helping sexual disorders, a deficiency easily remediable in a four-year training programme.

A different point reflects some of the above concerns. Many trainers think that personal therapy for psychotherapy trainees is central to training. This greatly increases training cost, narrowing the time available for other psychotherapy practice, study and research. Expensive recommendations like that for personal training would be better based on research results than on opinion. It would be timely to compare the outcome of patients treated by psychiatrists with and without personal training to see whether such a costly procedure is justified from the patient's point of view, or whether it should rather be made optional.

Some might feel that the chief guide to higher training should be trainees' preference for whatever forms of psychotherapy and patient problem happen to interest them, however limited those may be. Would we accept a general psychiatrist's argument that he wished to learn about and prescribe only a handful of drugs for a minority of patients in the population he served, as he was bored by the many other effective ones for the rest? The varied problems in the population tended by consultant psychotherapists would gain more from psychotherapists able to apply and supervise most of the methods likely to help those problems, especially the common ones, than from superspecialists schooled only in approaches useful for a small minority of cases. A whole four years of specialist training allows for diversification.

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## *Benzodiazepines and dependence*

DEAR SIRS

I am astonished to read this report in the March issue of the *Bulletin*. At a time when the public and the profession have finally got the message that these drugs should not be prescribed, the College publishes a statement explaining how they should be prescribed. Who are these patients with anxiety which is disabling, severe or subjecting the individual to unacceptable distress and who require short-term relief? Similarly, to which patients with insomnia does the statement refer? I would challenge the Committee to publish half a dozen vignettes of such patients in say five or six lines each as guidance to members of the College of what they mean. We might then be in a position to know what we are really talking about.

I cannot remember the last time I prescribed a benzodiazepine (except occasionally for the control of extremely disturbed psychotic behaviour in in-patients) and I have not felt the lack of them in treating a large number of patients with anxiety symptoms. Patients sometimes ask for tablets at the beginning of a consultation; after careful enquiry into the sources of anxiety and a discussion of how these might be remedied, a request is not usually repeated. Professor Anthony Clare has written of his concern for the "medicalisation of what are seen to be social problems" and refers to these drugs being "potentially hazardous".[1] Professor W. H. Trethowan coined the phrase "pills for personal problems" as prophylaxis against the irrationality of offering help in chemical terms where more rational, that is more scientific methods of intervention, would be appropriate. I have already written[2] that the time has arrived to state clearly that there is no use for these drugs in the treatment of anxiety and have referred to their role in generating symptoms including insomnia.

The report does not refer to the dangers of benzodiazepine drugs in the elderly and I would refer readers to the *Prescribers Journal* of December 1987 where Professor Elaine Murphy lists benzodiazepines under the heading 'Drugs to avoid'.

In conclusion I refer to the paragraph headed *Depression*. This states that depression is not an indication, it then goes on to say that the drugs may be prescribed under certain conditions and finally says how dangerous they are in that they may precipitate suicide. What is the College recommending? The paragraph then goes on to say that withdrawal may precipitate depression. Having withdrawn these drugs from large numbers of patients I must say that I have never seen anything but benefit although, of course, if benzodiazepines are used where there has been a failure to identify symptoms as having a depressive basis these symptoms may appear in greater force when the drugs are stopped. Patients who have been taking these drugs for a substantial period of time are sometimes angry if one suggests that they should stop them and their upset state is not uncommonly miscontrued as depression. If patients are told that stopping the tablets might ultimately improve their sleep and reduce their level of anxiety and if this is done sympathetically and with suitable explanation of what to expect, such patients frequently become amongst the most appreciative patients a psychiatrist can have.

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DEAR SIRS

The College Statement: Benzodiazepines and Dependence (*Bulletin*, March 1988, **12**, 107–109) commences with indications for the *prescription* of these drugs. Sections 1(a), (b) and (i) refer respectively to the use of benzodiazepines in 'anxiety', 'insomnia' and 'depression' accompanied by anxiety'; another section refers to 'excitement, agitation and severe psychotic disturbance'. In the first three of these 'indications' it is recommended that these drugs should be prescribed only when the condition is "disabling, severe and causing extreme distress"; in the first and third 'indication'

it is advised that prescription should be limited to one month. I wish to put forward reasons to consider that the Statement is misleading.

The evidence of the adverse effects of the benzodiazepines is now incontrovertible. The Statement recognises the problems of disinhibition, cognitive and psychomotor impairments; there is now a large iatrogenic dependence problem: the latest estimate[1] gives the prevalence of long-term consumption in the United Kingdom as between 1.5% and 3%. The medical profession has been driven into a defensive position by the mass media and pressure groups which have played the major role in informing the public of this problem[2]. Like many practitioners I accept that there is a need to continue long-term prescription for those people who are dependent on these drugs and who do not have the resources of determination and psychological stamina to cope with withdrawal but I do not accept that indications to *initiate* prescription still exist. I will consider the proposed indications in the Statement in turn.

*Anxiety reducing effect* If anxiety is so disabling and severe as to make pharmacological relief imperative then it is almost certainly due to underlying depressive disorder or else the form of anxiety state now termed panic disorder; in both these conditions, antidepressant drugs, not sedative drugs, are the correct treatment. If anxiety is psychogenic then it should *not* be treated with drugs which both delay resolution of the problem and foster a false belief in illness as the cause of the distress. Of all medical practitioners, psychiatrists should be steering opinion away from pharmacological treatment of psychogenic anxiety and should be putting major emphasis on the development of techniques of brief psychological intervention for distressing anxiety.

*Sleep-inducing effect* If insomnia is sudden and severe then there is either a psychological cause which requires discussion, a biogenic mental illness requiring appropriate treatment or a recent excessive use of alcohol or caffeine. All these require appropriate management but they do not justify the prescription of drugs with potential for causing dependence for, however firmly the person is advised that the drug should only be taken intermittently, there will be a proportion of vulnerable people who will take the drug continuously and become dependent on it.

*Depression* If anxiety-complicating depression is disabling and severe then the correct prescription is an adequate dose of an antidepressant drug which will itself have sufficient sedative effect. In fact the prescription of two drugs concurrently in depressive states is dangerous since the patient may become oversedated and omit the antidepressant or not take an adequate dose of it. Moreover many people suffering from depression, especially the young women with care of children, already suffer from distressing irritability[3] and the disinhibiting effect of a benzodiazepine drug may convert a potential into an actual batterer. The Statement implies that it is only those who are disordered in their personality whose drug-induced disinhibition results in unacceptable behaviour but that is not true.

*Excitement, agitation and psychotic disturbance* Many states of excitement are themselves induced by self-administered drugs or alcohol and the intramuscular injection of a benzodiazepine drug may be dangerous. Another major cause of severe excitement is psychosis and in such cases an adequate dose of an antipsychotic drug is preferable to a benzodiazepine.

One final comment. The urge that some doctors have to prescribe drugs is so strong that inevitably some other 'remedy' will be searched for when one becomes unacceptable. Already we are being assaulted with the sales promotion of a non-benzodiazepine sedative, buspirone. The effectiveness of this drug is meagre but the cost is very high; I hope that all of us who are concerned about the financial resources available to the NHS will not squander those resources on such drugs.

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DEAR SIRS

May I ask for whom 'A College Statement' on Benzodiazepines and Dependence is intended for? If it is intended as a guide for Members and Fellows it is surely an impertinence. I, and I am sure many of my colleagues, find your dogmatic views wholly impractical and unacceptable. It is almost ludicrous to imagine patients with disabling or severe insomnia and anxiety improving after treatment with a benzodiazepine for *one month* only. We are told to stop it at the end of this time, irrespective of their state. And do what instead? Presumably tell the patient to pull themselves together? Or that nanny knows what is best for them.

In severe anxiety a benzodiazepine may need to be given for a year or more, combined with psychotherapy or what other treatment is appropriate. During this time it is the responsibility of the therapist accurately to assess progress and the need for the continuation of the drug and its appropriate dosage. It is only the indifferent psychiatrist who allows a benzodiazepine to be continued beyond the time any one patient takes to recover. For you to publish statements containing 'Rules' like this surely only encourages sloppy psychiatry. It certainly does nothing to enhance the prestige of British psychiatry or the College.