

the crisis. Longer courses are very hazardous and likely to produce drug dependent patients.

There are a few psychopaths and inadequate people who are better on these drugs than without them, but I now only use them as a last resort. When their use was accepted in our area as a reasonable form of treatment, so many people were on tranquillisers that a partner suggested we might as well put chlordiazepoxide into the tap water.

Reduction in psychotropic prescribing

Ever since Peter Parish made me think again, I have been much more guarded in the use of these drugs, and I don't think that my patients have suffered. I am sure I have far fewer *new* drug dependent patients. I feel that one should treat the minor tranquillisers with the same respect that we have for the steroids or the opiates. Used in short sharp courses they can do no harm, but long-term use should be avoided.

If there is any question of depression I use antidepressants. These are so slow acting that they do not give a 'kick,' and patients when they feel better are glad to stop the tablets if only to get rid of the dry mouth, or to be able to consume cheese and alcohol. There is rarely a craving to keep on with them all the time.

Many patients improve on minor psychotherapy which need not take hours and hours of time. While some people accept this form of treatment, others demand some re-enforcement in the form of drugs. Most who ask for drugs do as well on vitamins as they do on anxiolytics and I believe that there is a place for the placebo in our work. I agree with the American doctor who said that the physician who did not believe in placebos should turn his hand to veterinary medicine.

After about 26 years of practising psychiatry in general practice, I feel that the place for the sedative and the minor tranquilliser is strictly limited, and I do not use these drugs nearly as much as I used to do.

REFERENCE

Parish, P. A. (1971). *Journal of the Royal College of General Practitioners*, 21, Supplement No. 4.

DISCUSSION

Dr P. A. Parish

Over one in three of all psychotropic drug prescriptions dispensed by National Health Service pharmacists in England and Wales in 1971 were for the proprietary preparations 'Librium,' 'Valium' or 'Mogadon.' These three drugs are benzodiazepines manufactured by the same company. They have four main effects—*anxiolytic, sedative, anticonvulsant and muscle relaxant.* 'Librium' (chlordiazepoxide) was launched in 1960 as an 'anxiolytic'; so was 'Valium' (diazepam) in 1963. 'Mogadon' (nitrazepam) was launched in 1965 as a 'sleep inducer.' Another 'anxiolytic' benzodiazepine (Nobrium) was launched in 1971.

'Librium' and 'Valium' were supplied free to hospitals, yet there have been no conclusive randomised clinical trials of these drugs because of the difficulty in measuring anxiety and its response to drug treatment, lack of knowledge of equivalent anti-anxiety dosages of other compounds, and human dose-response curves are not available. Cumulative action of these drugs further complicates such investigations. Nor has there been any comparison between the *anxiolytic and/or sedative effects of 'Librium,' 'Valium,' 'Mogadon' and 'Nobrium.'* If given in equi-therapeutic doses are these drugs similar in effect?

We all too readily abandon one drug and replace it with another, even if we know much less about the new drug. We feel we are being 'up to date' and yet I just wonder

what we will be saying about the benzodiazepines in 50 years' time. A recent example of fashionable prescribing was the use of 'Mandrax.' This drug, launched in 1965, became the most widely prescribed hypnotic in 1968. It started to replace the barbiturates and yet it was subsequently shown to possess all the disadvantages of the barbiturates and had additional ones as well. Such fashions reflect poorly upon the profession.

Dr W. Sargant

I think there is a danger—I have only just learned that 'Valium' and 'Mogadon' are similar. Here is a supposed expert being completely led up the garden path by this present situation. I hope that this conference will in some way make a strong resolution that in the future drugs with similar actions and effects are grouped together. Because of advertising, doctors are going from one drug to another quite unscientifically. This is the real problem we have to combat.

Professor W. H. Trethowan

Psychiatrists do not use minor tranquillisers all that much, but I would not like to go back to the use of barbiturates. There is pharmacological evidence to suggest, in certain psychiatric conditions at least, that barbiturates may be actually harmful. Further, there have been several quite well authenticated studies which show that behaviour disorders in children are made worse by phenobarbitone and that the EEG is made more dysrhythmic. There are also certain other conditions like depressive states in which barbiturates add to the depression rather than alleviate it. I am against the use of barbiturates for these reasons.

Dr C. A. H. Watts

I have examined my records of patients from 1946 to 1949 and in those days the average duration of a depressive episode was about ten months. I had to boost up their morale all the time, and keep seeing and encouraging them. The only thing that gave them any real relief was their barbiturate at night.

The same kind of depressive episode now lasts about seven months, and of course they are made to feel a lot more comfortable after two or three weeks on tricyclic antidepressant drugs. I wonder, from what has been said, whether the giving of barbiturates may not have contributed to the longer depression in the old days.

Professor O. L. Wade

Dr Watts, you told us that you found your patients did not need sedatives and minor tranquillisers, and that you had reduced their use. Can you give us any evidence that the patients treated with these drugs in the old days came to any harm?

Dr C. A. H. Watts

I do not think they came to any harm, but you could never stop the drugs.

I did a survey and I found over the years that I had 25 per cent of the people who saw me on either minor tranquillisers or antidepressants—I felt this was far too high a proportion.

Dr P. A. Parish

Can we argue that you kept the patient on these drugs? Are you not trying to blame the patient?

Dr C. A. H. Watts

I suppose you could, but it is very difficult to wean them off. If you stopped the drugs or reduced the dose, they came back and said they were not so well.

Dr T. P. Riordan

Dr Watts, you say that your depressed patients are getting better more quickly now with antidepressant drugs, whereas in the old days you sat and talked to them. I am wondering whether you talk to them now, or if you consider it unnecessary.

Dr C. A. H. Watts

Yes, they need support. However, I find that quite a few of them who have been on antidepressants and who have seen me once or twice, raise all kinds of problems that they did not mention at first. This is very helpful.

THE USE OF HYPNOTICS

DR J. D. POLLITT

Ten years ago the barbiturates satisfied most hypnotic needs and there were relatively few situations for which one or other of these drugs would not suffice in the short term. If it was a long-term clinical situation there was little else one could do. It was all too easy to assume that a patient who became dependent was inadequate and able to deal with the realities of life only by using barbiturates as a filter.

Then, insomnia was often regarded as a disorder in itself to be treated in isolation, but the last ten years have seen an almost total change in viewpoint. We can now use alternative sleep inducing drugs and measure sleep objectively. We are in a position to clarify an issue which has long been confused in relation to insomnia; the difference between comforting patients and curing them.

The range of sleep-inducing drugs is much wider, the range of sleep-disturbing disorders is clearly recognisable, and the opportunity to use 'curative' treatment is within the range of general practitioners and specialists alike. A remarkable change has occurred in prescribing habits. Some general practitioners are now able to say that they and their partners never give barbiturates.

History of the use of hypnotics

It is worthwhile considering briefly some of the beliefs and attitudes which can lead to the misuse of hypnotics, to give perspective to the way ahead. To do this we must consider beliefs which were current 25 years ago. In undergraduate teaching the main headings for the causes of insomnia, and indications for the use of hypnotics were pain, anxiety and 'psychological disturbance.' Patients in hospital had to receive effective hypnotics to allow them to sleep in an unfamiliar, noisy atmosphere, particularly in view of the alteration in sleep rhythm, for often as much as a three-hour shift was necessary to allow nursing duties to be performed. It was thought by many that a chronic disturbance of sleep pattern could be corrected by inducing sleep with hypnotics, and that once a regular pattern had been re-established, withdrawal of the hypnotic would leave the patient with his usual untroubled slumber.

These perhaps were the situations in which the doctor was likely to prescribe an hypnotic to comfort patients, but all these beliefs need to be examined in the light of modern views. From the clinical psychiatrist's point of view, if anxiety arises from a known stress the patient is most likely to be helped by reassurance and a psychological