mental handicap institutions serve the important function of increasing the psychiatrists' awareness of the inadequacy of the current practice and motivating them to seek improvement via the emphasis on more rational prescription guidelines, increase of medical input, introducing regular drug review, and alternative treatment approaches. Prescribing psychoactive drugs for the mentally handicapped patients in long-stay institutions requires extra care and consideration, and the dictum to follow is: "When in doubt, don't!" (Kirman, 1975).

T. W. FAN

Castle Peak Hospital
Tuen Mun, NT
Hong Kong

References

FAN, T. W. (1988) Drug prescription in a local mental handicap hospital. *Journal of Hong Kong Psychiatric Association*, **8**, 22–36.

KIRMAN, B. (1975) Drug therapy in mental handicap. *British Journal of Psychiatry*, **127**, 545–549.

AUTHORS' REPLY: We were interested to read Dr Fan's letter and see that his findings with regard to the prescription of antipyschotic drugs in the mentally handicapped are very similar to our own, despite differences in the ethnic and cultural background of his subjects. We would like to reply to the queries that he has raised.

We chose the use of antipsychotic medication in our study rather than other psychotropic drugs because we believe that antipsychotic drugs are prescribed too readily in mental handicap with insufficient pharmacological indications. Furthermore, the adverse effects of long-term prescription of these drugs are more serious than erroneous administration of alternative psychotropic agents.

We agree that it would have been helpful to look at all patients who received antipsychotic drugs four years before our investigation. However, the logistic task of identifying all patients in the hospital in 1982 and perusing their files was considered too major an exercise and, because of problems arising with patients who had died or who had left hospital in the four years before our study, it was likely that any enquiry of this nature would have been incomplete. We are now undertaking a further study examining the cohort of our 1986 sample to see what drugs they are at present receiving.

Dr Fan is quite right to point out our error in stating that female patients in our study received a significantly higher mean daily dose of chlorpromazine equivalents compared with that of the male patients. We agree that the considerable variation in dosage in the female patients is of interest and shows that there are some female mentally handicapped patients who receive very high doses of antipsychotic drugs. Examination of our data indicates that a group of these patients have a history of frequent disturbed behaviour and/or aggression.

STEPHEN TYRER
SUSAN WRESSELL
TOM P. BERNEY

Prudhoe Hospital
Prudhoe
Northumberland NE42 5NT

Buspirone in benzodiazepine withdrawal

SIR: Beeley & Hammersley (*Journal*, November 1990, **157**, 777) comment indignantly that our study of buspirone in benzodiazepine withdrawal (*Journal*, August 1990, **157**, 232–238) was clinically irrelevant and unethical. They castigate us for ignoring the "generally accepted" view that "gradual dosage reduction with appropriate psychological treatment is the best way to manage benzodiazepine withdrawal", and for perpetuating "the search down a blind alley for pharmacological short-cuts".

In Newcastle we have long advocated gradual dosage reduction in benzodiazepine withdrawal, which is individually tailored and combined with psychological support (Ashton, 1987, 1989). We have emphasised the distress that benzodiazepine withdrawal can cause in some patients and have drawn attention to the need for psychological help and for tranquilliser support groups (Ashton, 1984). For the past seven years we have conducted a benzodiazepine withdrawal clinic which operates in close liaison with clinical psychologists and with a tranquilliser advice and support group which we helped to establish. Our general policy has been to involve the patients closely in decisions about their own withdrawal regimes.

After experience with over 200 patients at the clinic (and many more at the support group) it is clear that present methods are not ideal. Although 90% of our patients have achieved and maintained benzodiazepine withdrawal (Ashton, 1987), the clinical course has not always been easy and we have learned that some patients do require additional pharmacological support. For example there is a real risk of suicide in withdrawal and a proportion of patients develop major depression requiring treatment with antidepressants (Ashton, 1987).

Hence we felt that it was (and still is) important to evaluate the effect of pharmacological and other

treatments in properly controlled studies of benzodiazepine withdrawal. The case for buspirone was particularly relevant at the time that our study was planned and initiated (1985/86) since there was a strong likelihood that this recently released drug, with proven anxiolytic activity (Feighner *et al*, 1982), would be widely used in benzodiazepine withdrawal, especially in general practice, where studies had shown it was effective in generalised anxiety disorder (Murphy *et al*, 1989). The study received the approval of the Joint Ethics Committee of the University and Newcastle District.

A fixed benzodiazepine withdrawal time of four weeks was chosen because we were anxious to obtain evidence of the utility or otherwise of buspirone in the shortest possible time in the minimum number of patients. Withdrawal regimes which are individually tailored may take over a year to complete (Ashton, 1987) and make it difficult to compare treatments. Furthermore, we had evidence that outcome is not affected by rate of withdrawal (Ashton, 1987) and that fairly rapid withdrawal may sometimes be appropriate (Ashton, 1984). We limited participation in the study to patients taking low to moderate doses of benzodiazepines, and most patients were referred because they had experienced difficulties during previous attempts with "generally accepted" methods of withdrawal. The study itself showed that 11 out of 12 patients in the placebo group were successful in achieving and maintaining withdrawal with the method used (one patient dropped out for reasons not connected with withdrawal).

The patients chose to take part in the trial; those who declined were still offered treatment at the clinic. Participants were given a full explanation of the aims and methods of the study; they were informed that they may or may not receive buspirone, and that the drug may or may not be helpful. There was no reason to anticipate that the drug might exacerbate withdrawal symptoms. It is not true, as Beeley & Hammersley claim, that the regimen took no account of the patients' response to withdrawal. All patients were able to discontinue the trial at any time. Indeed, many who were taking buspirone dropped out because of increasing symptoms or need for further medication, and the incidence of drop-out was one of the criteria used for assessing the effects of the drug. All patients were assessed at frequent intervals by consultant pharmacologists and psychiatrists experienced in benzodiazepine withdrawal. Patients were free to attend a support group or to be referred for psychological treatment if indicated. Those who dropped out were able to continue attending the clinic (and many were later successful in benzodiazepine withdrawal).

We feel that our study was useful in demonstrating that the use of buspirone in benzodiazepine withdrawal was associated with an increased drop-out rate, and possibly more severe symptoms, compared with dosage reduction under placebo. Our study does not perpetuate the use of a pharmacological short-cut; on the contrary, it shows that one pharmacological treatment is a cul-de-sac.

C. H. ASHTON
M. D. RAWLINS
S. P. TYRER

Clinical Psychopharmacology Unit
Department of Pharmacological Sciences
The Medical School, The University
Newcastle upon Tyne NE2 4HH

References

ASHTON, H. (1984) Benzodiazepine withdrawal: an unfinished story. *British Medical Journal*, **288**, 1135–1140.

ASHTON, H. (1987) Benzodiazepine withdrawal: outcome in 50 patients. *British Journal of Addiction*, **82**, 665–671.

ASHTON, H. (1989) Risks of dependence on benzodiazepine drugs: a major problem of long term treatment. *British Medical Journal*, **298**, 103–104.

FEIGHNER, J. P., MEREDITH, C. H. & HENDRICKSON, G. A. (1982) A double-blind comparison of buspirone and diazepam in outpatients with generalised anxiety disorder. *Journal of Clinical Psychiatry*, **43**, 103–107.

MURPHY, S. M., OWEN, R. & TYRER, P. (1989) Comparative assessment of efficacy and withdrawal symptoms after 6 and 12 weeks' treatment with diazepam or buspirone. *British Journal of Psychiatry*, **154**, 529–534.

Anorexia nervosa across cultures

SIR: I was excited to read the letter by Khandelwal & Saxena (*Journal*, November 1990, **157**, 784) who reported that in India anorexia nervosa (AN) is not only rare but is also not associated with any body image distortion and fear of obesity. As these have been regarded as 'core psychopathology' of AN and are of diagnostic importance in the West, their patients do not fulful DSM–III–R criteria and are placed in the residual category of 'eating disorders not otherwise specified'. However, they were noted to be amenorrheic and rigidly maintain a low body weight just as Western AN patients do. These findings echoed my study of Chinese AN patients in Hong Kong, where a clear distorted body image or an intense fear of obesity is lacking (Lee *et al*, 1989).

AN has often been described as a culture-bound syndrome. While there is more evidence on the greater prevalence of AN in Western than non-Western countries, much less information is available as to whether its clinical patterns also differ across cultures. I believe that they do, and would suggest that more