Poor tactics are evident even in the banners under which proponents of the various 'psychotherapies' stand. The term 'therapy' is obviously meant to match physical 'therapies', thereby obtaining equal status with the likes of organic psychiatry, surgery, and medicine in lecture programmes and health services. Equal status there should certainly be. But unfortunately, 'therapy' also contains all the other implications that go with a 'bioscientific' approach. However little surgeons and physicians know about psychiatry and psychotherapy, they do know that they are operating in quite a different realm, and they instinctively resist.

So the psychotherapies are hoist by their own petard. For example, it is much easier with physical therapies to tell whether the patient has taken the doctor's advice or not. Of course, psychotherapy is more than just advice-giving, but a lot of it is about 'resistance' of various kinds. In the (inevitable) absence of concrete description or 'markers' of what happens in the interactions and process of psychotherapy, mere attendance for appointments may be equated with 100% compliance with treatment. Attending appointments on its own would never be a sufficient criterion for assessing the efficacy of a physical treatment. Again, the sign outside the restaurant has promoted decades of serious misunderstanding – and it is *not* really the outsiders' fault.

With this belated clarification, I commend fellow psychiatrists who have previously and understandably been repelled from entering some fine restaurants in our quarter of town, to shut their eyes to the misleading (and now immovable) signs outside, and feast within!

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Comparison of diazepam and buspirone

SIR: In the past year British psychiatrists have received concentrated advertising designed to persuade them to prescribe buspirone for anxiety. It has been hinted that buspirone is less likely to lead to dependence than diazepam. Murphy *et al* (*Journal*, April 1989, **154**, 529–534) continue this theme.

Dr Murphy *et al* had four active treatment groups, each with only ten patients completing. There was no placebo group. The striking thing about their displayed results is that patients in all groups got better with the passage of time and the receiving of attention. At the end of 14 weeks, whether patients had had no active treatment for the past eight weeks or no active treatment for the past two weeks, as groups they were all much improved and did not differ from one another. Nor, one may suppose, would they have differed from a placebo group.

While anxiety levels were still initially high, and before time could have brought resolution, diazepam was significantly superior to buspirone in anxiety relief. There was also clear evidence of withdrawal effects after diazepam.

Dr Murphy *et al* have demonstrated again that diazepam is effective and that a drug effective against anxiety will lead to eventual withdrawal symptoms. Buspirone, not being noticeably effective, did not lead to noticeable withdrawal effects. Lack of potency of buspirone is no recommendation for its prescription.

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ASC and water intoxication

SIR: I would like to thank and clarify the interesting points raised by Cooney (*Journal*, August 1989, **155**, 266) regarding our case report (Lee *et al*, *Journal*, April 1989, **154**, 556–558). Dr Cooney expressed surprise at our suggestion that we were not aware of previous reports of the use of water to induce an altered state of consciousness (ASC), for three reasons: (a) many of his patients with excessive fluid intake presented as 'drunk'; (b) case 1 in Singh *et al* (1985) turned to excessive water drinking because it made him feel slightly drunk; and (c) Ripley *et al* (1989) remarked that mild overhydration may be experienced as pleasurable, leading to further polydipsia.

The first observation is based on Dr Cooney's unpublished personal experience, and should not

therefore lead to surprise at our report. As for the second reason, Singh *et al* (1985) did not elaborate on or discuss the brief sentence noted above, and actually stated in the beginning of their paper that "water does not alter perception" (this speaks against an ASC which characteristically causes perceptual distortions and body image change (Ludwig, 1966)). Besides, it was not clear whether depression (the patient's diagnosis) with an accompanying self-harming motive or an enjoyable ASC was the primary aetiological factor. It will take a meticulous reader to spot that sentence and think about it in the perspective of ASC. Incidentally, we have quoted even earlier and more likely mentions of ASC ("a feeling of unreality" and hysterical fugue in patient 2 (Barlow & De Wardener, 1959)) in our paper, but again ASC was not specifically discussed. A more recent review does not include ASC or allied factors in its discussion of possible aetiological factors in polydipsia (Illowsky & Kirch, 1988). Hence, we consider that it is still worthwhile to highlight ASC in our case report. Concerning the third reason, Ripley *et al*'s paper was published several months after our report was submitted and accepted for publication, and aims to show an association (they suggested both genetic and psychological reasons) between alcohol abuse and water intoxication in schizophrenic male patients. No specific discussion was made on ASC, which in my opinion may provide a valuable link between drunkenness from alcohol abuse and "pleasurable polydipsia" as hinted at by the author. Incidentally, a pleasurable experience, such as eating good food, may or may not constitute an ASC as it is usually described – Ludwig (1966) listed nine general characteristics. Viewing compulsive water drinking as "maladaptive ASC" (Ludwig, 1966) also carries treatment implications because, if verified, it will be possible to replace this potentially dangerous habit by methods of developing "adaptive ASC", as by self-hypnosis or Qigong, a popular Chinese breathing and physical exercise.

There is also some misunderstanding about water drinking in traditional Chinese medicine. A large amount of cool water does achieve a mildly 'cooling' effect, but an intake of 20 litres/day is exceptional, apparently because of the physical discomfort that ensues. Besides, most Chinese would prefer to take a smaller amount of a more potent 'cold' remedy (e.g. bitter tea or melon) rather than water (Koo, 1984), so that our patient's adverse complications are still very unusual. Cigarette smoking and the list of aetiological factors cited by Dr Cooney are all irrelevant to our case. Finally, I would be interested to learn, with regard to the "many patients with excess fluid intake who present as drunk" to Dr Cooney, what kinds of patients they are and whether it is feasible to investigate their drunkenness using an ASC scale.

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Better to be depressed in the sun

SIR: Further to the correspondence following the papers by Lee & Murray (*Journal*, December 1988, **153**, 741–751) and Kiloh *et al* (*Journal*, December 1988, **153**, 752–757), may I be permitted to suggest an alternative explanation to the apparent difference in outcome between London and Sydney depressives? It is now accepted that phototherapy is an effective treatment for the seasonal affective subgroup of endogenous depression. It is highly likely that representatives of this subgroup were included in both the London and Sydney cohorts. With, I gather, the exception of this year, the climatic differences between foggy London and sunny Sydney are well accepted. Might not therefore the Sydney group have unwittingly been practising autophototherapy as they disported on Bondi Beach and its environs?

Rather than suggest the drastic step of emigration to the Antipodes, might not Drs Lee & Murray advise their depressive patients to take a long sea voyage around the West Indies, thus proving what our Victorian forebears knew well?

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