process of illness negotiation between *both* the patient and the doctor (Swartz, 1987). In particular, doctors now in medical practice are likely to have been taught as medical students that eating disorder is a rare condition of the upper-class, white family. *Re-education* is obviously helpful, as this seems so inaccurate today.

SING LEE

Department of Psychiatry
Prince of Wales Hospital
Hong Kong

References

GARNER, D. M., OLMSTED, M. P., BOHR, Y., *et al* (1982) The eating attitudes test: psychometric features and clinical correlates. *Psychological Medicine*, **12**, 871–878.

KING, M. B. & BHUGRA, D. (1989) Eating disorders: lessons from a cross-cultural study. *Psychological Medicine*, **19**, 955–958.

LEE, S. (1989) Anorexia nervosa in Hong Kong – why not more in Chinese. *British Journal of Psychiatry*, **154**, 683–688.

MUMFORD, D. B. & WHITEHOUSE, A. M. (1988) Increased prevalence of bulimia nervosa among Asian schoolgirls. *British Medical Journal*, **297**, 718.

SWARTZ, L. (1987) Illness negotiation: the case of eating disorders. *Social Science and Medicine*, **24**, 613–618.

TSENG, M. C., LEE, M. B. & LEE, Y. J. (1989) A clinical study of Chinese patients with eating disorders. *Chinese Psychiatry*, **3**, 17–28.

Transsexualism

SIR: We wish to comment upon the two contributions to the literature on transsexualism (Mate-Kole *et al*, *Journal*, August 1990, **157**, 261–264; Burns *et al*, *Journal*, August 1990, **157**, 265–268). The first study is concerned with the outcome of gender reassignment and compares operated and waiting list patients. It is useful to present composite measures in terms of social activity and a self-assessment scale measuring neurotic symptoms. From these measures a generally improved quality of life may be discerned although the most important questions are left unanswered; these concern the patients' attitudes to the whole process of gender reassignment and the satisfaction, in retrospect, of having undergone the arduous procedures of approximation to the gender role requested. The matter of outcome assessment of this extraordinary intervention, conducted at the earnest request of the patient, requires greater attention than it has currently received, and assessments must be conducted by persons who are independent of the clinical team staff and 'neutral' in attitude toward the procedure of gender reassignment (Abramowitz, 1986; Snaith, 1987).

A small outcome study of our own, conducted with respect to these criteria, was reported briefly (Snaith, 1990). This gave us confidence to continue with the work but clearly more extensive studies are required to guide clinicians in these difficult decisions. We need to know more about the fate of those requesting gender reassignment whose requests are refused by gender identity clinic staff. At the time of rejection of application many patients appear to be very distraught but it may be that a number can later accept the grounds for refusal and lead more contented lives in pursuit of realistic aims.

The second study calls for further study of the phenomenology of transsexualism and the relation of these factors to outcome. This also is an important area of study. It is probable that whether or not the person fits the criteria of the DSM–III is of lesser importance than whether the person can live in the opposite gender role and be accepted in that role by family, friends and employers. The general stability of personality and ego strength are not assessed by the DSM but are vital factors in outcome. The care and pace at which a person is guided through a gender reassignment programme and the supervision of all aspects of this complicated procedure must certainly have a major effect upon the eventual outcome, relief of distress and improved quality of life which are the ultimate criteria on which reassignment procedures must be judged.

This close supervision can only be provided by a regional gender identity clinic team. The metropolitan centres at Charing Cross Hospital and the Maudsley Hospital offer a considerable service by accepting referrals without geographical restrictions but, for all their experience and excellence, they cannot provide the close social, psychological and endocrinological supervision to people living at a distance of some hundreds of miles; nor can they be immediately on hand to deal with the sometimes severe post-operative complications.

Although the nature of transsexualism remains elusive it is a human condition which is not likely to disappear and people will be requesting the services of experienced teams for many years to come. It is our experience that a satisfactory service can be established on a regional basis within the National Health Service. As regards private sector services these have the inherent danger that patients may purchase what they initially believe to be in their interests but which may end in disaster.

Transsexualism is listed in the classificatory systems as a psychiatric disorder. Whether or not this is correct may be debated but Gender Identity Clinics should be established under the supervision of psychiatrists who have the experience to assess stability of personality and to detect latent psychiatric disorder which would contraindicate gender reassignment. The Royal College of Psychiatrists should now

conduct a national enquiry of clinic practice in this area and contract to set up some general guidelines as to future practice.

R. P. SNAITH (Psychiatry)
D. R. BROMHAM (Endocrinology)
J. DONNELLY (Speech therapy)
P. H. SMITH (Surgery)

Gender Identity Clinic
St James' University Hospital
Leeds LS9 7TF

References

ABRAMOWITZ, S. I. (1986) Psychosocial outcomes of sex reassignment surgery. *Journal of Consulting and Clinical Psychology*, **54**, 183–189.

SNAITH, R. P. (1987) Gender reassignment today. *British Medical Journal*, **295**, 454.

—— (1990) Transsexuality. *Journal of the Royal Society of Medicine*, **83**, 125.

Carbamazepine in alcohol withdrawal

SIR: The article by Glue & Nutt (*Journal*, October 1990, **157**, 481–490) on overexcitement and disinhibition was both interesting and informative. It did however omit a discussion of carbamazepine in the treatment section.

Carbamazepine has been shown in a controlled trial (Malcom *et al*, 1989) to be of equal efficacy to oxazepam in reducing the symptoms of alcohol withdrawal. The authors postulated that this was due to its 'antikindling' effects, although its action on presynaptic adenosine receptors may also be important (Durcan & Morgan, 1990). In addition, with an increasing emphasis on out-patient detoxification programmes (Collins *et al*, 1990), carbamazepine has the advantage of a low potential for abuse or dependency.

C. G. BALLARD
R. N. C. MOHAN
S. HANDY

Department of Psychiatry
Walsgrave Hospital
Coventry CV2 2DX

References

COLLINS, M. N., BURNS T., VAN DEN BERK, A. H., *et al* (1990) A structural programme for out-patient alcohol detoxification. *British Journal of Psychiatry*, **156**, 871–874.

DURCAN, M. J. & MORGAN, P. F. (1990) The prospective role for adenosine and adenosinergic systems in psychiatric disorders. *Psychological Medicine*, **20**, 475–486.

MALCOM, R., BALLINGER, J. C., STURGIS, E. T., *et al* (1989) A double-blind trial comparing carbamazepine to oxazepam in the treatment of alcohol withdrawal. *American Journal of Psychiatry*, **146**, 617–621.

Culture as a confounding variable?

SIR: In their study of thought disorder in schizophrenics, manic–depressives and major depressives, Cutting & Murphy (*Journal*, September 1990, **157**, 355–358) were careful to compare their groups for IQ, age, sex and attentional factors. The study involved a judgement of the subjects' answers to multiple choice questions regarding social knowledge about their culture and general knowledge about the state of the world. It is a shame that the care taken to examine psychological differences is not matched by an equal care to examine social differences between the groups.

The important influence of culture in psychiatry is increasingly recognised and debated (see Leff, 1990; Littlewood, 1990). No mention is made in Drs Cutting & Murphy's study of the cultural background of the groups. This will surely have considerable influence on their judgement of a subject's knowledge of his or her own culture! If this questionnaire is to be of general use its validity across different cultures should be tested.

The difficulty in deciding which are social factors is demonstrated by the *post hoc* change of category of one question. From the 'non-social' category the answer to the question, 'What is the age of the oldest person in Britain?' will surely be influenced by the social experience of the respondent. If they come from a Nepalese culture this will be of a less elderly population than a respondent from another culture. The influences of culture must not be overlooked.

JONATHAN EVANS

Department of Psychiatry
Charing Cross Hospital
Fulham Palace Road
London W6 8RF

References

LEFF, J. (1990) The new cross-cultural psychiatry: a case of the baby and the bathwater? *British Journal of Psychiatry*, **156**, 305–307.

LITTLEWOOD, R. (1990) From categories to contexts: a decade of the new cross-cultural psychiatry. *British Journal of Psychiatry*, **156**, 308–327.

Buspirone in detoxification

SIR: I wish to comment on Ashton *et al*'s study (*Journal*, August 1990, **157**, 232–238).

The practice of prescribing additional drugs to aid detoxification in drug-dependent individuals is a controversial issue. The addition of one anxiolytic agent (busipirone) to aid withdrawal from another anxiolytic agent (diazepam) appears contradictory, especially when buspirone's data sheet specifically