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]

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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.

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'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.