We wish to thank Roussel Laboratories for their kind help and co-operation with this report.

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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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understood in independence of a political system of classification and social control, is extraordinary.

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Relationship of Mood Alterations to Bingeing Behaviour in Bulimia

SIR: In their study of 12 patients with bulimia, Kaye *et al* (*Journal*, October 1986, **149**, 479–485) have presented an example of the use of paradox in treatment. Subjects were first told they were entering hospital for a study rather than for treatment. They listed their favourite binge foods before admission and every effort was made to obtain these. They were given a private room and encouraged to take as much time as they needed to achieve the "desired effect" of their binge and vomit, having been supplied with a tray of 5000–6000 Kcal of food for the purpose. This was followed by the attentions of a physician as soon as the binge and vomiting was completed to the subjects' satisfaction. It would be interesting to know whether such a programme had any effect on the subjects' bingeing and vomiting behaviour. Could this be a model for a novel treatment approach?

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Is There a Lithium Withdrawal Syndrome?

SIR: The paper by Mander (*Journal*, October 1986, **149**, 498–501) contains problems and an attractive enigma. The author used the words "withdrawal" and "relapse" interchangeably: they are not so. In any chronic condition, whether on or off treatment, in a stable state, making any change to that regimen (e.g. stopping lithium) is likely to effect a reaction (e.g. a relapse). The author proves this point. The pursuit of the question as to whether there is a withdrawal effect on stopping lithium that increases the number of relapses in the early stages can only be shown if there is a fall in the relapse rate lower than expected for a period after the withdrawal syndrome has ended. However, the theoretical relapse rate can never be known since the withdrawal syndrome "shadows" it. How can one distinguish a withdrawal state causing relapse and relapse alone?

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CORRIGENDA

Journal, October 1986, **149**, 471–474 (P. Thompson). In Table I (page 472) the number of patients with 4–9 seclusions in 1984 should be 7 and not 1.

Journal, November 1986, **149**, 592–602 (W. A. Arrindell & P. M. G. Emmelkamp). The second sentence of the fourth paragraph of the 'Results' section (page 598) should read as follows: "On neuroticism, the partners scored as high as partners of other patients and as high as maritally non-distressed males, and significantly lower than maritally distressed males ($P < 0.0001$), who as a group had the highest mean score (Table I)". The first sentence of the 'Sexual maladjustment and sexual dissatisfaction' section (page 598) should read "Agoraphobics were found to rate their sexual relationships with their marital partners as less adjusted than maritally non-distressed females did, but as significantly more adjusted than those of female non-phobic psychiatric subjects, and as 'adjusted' as the sexual relationships of maritally distressed female subjects".

Journal, November 1986, **149**, 631–635 (R. Noyes *et al*). The following should be added to the penultimate paragraph (page 634): "Anxious patients often report unsatisfactory interaction with physicians and alienation from them as well (Clancy & Noyes, 1976). In fact, their hypochondriacal attitudes and behaviour can seriously disrupt the doctor–patient relationship, resulting in unsatisfactory treatment (Pilowsky, 1980)."

A HUNDRED YEARS AGO

Notes and News

We desire to draw attention to the usefulness of the "After-care Ladies Working Society" in aid of the association of the after-care of poor and friendless female convalescents on leaving the asylums for the insane. The object of this Society is to assist poor female convalescents, after leaving asylums, with gifts of clothing according to the special requirements of each case. The annual subscription is five shillings. Gifts of dresses, etc, are thankfully received. Communications on the business of the Society to be addressed to Mrs Richardson, Parkwood House, Whetstone, N.; or Miss Hawkins, Chaplin's House, Colney Hatch, N. – *Eds*.

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Researched by Henry Rollin, Emeritus Consultant Psychiatrist, Horton Hospital, Surrey.

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