

Rather than being ready for an assessment of its effectiveness and cost-effectiveness in non-experimental settings, as Thornicroft & Susser argue, cognitive therapy may be in the process of meeting the fate of an earlier treatment for schizophrenia where advocacy preceded rigorous evaluation – insulin coma.

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No long-term benefit for cognitive therapy in acute psychosis: a type II error

Drury *et al* (2000) reported no significant difference in relapse rates, positive symptoms or insight between a cognitive therapy group and a recreational activities and support group of patients who had an acute episode of a non-affective psychosis. This 5-year outcome study assessed 34 out of an original cohort of 40 patients.

Working on the basis of small trials having a large type II error, the group size for each group can be estimated. If the anticipated mean response in one group is μ_1 and the standard deviation is σ , to show a significant result the mean relapse of one group can be estimated at $2(\mu_1)$ and the standard deviation can be estimated at $1.5(\sigma)$. The estimated difference between the groups (δ) can be set at $0.5(\mu_2 - \mu_1)$. A formula to calculate the number (n) in each

group (Pocock, 1983: 127–128) can be used as follows:

$$n = \frac{2\sigma^2}{(\mu_1 - \mu_2)^2} \times f(\alpha, \beta)$$

The α (type I error) is by convention set at 0.05, and the β (type II error) can be set at 0.2. The power of finding a true result ($1 - \beta$) will therefore be 0.8 or 80% and, by using a statistical table, $f(\alpha, \beta)$ is 7.9. Therefore, n can be calculated as

$$\frac{2 \times 1.5^2}{0.5^2} \times 7.9 = 142$$

patients in each group.

It would therefore take a very large sample to prove the null hypothesis in the above hypothetical estimate. In the study by Drury *et al* (2000), it would be misleading to extrapolate that there was no long-term benefit of using cognitive therapy in schizophrenia in terms of relapse. Larger studies are needed in this rapidly evolving area.

Drury, V., Birchwood, M. & Cochrane, R. (2000) Cognitive therapy and recovery from acute psychosis: a controlled trial. 3. Five-year follow-up. *British Journal of Psychiatry*, **177**, 8–14.

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Seasonal variation in suicides: hidden not vanished

Yip *et al* (2000) demonstrated that, in England, the seasonal variation in suicide rates in the 1980s and 1990s decreased considerably when compared with that in the 1960s and 1970s. From monthly suicide frequencies, they concluded that current data hardly show any seasonal effects on suicide rates, and they predicted that seasonal variation in suicide rates would disappear completely in the years to come.

Although we fully agree with Yip *et al* (and several other authors) that there is a global decline in the amplitude of seasonal variation in suicide rate, we do not agree with the conclusion that seasonal influences are beginning to fade away. We came to this conclusion by a recent study of train

suicides (i.e. suicide by jumping before a moving train) in The Netherlands (van Houwelingen & Beersma, 2001). In this study ($n=30$) we confirmed the absence of a seasonal pattern in suicide rates as observed in 28-day intervals. We did, however, observe a strong seasonal influence on 24-hour patterns. Whereas the winter season showed two daily peaks in suicide rates, at around 9–11 am and 7–10 pm, the summer season revealed one major peak around 12–4 pm and a smaller peak shortly before midnight. The timing of the major summer peak is in the trough between the two winter peaks.

This more subtle influence of time of year on suicide rates adds a different dimension to what has been considered seasonality in suicidal behaviour and may generate new ideas concerning relevant factors involved. In train suicide data, seasonal influences are clearly present. This may also be true of other methods of suicide. In order to see this, time of day and time of year have to be taken into account simultaneously.

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Yip, P. S. F., Chao, A. & Chiu, C. W. F. (2000) Seasonal variation in suicides: diminished or vanished. Experience from England and Wales, 1982–1996. *British Journal of Psychiatry*, **177**, 366–369.

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Soviet-style psychiatry is alive and well in the People's Republic

The involuntary committal to psychiatric institutions of political dissenters has long been associated with the abuses of psychiatric practice perpetrated in the former Soviet Union. The detention of dissenters may be based upon psychiatric judgement but political factors are relevant when such abuse becomes widespread. International concern has been growing following the decision of the Chinese Government to outlaw the practice of *Falun Gong* and forcibly to assign psychiatric treatment to practitioners of this meditative discipline. *Falun Gong*, also known as *Falun Dafa*,