conduct a national enquiry of clinic practice in this area and contract to set up some general guidelines as to future practice.

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Carbamazepine in alcohol withdrawal

SIR: The article by Glue & Nutt (*Journal*, October 1990, **157**, 481–490) on overexcitement and disinhibition was both interesting and informative. It did however omit a discussion of carbamazepine in the treatment section.

Carbamazepine has been shown in a controlled trial (Malcom *et al*, 1989) to be of equal efficacy to oxazepam in reducing the symptoms of alcohol withdrawal. The authors postulated that this was due to its 'antikindling' effects, although its action on presynaptic adenosine receptors may also be important (Durcan & Morgan, 1990). In addition, with an increasing emphasis on out-patient detoxification programmes (Collins *et al*, 1990), carbamazepine has the advantage of a low potential for abuse or dependency.

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Culture as a confounding variable?

SIR: In their study of thought disorder in schizophrenics, manic–depressives and major depressives, Cutting & Murphy (*Journal*, September 1990, **157**, 355–358) were careful to compare their groups for IQ, age, sex and attentional factors. The study involved a judgement of the subjects' answers to multiple choice questions regarding social knowledge about their culture and general knowledge about the state of the world. It is a shame that the care taken to examine psychological differences is not matched by an equal care to examine social differences between the groups.

The important influence of culture in psychiatry is increasingly recognised and debated (see Leff, 1990; Littlewood, 1990). No mention is made in Drs Cutting & Murphy's study of the cultural background of the groups. This will surely have considerable influence on their judgement of a subject's knowledge of his or her own culture! If this questionnaire is to be of general use its validity across different cultures should be tested.

The difficulty in deciding which are social factors is demonstrated by the *post hoc* change of category of one question. From the 'non-social' category the answer to the question, 'What is the age of the oldest person in Britain?' will surely be influenced by the social experience of the respondent. If they come from a Nepalese culture this will be of a less elderly population than a respondent from another culture. The influences of culture must not be overlooked.

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Buspirone in detoxification

SIR: I wish to comment on Ashton *et al*'s study (*Journal*, August 1990, **157**, 232–238).

The practice of prescribing additional drugs to aid detoxification in drug-dependent individuals is a controversial issue. The addition of one anxiolytic agent (busipirone) to aid withdrawal from another anxiolytic agent (diazepam) appears contradictory, especially when buspirone's data sheet specifically

states that it will not block the withdrawal syndrome often seen with cessation of diazepam therapy. Furthermore it is an ideology that pushes the more immediate question of motivation into the background.

The authors argue that in certain circumstances such as benzodiazepine withdrawal, buspirone displays antagonist rather than agonist effects at the 5-HT1A receptor sites. This is a gross oversimplification of the pharmacodynamic profile of chronically anxious, withdrawing, benzodiazepine-dependent individuals on buspirone. No mention is made of possible interactions causing reduced dorsal raphe nucleus activity and hence reduced behavioural inhibition (Eison *et al*, 1983). In contrast to the benzodiazepines, buspirone increases locus coerulus firing (Sanghera *et al*, 1985). Studies report subjective and objective improvement in alertness and concentration and reduced confusion in patients taking buspirone compared with those taking benzodiazepines (Schweizer *et al*, 1986). It is not known, however, whether the combination of buspirone and a benzodiazepine produces changes in cognition. Thus an isolated discussion of 5-HT1A receptor effects does not do justice to what is known of both buspirone and diazepam.

Any study, no matter how well designed, as was the case here, can suffer from unforeseen errors. Randomisation does not guarantee equivalence and in this study there is no avoiding the fact that the group assigned buspirone were initially more anxious. In retrospect a stratified randomisation might have been a better design. It is my opinion that the more anxious the individual the slower their withdrawal should be. It was a small study and I would have appreciated the inclusion of confidence intervals to provide me with a range of uncertainty (Gardner & Altman, 1990). It has been suggested that weekly rating intervals are inadequate for detecting the full range of relapse, rebound and withdrawal phenomena because symptom increases may be transient (several days) and go undetected with weekly assessments (Rickels *et al*, 1986).

Out of 23 patients, 17 had a good outcome in the study, remaining off benzodiazepines at six and 12 months and here the authors should be congratulated. However, considering the high dropout rate for the buspirone group I am tempted to believe that the better outcome in the control group could in part be due to the authors' continued contact and rapport with these patients, especially since all the buspirone-treated patients who remained in the study achieved a similar good result.

In conclusion, when considering data from studies of adjunctive pharmacotherapy in withdrawal states, it is important to have a conceptual framework that allows specific drug–drug interactions to be viewed as occurring in a dynamic nervous system that has functional plasticity, multiple systems of parallel processing and complex heirarchical association mechanisms. In this way tentative statements of drug agonistic or antagonistic effects can be more realistically appreciated.

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Is psychiatric training still improving?

SIR: We read Brook's article "Is psychiatric training still improving" (*Journal*, September 1990, **157**, 335–338) with interest. As visiting psychiatric trainees from different countries, we hope to learn from psychiatric training in Britain.

The opinions of newly appointed consultants about their training provided the basis of Dr Brook's study. Unfortunately the opinions expressed as to satisfaction were retrospective, with the possibility of a personal 'halo' bias giving a more favourable view of their training. Also respondents were those ex-trainees who have successfully obtained consultant posts; what of the others who failed at this hurdle?

Dr Brook stated that statistical analysis would be inappropriate for 'opinions'. We would disagree. Statistical analysis is particularly important when one is dealing with such data if they are to be useful. Although Dr Brook reiterated that the results reflected opinions about training and that what may have been considered satisfactory ten years ago may not be considered satisfactory today, we feel that the results of the 1982 and 1987 surveys should be subjected to some form of statistical analysis if they are