who are busy integrating and improving the practice of psychotherapy and its evaluation. They find the question 'Is psychotherapy effective?' inappropriate rather than unimportant, just as a similar question applied to psychiatry, teaching, parenting or any other complex human activity would be judged unproductive by any sophisticated investigator.

As for Sam Weller, his comments hardly support Prof. Shepherd's argument, for the alphabet, however painfully achieved, was of immense benefit to the Victorian charity boy, even though research had not demonstrated the uses and effects of literacy. The uses and effects of psychotherapy are in the realm of value and meaning as well as of symptoms and behaviours and their measureement is never going to be easy. This is not to say that it should not be attempted, but any suggestion that only those effects that are easily measurable are real or important would be philistine in the extreme. We need more, and more subtle research, but we do not need to mount a 'vigorous initiative' by one section of the College on another, however much Prof. Shepherd might hanker after the role of Grand Inquisitor.

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Fear of AIDS

DEAR SIR,

The title of the article "A Pseudo AIDS' Syndrome following from Fear of AIDS" (Miller *et al*) (*Journal*, May 1985, **146**, 550–551) is not substantiated by the content of the article itself. They say "We report two cases showing psychiatric symptoms associated with a fear of Acquired Immune Deficiency Syndrome", but only in the second case of perhaps very understandable anxiety arising from a possible contact with an AIDS carrier could the (I feel unnecessary) invention of "Pseudo AIDS Syndrome" be stated to be *following* from a fear of AIDS. The other case they report is a classical description of a depressive illness.

Surely we need no further confusion in our already confusing and loose nosology. Do we call a depressive illness characterised in part by either hypochondrical, over-valued or frankly delusional ideas of cancer (even if the patient has been recently in contact with a cancer victim), a "Pseudo-Cancer Syndrome". No, I think not.

They say "The above cases highlight two manifestations of fears of AIDS resulting in significant impairment". What they actually describe, however, are two manifestations of psychiatric disturbance characterised *in part* by a fear of AIDS resulting in significant impairment but, contrary to the title of the article, they do not convincingly describe "The psychiatric symptoms resulting *from* a fear of AIDS" which they wish to refer to as "Pseudo AIDS".

Both these patients were at high risk of contracting AIDS, and further I fear that the invention of a "Pseudo AIDS' Syndrome", set against the backcloth of the difficulty of diagnosing AIDS itself in the early stages might prejudice the diagnosis of AIDS where it actually exists.

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Parasuicide in Adolescents

DEAR SIR,

Doctor Donald J. Brooksbank's recommendation (*Journal*, May 1985, **146**, 459–463) of "A short stay in hospital" for adolescents who have attempted suicide is not entirely borne out by the data cited.

In the first place these data suggest that, in the common case, where there is no identifiable psychiatric disorder, the immediate aftermath of the suicide attempt is a spell of safety. The overall suicide risk is greater than for the general population and most of this risk extends over the subsequent year. This suggests that, if the purpose of the hospitalisation is protective custody to prevent a second attempt, then the length suggested is almost exactly the wrong one.

In the second place much of the evaluation suggested is non-medical and even (by Dr. Brooksbank's statements) non-psychiatric. This being so, it might be equally well carried out in an out-patient clinic or (perhaps even better) by means of visits to the patient's home.

In the third place there is evidence that these young people are characterised by anti-social and manipulative behavior. A short term hospitalisation after a suicide attempt tends to be in the permissive atmosphere of an open ward of a general hospital. Such patients may be difficult to handle in such an

environment, and take up valuable nursing time that could be used to treat patients with demonstrable psychiatric illnesses, needing care which could only be provided by a hospital.

These are perhaps extrapolations from the data. If there is direct empirical evidence that lives are saved by short term hospitalization, then that would supersede other considerations.

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Lorazepam Dependence and Chronic Psychosis

DEAR SIR,

Over the past few years there have been increasingly frequent reports of both psychological and physical dependence on the benzodiazepines (Tyrer *et al*, 1981) and of transient paranoid psychotic symptoms or depression occurring during withdrawal (Ashton, 1984; Olajide & Lader, 1984). We report here a case of lorazepam (Ativan) dependence which was unusual in that it mimicked a chronic schizophrenic illness.

A single man aged 28 was admitted with a history of increasingly withdrawn bizarre behaviour over seven years. He had an uneventful childhood, performing well at school. At the age of 19, in his first year at technical college, he became socially anxious, his academic performance declined and he gave up his studies and stopped going out. His general practitioner prescribed lorazepam 1–2 mg daily, and during the next few years he took the drug in rapidly increasing amounts, reaching and continuing on 20–30 mg daily. He became increasingly withdrawn, solitary and apathetic, spending most of the five years before admission in his locked and filthy bedroom with the blinds permanently drawn, refusing to eat with his family. He often threatened his general practitioner with violence if she did not prescribe the drug, and was aggressive to his parents. In the year before admission he said that the neighbours were plotting to harm him, and often was heard talking to himself as if answering voices. He had been seen three times over the years by psyhiatrists but had always refused to come into hospital and his parents finally agreed to compulsory admission. Latterly he had been taking occasional aspirin and codeine tablets for toothache but there was no evidence of abuse of any other drugs or alcohol.

On admission he was extremely dirty and dishevelled with very long hair and finger nails. He was detached, preoccupied and slightly perplexed, avoiding all eye contact. There was no clouding of consciousness, nystagmus or dysarthria. He spoke little, but expressed the belief that the ward was bugged with television cameras. He was treated with haloperidol 9 mg daily and diazepam in an initial dosage of 40 mg daily reducing gradually over ten days. The haloperidol was discontinued after two weeks due to severe extrapyramidal side effects. The next day there was a dramatic improvement in his mental state with recovery of insight, complete disappearance of the psychotic symptoms and emergence of a personality which was warm and friendly. Six months have now elapsed and he has remained moderately anxious without a craving for lorazepam but no evidence whatever of personality deterioration. The insidious and steady deterioration in personality and social functioning over seven years, latterly with overt psychotic ideation, strongly suggested a diagnosis of chronic schizophrenia. The lorazepam dependence seemed secondary. The rapid resolution of symptoms after withdrawal of lorazepam suggested that the drug was the main cause of the 'defect state'. Although transient psychotic symptoms occurring with lorazepam withdrawal are well recognised, long-standing psychotic behaviour during the time of abuse is not. Benzodiazepine dependence should be considered in the differential diagnosis of chronic as well as acute psychotic states.

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Dupuytren's Disease and Mental Handicap

DEAR SIR,

Just over 150 years ago (1933), Baron Dupuytren's letter on 'Permanent retraction of the fingers produced by an affection of the palmar fascia", was published in the *Lancet* (1834) and the condition now bears his name. An extensive literature has since appeared concerning its aetiology, pathogenesis and treatment. Many possible causes or concomitants of Dupuytren's disease were reported, e.g. heredity, trauma,