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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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.

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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.

Five hundred and seventeen of the patients in the practice are over 65 years of age (12.5%). The clinical features are shown in Table 1.

Case 3 was diagnosed from classical symptoms which responded rapidly to steroids and relapsed as soon as the treatment was discontinued. Cases 6 and 4 are mother and daughter. Case 7 has subsequently died from an unrelated illness.

The practice would normally see only one or two cases of polymyalgia or temporal arteritis each year and this suggests that there must be an underlying cause for the increased incidence. The cause may be a viral trigger in genetically susceptable individuals and the diagnosis of the disease in a mother and daughter within a few weeks of each other supports this. In addition there was a high incidence of viral illness in the winter 1985/86.

It is hoped that this report will stimulate other practices to note clustering of cases of polymyalgia and temporal arteritis and perhaps this will help throw light on a trigger or predisposing factor.

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References

1. Turner RM. Polymyalgia rheumatica: a general practice experience. *J R Coll Gen Pract* 1983; **33:** 167-170.
2. Kyle V, Silverman B, Silman A, *et al.* Polymyalgia rheumatica/giant cell arteritis in a Cambridge general practice. *Br Med J* 1985; **291:** 385-387.
3. Barber HS. Myalgic syndrome with constitutional effects. *Ann Rheum Dis* 1957; **16:** 230-237.
4. Harmin B. Polymyalgia arteritica. *Acta Med Scand* [*Suppl*] 1972; S533.
5. Nielson JL. Polymyalgia rheumatica in husband and wife. *Scand J Rheumatol* 1980; **9:** 177-178.

An examiner's comment on the care of the elderly

Sir,

The oral examiner is afforded a unique view of trends in general practice. Having been a member of the working party that produced 'Training general practitioners in geriatric medicine',[1] I have studied the log diaries of candidates with the recommendations it put forward.

In the examination just concluded, for instance, I was able to examine 25 log diaries of candidates distributed widely throughout England and Wales. Of the total of 1200 unselected patients there were listed only 89 (7.4%) aged over 75 years, and a mere 42 (3.5%) aged between 70 and 74 years. Three of the candidates were young principals and they had marginally more records of elderly patients than those just concluding a traineeship.

The conclusions to be drawn are serious. If trainees are not being allocated older people at the outset of their training they are being denied the opportunity to provide continuity of care for a group which is becoming an increasingly large proportion of the population. It is no excuse to say, as many did, that they think older people prefer their own doctor. I have been able to show in my own practice that older people often like being introduced to a young doctor for a year of caring. Not one has returned to me with objections during the 10 years I have been a trainer.

The other aspect is of a different order. The government believes it necessary to reward doctors with a higher capitation fee for elderly people, presumably because they make heavier demands on doctors' services. There are suggestions at the present time that these should be increased again. I have long argued[2] that this would impoverish the care of the elderly and reward doctors falsely. The figures from the log diaries exemplify what I demonstrated in my own practice[2] that those aged between 65 and 74 years now make no greater demand on a doctor's services than younger patients. I can only suspect that those aged over 75 years are either cared for mainly by nurses, the repeat prescription list, or that they are a biological élite having no need of doctors.

What would be helpful would be item of service payments for restructuring the records of those aged 70-plus years on the lines of a nationally agreed proforma, and another to encourage doctors to conduct an examination and performance rating of older people.

I have greatly enjoyed my 10 years as an MRCGP examiner, and hope that these comments will be reviewed by those colleagues whose company has always been so stimulating to me.

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References

1. British Geriatrics Society and the Royal College of General Practitioners. Training general practitioners in geriatric medicine. *J R Coll Gen Pract* 1978; **28:** 355-359.
2. Thompson MK. Why not better care for the elderly. *J R Coll Gen Pract* 1982; **32:** 113.

Table 1. Clinical features of the cases of polymyalgia (P) and temporal arteritis (TA).

Case number	Diagnosis	Date of diagnosis	Age (years)	Sex	Initial ESR (mm^{-1})	ESR after treatment (mm^{-1})	Delay in diagnosis (weeks)
1	TA	Oct 85	61	Female	150	32	4
2	P	Nov 85	67	Female	57	15	2
3	P	Nov 85	64	Male	30	16	1
4	P	Jan 86	48	Female	110	25	6
5	P	Mar 86	60	Female	120	15	2
6	P	Mar 86	75	Female	68	16	4
7	TA	Mar 86	90	Male	80	25	2
8	P	May 86	58	Male	70	20	6

ESR = erythrocyte sedimentation rate.

Jewish Family Mediation Service

Sir,

Further to the article on the family conciliation services by Thelma Fisher (July *Journal,* p.300), I would like to inform general practitioners of the existence of the Jewish Family Mediation Service. We are based in central London and have been set up specifically to serve the Jewish community. We have been operational since April this year and are fully affiliated to the National Family Conciliation Council. Our team of mediators have all undertaken the specific training required by the NFCC and are knowledgeable in the Jewish and civil law concerning marriage and divorce.

Mediation can be of immense value to both parents and children when there are difficulties relating to access or other child-focussed matters. It is quick and low in cost. As Thelma Fisher stated 'it can have healing effects'. Doctors should not hesitate to recommend it when appropriate.

Anyone requiring further information on the JFMS should contact me at the address below, telephone 01-636 9380.

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