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.

ISAAC MARKS

Institute of Psychiatry
London SE5

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.

SAMUEL I. COHEN

The London Hospital Medical College, London E1

REFERENCES

[1] A. CLARE (1987) The Benzodiazepines in Current Clinical Practice. (eds H. Freeman and Y. Rue) *Royal Society of Medicine International Congress and Symposium Series*, 114.

[2] COHEN, S.I. (1987) Are benzodiazepines useful in anxiety? *The Lancet*, **ii**, 1080.

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'