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

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