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Obsessive-Compulsive Disorder – A Complication of Benzodiazepine Withdrawal

SIR: There has been increased awareness in recent years of the symptoms of benzodiazepine withdrawal. Although obsessional symptoms have been described as part of this withdrawal syndrome (Ashton, 1984), obsessive-compulsive disorder (American Psychiatric Association, 1980) has not previously been reported.

Case Report: The patient, a 32-year-old married woman, had a history of recurrent depression treated by diazepam (6 mg daily) for the previous 7 years. She discontinued this abruptly in June 1985 on her general practitioner's advice as she was planning a pregnancy. Two weeks after discontinuing medication she developed symptoms of anxiety, insomnia, nightmares, and hyperacusis, similar to those reported by Tyrer *et al* (1983), which persisted for several weeks. Four weeks after discontinuing diazepam, however, she also developed obsessive-compulsive symptoms related to a fear that she might inadvertently reveal information to other people which would lead to the loss of her home and family. This resulted in her hoarding rubbish and avoiding going out alone. When outside her home she would stop and collect any rubbish on the road or pavement. She repeatedly checked the contents of her dustbin and also her own and other people's clothes, shoes, pockets, and money. She frequently asked her family for reassurance and help with her checking rituals. She refused to be left alone in the house for fear that she might throw "evidence" out of the window and, ultimately, required a family member to accompany her to the toilet or bath. During the night she would wake her husband and request him to go into the garden to check that she had not thrown anything out of the window. Her symptoms temporarily abated when in September 1965 she recommenced diazepam for a 2-week period, but they returned and increased in intensity on its cessation. In December 1985 she developed a severe depressive illness and was admitted to hospital in February 1986 following her general practitioner's request for a psychiatric opinion. As an in-patient she was treated with clomipramine (150 mg daily) and after 4 weeks was free of depressive symptoms. However, her obsessive-compulsive symptoms remained until April 1986 when a treatment programme of graded exposure in real life with self-imposed response-prevention (Marks *et al*, 1975) was instituted. In July she was discharged from active behavioural treatment with marked improvement in her obsessive-compulsive symptoms. She has continued to improve with homework practice and at follow-up in September 1986 was able to perform home-management tasks with little fear, although remaining anxious when walking along outside her home.

As well as suggesting a previously unreported psychiatric complication of benzodiazepine withdrawal, this case demonstrates that when depression coexists with obsessive-compulsive disorder, treatment of the depressive symptoms may not lead to resolution of the obsessional symptoms (Marks *et al*, 1980).

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Schizophrenia and Ethnicity

SIR: The frank suggestion by Teggin *et al* (*Journal*, November 1986, **149**, 667–668) that South African Xhosa patients are members of the Third World whilst their White compatriots live in the First World is to be welcomed. Nevertheless, it seems somewhat disingenuous to take as instances of "scientific truth" social and psychological variables which are dependent upon a system of racial classification which for many years has had no scientific support from social scientists or physical anthropologists. "Ethnicity" is a complex and polyphemous notion; to use it unproblematically, however, as if the psychiatric characteristics of a particular group can be

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