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Psychological alternatives to long-term benzodiazepine use

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SUMMARY. The aim of the study was to evaluate the effectiveness of psychological management of anxiety as an alternative to long-term benzodiazepine medication. Fifty patients were identified who had been taking benzodiazepines continuously for at least one year. No significant differences were found between patients who joined a treatment group and patients who were simply advised by letter to cut down their pills. Patients gave a variety of reasons for initially requiring medication and somewhat different reasons for needing to maintain chemotherapy, which suggested that pill-taking might be self-maintaining through withdrawal symptoms.

Introduction

FORTY BILLION doses of benzodiazepines are reportedly consumed per day worldwide (Tyrer, 1980). In the United Kingdom, it has been estimated that 19 per cent of people aged 15 years or over receive psychotropic drugs on prescription during one year (Skegg *et al.*, 1977), and that 8.6 per cent of people take anti-anxiety or sedative drugs daily for at least one month in a year (Marks, 1978).

The Committee on the Review of Medicines (1980) recommended that benzodiazepines should be prescribed only for short-term use, yet Lader (1980) reported chronic use by 1.5 per cent of males and 3.5 per cent of females in the United Kingdom, with one quarter of a million people dependent on the benzodiazepines. One of the problems for the patient is that if medication is stopped suddenly, symptoms of withdrawal may be experienced which are similar to the anxiety symptoms for which the drug was prescribed initially. This leads to the belief that the original anxiety still exists and the patient resumes medication. Tyrer (1980) found that 27 per cent of patients who had taken lorazepam or diazepam in therapeutic dosage for at least four months had withdrawal symptoms when the medication was stopped abruptly. This percentage may well be an underestimate since it does not include those patients who immediately resumed medication at the first indication of an apparent resurgence of anxiety.

The work to be reported arose from the concern of the members of a group general practice that some patients had been receiving benzodiazepine medication for inappropriately long periods. These patients tended to be 'unobtrusive' in the sense that they did not seek consultations with the doctor or refer to outside agencies such as psychiatrists or psychologists, but apparently remained content with repeat prescriptions.

A programme was instigated which involved co-operation between the general practitioners and a member of the district psychology department who was conducting sessions at the practice. The advantages of such involvement as opposed to referral of patients to hospital-based departments of clinical psychology are well documented (Johnston, 1978; Bhagat *et al.*, 1979).

Aims

The aim of the study was to evaluate the effectiveness of psychological management of anxiety (Meichenbaum, 1977) in general practice patients on long-term benzodiazepine medication.

Method

Patients who had been receiving benzodiazepines on repeat prescriptions for at least two years were sent a letter from the general practitioners asking them to reduce their medication and explaining that the pills should be used only in crises. The

Table 1. Ages of patients.

Age range (years)	Number of patients
Under 25	1
25–34	3
35–44	9
45–54	14
55–64	14
65+	9
Total	50

Table 2. Treatment group characteristics related to outcome.

Characteristics	Success ($n=5$ patients)	Failure ($n=6$ patients)
Mean age (years)	52	65
Age range (years)	47–57	63–69
Duration of medication (years)	3×10+ 1× 3 1× 6	2×10+ 2× 7 2× 2

letter-writers acknowledged that some people might find it difficult to stop and offered help in the form of advice from psychologists, who were defined as being experienced in helping people to break bad habits. Some pains were taken to word the letter so as not to cause anxiety.

Letters were sent from the psychologists inviting the patients to attend for interview whether or not they had reduced medication. Up to three appointments were offered to each patient, at least one appointment being in the evening to accommodate those who worked during the day. Attempts were made to contact non-attenders by telephone. After interview, those patients who desired help were selected for one of two treatment groups according to when they were free to attend the surgery.

Group treatment

The treatment was designed to mimic the effects of the drugs through psychological procedures. It consisted of training in anxiety management, which combined physical relaxation with cognitive approaches such as self-monitoring and the substitution of positive for negative statements. The hypothesis was that if the effects of the mental and physical relaxation reduced the intensity of the patient's symptoms there would be less need for drugs. Each patient completed a weekly diary noting the number of pills taken, the intensity of symptoms and the degree of felt control over the symptoms. Treatment was over 11–13 weeks according to the group, with follow-ups at 5 and 10 weeks after treatment.

Results

Fifty patients were identified who had been taking benzodiazepines continuously for at least one year and who had not had treatment or assessment by a psychologist or psychiatrist within the previous two years. Two thirds of patients were female and the mean age overall was 52 years (Table 1). All patients received their medication by repeat prescriptions.

Thirty-four patients were interviewed (31 face-to-face and three by telephone). Twenty-two people said at interview that they were willing to join a group for help; 16 were invited to join, 13 patients did actually join treatment groups. Two of these patients had been in extremely anxious states at interview and both dropped out after the first session.

Of the 11 patients who continued in group treatment beyond the first week, five reported a significant reduction in pill consumption, maintained at follow-up. For four of these, there was also a reduction in symptom intensity and an increase in the patient's control of symptoms. The fifth patient felt more control but did not notice any reduction in symptom intensity. There was no evidence that duration of drug use affected outcome. All the unsuccessful patients were over 60 years of age (Table 2). The results tentatively suggest that psychological procedures which increase the patient's control of symptoms and thereby reduce their intensity can lead to a reduced need for benzodiazepines.

The prescriptions of all selected patients had been charted for roughly 12 months from the date of the doctors' letter being sent. By this time, a further eight patients had been eliminated from the sample: six had left the practice, one had died and one was found to be an alcoholic and would not have been a suitable candidate for treatment if he had attended the surgery. The final sample thus consisted of 42 patients: 11 who continued in the groups beyond the first week and 31 who had no psychological treatment. Of these 31 patients, 12 were viewed as successful in cutting down medication as they had had two or less prescriptions during the year. Four of these 12 patients had not attended interview and it was construed that they reduced medication in response to the letter. Eight patients attended interview and presumably gained some reassurance or impetus to manage without pills.

Overall, five patients in the treatment groups and 12 patients not receiving psychological treatment were viewed as successful in cutting down their medication—17 out of a final figure of 42 patients—which was roughly a 40 per cent success rate.

Discussion

We can only hypothesize about those patients who did not attend interview. However, from comments made by those who did attend, we know that there was an element of suspicion among some patients concerning the role of psychologists, and despite the careful wording of the letter some thought their medication might be stopped. It may be conjectured that those patients who refused to meet the psychologists were wary of what might happen to them and feared that they would be labelled mentally ill. Had we been able to contact these patients by telephone, they might have been willing to accept treatment.

From the interview data provided by 32 patients (two patients did not wish to receive treatment, and so were not pressed for full details), it was noted that almost half had been taking benzodiazepines regularly for over 10 years and two of these patients had used the drug for nearly 20 years.

Dependence on the pills was difficult to measure. The interview data revealed that the factors maintaining pill-taking were not always the ones which initiated the drug prescribing. For six patients there were clear indications that initial stress had been replaced by somewhat unfocussed feelings of anxiety or nervousness. Although there is no firm evidence, these feelings could be withdrawal symptoms produced when the patient had tried to stop taking the pills.

It might be questioned why the psychological treatment produced no more success than the letter or interview. Those who joined the group may have done so because they recognized that they were dependent on their pills and would have difficulty cutting down. There was also a feeling that some of the older patients not only lacked learning ability but also the motivation to reduce their medication.

Development of the psychological treatment of patients in general practice surgeries is being continued. Future work would involve a modification of the treatment and more stringent selection procedures for those entering treatment.

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