References

Adult disorders

1 World Health Organization. Schizophrenia: An International Follow-up Study. Chichester: John Wiley & Sons, 1979. (AIV) Large outcome study with two-year follow-up, showed that only 10-15% of patients did not recover from their illness in that two-year period. Another shorter-term follow-up study (Lieberman J, Jody D, Geisler S et al. Time course and biologic correlates of treatment response in first episode schizophrenia. Arch Gen Psychiatry 1993, 50: 369-376) showed that 83% of first-episode psychotic patients treated with antipsychotic medication remitted by one year post-inpatient admission.

2 Kavanagh DJ. Recent developments in expressed emotion and schizophrenia. Br J Psychiatry 1992, 160: 601-620. (AIII) Family support and education, which promotes a more supportive family environment, can reduce relapse rates substantially.

3 Driver and Vehicle Licensing Agency. At a Glance Guide to Medical Aspects of Fitness to Drive. URL http://www.dvla.gov.uk. Further information is available from The Senior Medical Adviser, DVLA, Driver Medical Unit, Longview Road, Morriston, Swansea SA99 ITU, Wales.

4 Atypical antipsychotics appear to be better tolerated, with fewer extrapyramidal side-effects, than typical drugs at therapeutic doses. Even at low doses, extrapyramidal side-effects are commonly experienced with typical drugs. Whether or not atypicals improve the long-term outcome has yet to be established. Risperidone, amisulpride and possibly olanzapine have a dose-related effect. Selected references:

4a American Psychiatric Association. Practice guidelines: schizophrenia. Am J Psychiatry 1997, 154(Suppl 4): 1-49. (BII) This reports 60% of patients receiving acute treatment with typical antipsychotic medication, develop significant extrapyramidal side-effects.

4b Mir S, Taylor D. Issues in schizophrenia. Pharmaceut J 1998, 261: 55-58. (CV) This work reviews evidence on efficacy, safety and patient tolerability of atypical antipsychotics. 4c Duggan L, Fenton M, Dardennes RM et al. Olanzapine for schizophrenia (Cochrane Review). In: The Cochrane Library. Oxford: Update Software, 1999. (CI) Twenty-one studies were analysed. Olanzapine was found to be an effective antipsychotic that produced fewer movement side-effects. It did tend to cause more weight gain than the older drugs, however.

4d Hunter RH, Joy CB, Kennedy E et al. Risperidone versus typical antipsychotic medication for schizophrenia (Cochrane Review). In: The Cochrane Library, Issue 2, 2003. Oxford: Update Software (C1) Twenty-three studies were analysed. Risperidone might be equally clinically effective as relatively high doses of haloperidol. It causes fewer adverse effects than the side-effect-prone haloperidol.

5 National Institute for Clinical Excellence. Schizophrenia: Core Interventions in the Treatment and Management of Schizophrenia in Primary and Secondary Care. Clinical Guideline 1. December 2002. URL http://www.nice.org.uk. (AI)

6 Bollini P, Pampallona S, Orza MJ. Antipsychotic drugs: is more worse? A meta-analysis of the published randomized control trials. Psychol Med 1994, 24: 307-316. (AI) For most patients,

higher than moderate doses of antipsychotic drugs bring increased side-effects but no additional therapeutic gains.

7 Dixon LB, Lehman AF, Levine J. Conventional antipsychotic medications for schizophrenia. Schizophrenia Bull 1995, 21(4): 567-577. (AI) This paper produces overwhelming evidence that continuing maintenance therapy reduces risk of relapse. The authors conclude that it is appropriate to taper or discontinue medication within six months to a year for first episode patients who experience a full remission of symptoms.

8 Taylor D, McConnell D, McConnel H, Kerwin R. The Bethlem and Maudsley NHS Trust Prescribing Guidelines 2001. London: Martin Dunitz Ltd, 2000.

9 United Kingdom Psychiatric Pharmacy Group (UKPPG). URL http://www.UKPPG.co.uk.

10a Mental Health Commission. Early Intervention in Psychosis: Guidance Note. Wellington, New Zealand, 1999.

b Falloon I, Coverdale J, Laidlaw T et al. Family management in the prevention of morbidity of schizophrenia: social outcome of a 2-year longitudinal study. Psychol Med 1997, 17: 59-66. (AII) Involvement of the family is vital. Education is important for engaging individuals and families in treatment and promoting recovery. Psychological therapies may be helpful.

11 Department of Health. National Service Framework for Mental Health. London: HMSO, 1999.

12 Consensus (BV). As people reacting to stresses such as unemployment or divorce are at high risk of developing a mental disorder, studies on prevention in high-risk groups may be relevant. These support the offering of social support and problem-solving. [NHS Centre for Reviews and Dissemination. Mental health promotion in high-risk groups. Effect Health Care Bull 1997, 3(3): 1-10.]

13 Catalan J, Gath D, Edmonds G, Ennis J. The effects of not prescribing anxiolytics in general practice. Br J Psychiatry 1984, 144: 593-602. (BII) GP advice and reassurance is as effective as administration of benzodiazepines. The mean time spent by the GP for giving advice and reassurance was 12 minutes, compared with 10.5 minutes for giving a prescription.

14a Roth AD, Fonagy P. What Works For Whom? A Critical Review of Psychotherapy Research. New York: Guilford Press, 1996. (CII) The efficacy of counselling in primary-care settings is difficult to assess because of the methodological problems of available research. It seems more appropriate for milder presentations of disorders, however, than for more severe presentations, and evidence is better for counselling focused on a particular client group (eg relationship or bereavement counselling).

14b Bower P, Rowland N, Mellor Clark J et al. Effectiveness and cost-effectiveness of counselling in primary care (Cochrane Review). In: The Cochrane Library, Issue 2, 2003. Oxford: Update Software. (B1) Seven studies were analysed. Results showed that counselling is significantly more effective than 'usual care' in the short- but not the long-term. Satisfaction with counselling was high. Patients had a mix of 'emotional disorders'.

15 Rosenberg H. Prediction of controlled drinking by alcoholics and problem drinkers. Psychol Bull 1993, 113: 129-139. (BII) This is a qualitative review of the literature. Successful achievement of controlled drinking is associated with less severe dependence and a belief that controlled drinking is possible.

16 NHS Centre for Reviews and Dissemination. Brief interventions and alcohol use. Effect Health Care Bull 1993, 1: 1-12. (AI) Brief interventions, including assessing drinking and related problems, motivational feedback and advice, are effective. They are most successful for less severely affected patients.

17 Slattery J, Chick J, Cochrane M et al. Prevention of Relapse in Alcohol Dependence. Health Technology Assessment Report 3. Glasgow: Health Technology Board for Scotland, 2003. URL http://www.htbs.co.uk.(A1) This study looked at treatments for individuals with alcohol dependence. Psychological treatments are effective but brief psychological treatments have no effect. Acamprosate and naltrexone showed significant beneficial effects.

18 Miller WR, Wilbourne PL. Mesa Grande: a methodological analysis of clinical trials of treatments for alcohol use disorders. Addiction 2002, 97(3): 265-277. (A1) Three hundred and sixty-one studies were analysed. There is strong evidence for the use of psychological treatments and the drugs acamprosate and naltrexone in treatment of alcohol use disorders.

19 McCrady B, Irvine S. Self-help groups. In: Hester R, Miller W (eds.) Handbook of Alcoholism Treatment Approaches: Effective Alternatives. 2nd edition. New York: Allyn and Bacon, 2003. (AIV) This chapter discusses the characteristics of patients who are good candidates for Alcoholics Anonymous (AA). Several studies show AA to be an important support in remaining alcohol-free to patients who are willing to attend.

20 American Psychiatric Association. Practice Guidelines: Substance Use Disorders, 1996. (BIV) Where patients have mild to moderate withdrawal symptoms, general support, reassurance and frequent monitoring is sufficient treatment for two thirds of them, without pharmacological treatment.

21 Collins MN, Burns T, Van den Berk PA, Tubman GF. A structured programme for out-patient alcohol detoxification. Br J Psychiatry 1990, 156: 871-874. (BIV)

22 Srisurapanont M, Jarusuraisin N. Opioid antagonists for alcohol dependence (Cochrane Review). In: The Cochrane Library, Issue 1, 2003. Oxford: Update Software. (B1) Nineteen studies were analysed. Naltrexone may decrease alcohol consumption in people with alcohol dependency but their compliance with treatment appears problematic. It should be given with psychological intervention.

23 Duncan D, Taylor D. Chlormethiazole or chlordiazepoxide in alcohol detoxification. Psychiatr Bull 1996, 20: 599-601. (AIV) This paper describes randomized controlled trials that show chlordiazepoxide and chlomethiazole to be of equal efficacy; however, chlordiazepoxide is a safer alternative (there is a risk of fatal respiratory depression with alcohol and chlomethiazole) and chlomethiazole is no longer recommended for outpatient use.

24 Cook CC, Hallwood PM, Thomson AD. B vitamin deficiency and neuropsychiatric syndromes in alcohol misuse. Alcohol Alcoholism 1998, 33(4): 317-336.

25 Kranzler H, Burleson J, Del Boca F et al. Buspirone treatment of anxious alcoholics: a placebo-controlled trial. Arch Gen Psychiatry 1994, 51: 720-731. (BII)

26 Hughes JC, Cook CC. The efficacy of disulfiram: a review of outcome studies Addiction 1997, 92(4): 381-395. (C1) Thirty-eight studies were analysed. Support for the general use of oral disulfiram is equivocal, mostly leading to reduced quantity of alcohol consumed and a reduced number of drinking days.

27 Alcohol Concern. Brief Interventions Guidelines. London, 1997. Available from Alcohol Concern, Waterbridge House, 32-36 Loman Street, London SE1 OEE, UK. Tel: +44 20 7928 7377. URL http://www.alcoholconcern.org.uk.

28 Holder H, Longabaugh R, Miller W, Rubonis A. The cost effectiveness of treatment for alcoholism: a first approximation. J Stud Alcohol 1991, 52: 517-540. (AI) Treatments aim to improve self-control and social skills - for example, relationship skills, assertiveness and drink refusal.

29 Hunt G, Axrin N. A community reinforcement approach to alcoholism. Behav Res Ther 1973, 11: 91-104. (AI) This approach uses behavioural principles and includes training in job finding, support in developing alcohol free social and recreational activities, and an alcohol-free social club.

30 Raphael B. Preventive intervention with the recently bereaved. Arch Gen Psychiatry 1997, 34: 1450-1454. (BIII) This work demonstrates that 'high-risk' bereaved people who receive counselling have fewer symptoms of lasting anxiety and tension than those who do not.

31 Kato PM, Mann T. A synthesis of psychological interventions for the bereaved. Clin Psychol Rev 1999, 19(3): 275-296. (C1) Fourteen studies were analysed. A slight improvement is seen for individual therapies.

32 Manic Depression Fellowship. Inside Out: A Guide to Self-Management of Manic Depression. London, 1995. Available from the Manic Depression Fellowship, 8-10 High Street, Kingston-upon-Thames, London KT1 1EY, UK. This advice is based on self-management training, 7-12 sessions of which have been shown to increase time between manic episodes. See Perry A, Tarrier N, Morris R et al. Randomised control trial of efficacy of teaching patients with bipolar disorder to identify early symptoms of relapse and obtain treatment. Br Med J 1999, 318: 149-152. (BII) Teaching patients to recognise early symptoms of manic relapse and seek early treatment is associated with important clinical improvements in time to first manic relapse, social functioning, and employment.

33 Chou JC-Y. Recent advances in treatment of acute mania. J Clin Psychopharm 1991, 11: 3-21. (BII) Antipsychotics are effective in mania, and they appear to have a more rapid effect than lithium.

34 Rifkin A, Doddi S, Karajgi B et al. Dosage of haloperidol for mania. Br J Psychiatry 1994, 165: 113-116. (BII) Doses of haloperidol over 10 mg a day in management of mania confer no benefit.

35 American Psychiatric Association. Practice Guidelines: Bipolar Disorder. Washington, DC, 1996. (AII) Four randomized control trials show that benzodiazepines are effective, in place of, or in conjunction with, a neuroleptic in sedating acutely agitated, manic patients.

36a Cookson J. Lithium: balancing risks and benefits. Br J Psychiatry 1997, 171: 113-119. (BIII)

36b Dali I. Mania. Lancet 1997, 349: 1157-1160.

36c Bowden C, Brugger A, Swann A et al. Efficacy of divolproex versus lithium and placebo in the treatment of mania. The Depakote Mania Study Group. JAMA 1994, 271: 918-924. (CII) This is a randomized controlled trial. Lithium is as effective as valproate and more effective than placebo.

36d A Cochrane Review will soon be available: Bhagwagar Z, Goodwin G, Geddes J. Lithium for acute mania (Protocol for a Cochrane Review). In: The Cochrane Library, Issue 2, 2003. Oxford: Update Software.

37a Zornberg G, Pope H Jr. Treatment of depression in bipolar disorder: new directions for research. J Clin Psychopharmacol 1993, 13: 397-408. (BIII) A review of nine controlled studies shows a high response rate to lithium for acute bipolar depression. Response may take six to eight weeks to become evident, however.

37b A Cochrane Review will soon be available. Gijsman HJ, Rendell J, Geddes J, Nolen WA, Goodwin GM. Antidepressants for bipolar depression (Protocol for a Cochrane Review). In: The Cochrane Library, Issue 2, 2003. Oxford: Update Software.

37c A Cochrane Review will soon be available. Bhagwagar Z, Goodwin G and Geddes J. Lithium for bipolar depression (Protocol for a Cochrane Review). In: The Cochrane Library, Issue 2, 2003. Oxford: Update Software.

38a Goodwin G. Lithium revisited: a re-examination of the placebo-controlled trials of lithium prophylaxis in manic-depressive disorder. Br J Psychiatry 1995, 167: 573-574. (BIII) Trials show prophylactic use of lithium to be effective, although most trials have had methodological flaws.

38b Berghofer A, Kossmann B, Muller-Oerlinghausen B. Course of illness and pattern of recurrence in patients with affective disorders during long-term lithium prophylaxis: a retrospective analysis over 15 years. Acta Psychiatr Scand 1996, 93: 349-354. The prophylactic effect of lithium can be maintained over at least 10 years.

39 Burgess S, Geddes J, Hawton K, Townsend E, Jamieson K, Goodwin G. Lithium or maintenance treatment of mood disorders (Cochrane Review). In: The Cochrane Library, Issue 1, 2003. Oxford: Update Software. (A1) Nine studies were analysed. Lithium was more effective than placebo in preventing relapse in bipolar disorder. Caution should be exercised in abruptly stopping lithium therapy in patients who have been taking it successfully for some time, because of the high risk of relapse.

40 Macritchie K, Geddes J, Scott J et al. Valproate for acute mood episodes in bipolar disorder (Cochrane Review). In: The Cochrane Library, Issue I. Oxford: Update Software, 2003. (A1) Ten studies were analysed. No significant difference in efficacy was seen between valproate and lithium or between valproate and carbamazepine. Valproate might be less effective in reducing manic symptoms than olanzapine but it could cause less sedation and weight gain.

41 Schou M. Effects of long-term lithium treatment on kidney function: an overview. J Psychiatry Res 1988, 22: 287-296. This is a qualitative literature review.

42 Goodwin GM. Recurrence of mania after lithium withdrawal. Implications for the use of lithium in the treatment of bipolar affective disorder. Br J Psychiatry 1994, 164(2): 149-152. (BIII) Fourteen studies were analysed. More than 50% of new episodes of illness occurred within three months of treatment cessation. Lithium should not be introduced for the prophylactic treatment of bipolar illness unless or until the doctor and patient understand that it must be used for a minimum of two years. If after two years there is no worthwhile benefit, it is more likely that harm, in the form of premature recurrence of mania, will be done.

43 An Independent Working Group. Working Party on CFS/ME to the Chief Medical Officer for England and Wales. London: Department of Health, 2002.

44 Fukuda K, Strauss SE, Hickie I, Sharp M et al. and the International Chronic Fatigue Study Group. The Chronic Fatigue Syndrome: a comprehensive approach to its definition and study. Ann Intern Med 1994, 121: 953-959.

45 Abbey S, Garfinkel P. Chronic fatigue syndrome and depression: cause, effect or covariate. Rev Infect Dis 1991, 13(suppl 1): S73-S83.

46 Prins J, Bleijenberg G, Rouweler E et al. Doctor-patient relationship in primary care of chronic fatigue syndrome: Perspectives of the doctor and the patient. J Chronic Fatigue Syndrome 2001, 7: 3-15.

47 Butler C, Rollnick S. Missing the meaning and provoking resistance: a case of myalgic encephalomyelitis. Family Pract 1996, 13: 106-109.

48 Whiting P, Bagnall A, Sowden A et al. Interventions for the treatment and management of chronic fatigue syndrome: a systematic review. JAMA 2001, 286: 1360-1368. (AI) Forty-four studies were analysed. Interventions that have shown promising results include cognitive behavioural therapy and graded exercise therapy.

49 Fulcher K, White P. Randomised controlled trial of graded exercises in patients with chronic fatigue syndrome. Br Med J 1997, 314: 1647-1652. (AII) Fatigue, functional capacity and fitness were significantly better after exercise than after flexibility treatment in patients with chronic fatigue syndrome.

50 Powell P, Bentall R, Nye F, Edwards R. Randomised controlled trial of patient education to encourage graded exercise in chronic fatigue syndrome. Br Med J 2001, 322: 387-390. (AII) Treatment of patients with Chronic fatigue syndrome incorporating evidence-based physiological explanations for symptoms was effective in encouraging self-managed graded exercise. This resulted in substantial improvement compared with standardized medical care.

51 Price JR, Couper J. Cognitive behaviour therapy for chronic fatigue syndrome in adults (Cochrane Review). In: The Cochrane Library, Issue 4, 1998. Oxford: Update Software. (AI) Three studies were analysed. Cognitive behaviour therapy appears to be an effective and acceptable treatment for adult outpatients with chronic fatigue syndrome.

52 Essame C, Phelan S, Aggett P, White P. Pilot study of a multidisciplinary inpatient rehabilitation of severely incapacitated patients with chronic fatigue syndrome. J Chronic Fatigue Syndrome 1998, 4: 51-60. (CIV) This is a descriptive outcome study of multidisciplinary inpatient rehabilitation. Intervention might be effective, but the studies carried out have not been well controlled.

53 Cox, Findley L. Severe and very severe patients with chronic fatigue syndrome: perceived outcome following an inpatient programme. J Chronic Fatigue Syndrome 2000, 7: 33-47. (CIV) This is a descriptive outcome study of an inpatient unit. There is a tentative trend towards positive outcomes.

54 Consensus, plus some - usually small - trials. For example, Donnan P, Hutchinson A, Paxton R et al. Self help materials for anxiety: a randomized controlled trial in general practice. Br J Gen Pract 1990, 40: 498-501. (BV) An audiotape and booklet were given to patients with chronic anxiety. Intervention led to reduced scores for depression, as well as for anxiety.

55 Lima M, Moncrieff J. Drugs versus placebo for the treatment of dysthymia (Cochrane Review). In: The Cochrane Library, Issue 2, 2003. Oxford: Update Software. (AI) Fifteen studies were

analysed. There is some evidence of efficacy of most antidepressants in dysthymia (chronic, mild depressive syndrome) that has been present for at least two years.

56 McLean J, Pietroni P. Self care - who does best? Soc Sci Med 1990, 30(5): 591-596. (BIII) This describes a controlled trial of a general-practice-based class teaching self-care skills, relaxation, stress management, medication, nutrition and exercise. Significant improvements were seen and maintained after one year.

57 Catalan J, Gath DH, Anastasiades P et al. Evaluation of a brief psychological treatment for emotional disorders in primary care. Psychol Med 1991, 21: 1013-1018. (BII) This paper describes a small randomized control trial. Patients - selected for high symptom scores - did significantly better with problem-solving therapy than with routine care. Other patients - with lower symptom scores -who were not treated showed similar improvement to the treated group.

58a Roth AD, Fonagy P. What Works For Whom? A Critical Review of Psychotherapy Research. New York: Guilford Press, 1996. (CII) This work concludes that the efficacy of counselling in primary-care settings is difficult to assess because of the methodological problems of available research. Counselling seems more appropriate for milder than for more severe disorders, and evidence seems better for counselling focused on a particular client group (eg relationship or bereavement counselling).

58b See reference 14b.

59 Adams CE, Eisenbruch M. Depot fluphenazine for schizophrenia (Cochrane Review). In: The Cochrane Library, Issue 2, 2003. Oxford: Update Software. (CI) The use of depot fluphenazine continues to be based on clinical judgement rather than on evidence from methodical evaluation within trials.

60 Kendrick T, Millar E, Burns T, Ross F. Practice nurse involvement in giving depot neuroleptic injections: development of a patient assessment and monitoring checklist. Prim Care Psychiatry 1998, 4(3): 149-154 (AIV) Of the 25% of people with schizophrenia who have no specialist contact, many have a practice nurse as their only regular professional contact. Levels of knowledge of schizophrenia and its treatment of those nurses was often no better than a lay person's.

61 Kemp R, Kirov G, Everitt B, David A. A randomised controlled trial of compliance therapy: 18-month follow-up. Br J Psychiatry 1998, 172: 413-419. (AII) Patients who received specific counselling regarding their attitudes towards their illness and drug treatment were five times more likely to take medication without prompting compared with controls.

62 Pharoah FM, Mari JJ, Streiner D. Family intervention for schizophrenia (Cochrane Review). In: The Cochrane Library, Issue 2, 2003. Oxford: Update Software. (AI) Thirteen studies were analysed. Families receiving this intervention, which promotes a more supportive family environment, can expect the family member with schizophrenia to relapse less and to be in hospital less.

63 Cormac I, Jones C, Campbell C, Silveira da Mota Neto J. Cognitive behaviour therapy for schizophrenia (Cochrane Review). In: The Cochrane Library, Issue 2, 2003. Oxford: Update Software. (AI) Thirteen studies were analysed. Four small trials show that cognitive behaviour therapy is associated with substantially reduced risk of relapse.

64 Rabins PV. Psychosocial and management aspects of delirium. Int Psychoger 1991, 3(2): 319-324. (BV) This is a review of 21 papers, concluding that the evidence base is very thin.

65a Inouye SK, Bogardus ST Jr, Charpentier PA et al. A multicomponent intervention to prevent delirium in hospitalized older patients. N Engl J Med 1999, 340: 669-676. (CIII) Intervention was associated with significant improvement in the degree of cognitive impairment among patients with cognitive impairment at admission, and with a reduction in the rate of use of sleep medication among all patients.

65b A Cochrane Review will soon be available. Britton A, Russell R. Multidisciplinary team interventions for delirium in patients with chronic cognitive impairment (Cochrane Review). In: The Cochrane Library, Issue 2, 2003. Oxford: Update Software Issue 4, 2003.

66 Rummans TA, Evans JM, Krahn LE, Fleming KC. Delirium in elderly patients: evaluation and management. Mayo Clinic Proc 1995, 70(10): 989-998. (BV). This reviews 55 papers, concluding that the evidence base is thin.

67 Ballard C, Grace J, McKeith I et al. Neuroleptic sensitivity in dementia with Lewy bodies and Alzheimer's disease. Lancet 1998, 351: 1032-1033. (CV) This is a case-register study. Other interventions should be explored before the use of neuroleptics in patients with dementia, particularly in those with dementia with Lewy bodies.

68 Eccles M, Clark J, Livingstone M et al. North of England evidence-based guidelines development project: guidelines for the primary-care management of dementia. Br Med J 1998, 317: 802-808.

69 National Institute for Clinical Excellence. Guidance on the Use of Donepezil, Rivastigmine and Galantamine for the Treatment of Alzheimer's Disease (Technology appraisal guidance 19). London: NICE, 2001. URL http://www.nice.org.uk. (AI)

70 Areosa Sastre A, Sherriff F. Memantine for dementia (Cochrane Review). In: The Cochrane Library, Issue 1, 2003. Oxford: Update Software. (BI) Seven studies were analysed. Results are awaited from two large trials, but those to date suggest a small beneficial effect from 20 or 30 mg/day of memantine on cognitive function measured at 6 and 28 weeks and on global function in patients with mild to moderately severe Alzheimer's disease, vascular and mixed dementia.

71 Reisberg B, Doody R, Stoffler A et al. Memantine in moderate-to-severe Alzheimer's disease. N Engl J Med 2003, 348(14): 1333-1341. (BII) Memantine reduced clinical deterioration in moderate to severe Alzheimer's disease, a phase associated with distress for patients and burden on caregivers, for which other treatments are not available. It was not associated with a significant frequency of adverse events.

72 NICE will publish a guideline on the management of depression in February 2004.

73 Lawlor DA, Hopker SW. The effectiveness of exercise as an intervention in the management of depression: systematic review and meta-regression analysis of randomised controlled trials. Br Med J 2001, 322: 763-767. (BI) Fourteen studies were analysed. The effectiveness of exercise in reducing symptoms of depression cannot be determined because of a lack of good-quality research on clinical populations with adequate follow-up.

74 Greden JF. Anxiety or caffeinism: a diagnosis dilemma. Am J Psychiatry 1974, 131: 1089-1092. (AV)

75 Schuckit M. Alcohol and major depressive disorder: a clinical perspective. Acta Psychiatrica Scand 1994, 377: 28-32. (AIV)

76 Wallin M, Rissanen A. Food and mood: relationship between food, serotonin and affective disorders. Acta Psychiatr Scand 1994, 377(Suppl): 36-40. (CV) Quoted in Guidelines for the Treatment and Management of Depression by Primary Health Care Professionals. National Health Committee of New Zealand, 1996.

77 Schulberg H, Katon W, Simon G, Rush AJ. Best clinical practice: guidelines for managing major depression in primary care. J Clin Psychiatry 1999, 60(Suppl 7): 19-24. (BII) The authors conclude that recovery rates for an acute episode of major depression in primary care are similar for guideline-driven pharmacotherapy and depression-specific psychotherapies, such as interpersonal therapy and problem-solving treatments. Medication takes four to six weeks to show effect and psychotherapies six to eight weeks. Another conclusion from this paper is that recent randomized controlled trials conducted in primary care show a 50-60% response rate to all classes of antidepressants in primary-care patients.

78 Lave J, Frank R, Schulberg H, Kamlet M. Cost-effectiveness of treatments for major depression in primary care practice. Arch Gen Psychiatry 1998, 55(7): 645-51. (BII) The authors describe a high-quality randomized control trial comparing standardized treatment by nortriptyline, interpersonal psychotherapy and primary physician's usual care (n >90 for each group) for major depression in primary care. Both standardized therapies were better than usual care, and more expensive. Those taking drugs did slightly better with respect to both quality of life and economic outcomes.

79 Paykel E, Hollyman J, Freeling P, Sedgwick P. Prediction of therapeutic benefit from amitriptyline in mild depression: a general practice, placebo-controlled trial. J Affective Disord 1988, 14: 83-95. (BIII) Antidepressants do not show efficacy in mild, acute depression.

80 NHS Centre for Reviews and Dissemination, University of York. The treatment of depression in primary care. Effect Health Care 1993, March(5): 1-12. (AII) Effective strategies to improve the detection and appropriateness of treatment of depression in primary care are available.

81a Prien R, Kupfer D. Continuation drug therapy for major depressive episodes: how long should it be maintained? Am J Psychiatry 1986, 143: 18-23. (BII) The authors conclude that patients treated for a first episode of uncomplicated depression, who respond well to an antidepressant, should receive a full therapeutic dose for at least 16-20 weeks after achieving full remission.

81b A Cochrane Review will soon be available. Carney S, Geddes JR, Furukawa T et al. Duration of treatment with antidepressants in depressive disorder (Protocol for a Cochrane Review). In: The Cochrane Library, Issue 2, 2003. Oxford: Update Software Issue 4, 2003.

82a Reimherr F, Amsterdam J, Quitkin F et al. Optimal length of continuation therapy in depression: a prospective assessment during long-term fluoxetine treatment. Am J Psychiatry 1998, 155: 1247-1253. (BIII)

82b A Cochrane Review will soon be available. Cipriani A, Brambilla P, Barbui C, Hotopf M. Fluoxetine versus other types of pharmacotherapy for depression (Protocol for a Cochrane Review). In: The Cochrane Library, Issue 2, 2003. Oxford: Update Software Issue 4, 2003.

83 Kupfer D, Frank E, Perel J et al. Five-year outcomes for maintenance therapy: possible mechanisms and treatments. J Clin Psychiatry 1998, 59: 279-288. 260 References 05-WHO-(Refs)-resize-cpp 19/1/2004 2:33 pm Page 260 This is a study carried out by psychiatric patients. There are no comparable clinical trials of the efficacy of maintenance treatment in reducing recurrence of depression in primary care.

84 Donoghue J. Sub-optimal use of tricyclic antidepressants in primary care: Editorial. Acta Psychiatrica Scand 1998, 98(6): 429-431. (CV)

85 Furukawa TA, McGuire H, Barbui C. Meta-analysis of effects and side-effects of low dosage tricyclic antidepressants in depression: systematic review. Br Med J 2002, 325: 991-995. (AI) Treatment of depression in adults with low dose tricyclics is justified.

85b A Cochrane Review will soon be available. Furukawa T, McGuire H, Barbui C. Low dosage tricyclic antidepressants for depression (Cochrane Review). In: The Cochrane Library, Issue 4, 2003. Oxford: Update Software.

86 Linde K, Mulrow CD. St John's wort for depression (Cochrane Review). In: The Cochrane Library, Issue 2, 2003. Oxford: Update Software. (AI) Twenty-seven studies were analysed. St John's Wort demonstrated beneficial effects in mild and moderate depressive disorders. St John's Wort extracts have fewer short-term side-effects than older antidepressants; however, the preparations available on the market could vary considerably in their pharmaceutical quality.

87 Thiede HM, Walper A. Inhibition of MAO and CoMT by Hypericum extracts and hypericin. J Geriat Psychiatr Neurol 1994, 7(Suppl 1): S54-S56.

88 Interactions with tyramine-containing foods (eg beans, some cheeses, yeast, bovril, bananas, pickled herrings), are theoretically possible. However, there is, to date, an absence of spontaneous reports of these problems occurring.

89 Izzo AA, Ernst E. Interactions between herbal medicines and prescribed drugs: a systematic review. Drugs 2001, 15: 2163-75. (BIII) Interactions between herbal medicines and synthetic drugs exist and can have serious clinical consequences. Healthcare professionals should ask their patients about the use of herbal products and consider the possibility of herb-drug interactions.

90a DeRubeis RJ, Crits-Cristoph P. Empirically supported individual and group psychological treatments for adult mental disorders. J Consulting Clin Psychol 1998, 66(1): 37-52. (BI) This work supports cognitive behaviour therapy, behaviour therapy and structured problem-solving. Studies reviewed are based in secondary care.

90b Churchill R, Hunot V, Corney R et al. A systematic review of controlled trials of the effectiveness and cost effectiveness of brief psychological treatments for depression. Health Technol Assess 2001, 5(35): 1-173. (AI) Brief psychological treatments, particularly those derived from cognitive/behavioural models, are beneficial in the treatment of people with depression managed outside the hospital setting.

90c Mynors-Wallis LM, Gath DH, Lloyd-Thomas AR, Tomlinson D. Randomised controlled trial comparing problem-solving treatment with amitriptyline and placebo for major depression in primary care. Br Med J 1995, 310: 441-445. (AII) Where the therapies have been compared with each other, none appears clearly superior to the others. More variance in outcomes may be due to the strength of the therapeutic relationship, rather than to the treatment method used. Problem-solving is the easiest therapy to learn and can be provided by GPs and primary-care nurses. Brief cognitive behaviour therapy is difficult to deliver, even using trained therapists (Scott J. Editorial: Psychological treatments for depression - an update. Br J Psychiatry 1995, 167: 289-292). Evidence for the effectiveness of therapies in depression in primary care tends to be weaker than in major depressive disorder in secondary care.

91a Thase M, Greenhouse J, Frank E et al. Treatment of major depression with psychotherapy or psychotherapy-pharmacotherapy combinations. Arch Gen Psychiatry 1997, 54: 1009-1015. (CIV)

Combined therapy was not significantly more effective than psychotherapy alone in patients with milder depression; a highly significant advantage was observed in more severe recurrent depressions. Poorer outcomes were also observed in women and older patients.

91b A Cochrane Review will soon be available. Churchill R, Wessely S, Lewis G. Combinations of pharmacotherapy and psychotherapy for depression (Cochrane Review). In: The Cochrane Library, Issue 4, 2003. Oxford: Update Software.

92a Evans M, Hollon S, De Rubeis R et al. Differential relapse following cognitive therapy and pharmacotherapy of depression. Arch Gen Psychiatry 1992, 49: 802-808. (BII) It appears that providing cognitive therapy during acute treatment prevents relapse.

92b A Cochrane Review will soon be available. Churchill R, Wessely S, Lewis G. Antidepressants alone versus psychotherapy alone for depression (Protocol for a Cochrane Review). In: The Cochrane Library, Issue 4, 2003. Oxford: Update Software.

93 Ostler KJ, Thompson C, Kinmonth ALK et al. Influence of socio-economic deprivation on the prevalence and outcome of depression in primary care: the Hampshire Depression Project. Br J Psychiatry 2001, 178(1): 12-17. The authors show a strong link between high indices of deprivation and poor prognosis for depression in primary care.

94 Golding JM. Intimate partner violence as a risk factor for mental disorders: a meta-analysis. J Family Violence 1999, 14: 99-132. (CIV) This is a literature review of 38 studies. Existing research is consistent with the hypothesis that intimate partner violence increases the risk for mental health problems such as depression, suicidality, Post-traumatic stress disorder and drug abuse.

95 Home Office. Domestic Violence: Finding from a New British Crime Survey Self-Completion Questionnaire. London: Home Office Research Studies, 1999.

96 Richardson J, Coid J, Petruckevitch A et al. Identifying domestic violence: cross-sectional study in primary care. Br Med J 2002, 324: 274-277 (CIV) This is a survey and review of medical records. Health professions should be aware of domestic violence, but the case for screening has not been made. One in six subjects surveyed objected to screening.

97 Ramsay J, Richardson J, Carter YH et al. Should health professionals screen women for domestic violence? Systematic review. Br Med J 2002, 325: 314 (CIV) Twenty studies in surveys and interventions studies were reviewed. Most subject were in favour of screening. None of the studies measured quality of life, mental health outcomes or potential harm from screening programmes.

98 Burton S, Regan L, Kelly L. Supporting Women and Challenging Men: Lessons From the Domestic Violence Intervention Project. Bristol: Policy Press, 1998 (CIV) Women benefit from the combination of forms of support, with support groups being the most effective in combating shame, self-blame and the destruction of self-belief, which can strongly inhibit a woman's attempts to end violence. Although two in three men dropped out of the programme, there was a substantial impact on attitudes and behaviour for most men who did complete it.

99 Abel E. Psychosocial treatments for battered women: a review of the empirical research. Res Social Work Practice 2000, 10: 55-77.

100 Kaltenbach K, Finnegan L. Children of maternal substance misusers. Curr Opin Psychiatry 1997, 10: 220-224. Most harm to children is indirect, for example via ill health of the mother, poor

antenatal care or cigarette smoking. There is a smaller risk of direct harm caused by heroin - growth retardation - and cocaine and amphetamines.

101 Miller W, Rollnick S. Motivational Interviewing: Preparing People to Change Addictive Behaviour. New York: Guilford Press, 1991. (AV)

102a Gossop M, Stewart D, Marsden J. NTORS at One Year: The National Treatment Outcome Research Study. Change in Substance Use, Health and Criminal Behaviour One Year After Intake. London: Department of Health, 1998. (A1)

102b Ward J, Mattick R, Hall W. Maintenance Treatment and Other Opioid Replacement Therapies. London: Harwood Academic Press, 1997.

102c Jeffries V, Gabbay M, Carnwath T. Treatments for Opiate Users in Primary Care. Monograph for Enhancing Shared Care Project, Chapel Road, Sale, Manchester M33 7FD, UK.

103 Lader M, Russell J. Guidelines for the prevention and treatment of benzodiazepine dependence: summary of a report from the Mental Health Foundation. Addiction 1993, 88(12): 1707-1708.

104 Royal College of Psychiatrists. Benzodiazepines: Risks, Benefits and Dependence - A Re-Evaluation. London: The Royal College of Psychiatrists, UK. URL http://www.rcpsych.ac.uk/publications/cr/cr59.htm.

105 The Task Force to Review Services for Drug Misusers. Report of an Independent Review of Drug Treatment Services in England. London: DoH, 1995.

106 American Psychiatric Association. Practice Guidelines: Substance Use Disorders. Washington DC, 1996. (BII) This publication reports a large randomized controlled trial replicated in a controlled trial comparing drug counselling, drug counselling plus supportive psychotherapy, and drug counselling plus cognitive behaviour therapy for methadone maintenance patients. Those with moderate to high depression or other psychiatric symptoms did better with either therapy in addition to drug counselling. For patients with low levels of psychiatric symptoms, all three treatments were equally effective.

107 Khantzian E. The primary-care therapist and patient needs in substance abuse treatment. Am J Drug Alcohol Abuse 1988, 14: 159-167. The authors review studies of relapse prevention through, for example, encouraging improved social and other relationships and activities.

108 Department of Health, The Scottish Office, The Welsh Office and DHSS Northern Ireland. Drug Misuse and Dependence: Guidelines on Clinical Management, 1999.

109 Amato L, Davoli M, Ferri M, Ali R. Methadone at tapered doses for the management of opioid withdrawal (Cochrane Review). In: The Cochrane Library, Issue 2, 2003. Oxford: Update Software. (AI) Tapered methadone seems to be useful and causes fewer side-effects than other medicated detoxification methods. Moreover, the rate of completion is higher. However, relapse rates are high.

110 Marsch LC. The efficacy of methadone maintenance interventions in reducing illicit opiate use, HIV risk behaviour and criminality: a meta-analysis. Addiction 1998, 93: 515-532. (A1) This is a systematic review of 11 studies. Results demonstrate a consistent, statistically significant relationship between methadone maintenance treatment and the reduction of illicit opiate use, HIV risk behaviours and drug- and property-related criminal behaviour.

111 Mattick RP, Kimber J, Breen C, Davoli M. Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence (Cochrane Review). In: The Cochrane Library, Issue 2, 2003. Oxford: Update Software. (BI) Buprenorphine is an effective intervention for use in the maintenance treatment of heroin dependence, but it is not more effective than methadone at adequate doses.

112 Gowing L, Farrell M, Ali R, White J. Alpha2 adrenergic agonists for the management of opioid withdrawal (Cochrane Review). In: The Cochrane Library, Issue 2, 2003. Oxford: Update Software. (BI) Ten studies compared a treatment regimen based on an alpha2-adrenergic agonist, with one based on reducing doses of methadone. Participants stay in treatment longer with methadone regimens, which may provide greater opportunity for psychosocial intervention. Methadone regimes may be preferable for withdrawal in outpatient settings where the risk of relapse to heroin use is high. Methadone might also facilitate transfer to maintenance treatment, should completion of withdrawal become unlikely. For those who are well prepared for withdrawal and seeking earlier resolution of withdrawal symptoms, alpha2-adrenergic agonist treatment may be preferred. Clonidine and lofexidine appear equally effective for inpatient settings, but the lower incidence of hypotension makes lofexidine more suited to use in outpatient settings.

113 Brown AS, Fleming PM. A naturalistic study of home detoxification from opiates using lofexidine. J Psychopharmacol 1998, 12: 93-96.

114 McLellan AT, Arndt IO, Metzger DS. The effects of psychosocial services in substance abuse treatment. JAMA 1993, 269: 1953-1959. (BII) Patients who received employment help, psychiatric care and family therapy had better outcomes than those who received counselling, who in turn had better outcomes than those who received methadone only.

115 NICE will publish a guideline on the management of eating disorders in January 2004.

116 Fairburn CG, Harrison PJ. Eating disorders. Lancet 2003, 361: 407-416. (AI) This is an up-to-date evidence-based review of all aspects of eating disorders including their management. A specific form of cognitive behaviour therapy is the most effective treatment for patients with eating disorders, although few patients seem to receive it in practice. Treatment of anorexia nervosa and atypical eating disorders has received remarkably little research attention.

117 A Cochrane review will soon be available. Schmidt U, Perkins S, Winn S et al. Self-help and guided self-help for eating disorders (Protocol for a Cochrane Review). In: The Cochrane Library, Issue 4, 2003. Oxford: Update Software.

118 Bacaltchuk J, Hay P. Antidepressants versus placebo for people with bulimia nervosa (Cochrane Review). In: The Cochrane Library, Issue 2, 2003. Oxford: Update Software. (AI). Sixteen studies were analysed. The use of a single antidepressant agent was clinically effective for the treatment of bulimia nervosa compared with placebo, with an overall greater remission rate but a higher dropout rate. No differential effect regarding efficacy and tolerability among the various classes of antidepressants could be demonstrated.

119 Treasure J, Schmidt U. Anorexia nervosa. Clinical Evidence 2002, 8: 903-913. (AI) No evidence was found of beneficial effects for tricyclic antidepressants or SSRIs.

120 Russell GFM, Szmukler GI, Dare C, Eisler I. An evaluation of family therapy in anorexia nervosa and bulimia nervosa. Arch Gen Psychiatr 1987, 44: 1047-1056. (CIII) Patients with anorexia nervosa with onset at or before age 18 and of less than three year's duration did better with family therapy than individual therapy. Moreover, older patients did better with individual therapy. However, a major UK review, while supporting these recommendations, states that there are currently no high quality reviews of psychological treatments for anorexia nervosa (Gloaguen

V, Cottraux J, Cucherat M et al. A meta-analysis of the effects on cognitive therapy in depressed patients. J Affect Disord 1998, 49: 59-72).

121 A Cochrane review will soon be available. Hay P, Bacaltchuk J, Claudino A, Ben-Tovim D. Individual psychotherapy in the outpatient treatment of adults with anorexia nervosa (Cochrane Review). In: The Cochrane Library, Issue 4, 2003. Oxford: Update Software.

122a Bacaltchuk J, Hay P, Trefiglio R. Antidepressants versus psychological treatments and their combination for bulimia nervosa (Cochrane Review). In: The Cochrane Library, Issue 2, 2003. Oxford: Update Software (AI) Seventeen studies were looked at. Using a more conservative statistical approach, combination treatments were superior to single psychotherapy. Psychotherapy appeared to be more acceptable to subjects. When antidepressants were combined with psychological treatments, acceptability of the latter was significantly reduced.

122b Hay PJ, Bacaltchuk J. Psychotherapy for bulimia nervosa and binging (Cochrane Review). In: The Cochrane Library, Issue 2, 2003. Oxford: Update Software. (AI) Thirty-four studies were analysed. There is small body of evidence supporting the efficacy of cognitive behaviour therapy in bulimia nervosa and similar syndromes.

123 Eating Disorders Special Interest Group, Royal College of Psychiatry. Primary Care Protocol for the Management of Adults with Eating Disorders. URL http://www.rcpsych.ac.uk/college/sig/eatdis.htm.

124 Smith D, Defalla BA, Chadwick DW. The misdiagnosis of epilepsy and the management of refractory epilepsy in a specialist clinic. Q J Med 1999, 92: 15-23.

125 Crawford PM, Appleton R, Betts T, Duncan J, Guthrie E, Morrow J. Best practice guidelines for the management of women with epilepsy. Seizure 1998, 8: 201-217.

126 NICE are due to publish a guideline on the management of Epilepsy in June 2004.

127 Marson A, Ramaratnam S. Epilepsy. Clinical Evidence 2002, 8: 1313-28. (AI) Reviews in people with drug-resistant partial epilepsy have found that adding gabapentin, levetiracetam, lamotrigine, oxcarbazepine, tiagabine, topiramate, vigabatrin or zonisamide to their usual treatment significantly reduces seizure frequency (compared with adding placebo). Adding second-line drugs compared with adding placebo increases the frequency of adverse effects. Randomized controlled trials have found that immediate treatment of single seizures with antiepileptic drugs (compared with no treatment) reduces seizure frequency over a two-year follow-up period. No evidence was found that treatment alters long-term prognosis. Long-term antiepileptic drug treatment is potentially harmful.

128 Berg AT, Shinnar S. The risk of seizure recurrence following a first unprovoked seizure: a quantitative review. Neurology 1991, 41: 965-972.

129 Marson AG, Williamson PR, Hutton JL et al.; on behalf of the epilepsy monotherapy trialists. Carbamazepine versus valproate monotherapy for epilepsy (Cochrane Review). In: The Cochrane Library, Issue 2, 2003. Oxford: Update Software. (AI) Eight studies were analysed. There was some evidence to support the policy of using carbamazepine as the first treatment of choice in partial epilepsies, but no evidence to support the choice of valproate in generalized epilepsies. Confidence intervals were too wide to confirm equivalence, however.

130 Sirven JI, Sperling M, Wingerchuk DM. Early versus late antiepileptic drug withdrawal for people with epilepsy in remission (Cochrane Review). In: The Cochrane Library, Issue 2, 2003. Oxford: Update Software. (BI) Seven studies were examined. There is evidence to support

waiting for at least two or more seizure-free years before discontinuing anti-epileptic drugs (AEDs) in children, particularly if patients have an abnormal EEG and partial seizures. There is insufficient evidence to establish when to withdraw AEDs in paediatric patients with generalized seizures. There is no evidence to guide the timing of withdrawal of AEDs in adult seizure-free patients.

131 Shear K, Schulberg H. Anxiety disorders in primary care. Bull Menninger Clinic 1995, 59(2; Suppl A): 73-82. (BI) Studies of psychoeducation and minimal intervention in primary care show much promise as first-line interventions for anxiety disorders in primary care. More severely ill patients require more specialist intervention.

132 NICE will publish a guideline on Anxiety (generalized) in June 2004. (AI)

133 Hawton K, Kirk J. Problem-solving. In: Hawton K, Salkovskis PM, Kirk J, Clark DM (eds.) Cognitive Therapy for Psychiatric Problems: A Practical Guide. Oxford: Oxford University Press, 1989: 406-426. (AII)

134 See reference 13.

135a Gould RA, Otto MW, Pollack MH, Yap L. Cognitive behavioural and pharmacological treatment of generalised anxiety disorder: a preliminary meta-analysis. Behaviour Ther 1997, 28(2): 285-305. (BI) This paper discusses the effectiveness of different treatments for anxiety. Buspirone had a much lower effect size than either benzodiazepines or antidepressants, and its onset is slow (up to four weeks). However, problems with dependence and withdrawal are minimal compared with benzodiazepines. Cognitive behaviour therapy (CBT) and anxiety management were the most efficacious psychological treatments; each was equally efficacious in the short term. Gains of CBT and anxiety management were maintained at six months.

135b Lader MH, Bond AJ. Interaction of pharmacological and psychological treatments of anxiety. Br J Psychiatry 1998, 173(Suppl 34): 165-8. Firm conclusions are not possible. Observations suggest using benzodiazepines for treating anxiety initially, as these produce rapid symptomatic improvement; then psychological treatments can take over.

135c A Cochrane review will soon be available. Gale C, Kapczinski F, Busnello JV et al. Benzodiazepines for generalized anxiety (Protocol for a Cochrane Review). In: The Cochrane Library, Issue 4, 2003. Oxford: Update Software.

136a Kapczinski F, Lima MS, Souza, JS, Schmitt, R. Antidepressants for generalized anxiety disorder (Cochrane Review). In: The Cochrane Library, Issue 2, 2003. Oxford: Update Software (AI) Fifteen studies were examined. Antidepressants are superior to placebo in treating general anxiety disorder (GAD) and are tolerated by GAD patients.

136b A Cochrane review will soon be available. Kapczinski F, Ribeiro L, Quevedo J et al. 5HT-1 agonists for generalized anxiety (Protocol for a Cochrane Review). In: The Cochrane Library, Issue 4, 2003. Oxford: Update Software.

137 Tyrer P. Use of beta-blocking drugs in psychiatry and neurology. Drugs 1980, 20: 300-308.

138 Kupshik G, Fisher C. Assisted bibliotherapy: effective, efficient treatment for moderate anxiety problems. Br J Gen Pract 1999, 49: 47-8. (BIII) Learning self-help skills through reading, supported by contact with a clinician, significantly improved symptoms. More patients improved with more clinician contact, especially if less educated.

139 Bower P, Richards D, Lovell, K. The clinical and cost-effectiveness of self-help treatments for anxiety and depressive disorders in primary care: a systematic review. Br J Gen Pract 2001, 51: 838-845. (AI) Self-help treatments may have the potential to improve the overall cost-effectiveness of mental health service provision.

140. Steiner TJ, Scher AI, Stewart WF et al. The prevalence and disability burden of adult migraine in England and their relationships to age, gender and ethnicity. Cephalalgia 2003; 23: 519-527.

141. Rasmussen BJ, Jensen R, Schroll M, Olesen J. Epidemiology of headache in a general population - a prevalence study. J Clin Epidemiol 1991; 44: 1147-1157.

142. Schwartz BS, Stewart WF, Simon D, Lipton RB. Epidemiology of tension-type headache. JAMA 1998; 279: 381-383.

143. British Association for the Study of Headache. Guidelines for all doctors in the diagnosis and management of migraine and tension-type headache, 2nd edition (revised). BASH 2003 at www.bash.org.uk.

144. Srikiatkhachorn A, Phanthurachinda K. Prevalence and clinical features of chronic daily headache in a headache clinic. Headache 1997; 37: 277-280.

145. Limmroth V, Katsavara Z, Fritsche G et al. Features of medication overuse headache following overuse of different acute headache drugs. Neurology 2002; 59: 1011-1014.

146. International Headache Society Classification Subcommittee. International classification of headache disorders, 2nd edition. Cephalalgia 2004; 24 (suppl 1):1-160.

147. Steiner TJ. Headache burdens and bearers. Funct Neurol 2000; 15 (suppl 3): 219-223.

148. Lipton RB, Bigal ME, Kolodner K et al. The family impact of migraine: population-based studies in the USA and UK. Cephalalgia 2003; 23: 429-440.

149. Rasmussen BK, Olesen J. Migraine with aura and migraine without aura: an epidemiological study. Cephalalgia 1992; 12: 221-228.

150. MacGregor EA. Menstruation, sex hormones and headache. Neurol Clin 1997; 15: 125--141.

151. MacGregor EA, Guillebaud J (on behalf of the Clinical and Scientific Committee of the Faculty of Family Planning and Reproductive Health Care of the Royal College of Obstetricians and Gynaecologists). Recommendations for clinical practice: Combined oral contraceptives, migraine and stroke. Br J Fam Planning 1998; 24: 53-60.

152. World Health Organization. Improving access to quality care in family planning. Medical eligibility criteria for contraceptive use (2nd edition). Geneva: WHO 2000.

153. Ferrari MD, Roon KI, Lipton RB, Goadsby PJ. Oral triptans (serotonin 5-HT1B/1D agonists) in acute migraine treatment: a meta-analysis of 53 trials. Lancet 2001; 358: 1668-1675.

154. Ramadan NM, Schultz LL, Gilkey SJ. Migraine prophylactic drugs: proof of efficacy, utilization and cost. Cephalalgia 1997; 17: 73-80.

155. Hopkinson HE. Treatment of cardiovascular diseases. In Rubin P (ed), Prescribing in pregnancy. London: BMJ Publishing Group 1995, p. 98.

156. Rothrock JF. Clinical studies of valproate for migraine prophylaxis. Cephalalgia 1997; 17: 81-83.

157. Steiner TJ, Lange R, Voelker M. Aspirin in episodic tension-type headache: placebo-controlled dose-ranging comparison with paracetamol. Cephalalgia 2003; 23: 59-66.

158. Kudrow L. Treatment of cluster headache. Headache Quart 1993; 4: 42-47.

159. Gabai IJ, Spierings ELH. Prophylactic treatment of cluster headache with verapamil. Headache 1989; 29: 167-168.

160. Schnider P, Aull S, Baumgartner C et al. Long-term outcome of patients with headache and drug abuse after inpatient withdrawal: five-year follow-up. Cephalalgia 1996; 16: 481-485.

161. Hering R, Steiner TJ. Abrupt outpatient withdrawal of medication in analgesic-abusing migraineurs. Lancet 1991; 337: 1442-1443.

162. World Federation of Neurology Research Group on Neuromuscular Diseases. El Escorial World federation of Neurology criteria for the diagnosis of amyotrophic lateral sclerosis. J Neurol Sci 1994; 124S: 96-107.

163. Brockington A, Shaw PJ. Developments in the treatment of motor neurone disease. Advances in Clinical Neuroscience and Rehabilitation 2003 (In press).

164. Miller RG, Rosenberg JA, Gelinas DF et al. Practice parameter: the care of the patient with amyotrophic lateral sclerosis (an evidence-based review): report of the quality standards subcommittee of the American Academy of neurology. ALS Practice Parameters Task Force. Neurology 1999; 52: 1311-1323.

165. Langmore SE, Kasarskis EJ, Manca ML, Olney R. Enteral feeding for amyotrophic lateral sclerosis: Protocol for a Cochrane review 2003.

166. Lannacone S, Ferini-Strambi L. Pharmacological treatment of emotional lability. Clinical Neuropharmacol 1996; 19: 532-535.

167. Bourke SC, Bullock RE, Williams TL et al. Non-invasive ventilation in ALS: indications and effect on quality of life. Neurology 2003; 61: 171-177.

168. Miller RG, Mitchell JD, Lyon M, Moore DH. Riluzole for amyotrophic lateral sclerosis (ALS)/motor neurone disease (MND). Cochrane Database Systematic Review 2002; CD001447.

169. National Institute of Clinical Excellence. Guidance on the use of riluzole (rilutek) for the treatment of motor neurone disease. National Institute of Clinical Excellence 2001.

170. Compston A, Coles A. Multiple Sclerosis. Lancet 2002; 359: 1221-1231.

171. McDonald WI, Compston A, Edan G et al. Recommended diagnostic criteria for Multiple Sclerosis: Guidelines from the international panel on the diagnosis of Multiple Sclerosis. Ann Neurol 2001; 50: 121-127.

172. Rice GA, Incorvara B, Munan L et al. Interferon in relapsing-remitting Multiple Sclerosis. In: The Cochrane Library, Issue 2, 2002.

173. Burgess M. MS symptoms and their treatment. In: Multiple Sclerosis: Theory & Practice for Nurses. London: Whurr 2002, pp. 72-100.

174 NICE will publish a guideline on the management of Obsessive-compulsive disorder in February 2005.

175 Greist JH, Marks IM, Baer L et al. Behaviour therapy for obsessive compulsive disorder guided by a computer or by a clinician compared with relaxation as a control. J Clin Psychiatry 2002, 63: 138-145 (CII) This is a randomized controlled trial. Computer-guided behaviour therapy was effective for patients with Obsessive compulsive disorder, although clinician-guided behaviour therapy was even more effective. Systematic relaxation was ineffective.

176 Freeston MH, Ladouceur R. The cognitive-behavioural treatment of obsessions. In: Caballo VE (ed) International Handbook of Cognitive and Behavioural Treatment of Psychological Disorders. Oxford: Pergamon, 1998: 127-160.

177 Salkovskis PM, Kirk J. Obsessional disorders. In: Hawton K, Salkovskis PM, Kirk J, Clark M (eds.) Cognitive Behaviour Therapy for Psychiatric Disorders. Oxford: Oxford University Press, 1988: 129-168.

178 Stern R, Drummond L. The Practice of Behavioural and Cognitive Psychotherapy. Cambridge: Cambridge University Press, 1991

179 Marks IM. Fears, Phobias and Rituals. New York: Oxford University Press, 1987.

180 Soomro GM. Obsessive compulsive disorder. Clinical Evidence 2002, 8: 991-1002. (AI) This is a review. Selective serotonin reuptake inhibitors, behaviour therapy, cognitive therapy and combined treatment (fluvoxamine and behaviour therapy) are beneficial in Obsessive-compulsive disorder.

181 Cottraux J, Note I, Yao SN et al. A randomized controlled trial of cognitive therapy versus intensive behavior therapy in Obsessive-compulsive disorder. Psychother Psychosom 2001, 70(6): 288-297. (BII) This is a randomized controlled trial. Cognitive therapy and behaviour therapy were equally effective for patients with Obsessive-compulsive disorder.

182 de Haan E, Hodgduin KA, Buitecaar JK et al. Behavior therapy versus clomipramine for the treatment of obsessive-compulsive disorder in children and adolescents. J Am Acad Child Adolesc Psychiatry 1998, 37(10): 1022-1029. (CII) This is a randomized controlled trial. Behaviour therapy is shown to be a good alternative to drug treatment.

183 Swinson RP, Soulios C, Cox BJ, Kuch K. Brief treatment of emergency-room patients with panic attacks. Am J Psychiatry 1992, 149: 944-946. (BIII) People presenting to Accident and Emergency with panic who went on to have psychoeducation and exposure instructions improved significantly more at follow-up compared with controls.

184 Kumar S, Oakley-Browne. Panic disorder. Clinical Evidence 2002, 8: 1003-1009. (AI) Selective-serotonin reuptake inhibitors and tricyclic antidepressants are effective in Panic disorder.

185a American Psychiatric Association. Practice guideline for the treatment of patients with panic disorder. Am J Psychiatry 1998, 155(Suppl): 1-26. (AII) Tricyclic antidepressants (TCAs), selective serotonin re-uptake inhibitors, monoamine oxidase inhibitors and benzodiazepines had roughly comparable short-term efficacy in patients with panic disorder. Benzodiazepines help in the very short term if very rapid control of symptoms is critical. TCA side-effects might be problematic. Discontinuation of medication commonly leads to relapse, so longer-term use is recommended - 2-18 months -after which period, the relapse rate is unknown.

185b A Cochrane review will be available soon. Mendes HA, Lima MS, Hotopf MH. Serotonin reuptake inhibitors and new generation antidepressants for panic disorder (Protocol for a Cochrane Review). In: The Cochrane Library, Issue 4, 2003. Oxford: Update Software.

186 Barlow DH, Gorman JM, Shear KM et al. Cognitive behavioural therapy, imipramine or their combination for panic disorder: a RCT. JAMA 2000, 283: 2529-2536. (BII) Combining imipramine and cognitive behaviour therapy (CBT) appears to confer limited advantage acutely but more substantial advantage by the end of maintenance. Each treatment worked well immediately following treatment and during maintenance; CBT appeared durable in follow-up.

187 Haug TT, Blomhoff S, Hellstrom K et al. Exposure therapy and sertraline in social phobia: 1-year follow-up of a randomised controlled trial. Br J Psychiatry 2003, 101: 312-318. (BII) Exposure therapy alone yielded a further improvement during follow-up, whereas exposure therapy combined with sertraline and sertraline alone showed a tendency towards deterioration after the completion of treatment.

188 Marks I, Swinson P, Basoglu M et al. Alprazolam and exposure alone and combined in panic disorder with agoraphobia. A controlled study in London and Toronto. Br J Psychiatry 1993, 162: 776-787. (BII) Where agoraphobic fear and avoidance is present, with panic, exposure - a behavioural treatment - proved to be twice as effective as alprazolam.

189. Hughes AJ, Daniel SE, Kilford L, Lees AJ. Accuracy of clinical diagnosis of idiopathic Parkinson's disease: a clinico-pathological study of 100 cases. J Neurol Neurosurg Psychiatry 1992; 55: 181-184.

190. Hughes AJ, Ben-Shlomo Y, Daniel S, Lees AJ. What features improve the accuracy of clinical diagnosis in Parkinson's disease. Neurology 1992; 42: 1142-1146. This large series of post-mortem-proven Parkinson's disease studied the reliability of the clinical diagnosis of idiopathic PD, and the frequency of a particular symptom and its reliability in making a diagnosis of PD.

191. Gelb DJ, Oliver E, Gilman S. Diagnostic criteria for Parkinson's disease. Arch Neurol 1999; 56: 33-39. A clinical diagnostic classification based on a thorough review of the literature concerning the sensitivity and specificity of the clinical features of PD.

192. Ben-Shlomo Y. How far are we in understanding the cause of Parkinson's disease? J Neurol Neurosurg Psychiatry 1996; 61: 4-16. Thorough review of current understanding of the evidence about the epidemiology of PD.

193. Betchen SA, Kaplitt M. Future and current surgical therapies in Parkinson's disease. Curr Opin Neurol 2003; 16: 487-493.

194. Fung VS, Morris JG, Pell MF. Surgical treatment for Parkinson's disease. Med J Australia 2002; 177: 1130-1142.

195 UK Department of Health guidelines on personality disorder. Personality Disorder: No Longer a Diagnosis of Exclusion. Policy Implementation Guidance for the Development of Services for People with Personality Disorder. URL http://www.doh.gov.uk/mentalhealth/personalitydisorder.htm.

196 Benzodiazepines are effective in many cases in suppressing panic in the short term. They are not effective for chronic panics or phobias - there is no evidence that any gains continue when drugs are withdrawn, and there is some evidence that they do not. Where patients are doing exposure therapy by gradually facing the fear, there is some evidence that benzodiazepines actually interfere with maintenance of longer-term gains. Selected references (BII):

196a See references 185a and 188.

196b A Cochrane review will be available soon. van der Linden GJH, van Balkom JLM, Zungdirwayi N, Stein DJ. Pharmacotherapy for social phobia (Protocol for a Cochrane Review). In: The Cochrane Library, Issue 4, 2003. Oxford: Update Software.

197 NICE will publish a guideline on the management of Post-traumatic stress disorder in January 2005.

198 Rose S, Bisson J, Wessley S. Psychological debriefing for preventing post traumatic stress disorder (Cochrane Review). In: The Cochrane Library, Issue 1, 2003. Oxford: Update Software. (AI). The routine use of single-session debriefing given to non-selected trauma victims cannot be recommended at present.

199 Bisson JI.Early interventions following traumatic events. Psychiatric Ann 2003, 33: 37-44. (BI) The authors review randomized controlled trials and conclude that the evidence base does not support routine early intervention but that multiple session cognitive behavioural early interventions might help.

200a Foa EB, Keane TM, Friedman MJ (eds.) Effective Treatments for PTSD. New York: Guildford Press, 2000. This work summarizes evidence for a wide variety of treatment approaches for Post-traumatic stress disorder. Cognitive therapy and exposure therapy emerge as the psychological treatments with the best evidence for efficacy.

200b Bisson JI., Andrew M. Psychological treatment of Post-traumatic stress disorder (PTSD) (Protocol for a Cochrane Review). In: The Cochrane Library, Issue 2, 2003. Oxford: Update Software.

201 Marks I, Lovell K, Noshirvani H et al. Treatment of Post-traumatic stress disorder by exposure and/or cognitive restructuring: a controlled study. Arch Gen Psychiatry 1998, 55: 317-25. (BII) This randomized control trial shows that exposure, cognitive restructuring, or both combined, were equally effective in Post-traumatic stress disorder and better than relaxation without exposure.

202 Shepherd J, Stein K, Milne R. Eye movement desensitization and reprocessing in the treatment of Posttraumatic stress disorder: a review of an emerging therapy. Psychol Med 2000, 30(4): 863-871. (AI) This is a systematic review of 16 studies. Eye movement desensitization and reprocessing might be as effective as imaginal exposure therapy and more effective than relaxation techniques in Post-traumatic stress disorder but it is unclear if it is the technique or the imaginal exposure component that is effective.

203 Stein DJ, Zungu-Dirwayi N, Van der Linden GJ, Seedat S. Pharmacotherapy for post-traumatic stress disorder (Cochrane Review). In: The Cochrane Library, Issue 2, 2003. Oxford: Update Software. (AI) Fifteen studies were examined. The research base is limited but there is increasing evidence that drugs can help in Post-traumatic stress disorder. Sertraline and paroxetine have been the most researched and have been shown to be effective. There is good evidence for the efficacy of fluoxetine and some evidence for tricyclic antidepressants and monoamine oxidase inhibitors.

204 Ray KL, Hodnett ED. Caregiver support for postpartum depression (Cochrane Review). In: The Cochrane Library, Issue 2, 2003. Oxford: Update Software. (CI) Women with postpartum (postnatal) depression who are supported by caregivers are less likely to remain depressed, although the most effective support from caregivers remains unknown.

205 Harris B, Huckle P, Thomas R et al. The use of rating scales to identify postnatal depression. Br J Psychiatry 1989, 154: 813-817

206 Appleby L, Warner R, Whitton A, Faragher B. A controlled study of fluoxetine and cognitive behavioural therapy in the treatment of postnatal depression. Br Med J 1997, 314: 932. (BII) Both fluoxetine and cognitive-behavioural counselling given as a course of therapy are effective treatments for non-psychotic depression in postnatal women. After an initial session of counselling, additional benefit results from either fluoxetine or further counselling

207 Holden JM, Sagovsky R, Cox JL. Counselling in a general practice setting: a controlled study of health visitor intervention in treatment of postnatal depression. Br Med J 1989, 298: 223-6. (BII) Counselling by health visitors is valuable in managing non-psychotic postnatal depression.

208 O'Hara M, Stuart S, Gorman L, Wenzel A. Efficacy of interpersonal psychotherapy for postnatal depression. Arch Gen Psychiatry 2000, 57: 1039-1045. (BII) Interpersonal psychotherapy is an efficacious treatment for postpartum depression. It reduced depressive symptoms and improved social adjustment, and represents an alternative to pharmacotherapy, particularly for women who are breastfeeding.

209 Hoffbrand S, Howard L, Crawley H. Antidepressant treatment for post-natal depression (Cochrane Review). In: The Cochrane Library, Issue 2, 2003. Oxford: Update Software Ltd (CI) One study was examined. Women with postnatal depression can be treated effectively with fluoxetine, which is as effective as a course of cognitive-behavioural counselling in the short-term.

210 Altshuler LL, Cohen L, Szuba MP et al. Pharmaceutical management of psychiatric illness during pregnancy. Am J Psychiatry 1996, 153: 592-606. (BI) This is a review. The use of psychotropic medications during pregnancy is appropriate in many clinical situations and should include thoughtful weighing of risk of prenatal exposure with risk of relapse following drug discontinuation.

211 NICE will publish a guideline on the management of self-harm in March 2004.

212 Hawton K, Townsend E, Arensman E et al. Psychosocial and pharmacological treatments for deliberate selfharm (Cochrane Review). In: The Cochrane Library, Issue 2, 2003. Oxford: Update Software. (AI) Twenty-three studies were analysed. Promising results were found for problem-solving therapy, provision of a card to allow emergency contact with services, depot flupenthixol for recurrent repeaters of self-harm and long-term psychological therapy for female patients with borderline personality disorder and recurrent self-harm.

213 Ralph D, McNicholas T; for the Erectile Dysfunction Alliance. UK Management Guidelines for Erectile Dysfunction. Br Med J 2000, 321: 499-503.

214a Montorsi F, Salonia A, Deho F et al. Pharmacological management of erectile dysfunction. Br J Urol Int 2003, 91(5): 446-454. (CI)

214b Vitezic D, Pelcic-Mrsic J. Erectile dysfunction: oral pharmacotherapy options. Int J Clin Pharmacol Ther 2002, 40(9): 393-403. (AI)

214c Werneke U, Crowe M. Review of patients with erectile dysfunction attending the Maudsley Psychosexual Clinic in 1999: the impact of sildenafil. Sex Relation Ther 2002, 17(4): 171-185. (CIV) Sildenafil has a very satisfactory efficacy/safety profile in all patient categories.

214d A Cochrane Review will be available soon. Fink H, Wilt T, MacDonald R et al. Sildenafil for erectile dysfunction (Protocol for a Cochrane Review). In: The Cochrane Library, Issue 4, 2003. Oxford: Update Software.

215a Kuan J, Brock G. Selective phosphodiesterase type 5 inhibition using Tadalafil for the treatment of erectile dysfunction. Expert Opin Invest Drugs 2002, 11(11): 1605-1613. (AI) This is a review. Tadalafil is likely to play an important role in the management of erectile dysfunction across a broad spectrum of aetiologies, once past the ongoing regulatory review process. Side-effects are generally mild to moderate.

215b A Cochrane Review will be available soon. Urciuoli R, Cantisani TA, Carlini M et al. Prostaglandin E1 for treatment of erectile dysfunction (Protocol for a Cochrane Review). In: The Cochrane Library, Issue 4, 2003. Oxford: Update Software.

216 Padma-Natham H, Hellstrom WJG, Kaiser RE et al. Treatment of men with erectile dysfunction with transurethral alprostadil. N Engl J Med 1997, 336: 1-7. (AII)

217 Linet OI, Ogrine FG. Efficacy and safety of intracavernosal alprostadil in men with erectile dysfunction. N Engl J Med 1996, 334: 873-877. (AII)

218 Kupfer DJ, Reynolds CF. Management of insomnia. N Engl J Med 1997, 336: 341-346.

219 Ancoli-Israel S. Insomnia in the elderly: a review for the primary-care practitioner. Sleep 2000, 23(Suppl 1): S23-S30.

220 Edinger JD, Wohlgemuth WK. The significance and management of persistent primary insomnia: the past, present and future of behavioural insomnia therapies. Sleep Med Rev 1999, 3: 101-118.

221 Stores G. Dramatic parasomnias. J R Soc Med 2001, 94: 173-176.

222 Royal College of Physicians. Nicotine Addiction in Britain. A Report of the Tobacco Advisory Group of the Royal College of Physicians. London: Royal College of Physicians, 2000

223 Rigotti NA. Clinical practice. Treatment of tobacco use and dependence. N Engl J Med 2002, 346(7): 506-512. (CIV)

224 National Institute for Clinical Excellence. Guidance on the Use of Nicotine Replacement Therapy and Bupropion for Smoking Cessation. URL http://www.nice.org.uk. (AI) Both drugs are effective in smoking cessation.

225 Jackson G, Bobak A, Chorlton I et al. Smoking cessation: a consensus statement with special reference to primary care. ICGP 2001, 55: 385-392

226 Raw M, McNeill A, West R. Smoking cessation guidelines for health professionals. Thorax 1998, 53(Suppl 5,Part 1): S1-S19.

227 West R, McNeill A, Raw M. Smoking cessation guidelines for health professionals: an update. Thorax 2000, 55(12), 987-999.

228 Silagy C, Mant D, Fowler G, Lancaster T. Nicotine replacement therapy for smoking cessation. (Cochrane Review). In: The Cochrane Library, Issue 2, 1999. Oxford: Update Software. (AI) One hundred and ten studies were analysed. All forms of nicotine replacement therapy can help people quit smoking, almost doubling long-term success rates.

229 Gubitz G, Sandercock P. Stroke management. Clin Evidence 2002; 8: 169-183. (AI) This systematic review in people with ischaemic stroke found that giving aspirin (compared with placebo) within 48 hours of stroke onset significantly reduces death or dependency at six months and significantly increases the numbers making a complete recovery. Specialist stroke rehabilitation units significantly reduce death or dependency after a median follow-up of one year compared with usual non-specialist care.

230 Clinical Evidence Writers on Stroke Prevention. Stroke prevention. Clin Evidence 2002; 8: 184-208. (AI) Antiplatelet treatment reduces the risk of serious vascular events in people with previous stroke or transient ischaemic attack (TIA) compared with placebo or no antiplatelet treatment. Antihypertensive treatment reduced stroke among people with a previous stroke or TIA, whether they were hypertensive or not. Low-dose aspirin (75-100 mg) daily is as effective as higher doses in the prevention of serious vascular events.

231 PROGRESS Collaborative Group. Randomised trial of a perindopril-based blood-pressure-lowering regimen among 6,105 individuals with previous stroke or transient ischaemic attack. Lancet 2001; 358: 1033-1041. (BII) This blood-pressure-lowering regimen reduced the risk of stroke among both hypertensive and nonhypertensive individuals with a history of stroke or transient ischaemic attack.

232 Sandercock P, Gubitz G, Foley P, Counsell C. Antiplatelet therapy for acute ischaemic stroke (Cochrane Review). In: The Cochrane Library, Issue 2, 2003. Oxford: Update Software. (AI) Nine studies were analysed. Antiplatelet therapy with aspirin at 160-300 mg daily, started within 48 hours of onset of presumed ischaemic stroke, reduces the risk of early recurrent ischaemic stroke without a major risk of early haemorrhagic complications and improves long-term outcome.

233 Antithrombotic Trialists' Collaboration. Collaborative meta-analysis of randomised trials of antiplatelet therapy for prevention of death, myocardial infarction, and stroke in high-risk patients. Br Med J 2002; 324: 71-86. (Erratum appears in Br Med J 2002; 324: 141.) (AII) Aspirin (or another oral antiplatelet drug) is protective in most types of patient at increased risk of occlusive vascular events, including those with ischaemic stroke or previous stroke. Low-dose aspirin (75-100 mg) is an effective antiplatelet regimen for long-term use, but in acute settings an initial loading dose of at least 150 mg may be required. Adding a second antiplatelet drug to aspirin may produce additional benefits in some clinical circumstances, but more research into this strategy is needed.

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235 Heart Protection Study Collaborative Group. MRC/BHF Heart Protection Study of cholesterol lowering with simvastatin in 20,536 high-risk individuals: a randomised placebo-controlled trial. Lancet 2002, 360: 7-22. (CII) Among the high-risk individuals studied, these antioxidant vitamins appeared to be safe. Although this regimen increased blood vitamin concentrations substantially, however, it did not produce any significant reductions in the five-year mortality from, or incidence of, any type of vascular disease, cancer or other major outcome.

236 Mayou R, Farmer A. ABC of psychological medicine. Functional somatic symptoms and syndromes. Br Med J 2002, 325: 265-268

237 Goldberg R, Dennis H, Novack M, Gask L. The recognition and management of somatization: what is needed in primary care training. Psychosomatics 1992, 33(1): 55-61. (BV)

238 Smith GR, Rost K, Kashner M. A trial of the effect of a standardised psychiatric consultation on health outcomes and costs in somatising patients. Arch Gen Psych 1995, 52(3): 238-243. (BII)

239 Fishbain DA, Cutler RB, Rosomoff HL, Rosomoff HL. Do antidepressants have an analgesic effect in psychogenic pain and somatoform pain disorder? A meta-analysis. Psychosom Med 1998, 60(4): 503-509.

240 Speckens A, Van Hemert A, Spinhoven P et al. Cognitive behavioural therapy for medically unexplained physical symptoms: a randomized controlled trial. Br Med J 1995, 311: 1328-1332. (BII) Six to 16 sessions of cognitive behaviour therapy were conducted in medical outpatients. Intervention was found to be effective and acceptable to patients, and gains were maintained at 12-month follow-up.

241 Kashner TM, Rost K, Cohen B et al. Enhancing the health of somatization disorder patients: effectiveness of short-term group therapy. Psychosomatics 1995, 36: 924-932. (BII) Randomized controlled trial of 70 patients in primary care offered eight sessions of group therapy. Improvement, both physical and emotional, were maintained.

242 Guthrie E. Emotional disorder in chronic illness: psychotherapeutic interventions. Br Med J 1996, 168(30): 265-273.