

Patients' perceptions of psychotropic drugs

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SUMMARY. This pilot study examined patients' perceptions of, and attitudes towards, psychotropic drug-taking. Fifty chronic users of benzodiazepines in two Middlesex group practices were interviewed, and data were collected on their knowledge, experience and expectations of these drugs.

The data suggest that psychotropic drug-taking has become an important part of many patients' self-image and of their social relationships, and that these factors should be taken into account when dealing with psychological dependence on psychotropic drugs.

conflicts, rather than allowing the patient to confront these with the aid of psychotherapy (Trethowan, 1975; Claridge, 1970).

Studies of psychotropic drug-taking have largely ignored the phenomenon from the patient's point of view. Many general practitioners are ignorant of their patients' beliefs, expectations, knowledge and experience of taking psychotropic drugs; yet these factors can influence attitudes towards and compliance with drug therapy, as well as the non-pharmacological or placebo effects of the drug itself (Blum, 1968; Claridge, 1970; Ley, 1979). They may also exert a subtle effect on the prescribing habits of general practitioners.

Introduction

DURING the last 20 years there has been a progressive rise in the prescribing of psychotropic drugs in Britain, particularly in general practice (Parish, 1971 and 1973; Tyrer, 1976 and 1978). Tyrer (1978) has estimated that more patients take tranquillizers regularly for over a month in Britain than in any other Western country; other surveys estimate that every tenth night of sleep in England is induced by a hypnotic drug (Dunlop, 1970), and that 27 per cent of British homes have some psychoactive drugs in them (Dunnell and Cartwright, 1972). Many authors have pointed out the dangers of this increase, especially with regard to the benzodiazepines. There is general agreement that these drugs are overused or misused (*Lancet*, 1973; Sellers, 1978), particularly the hypnotics (Parish, 1971; Solomon *et al.*, 1979). The numerous side-effects of the benzodiazepines have been noted, particularly their tendency to cause psychological dependence or habituation (British Medical Association, 1974; Hall and Kirkpatrick, 1978; Smith and Rawlins, 1977; Tyrer, 1978; Wade, 1977). Doubt has also been cast on whether it is always advisable to suppress anxiety and emotional

Aim

This pilot study set out to explore patients' perceptions of psychotropic drugs—especially those of chronic users—and the symbolic part played by these drugs in the patients' lives. By viewing these perceptions from the patient's point of view, the study aimed to improve communication between doctor and patient and to lead to a more rational use of psychotropic drugs. The study was not designed to gather large-scale statistical data, but rather to formulate concepts from an initial small sample which could then be tested in a second, larger survey.

Method

The survey was carried out, starting in February 1979, in two group practices in Edgware and Stanmore, Middlesex. Fifty patients were interviewed with the aid of a standardized questionnaire. The sample was chosen randomly from among chronic users of benzodiazepines who attended the surgeries during the period of the survey; all had been receiving repeat prescriptions for one of the benzodiazepines for at least six months prior to the date of the interview. They were interviewed after their consultation, and with their general practitioner's permission. It was stressed that the questionnaires were anonymous, and would have no effect on their treatment. Patients' comments were, as far as possible, recorded verbatim on the questionnaires. Of the 50 adults interviewed, all were middle class, and 40 of them were women.

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Results

The questions and the results of the questionnaire are set out in Tables 1 to 6.

Table 1a. Age of patients.

Age in years	Number	Percentage
20-39	4	(8)
40-59	9	(18)
60-79	37	(74)

Table 1b. Marital status.

	Number	Percentage
Married	33	(66)
Widowed	10	(20)
Single	5	(10)
Divorced	2	(4)

Table 2. Drugs used by patients in the sample.

	Number	Percentage
Diazepam (Valium)	26	(52)
Nitrazepam (Mogadon)	14	(28)
Flurazepam (Dalmane)	5	(10)
Chlordiazepoxide (Librium)	3	(6)
Lorazepam (Ativan)	1	(2)
Oxazepam (Serenid-D)	1	(2)

Table 3. Reasons for taking the drug.

Question: Why are you taking [name of drug]?

	Number	Percentage
*"Insomnia", "sleeplessness"	23	(46)
"Nerves", "anxiety", "tension" and related symptoms	19	(38)
"Depressed", "low"	5	(10)
"A nervous breakdown"	3	(6)

*"Insomnia" included feelings of restlessness, loneliness, or "bad thoughts or memories" occurring at night. Subjective symptoms or "nerves" or anxiety occurring during the day sometimes followed a night of insomnia.

Perceived effects of taking the drug

One third of the patients placed the site of maximum effect in their "mind", "brain", or "head", which they regarded as the site of unpleasant or troubling emotions (Table 4a). A smaller number indicated an organ most affected by psychosomatic symptoms, such as "a tight stomach", or "a palpitating heart".

Table 4a. Part of the body most affected.

Question: On which part of your body does it seem to have most of its effect?

	Number	Percentage
"Mind", "brain", or "head"	16	(32)
The "whole body", "all over"	7	(14)
"Stomach"	2	(4)
"The sleep centre", "the sleeping part"	2	(4)
"Nerves"	2	(4)
"Heart"	1	(2)
"Eyes"	1	(2)
"Don't know"	19	(38)

Table 4b. Effect of drug on patient.

Question: What effect, if any, does it have on you? Do you notice any difference after taking it?

	Number	Percentage
No effect	20	(40)
Improvement in mental state	17	(34)
Fall asleep	13	(26)

Table 4c. Side-effects.

Question: Does it, as far as you know, have any side-effects on you?

	Number	Percentage
No side-effects	39	(78)
Side-effects	10	(20)
Don't know	1	(2)

The 20 patients who noticed no subjective change after ingestion of the drug, either physical or psychological, may indicate the development of tolerance or incorrect dosage of the drug (Table 4b). It is interesting that in answering this question 13 patients cast doubt on whether the drug actually had any pharmacological effect on them, and speculated that its effect was "probably psychological":

"I don't know if it makes me relax or not; having taken it my mind says 'I'm going to relax soon'. It's probably psychological."

"I feel a little more confident. I don't know if it's that or me. Whether it was autosuggestion or me—it calmed me. You become so reliant on them you feel it's doing you good, even if it isn't."

"I take one at night—it doesn't work any more. It's like a kind of prop—otherwise I think I won't fall asleep. I kid myself that I sleep better with Valium."

Table 4d. Patients' views of alternatives to taking the drug.

Question: What would you have done, or do now, if (the drug) was unobtainable for any reason, or if it had never been invented?

	Number	Percentage
Taken another drug (self-prescribed or from a doctor)	18	(36)
Done without and coped well	14	(28)
Don't know	8	(16)
Continued with symptoms as before	5	(10)
Suffered a "mental breakdown"	2	(4)
"Gone to drink"	1	(2)
Seen a psychologist	1	(2)
Gone on a "nature cure"	1	(2)

Side-effects (Table 4c) included "nightmares", "feeling sleepy during the day", "slightly more depressed", "bad taste in mouth" and, in one case, impotence.

Anticipated effect of withdrawal of drug

When asked what they would do or would have done if their drug was unobtainable (Table 4d), 18 patients would have switched to another drug. These included: aspirin, 'Aspro', paracetamol, 'Panadol', 'Veganin', and 'Metatone'. With one exception, all would choose analgesics for their psychological symptoms. In Jefferys' study (1960) of self-medication on a working-class estate, aspirins were widely used for a variety of symptoms, including "nerves", "sleeplessness" and other mental disorders.

Despite being chronic users, 14 patients believed they would have coped well without medication, and only three thought they would have turned to drink, or suffered a mental breakdown.

The data in Tables 4e, 4f and 4g indicate that 19 patients did not see the drug, or its withdrawal, as having any effect on their relationships. However, 15 patients who perceived no direct effect of the drug on relationships still anticipated negative effects arising from its withdrawal, as though without it they were in a psychotropic deficiency state. Including this group, a total of 26 patients feared the effect of withdrawal of the drug on their relationships. In particular, they expressed fears of losing or damaging relationships due to their inability to conform to an idealized model of normal behaviour and social values. A number of positive attributes were thought to be absent from the personality if the drug was not taken; these included: being normal, being oneself, even-tempered, self-controlled, patient, tolerant, good to live with, nurturing, sociable, friendly, non-complaining, confident, popular, and being able to cope with personal and social responsibilities:

"Without it I'd be nasty, jumpy—not nice to live with."

"I'd be unbearable to live with—all groans and moans."

Table 4e. Effect on relationships.

Question: What effect, if any, does it have on your relationships with other people? (spouse, children, relatives, friends, neighbours, workmates, etc).

	Number	Percentage
No effect	36	(72)
Positive effect	13	(26)
Negative effect	1	(2)

Table 4f. Anticipated effect of withdrawal on relationships.

Question: What would be the effect, if any, on your relationships with other people if [the drug] were withdrawn or unobtainable?

	Number	Percentage
No effect	21	(42)
Positive effect	—	—
Negative effect	26	(52)
Don't know	3	(6)

Table 4g. Correlation of tables 4e, 4f.

		Effect of drug on relationships		
		No effect	Positive effect	Negative effect
Effect of withdrawal of drug on relationships	No effect	19	2	—
	Positive effect	—	—	—
	Negative effect	15	10	1
	Don't know	2	1	—

"If I wasn't taking them [tranquillizers], I couldn't help those I love."

Women stressed in particular the loss of their nurturing role in the family if the drug were withdrawn (a similar finding to Cooperstock and Lennard, 1979). Men's anxieties related to work situations and to loss of self-control.

Knowledge of drug-taking

Tables 5a, 5b and 5c indicate widespread knowledge and acceptance of psychotropic drug-taking in the sample's social contacts. Only nine patients reported strong disapproval by others of their taking these drugs; the remainder were either neutral or in favour. Thirty-six patients knew of someone else taking the same drug, and with 44 patients someone else knew of their taking the drug. Little social stigma seemed to be attached to psychotropic drug usage. Stimson and Webb (1975) have noted that local friendship and family networks make possible the exchange of information about drugs, what they are to be used for, what the effects are, and when they should be taken or not taken.

Table 5a. Knowledge among others of patients' drug-taking.

Question: Who else knows that you are taking (the drug)?	Number	Percentage
Spouse, relative, friend, or neighbour	44	(88)
No-one	6	(12)

Table 5b. Attitudes of others towards patients' drug-taking.

Question: What do they think of your taking (the drug)?	Number	Percentage
Approve	10	(20)
Disapprove	9	(18)
Neutral	29	(58)
Don't know	2	(4)

Table 5c. Patients' knowledge of drug-taking by others.

Question: Who else do you know who is also taking (the drug)?	Number	Percentage
Spouse, relative, friend or neighbour	36	(72)
No-one	14	(28)

Table 6a. Patients' attitudes towards drug-taking.

Question: What do you think of taking drugs? (Note: the word 'drug' had not been used in the questionnaire until this point)	Number	Percentage
In favour	15	(30)
Against	34	(68)
Don't know	1	(2)

Table 6b. Patients' idea of a drug.

Question: Is what you are taking a drug?	Number	Percentage
Yes	41	(82)
No	8	(16)
Don't know	1	(2)

Only six patients admitted sharing their drugs with others. However, in Warburton's study (1978), 68 per cent of young adults admitted being given psychotropic drugs by friends or relatives.

Attitudes towards drug-taking

The 34 patients who expressed disapproval of 'drug-taking' in general (Table 6a) often qualified this disapproval; for example:

"I hate taking sleeping tablets. I'm against them. I only take them if I'm driven to it. I would like to do without them."

"I'm against it—but everyone needs a little help."

Fifteen patients did approve of drugs, but often placed full responsibility for taking them on the doctor; for example:

"I'm not against drugs. I take whatever I'm given to swallow."

The apparent discrepancy between disapproval of drugs, and the admission by 41 patients that they were taking a drug, is clarified by their answers to the second part of the question; that is, "If so, what type? If not, what is it?". These indicate two of the lay uses of the word drug, i.e. (1) an ingested chemical on which one is dependent, and over which one has no control, and (2) an ingested chemical which greatly alters the level of consciousness:

"It's not a drug. If you took more of it, it might become a drug."

"It doesn't drug me—I keep on the go."

Among the 41 patients who admitted taking a drug, there was a strong stigma against the loss of personal control over one's psychotropic medication. They were anxious to point out that 'their' drug was under their control, and minimized its power and effects:

"It's a little bit of help—not a powerful drug."

"It's a calmer, a help—I can cut it off when I want to."

Psychotropic drugs and learnt behaviour

During the interviews, six patients indicated that psychotropic drug-taking, and the subjective experiences associated with it, might be a form of learnt behaviour; for example:

"If it had never been invented, I wouldn't have had the experience of relying on them."

"If I didn't know of it, there would have been nothing I could do about it—I would think: 'I'm a miserable so-and-so, and I'm stuck with it'."

Discussion

The data for this pilot study were from a sample of middle-class patients, most of them women. Their answers to the questionnaire reveal a wealth of lay beliefs and theories about what psychotropic drugs are, how they work and what happens if they are withdrawn.

Placebo effect

Several authors have noted that such beliefs and expectations may affect the placebo response to the drugs, as well as compliance with medical instructions (Blum, 1968; Chein, 1969; Claridge, 1970). They may also affect psychological dependence, as one can also become dependent on a placebo (*Lancet*, 1972); in Joyce's view (1969), the longer a drug is taken, the larger its symbolic or placebo significance for the patient. Thirteen patients in the current study were aware of this possibility, and speculated that the drug's effects on them were "probably psychological". Patients' recourse to "pills for personal problems" (Trethowan, 1975) can be unrelated to the pharmacology of these drugs; 18 patients in the sample would have turned to self-prescribed Veganin, aspirin (see Jefferys *et al.*, 1960) or similar preparations, or requested another drug from their doctor. Patients did not differentiate between tranquillizers and hypnotics; all preparations taken for insomnia, including tranquillizers, were termed "sleeping tablets". Their effect was perceived as being both on insomnia itself ("It's a nice feeling—a block in my head—and I can't think beyond it into my miserable thoughts. Something stops me thinking and then allows me to drift into sleep"), or on one's mental state the following day ("I get a good long night's sleep, and wake up feeling normal"). In another study, Dunnell and Cartwright (1972) found that 29 per cent of patients thought doctors could cure sleeplessness, and 63 per cent believed that this symptom could be helped by medication.

Effect on social relationships

From the perspective of some patients the importance of psychotropic drug-taking may have lain in its indirect effect on social relationships, especially if these relationships (with husbands, children, relatives and so on) were perceived as static, with the only components within them that could be changed being the patient's state of mind or emotions—with the aid of psychotropics ("I wish I could send the four children away, I might learn to cope [without the drug]—otherwise it would be impossible").

Drug-taking and ideas of normality

The results of this study reveal widespread knowledge and acceptance of psychotropic drug-taking among the sample's social contacts. In an atmosphere of such knowledge and tolerance of psychotropics, together with a belief in their limited power to cause psychological dependence, fashions of drug-taking (and prescribing) may flourish (see Parish, 1973). This is particularly true with the increased consumption of what Tyrer (1978) terms "Me-too" drugs (for example, "but all the widows are taking them [hypnotics]" and "all my friends are on Valium").

Although psychotropic drugs undoubtedly have a place in the management of psychological disorders, they do have several dangers. One is that in prescribing such drugs for personal problems, doctors may be communicating a model for dealing with these problems—not by confronting them, but by providing a prop. This danger has been noted by several authors (Blum, 1968; Parish, 1973; Warburton, 1978; Watts, 1973). Six patients in the sample indicated that they had learnt the experience of relying on these drugs and the subjective symptoms associated with their ingestion. Doctors may be reinforcing or communicating a model of fictional 'normality'—a life theoretically free of anxieties and bad thoughts where personal equilibrium and social relationships are largely maintained by the frequent ingestion of psychotropic drugs. One result might be that these drugs, or the taking of them, may be incorporated into the patients' self-images as something that completes them or makes them normal; continued prescribing of psychotropics may confirm a self-image of being perpetually ill or inadequate without the drug (see Pfefferbaum, 1977), as well as being dependent on the doctor.

Balint (1974) has pointed out how the consultation itself may be a form of drug; in this case, the repeated prescribing of psychotropics can constitute a symbolic gift or link between doctor and patient, and there may be little incentive to break this link, especially in a socially isolated individual. As the results of the questionnaire indicate, there is widespread knowledge among the sample's social contacts of their taking psychotropic medication. In this setting, the taking of a psychotropic can become a badge of membership of a community of suffering ("all my friends are on Valium"), as well as a topic of conversation.

Identifying the possibility of dependency

The impression gained from this pilot study is that patients' stated beliefs about and perceptions of psychotropic drug-taking are relevant in determining which patients are most at risk of becoming chronic users of these drugs. A further impression is that the following criteria are likely to be important in assessing whether patients are at risk:

1. The extent to which the patient believes he or she can control the amount of drug taken and when and whether it should be taken at all.
2. Beliefs about the effects of the drug, or its withdrawal, on the patient's subjective emotional state.
3. Beliefs about the effect of the drug on the patient's social relationships.
4. Attitude of the patient to drugs in general, and the prescribed drug in particular.

A further factor might be the patient's perception of whether the maximum effect of the drug is mainly on: (1) the patient, (2) their relationships or (3) both.

References

Balint, M. (1974). *The Doctor, his Patient and the Illness*. 2nd edn. London: Pitman.

Blum, R. H. (1968). Social and epidemiological aspects of psychopharmacology. In *Psychopharmacology: Dimensions and Perspectives*. Ed. Joyce, C. R. B. pp. 243-282. London: Tavistock Publications.

British Medical Association & The Pharmaceutical Society of Great Britain (1972-1974). *British National Formulary*. London: BMA.

Chein, I. (1969). Psychological functions of drug use. In *Scientific Basis of Drug Dependence*. Ed. Steinberg, H. pp. 13-30. London: Churchill.

Claridge, G. (1970). *Drugs and Human Behaviour*. London: Allen Lane.

Cooperstock, R. & Lennard, H. L. (1979). Some social meanings of tranquillizer use. *Sociology of Health and Illness*, 1, 331-347.

Dunlop, D. (1970). The use and abuse of psychotropic drugs. *Proceedings of the Royal Society of Medicine*, 63, 1279-1282.

Dunnell, K. & Cartwright, A. (1972). *Medicine Takers, Prescribers and Hoarders*. London: Routledge and Kegan Paul.

Hall, R. C. & Kirkpatrick, B. (1978). The benzodiazepines. *American Family Physician*, 17, 131-134.

Jefferys, M., Brotherston, J. H. F. & Cartwright, A. (1960). Consumption of medicines on a working-class housing estate. *British Journal of Preventive and Social Medicine*, 14, 64-76.

Joyce, C. R. B. (1969). Quantitative estimates of dependence on the symbolic function of drugs. In *Scientific Basis of Drug Dependence*. Ed. Steinberg, H. pp. 271-279. London: Churchill.

Lancet (1972). Drug or placebo? Editorial. 2, 122-123.

Lancet (1973). Benzodiazepines: use, overuse, misuse, abuse? Editorial. 1, 1101-1102.

Ley, P. (1979). What patients expect from drugs and doctors. *MIMS*, 15 June, 45-49.

Parish, P. A. (1971). The prescribing of psychotropic drugs in general practice. *Journal of the Royal College of General Practitioners*, 21, Suppl. 4.

Parish, P. A. (1973). The medical use of psychotropic drugs. *Journal of the Royal College of General Practitioners*, 23, Suppl. 2, 49-58.

Pfefferbaum, A. (1977). Psychotherapy and psychopharmacology. In *Psychopharmacology*. Eds. Barchas, J. D. et al. New York: Oxford University Press.

Sellers, E. M. (1978). Clinical pharmacology and therapeutics of benzodiazepines. *Canadian Medical Association Journal*, 118, 1533-1538.

Smith, A. & Rawlins, M. D. (1977). Benzodiazepines. *British Medical Journal*, 2, 447.

Solomon, F., White, C. C., Parron, D. L. & Mendelson, W. B. (1979). Sleeping pills, insomnia and medical practice. *New England Journal of Medicine*, 300, 803-808.

Stimson, G. & Webb, B. (1975). *Going to See the Doctor*. London: Routledge and Kegan Paul.

Trethowan, W. H. (1975). Pills for personal problems. *British Medical Journal*, 3, 749-751.

Tyrer, P. (1976). Drugs for anxiety. *Prescribers' Journal*, 16, 1-8.

Tyrer, P. (1978). Drug treatment of psychiatric patients in general practice. *British Medical Journal*, 2, 1008-1010.

Wade, A. (Ed.) (1977). *Martindale: The Extra Pharmacopoeia*. 27th edn. London: The Pharmaceutical Press.

Warburton, D. M. (1978). Poisoned people: internal pollution. *Journal of Biosocial Science*, 10, 309-319.

Watts, C. A. H. (1973). The use of sedatives and minor tranquillizers. *Journal of the Royal College of General Practitioners*, 23, Suppl. 2, 30-33.

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DOCTORS ON THE MOVE

Occasional Paper 7

At a time when organizational changes are coming thick and fast in general practice, *Occasional Paper 7* reports a novel and interesting experiment in which the premises of one general practice were completely reorganized so that traditional consulting rooms were replaced and the doctor, instead of remaining static in one room, moved around.

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General practice training

The current average cost of a trainee in general practice is about £15,000 per year.

At 1 October 1979, there were 1,143 and 93 trainees in general practices in England and Wales respectively; each year about 600 doctors also start two-year organized training schemes in hospitals prior to entering general practice.

Over the past three years the numbers of doctors undertaking the year's training in general practice in England and Wales were as shown in Table 1.

Little additional regional machinery has been required to administer the scheme and the majority of the cost of the training is met from funds provided for general medical services and general practitioners' post-graduate education.

The portion of the cost falling to health authorities is too small to have a measurable effect on the provision of other services.

Table 1. Numbers of doctors undertaking a year's training in general practice over the period 1977 to 1979.

	England	Wales
1977	866	66
1978	997	77
1979	1,143	93

Source: *House of Commons Official Report* (1980). No. 1179, vol. 987, cols 728-729.