tion in virtually all neuroses. I would suggest that there is sufficient evidence to justify the commitment of practice funds for hypnotherapy. Considering the morbidity and suffering affecting families as well as patients, the long-term drug treatment and/or the surgical interventions sometimes necessary in these disorders, it would appear to be mandatory to consider hypnotherapy.

Apart from the exceptional patient benefit in conditions responding poorly to previous conventional treatment, the saving of general practitioner and hospital outpatient consulting time, the reduction in expensive drug therapy and the reduction of admission, investigation and surgical rates must all represent an extraordinary potential for cost saving as well as a lessening of workload.

K D PHILLIPS

The P R P Clinic
97 Pinner Road
Harrow
Middlesex HA1 4ET

References

1. Whorwell PJ, Prior A, Faragher EB. Controlled trial of hypnotherapy in the treatment of severe intractable irritable bowel syndrome. *Lancet* 1984; **2:** 1232-1234.
2. Whorwell PJ, Prior A, Colgan SM. Hypnotherapy in severe irritable bowel syndrome. *Gut* 1987; **28:** 423-425.
3. Whorwell PJ. Hypnotherapy in the irritable bowel syndrome. *Stress Med* 1987; **3:** 5-7.
4. Prior A, Colgan SM, Whorwell PJ. Changes in rectal sensitivity after hypnotherapy in patients with irritable bowel syndrome. *Gut* 1990; **31:** 896-898.
5. Colgan SM, Faragher EB, Whorwell PJ. Controlled trial of hypnotherapy in relapse prevention of duodenal ulceration. *Lancet* 1988; **1:** 1299-1300.
6. Schmidt CF. Hypnotic suggestions and imaginations in the treatment of colitis ulcerosa. *Hypnos* 1992; **19:** 237-242.
7. Fry L, Mason AA, Pearson RSB. Effect of hypnosis on allergic skin responses in asthma and hay fever. *BMJ* 1964; **1:** 1145-1148.
8. Hughes H, Gray S, Toledo JR, Olen E. Psychological treatment of skin disorders. *Psychology* 1981; **11:** 12-32.
9. Boncz I, Farkas B, Hunyadi J. Experiences with group hypnotherapy of psoriatic patients. *Aust J Clin Hypnotherapy Hypnosis* 1990; **11:** 16-19.
10. Syrjala KL, Cummings C, Donaldson GW. Hypnosis or cognitive behaviour training for the reduction of pain and nausea during cancer treatment: a controlled trial. *Pain* 1992; **48:** 137-146.

Benzodiazepine super-abuse

Sir,

In recent years the trend towards an increasing misuse of benzodiazepines by young people in Scotland has been noticed, but official anxieties and new constraints seem to have concentrated on the intravenous abuse of temazepam capsules. Reports noting these include the update from the Advisory Council on Misuse of Drugs[1] and will no doubt be noted by the impending reports from the Scottish drugs task force and the Scottish home affairs committee report on misuse in Scotland.

Perhaps what is less well understood is the magnitude of the benzodiazepine taking by young people. More than injecting these drugs, oral abuse seems to be common, at least on the east side of Scotland. It is well known that people who have never injected drugs take large quantities of the commonly prescribed hypnotics. Our own experience of self-reported information by young people involved with prostitution, and others, is of doses ranging from 50 mg to 400 mg taken on a regular basis. Regrettably, a wide variety of benzodiazepines are used interchangeably. Recent experience has included some people topping these doses by taking up to 700 mg of diazepam at one time, and similarly massive doses of other benzodiazepines. Withdrawal fits are common.

An event validating these self-reported data occurred recently in the surgery. A young woman attending a regular appointment demonstrated dramatically the level of her dependence by producing 70 10mg tablets of diazepam, placing these in one hand, projecting them into her mouth and with a small sip of water swallowing the lot. She happily agreed to wait in the surgery under observation for several hours, and two hours later became impatient and insisted that she had things to do and would have to leave. At that time there was some objective evidence of slowing of decision making but no disorientation, no sign of serious sedation and a continuing ability to negotiate about her drugs prescription which included further benzodiazepines which 'she needed' for later that day. She was unconcerned about negotiating over her opiate habit which she considered to be mild at a mere 25 to 30 dihydrocodeine tablets per day. Followed up 48 hours later she was said by her boyfriend to be out at the shops trying to purchase some drugs.

Although this level of benzodiazepines or at least similar levels are often reported, they are equally often disbelieved by medical practitioners, including ourselves. This group of patients, however, seems to be on the increase and represents the 1990s wave of damaging drug use equivalent to what we saw in the 1980s with the heavy injecting. Treatment and solutions are not immediately apparent and I would be grateful for any helpful suggestions or comments.

J ROY ROBERTSON

Muirhouse Medical Group
1 Muirhouse Avenue
Edinburgh EH4 4PL

Reference

1. Advisory Council on the Misuse of Drugs. *Aids and drug misuse. Update.* London: HMSO, 1993.

Burnout

Sir,

I was most interested to read the editorial by Chambers on burnout.[1] I agree that the medical profession is better at recognizing that the problem exists than knowing what to do about it. Since the early 1980s I have been running groups for health professionals which provide an opportunity for busy clinicians to look at their own personal and professional problems in the hope of reducing their own stress and improving the service they provide to patients. A number of general practitioners have attended these groups and commented on them favourably; indeed, some have attended on a regular basis over a period of years. Weekend groups are held twice yearly in Bristol and there is a one week residential group in Devon in the summer. I should be happy to send further information to any readers who might be interested.

RICHARD TILLETT

Psychotherapy Department
Wonford House Hospital
Dryden Road
Exeter EX2 5AF

Reference

1. Chambers R. Avoiding burnout in general practice [editorial]. *Br J Gen Pract* 1993; **43:** 442-443.

Information feedback

Sir,

We read with interest the paper by Szczepura and colleagues on the effectiveness and cost of different strategies for feedback in general practice (January *Journal*, p.19). The authors conclude that their study provides valuable information on how centrally collected data might be used cost effectively to develop information feedback at practice level.

We work within a health commission which purchases health care on behalf of both the family health services authority and the district health authority and believe that health authorities have a duty to feed back to general practitioners information available to them from a variety of sources. Such information might facilitate audit and promote an improvement in the quality of services delivered in primary care.