within 2 hours in the first day of treatment with diazepam 20 mg orally administered, and the patient was treated with the same dose of diazepam for another 6 days. After suspension of the diazepam, the symptoms did not recur. Also in this case, the detoxification programme was safe. We are very pleased to know that our findings are in perfect agreement with

that of Price; since several cases of GHB misuse and dependence have been described in recent years (see Addolorato *et al*, 2000), we think that these reported experiences, as well as the recent case described by Hutto *et al* (2000) about the utility of chloral hydrate, could be of clinical relevance, particularly considering the difficult management of these patients.

Addolorato, G., Caputo, F., Capristo, E., et al (1999) A case of gamma-hydroxybutyric acid withdrawal syndrome during alcohol addiction treatment: utility of diazepam administration. *Clinical Neuropharmacology*, **22**, 60–62.

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Hutto, B., Faichild, A. & Bright, R. (2000) Gamma-hydroxybutyrate withdrawal and chloral hydrate. *American Journal of Psychiatry*, **157**, 1706.

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G. Addolorato, F. Caputo, E. Capristo, G. Gasbarrini Institute of Internal Medicine, Catholic University of Rome, Largo A. Gemelli 8, 00168 Rome, Italy

Seasonality of suicides

We read with interest Yip *et al*'s (2000) report on the decrease or disappearance in seasonal variation of suicides in the 1980s and 1990s in England and Wales. The authors have suggested a similar trend in other countries (Ho *et al*, 1997; Yip *et al*, 1998). This paper inspired us to explore seasonality of suicide in Japan, where national data on monthly suicides are collected and published every year by the Ministry of Welfare. We examined monthly data by gender for the 15-year period 1982–1996. A daily mean suicide incidence was calculated for each month. Harmonic analysis (Pocock, 1974) was applied to identify seasonal components in the variation of monthly suicides.

A total of 332 651 suicides (215 686 male, 116 965 female) were identified for the period (mean suicide rate 25.8 and 13.2 per 100 000 for men and women, respectively). During the entire period, the age distribution of suicide rates, which generally increases with age, and popular methods of suicides (approximately 60% violent, nearly 35% non-violent, remainder unclassifiable or method not known) were generally unchanged. Regardless of gender, mean daily suicide incidence by month

demonstrated a clear bimodal distribution, with a largest peak in April and a smaller peak in September. Harmonic analyses revealed that over 65% (66.7% for men and 66.2% for women) of the total variance in suicides was explained by the seasonal component, where one-cycle and two-cycle components illustrate the majority of total seasonal harmonics (one-cycle: 64.3% for men and 69.1% for women; two-cycle: 32.9% for men and 28.7% for women). No gender difference was found in the results from the harmonic analyses.

Unfortunately, no data on monthly suicides by age, by method or by place are available from the Japanese Government, which complicates further analyses regarding the backgrounds of such a marked seasonality in suicides. It may be noted that the school and business year begins in April in Japan, which may affect the seasonality of suicides, at least the largest peak of suicides in April. Overall, the results of our analyses indicate limitations in generalising from Yip *et al*'s conclusions and suggest a wide variability in seasonality of suicide in different areas.

Ho, T. P., Chao, A. & Yip, P. S. F. (1997) Seasonal variation in suicides re-examined: no sex difference in Hong Kong and Taiwan. *Acta Psychiatrica Scandinavica*, **95**, 25–31.

Pocock, S. J. (1974) Harmonic analysis applied to seasonal variations in sickness absence. *Applied Statistics*, **23**, 103–120.

Yip, P. S. F., Chao, A. & Ho, T. P. (1998) A re-examination of seasonal variation in suicides in Australia and New Zealand. *Journal of Affective Disorders*, **47**, 141–150.

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T. Sato Psychiatrische Klinik and Poliklinik, LMU München, Nussbaumstrasse 7, 80336 München, Germany

Reflecting on the diminished seasonal variation in suicides reported by Yip *et al* (2000), I was mindful of the recent extreme weather conditions – gales, floods, tornadoes – and the absence of ‘Novemberness’ – trees retaining their leaves, moderate temperatures, the absence of frost. Additionally in recent years we have been spared cold winters and lamented the loss of any recognisable British summertime. Therefore, one might wonder whether the disappearance of seasonal variation in suicide mirrors the