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Note to authors of letters: Please note that all letters submitted for publication should be typed with *double spacing*. Failure to comply with this may lead to delay in publication.

Treatment of acute otitis media

Sir,

I was interested to read the article by Jones and Bain (August *Journal*, p.356) comparing three and seven day courses of antibiotic in the treatment of acute otitis media.

The summary suggests that a three day course of cefaclor 125 mg tds is as effective as a seven day course. However, I note that two cases, from the three day course group, were excluded from follow up and not included in the study because of recurrence of symptoms and the antibiotic was subsequently changed.

If these cases had been included this implies a failure rate of at least 2%. Extrapolating this further with the figures given of 1.5 million cases of acute otitis media per year would mean that 30 000 of these cases would be inadequately treated.

Surely further comprehensive studies on this subject should be undertaken before it is suggested that general practitioners change their management of acute otitis media.

HELEN COSGROVE

46 Regent Road
Gosforth
Newcastle upon Tyne
Tyne and Wear

Doctors in South Africa

Sir,

I was concerned by Dr Murrell's letter objecting to the presence of South African doctors at the WONCA conference (July *Journal*, p.335). This was not because of the writer's main argument about the inequalities and the injustices that spill over even into the health care of this sad country, with which I agree, but because of the inaccuracies and the vindictiveness of the letter. My experience here is that a large number of doctors, not just a tiny minority as Dr Murrell describes, are deeply committed to improving health care for all. This is particularly true in the area of general practice where the newer faculties are often dominated by ex-mission hospital doctors, for example Professor Sam Fehrsen of Medunsa Hospital and University, who, with others, have been instrumental in developing the family institute training, similar to vocational training in the UK. This training includes a compulsory year spent in one of the many ex-mission hospitals, which, in theory at least, are multiracial, although in reality only the very occasional white patient is seen in them.

There is great respect among the profession as a whole for the 'general hospital practitioners' who run these rural hospitals, and in one sense, there is a unique situation in South Africa where teaching hospitals, designed to produce 'first world' doctors have such close contact with third world medicine. Ironically, compulsory military service has increased this contact as many young doctors work in these rural hospitals on a short-term basis as members of the army, or for a term of six years as conscientious objectors. So, I believe, suitably chosen members of South Africa's medical community do have a considerable contribution to make to the world-wide debate about health care.

It is easy to shout 'foul' from many thousands of miles away, but doctors here need support, not spite, in fighting for change. Many work in poor conditions, some face six years in gaol if they object to military service on any grounds other than complete pacifism. Nor is Dr Wendy Orr an isolated 'phenomenon'. So keep up the pressure, but until you have spent 30 years working in a mission hospital, and so proved your real concern for the welfare of the underprivileged, please do not exclude those that have from contributing to the improvement of world health.

A.J.M. QUAYLE

12 Highland Flats
165 Alexandra Road
Pietermaritzburg
South Africa

Clinical psychology in general practice

Sir,

We were interested in Espie and White's paper on the effectiveness of psychological intervention (July *Journal*, p.310). They are, however, incorrect in their claim that they are the first to compare independent ratings by general practitioners, patients and psychologists in assessing the outcome of psychological treatments in primary care.

We mounted a randomized controlled trial of 429 patients[1,2] assessing outcome by 9-point visual analogue scales completed by general practitioners, patients, significant others and a blind assessor. We also measured general practitioners' and patients' satisfaction with outcome, consumption of psychologists' time, drug costs and general practitioner consultation rates in the psychologist treated and normal general practice management conditions. We believe this to be the most comprehensive study on the subject to date and, apart from Earll and Kincey's,[3] the only published one to utilize a control group. Both our study and the important paper by Freeman and Button,[4] which points out the pitfalls of assessing outcome without considering the natural history of the patient's problems, seem to have escaped your authors' notice.

Our study had some similarities to the one reported as we used scales of improvement and Kincey's[5] categories. It differed in that it was controlled, used more sophisticated scales, additional outcome measures and multiple follow-up assessment times.

The results also found high inter-rater reliability but our general practitioners' rating of average improvement was higher than that of the patients. We also found a superior response to treatment in those patients with anxiety disorders. The whole subject population showed considerable significant short-term gains across the wide range of measures. The control group improved much more slowly but

had nearly caught up at one year. We think that this is a reflection of the high-frequency low-intensity problems related to the life events and transitions commonly met in primary care. It is these patients who should be a special concern of the primary care psychologist and have to date been largely neglected and regarded as trivial by psychologist authors more used to working in a hospital setting.

For this reason we have now turned our attention to minimal interventions especially adapted for the primary care patient which are the subject of our recent book.[6]

RICHARD FRANCE
MEREDITH ROBSON

Medical Centre
Oaklands
Yateley
Camberley
Surrey GU17 7LS

References

1. Robson MH, France R, Bland M. Clinical psychologist in primary care: controlled clinical and economic evaluation. *Br Med J* 1984; **288:** 1805-1808.
2. France R, Robson MH. Work of the clinical psychologist in general practice. *J R Soc Med* 1982; **75:** 185-190.
3. Earll L, Kincey J. Clinical psychology in general practice: a controlled trial evaluation. *J R Coll Gen Pract* 1982; **32:** 32-37.
4. Freeman GK, Button EJ. The clinical psychologist in general practice: a six year study of consulting patterns for psychosocial problems. *J R Coll Gen Pract* 1984; **34:** 377-380.
5. Kincey JA. General practice and clinical psychology — some arguments for a closer liaison. *J R Coll Gen Pract* 1974; **24:** 882-888.
6. France R, Robson MH. *Behaviour therapy in primary care: a practical guide.* London: Croom Helm, 1986.

Psychological treatment for benzodiazepine dependence

Sir,

Espie and White (July *Journal,* p.310) in their study of the effectiveness of psychological intervention in primary care, comment on a need for further studies which aim to identify those factors which are predictive of outcome and the maintenance of improvement.

We wish to present the preliminary results of a study of anxiety management training groups for benzodiazepine withdrawal. The patients under study had all been dependent on benzodiazepine tranquillizers for more than two years and had failed to withdraw on previous attempts.

Anxiety management treatment similar to that described by Teare,[1] started with a period of didactic teaching which covered relaxation and its application, controlling and changing thoughts, problem solving, and timetabling daily life to reduce stress. This was followed by a discussion of problems and symptoms with practical advice on ways to live with and reduce symptoms. For example advice on insomnia included techniques which would encourage sleep but was also combined with how to deal with hours of wakefulness, such as listening to story tapes, taking warm drinks, list making and so on. Group meetings were held weekly for five weeks, then after two and then four weeks.

Of 12 patients offered treatment by a clinical psychologist (M.R.), nine attended until the end of the programme. Initial tranquillizer doses ranged from 4 mg to 40 mg of diazepam daily. After nine weeks, four patients had stopped taking tranquillizers and three were taking less than 25% of their initial dose. Two were still taking between 25% and 50% of the initial dose. At three-month follow up six patients had stopped taking tranquillizers.

At the end of the seventh group meeting members were given a questionnaire and asked to rate the amount of help gained from the six components of the anxiety management treatment on a linear analogue scale (Table 1). They were also asked what aspects of the treatment they would like to change.

Table 1. Mean scores for the helpfulness of the components of the anxiety management treatment on a linear analogue scale of 0–100.

	Mean score
Learning to cope with symptoms	84
Sharing problems with others	76
Learning to change thoughts	65
Learning relaxation	56
Problem solving	52
Timetabling life to reduce stress	52

Patients appeared to benefit from all techniques but group support followed by learning to control and change thoughts were rated most highly. Patients felt they would like more group sessions and suggested it would help to have a partner or confidant attending on one occasion to help them understand the problem. Patients asked for more help with relaxation techniques, problem solving and other anxiety management techniques at a later stage when in most cases they had stopped medication.

It is reasonable to assume that anxiety management (including cognitive restructuring) would be the treatment of choice for patients who are dependent on benzodiazepines and who exhibit typical anxiety symptoms on withdrawal, but this may not necessarily be true. Patients who take benzodiazepines complain both before and during withdrawal of lack of concentration and memory difficulties. This may make it difficult or impossible for them to learn new techniques and may increase their feelings of helplessness.

The results presented here indicate that cognitive change is important in efforts to give up tranquillizers. Cognitive therapy, support, practical advice on how to cope with and minimize symptoms are important components of treatment. In addition, the application of an anxiety management package a month after patients have withdrawn may provide the best help for these patients in their efforts to give up benziodiazepines permanently.

MEREDITH ROBSON
GRAEME CROUCH
COSMO HALLSTROM

Department of Psychiatry and Psychology
Charing Cross Hospital
London W6 8RF

Reference

1. Teare P. Skills not pills: learning to cope with anxiety symptoms. *J R Coll Gen Pract* 1984; **34:** 285-260.

'Epidemic' of polymyalgia and temporal arteritis

Sir,

Polymyalgia and temporal arteritis are thought to be two variants of the same disease whose cause is unknown. The symptoms include muscle pain and stiffness especially in the mornings, general malaise and in temporal arteritis severe temporal headache. Diagnosis is confirmed by history, a raised erythrocyte sedimentation rate (greater than 50 mm^{-1}) and a rapid response to oral steroids. The disease usually occurs in patients over the age of 60 years and is more common in women than men (ratio 4:1).

The incidence in general practice is uncertain. Turner[1] found 10 cases in a practice of 10 000 patients over a eight-year period while Kyle[2] found 19 cases in a practice of 5500 patients over a similar period. Three studies have recorded the disease occurring in more than one member of a family.[3-5]

In a suburban/rural practice of 4400 patients six new cases of polymyalgia and two of temporal arteritis were diagnosed in the period October 1985 to May 1986.