

Long term use of benzodiazepines: the views of patients

MICHAEL B KING

JONATHAN GABE

PAUL WILLIAMS

E K RODRIGO

SUMMARY. All long term benzodiazepine users in one inner London general practice were asked to participate in a study of their attitudes to their drugs. The 64 respondents had mixed views about benzodiazepines and did not conform to the stereotype presented in the media. Although 58% of the sample had attempted to stop taking benzodiazepines, this was usually not until at least one year of taking the drug. At the time of interview, 50% of the sample expressed a desire to stop taking their tablets. However, the majority were uncertain whether their general practitioner wished them to continue taking the drugs or not. It is argued that users' views of their medication must be taken into account in the debate about tranquillizer dependence.

Introduction

PRESCRIBING of benzodiazepines in the United Kingdom reached a peak in 1979 when almost 31 million prescriptions were dispensed.¹ Since that time the number of prescriptions dispensed in most industrialized countries has dropped sharply.² Although in the UK the number of prescriptions for these drugs had fallen by 16% in 1985,¹ recent figures show a more gradual decline.³ This change has been due mainly to a drop in new prescribing,⁴ leaving a core of long term users who are principally treated in general practice. It is estimated that there are between 800 000 and 1.6 million chronic users of benzodiazepines in the UK.^{1,5-6} Although the prescribing habits of general practitioners have been studied⁷⁻⁸ and the psychiatric profile of long term users described,^{6,9} scant attention has been paid to the views of patients themselves. Despite a small social science literature on this issue,¹⁰⁻¹³ only one study¹⁴ appears to have been undertaken since the early 1980s when public opinion began to turn against these drugs. Claims by experts and mental health pressure groups have been seized upon by the British media as a part of a wider social legitimization of dependence as a problem,¹⁵ inevitably increasing patient concern.

In order to fully understand why patients continue to use minor tranquillizers it is important to explore their attitudes and beliefs concerning them. The aim of this study was to investigate the attitudes of a population of long term benzodiazepine users in general practice.

M B King, MD, PhD, MRCP, MRCPsych, senior lecturer, Academic Department of Psychiatry, Royal Free Hospital, London. J Gabe, BSocSci, PhD, lecturer in sociology, P Williams, MD, FRCPsych, honorary senior lecturer and E K Rodrigo, MD, MRCPsych, research worker, Institute of Psychiatry, London.

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Method

The study was conducted in a two partner practice with nearly 4000 patients which formed one part of a health centre in inner south London. Both doctors were familiar with research methods and kept careful typewritten records. One had undertaken psychiatric training before entering general practice. The practice catered for a predominantly working class, inner London community with a stable indigenous population with a high proportion of elderly people, together with a relatively high proportion of immigrants. All patients who had received a benzodiazepine prescription continuously for one year or more were identified by the general practitioners through an audit of their repeat prescribing.

Subjects were sent a letter asking if they were prepared to be interviewed about their attitudes to their drugs. Non-respondents were followed up by telephone. The interviews took an average of one hour and all were carried out by MK and ER. Patients were usually seen in their own home but occasionally at the practice if they so wished. Answers were recorded by coding at the time of interview as well as by verbatim recording for later, more detailed analysis. Data was collected in the winter months of 1986/87.

Sociodemographic details were collected from the subjects and a standardized psychiatric interview, the clinical interview schedule,¹⁶ was administered. This interview is widely used in community and medical settings to establish the presence and severity of psychiatric disorder. It has been shown to have high reliability when used by trained medical assessors.

The subjects' experience with their drugs was then examined using a semi-structured interview constructed to cover the following areas: type of benzodiazepine and dosage schedules, reasons for use, drug effects, ways of managing their daily lives apart from the drug, perceptions of their doctor's attitude to the benzodiazepine, efforts to stop taking the tablets and use of other drugs. Although, inevitably, this information was based on impressions, careful construction of the interview, together with frequent scrutiny of its application, ensured an acceptable degree of reliability between the two interviewers. Questions concerning socially or morally sensitive subjects were left as open as possible, and answers were explored further depending on the response. It was assumed that the tendency for patients to give 'acceptable' answers, particularly to questions concerning dependence, would be reduced as it was made clear at the outset that the interviewer had no direct connection with the patient's day-to-day general practice care and that all information would be used solely for the purposes of research.

Results

This paper reports patients' views of their benzodiazepines and the doctors who prescribed them, their attempts to withdraw and ways in which they coped with difficulties, other than by use of tablets. Detailed information about patients' physical and psychiatric health has appeared in an earlier report.⁶

Response rates and demographic characteristics

Eighty two patients (20 men, 62 women) were identified, of whom 64 (16 men, 48 women) took part in the study (78%). Of the 18 patients not interviewed only three actually refused. Two were not interviewed as their general practitioner thought

it was contraindicated on the grounds of their psychological health, four had moved away from the area, one had died and eight could not be contacted despite considerable effort.

Of those taking part, only five were under 40 years of age and 26 (41%) were aged 70 years or older. According to the criteria of Goldthorpe and Hope¹⁷ 73% of the subjects were working class. Further demographic details are given elsewhere.⁶

Type of benzodiazepine and pattern of use

The principal benzodiazepines taken were: temazepam (23 subjects), diazepam (14), nitrazepam (11), lorazepam (nine), chlor-diazepoxide (four) and triazolam (three). Fifty four subjects (84%) reported that when they were first prescribed benzodiazepines they took the tablets once a day or more often. The median duration of consumption was five years (range one to 25 years). Eighteen subjects (28%) said there had been no change in the dose of drug after it was first prescribed, and 29 (45%) claimed that the dose had increased.

Reasons for taking benzodiazepines

The original prescription for benzodiazepines had been issued by a general practitioner for 51 subjects (80%). Thirty nine subjects (61%) claimed that they initially received benzodiazepines for problems of insomnia. Of the remainder, 11 subjects reported anxiety, seven depression and four muscle tension as the initial reason, while three were unable to remember. Fifty nine respondents (92%) gave one or more current reasons for continuing to take the tablets. Of these, 37 believed they took the drug for sleep problems, 20 for nervous trouble and one for physical disease. Only one person reported being unable to stop taking the drug.

Patients' views of their tablets

When asked an open question on how they felt about their tablets, 25 respondents considered them helpful and 11 could not do without them. In contrast, 13 disliked them and eight wanted to reduce or stop taking them. Although a further four subjects said they were worried about taking the tablets, only one of them mentioned being concerned by television publicity about benzodiazepines. Three subjects had no particular view about their tablets.

When patients were asked in what ways the tablets were helpful there was a variety of responses (Table 1); the most common benefits were help with sleep and a calming effect. Subjects were also asked to name specific daily activities for which taking a benzodiazepine was of some help. Again there was a range of replies, the principal three being assistance with work (16 subjects), running the home (eight) and mixing with people (seven).

When asked what they would do if their prescription ran out and local pharmacies were closed, most respondents (78%) claimed they would merely wait until the following day to

Table 1. Ways in which patients found benzodiazepines helpful.

	Number (%) of affirmative responses ^a
Help with sleep	51 (80)
Produce calming effect	36 (56)
Reduce worry/tension	25 (39)
Give more confidence	18 (28)
Make for greater happiness	14 (22)
Reduce irritability	13 (20)

^a Patients could give more than one reply.

obtain further supplies. Only two patients suggested they might borrow similar tablets from friends or family. Finally, as a further indication of their attachment to the benzodiazepine, 48 subjects (75%) said they were prepared to pay for the prescription privately if it were not freely available on the National Health Service.

Undesirable effects of benzodiazepines

Ten respondents (16%) experienced undesirable effects from their benzodiazepines. These were principally difficulties with memory and concentration or 'hangover' effects. Only three subjects, however, considered that the tablets actually interfered with their daily activities.

Additional ways of managing their daily lives

Although 27 patients could not suggest any activity that was helpful in managing their daily lives besides the drug, the remainder were able to list a wide range of activities (Table 2). When asked what they would do if their tablets were unavailable, 25 respondents could offer no suggestion, while four claimed they would be extremely worried or might become mentally ill. In contrast, nine were not particularly concerned about going without the tablets and the remaining 26 made suggestions similar to those shown in Table 2.

Table 2. Other activities that helped patients manage their daily lives.

Activity	Number (%) of respondents finding activity helpful ^a
None	27 (42)
Hot/cold drinks	14 (22)
Solitary activities (eg knitting, gardening)	12 (19)
Reading	11 (17)
Alcohol	7 (11)
Relaxation	6 (9)
Group activities (eg dancing, social group)	4 (6)
Cigarettes	3 (5)

^a Patients could give more than one activity.

Patient's perceptions of their general practitioner's attitudes

Only 12 patients (19%) reported that their doctor had ever tried to help them stop taking their benzodiazepines. At the time of the interview, 24 respondents believed that their doctor encouraged them to take the drug and only seven that their doctor discouraged them. However, the majority of patients (33, 52%) had no idea how their doctor regarded their use of benzodiazepines.

Attempts to stop taking benzodiazepines

Thirty seven patients (58%) had tried to stop taking the drug at least once in the past, but only eight had made any attempt within the first year of taking it. In fact, 10 of the 37 patients had made eight or more attempts. The three principal reasons given for trying to stop taking the drug were a fear of dependence (12 subjects), because they felt better (eight) and on instruction from their doctor (five). All those who had never tried to stop taking the drug cited a continuing need as their principal reason.

When the respondents were asked if they would like to stop taking benzodiazepines exactly half (32) claimed they would if they could, but 19 said they were unable to do so because of persisting symptoms. The remaining 13 were frightened of relapse

or withdrawal symptoms. As regards the future, 22 subjects (34%) were unsure how long they would continue to need the benzodiazepine. Of those subjects who were sure, one believed it would be only for a matter of weeks, whereas 12 felt it would be months or years. Twenty nine respondents claimed that they would always require the drug.

Discussion

In recent years much media attention has been given to long term use of benzodiazepines. An image has been created of the chronic user as a middle-aged woman who is the passive recipient of an 'addictive' drug.¹⁵ Although the results presented here are confined to the retrospective self-reports of patients in one inner London general practice, this study of an unselected group of chronic users shows that although the majority are older women, they are far from being an homogeneous group. Our respondents had very mixed views about their drugs but did not regard themselves as ill or morally culpable, despite media coverage of the issue in the past five years. More than half reported a range of other helpful activities which they used in the management of their daily lives. Furthermore, many were elderly and took the tablets for sedation.

Other researchers of chronic benzodiazepine users have rarely taken patients' views of the drugs into account.^{9,18-19} Of those who have explored patient opinion,¹⁰⁻¹⁴ most have studied groups that are unrepresentative of chronic users, or in two cases possibly biased in their responses because patients were known to the investigator.^{11,14} Nevertheless, there is broad agreement with this study that the views of chronic users do not conform to the particular pattern suggested in the media.

In this study half of the sample expressed a wish to stop taking the drug and many had attempted to stop in the past. One explanation for why they were not currently attempting to do so may lie in the nature of their relationship with their general practitioner. In contrast to the chronic users in a recent study¹⁴ who were aware of their general practitioner's aversion to benzodiazepines, the majority of the benzodiazepine users in this study claimed they had little idea of how their general practitioner regarded their drug taking. This is surprising given the high standard of clinical service given by these doctors, the length of time patients had been taking the drug and the need for regular prescriptions. It is possible that many patients were receiving repeat prescriptions and both patient and doctor had abandoned further discussion on the topic.

It is also noteworthy that three quarters of these chronic users stated that they would be prepared to pay for their drugs privately if they were unavailable on the National Health Service. This work was conducted close to the time of introduction of the limited list when patients were sensitive to the possibility that their drugs might become unavailable. Thus, although a device such as the limited list might result in savings for the National Health Service, it would not necessarily lead to savings for the country as a whole. However, experience indicates that in the time since the introduction of this list most patients have changed to a drug available on that list.

These findings have important implications for our approach to chronic users. Any form of 'pharmacological Calvinism',²⁰ which opposes all tranquilizers, is blind to the complexity of their use and creates a moral climate which militates against sensible prescribing practice.²¹ Rather, doctors need to be aware that their patients who take benzodiazepines in the longer term have a range of attitudes and responses towards the drugs and vary in the extent to which they are actively seeking to stop taking them. It is becoming recognized that patients' views of their treatment should be an important consideration for health workers.²² Opening a dialogue with chronic users will establish

the particular reasons behind their continuing use. Perhaps, after consideration, a joint decision would be made by doctor and patient to continue the drug. It is important that doctors are not unduly influenced in their clinical decisions by interest groups, campaigning journalists or the more recent threat of litigation. Even more importantly, doctors should be aware of the danger of attributing all long term use to the personality profile of their patients,²³ as once again this discourages an appreciation of patients' heterogeneity, and their potential for change.

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Address for correspondence

Dr M King, Academic Department of Psychiatry, Royal Free Hospital School of Medicine, Pond Street, London NW3 2QG.