We do, however, disagree that the management we advocate is to 'get out and exercise'. This is a common misconception. Cognitive behavioural therapy is not exercise therapy, and we are not physiotherapists. It is true that in the later stages of treatment patients are encouraged to increase their activity (which must ultimately be the aim of any treatment) but therapy does not involve the simple prescription of set amounts of exercise. Instead, treatment is based on mutually agreed targets, which are themselves jointly chosen as being some activity that the patient wishes to undertake, but has avoided. In practice this may simply be brushing one's teeth, or sitting out of bed to eat a meal. The behaviour is chosen solely on the basis of avoidance; the physiological and ergonomic consequences of such activity are irrelevant. The aim is to introduce predictability, and the return of self-control and self efficacy, not to restore muscle power. Furthermore, the other important component of our approach to management is an awareness of emotional disorders, and a recognition that these may need treatment in their own right.

We agree that the management we advocate is neither new nor unique. Almost identical management is now the treatment of choice for chronic pain[5] and fibromyalgia.[6] The latter is particularly relevant, since it is increasingly accepted that fibromyalgia may indeed be the same condition as post-viral fatigue.[7] Furthermore, it is difficult to think of a pathological mechanism by which gradual increased activity could be harmful,[8,9] even in the minority of patients with clear cut neuromuscular pathology.

The final decision must be based on evidence. We have already announced preliminary details of a pilot evaluation of cognitive behavioural therapy (Wessely S, *et al,* abstract presented at the scientific meeting of the Royal College of Psychiatrists, London, 25 September 1989). Our conclusion was that the advice currently offered to these patients may not be accurate, and that the current therapeutic nihilism in this condition may be unduly pessimistic.

In summary, the differences between our approach and that of Dr Ho-Yen may be less marked than at first sight. Given the difference in our samples and clinical experience, one might summarize by saying that whereas Dr Ho-Yen correctly emphasizes the dangers of doing too much, too early in the natural history of the condition, we emphasize the equally damaging consequences of doing too little, too late. The most appropriate strategy depends upon the stage of the illness reached by the patient.

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Advising patients on their benzodiazepine use

Sir,

We read with interest the paper by Cormack and colleagues (October *Journal,* p.408) on the subject of advising patients on their benzodiazepine use. We have obtained comparable results from a similar, but not identical, study which we have just completed. In our prospective study in an inner city practice of 12 100 patients we identified 46 patients (0.4%) who were receiving benzodiazepines on repeat prescriptions. All were long-term users, the mean duration of use being 14 years (range three to 21 years), and they were an older group than that studied by Cormack and colleagues with a mean age of 62 years (range 30 to 89 years).

In their paper Cormack and colleagues noted that strategies used by patients to reduce benzodiazepine consumption were 'vague and unsophisticated'. We offered a simple programme to all our patients. Intervention consisted initially of ceasing all repeat prescribing of benzodiazepines and instituting regular consultations for all those individuals wanting such medicines. At these consultations the patients were given verbal and written information about the known risks of long-term benzodiazepine use, and were offered a phased withdrawal programme involving dose reduction, reduced frequency of use and reduction in preparation potency, prior to cessation of all use. Progress was reviewed at subsequent consultations, and counselling support was offered within the practice (by practice counsellors) and outside the practice (in health authority clinics), although no patients took advantage of these options. Therefore, this strategy, while involving extra consultation time and the preparation of simple written material, used only resources available to all general practitioners.

One year after this intervention, six of the 46 patients (13.0%) had stopped all benzodiazepine use, 22 (47.8%) had reduced their consumption and 14 (30.4%) had not changed their pattern of use. No patients had increased benzodiazepine use, but two had left the practice and two had died.

Although this intervention was applied to an elderly subpopulation that we presumed would resist reduction of their benzodiazepine use, the success in changing habits was greater than anticipated. The assumption that such patients are 'hopeless addicts' appears unfounded. Formal challenge, the provision of verbal and written information and regular follow-up consultations seems a clear and effective strategy for approaching the problem of long-term dependency.

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Traveller gypsies

Sir,

I read with interest the recent review article on traveller gypsies and primary care (October *Journal,* p.425). While it covered many of the issues about travellers and health care, there are several further points that I would like to raise.

First, the review suggests that epidemics of infectious diseases have not been documented among the traveller popula-