

Much of the discussion on AN in Asians has focused on the role of exposure to Western ideas and culture which emphasise slimness and diet control. However, three of our patients came from very traditional Indian households. The youngest patient had never been sent to school by her illiterate parents and had not even travelled outside her village until she was forced to do so because of her symptoms. The view that slimness is not a requisite for beauty in Indian culture may also be an oversimplification. Anything beyond a well-fed look in an adolescent is very likely to subject her to ridicule from peers and family members (a precipitating factor in three of our patients), and may adversely affect her prospects even in the arranged marriage system.

Our observations seem to indicate that conflicts over body weight may not be a phenomenon unique to the West. The lower prevalence of AN in India may be because of the qualitative and quantitative aspects of the diet in a less affluent society, the tradition for women to eat the last, and often the least, in the family, and the society's acceptance of a wider range of weight as being consistent with good appearance. Consequently, fewer women would cross the upper limit and feel under pressure to diet.

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The clinical application of restricted environmental stimulation therapy (REST): observations of a psychiatrist

SIR: The idea that solitude and the reduction of environmental stimulation are conducive to the improvement of mental health, and health in general, is not new. What is new is the development of a precise technique by which environmental stimulation can be reduced and controlled. The exact methods employed in the REST programme have been described elsewhere (Suedfeld, 1980).

The REST programme is the result of a pioneering research by Suedfeld and his colleagues at the department of psychology at the University of British Columbia.

Its origin lies in the massive research done by Zubek and his colleagues in the 1960s in the area of sensory deprivation. The initial data on the subject have been summarised by the late Professor Zubek (Zubek, 1969). REST uses several of the major concepts of the sensory deprivation technique, but departs from it by abandoning, "physical restraints, cardboard cuffs, gloves, goggles and ear-phones etc. . . ." (Suedfeld & Kristeller, 1982).

The author, a practising psychiatrist in Vancouver, Canada, was impressed with the positive results obtained in the treatment of tobacco addiction. One of his employees, a senior health care nurse, was a heavy smoker. The nurse had tried various methods to stop smoking cigarettes. Finally, he volunteered to undergo REST treatment in a non-university setting. At that time, the REST treatment programme was in its early stage of development at the University of British Columbia.

After the completion of the programme, the nurse stopped smoking completely, and showed several positive attitudinal changes which were noted by his family members and colleagues. This case has been reported as "Mr F" in a paper illustrating the beneficial side-effects of REST in a smoking cessation programme (Suedfeld & Best, 1977).

REST has been applied to various clinical conditions which range from obesity to autism (e.g., Suedfeld & Schwartz, 1983). There has been some study of the effect of the REST programme in the treatment of essential hypertension (Fine & Turner, 1982).

During the last few years, the author has referred a number of patients to the REST clinic at the University of British Columbia. These patients were randomly chosen to participate in a research project at the university which was evaluating the effect of REST programme in reducing blood pressure without the use of medication. The patients were attending my office for psychotherapy. The complaints of the patients were psychosomatic in nature; increased blood pressure was one of their symptoms. Unfortunately, these patients were not showing a great deal of improvement. Some of them had developed insight, but they were unable to change their counterproductive attitudes. The author noted remarkable changes in their attitudes, after only one session of the REST programme, which employed a flotation tank, various relaxation tapes and the REST chamber for 24 hours. The following case history of one such patient is presented as an example.

Case report. Mr PG is a 36-year-old male, East Indian, real estate agent, who was referred to the author with a history of unexplained muscular tension, neck pain, and general symptoms of anxiety. During the interview, the author

noted that he had seen Mr PG on previous occasions when he used to bring his father to the author's office. His father suffered from depression. During the sessions with his father, Mr PG was noted to be calm and caring but controlled.

However, when Mr PG presented himself as a patient, he complained of the following symptoms:

- (a) Pain at the base of his neck
- (b) Periodic panic attacks
- (c) Hypertension for which no cause has been found
- (d) Other somatic symptoms for which multiple investigations have been done.

He made little progress after several sessions of psychotherapy. The author discussed with him the possibility of participation at the REST clinic at the University of British Columbia for the treatment of hypertension. Mr PG was most interested and subsequently discussed the matter with his family doctor. Appropriate referral to the REST clinic was made.

Two months later, Mr PG came to see the author and told him that he had completed a 24-hour programme in the REST chamber. He described his experience at the REST chamber with enthusiasm. He told the author that since he participated in the programme, his lifestyle had changed. Mr PG appeared relaxed and happy with his life in Canada. (He used to complain about harshness of Canadian life as compared to his experience in India.) He used to ruminate bitterly about his commitment to support all of his siblings in accordance with Indian tradition, since he was the eldest son. It was obvious that there had been a change in Mr PG's attitude. He was no longer complaining of somatic symptoms and apparently his blood pressure had returned to normal. He was not using any medication.

It is not clear at this stage whether the REST programme is effective in the treatment of essential hypertension. It is clear, however, that the programme is useful in a number of psychiatric conditions particularly those which fall into the category of psychosomatic disorder. The treatment technique does not require the use of any medication and it is simple to administer.

REST drew the author's attention when he observed how successful the technique was in helping people give up smoking. Individuals not only gave up smoking, they also gave up some of their negative attitudes.

REST is a simple technique. It is harmless, and cheaper than many of the non-drug therapies available today. It is capable of inducing deep relaxation in a shorter time-span than meditation. It can be used as an adjunct to psychotherapy. The author hopes that medical practitioners, psychiatrists and others will give some serious attention to this unique therapeutic tool.

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Is oncogene activity involved in the alcohol withdrawal syndrome?

SIR: In the single episode paradigm for alcohol intoxication and withdrawal there is a symmetrical relationship between severity and duration of intoxication on one side and the degree of physical dependence (the withdrawal reaction) on the other (Majchrowicz, 1975). Accordingly, the adaptation-rebound hyperactivity concept has been the main lead in investigations of alcohol withdrawal reactions (Kalant *et al*, 1971). In clinical reality, however, withdrawal reactions progress from physical withdrawal to overt psychosis and seizures during a 5–15 year period (Ballenger & Post, 1978), and this progressive nature of the neuroexcitatory state of alcohol withdrawal has been confirmed in animals. This seriously challenges the adaptation-hyperreactivity concept as an exhaustive theory for alcohol withdrawal. Also the insufficiency of that concept is highlighted by the fact that none of the changes in CNS-modulatory systems or mechanisms so far investigated (inhibitory and excitatory neurotransmitters, neuroreceptors, enzyme activity, energy metabolism, membrane phospholipid configuration or synaptic structure) are able to explain a long standing non-structural, inextinguishable hyperreactivity that remains unaffected by intervals of non-intoxication and non-withdrawal (Lipowski, 1990). Currently, a specific hypothesis is needed to explain how CNS-hyperreactivity can progress in extension and severity over long time periods without leaving circumscribed structural lesions. How does the alcoholic brain 'remember' that it has an altered capacity to express excitation? Logically, this can be explained by an aberration of genome expression. In mature neurons of the CNS, oncogenes cannot express themselves by mitogenous