

which helped to put her fears into perspective. Another patient came in with a long list of symptoms. She felt giddy, had severe headaches, stomach pains and so on. When she had finished, the doctor asked, 'Is that the lot?'. She nodded, and he added, 'Well, I don't know if you still feel dizzy but I certainly do'. After a moment's thought the patient started to laugh. While this might have been unwise because the doctor began by laughing at the patient, it proved to be a turning point in the relationship. It was a highly beneficial consultation because the patient learnt to find a release for her fears in the form of laughter and continued to do so at later consultations.

Although the introduction of laughter is a useful technique in the consultation the doctor must be selective. One lady came to have her vaginal ring pessary changed and at the same consultation the doctor syringed her ears. 'Now I've done you top and bottom', he quipped, and was met with a freezing stare. The doctor must be sensitive to the patient's likely reaction.

Laughter is not generally recognized as a psychiatric technique despite its wide occurrence in general practice and hospital medicine.⁶ Most psychiatrists agree with the ancient philosophers that laughter prevents a logical approach to the problem; they also feel that it allows patients to escape from sensitive issues. Training in psychiatry lays stress on detachment rather than attachment; laughing with patients is considered to be too intimate to be helpful. In group therapy too, laughter is generally thought undesirable because it is either used as a weapon against an individual or as an escape when the group has reached a crucial point in the discussion. However, the value of laughter in bonding a group together is well recognized.

Ventis has described a case where laughter was used therapeutically.⁷ The patient was an anxious girl who was terrified of going to a dinner party, largely because her ex-boyfriend was also going. There was not time to practise the psychiatrist's usual technique of systematic desensitization so he persuaded the girl to imagine what the dinner party would be like and the anxious moments leading up to it. He then asked her to add comic touches such as the boyfriend appearing in an amusing costume. Apparently the therapy was successful and amusement overcame her worry.

It is surprising that laughter is rarely used in psychiatry and seldom mentioned in the literature. It is discussed theoretically but is not considered as a form of practical treatment. Some

patients consider that their condition is made worse by attempts at psychotherapy and this may be because they are taught to take their experiences too seriously. Laughter is a natural escape from tension and could be used to great effect in certain cases.

In general practice laughter is a tool which is much used but rarely discussed. It is not studied in vocational training programmes and this may be because the innate quality of a sense of humour and the spontaneous nature of laughter make them unsuitable for analysis. As E.B. White put it, 'Humour can be dissected, as a frog can, but dies in the process'. It may be impossible to teach anyone to have a sense of humour but it should be possible to train doctors to use their natural humour and wit. This would be best achieved by collecting and studying videotape recordings of consultations where both successful and unsuccessful jokes are made by either the doctor or the patient. It is even more important to be able to recognize the crucial moments when the doctor and patient smile at each other and to decide what led to this mutual understanding which may be more important than diagnosis or formal treatment.

The gift of laughing at oneself and the world is more valuable than people realize, both for the doctor and the patient.

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Treating insomnia

THE use of hypnotic drugs for the treatment of insomnia is less popular now than in the 1970s when approximately 20 million prescriptions for these drugs were issued in England and Wales.¹ In 1980 over 13 million prescriptions for hypnotic drugs were issued in England alone (the latest figure published by the Department of Health and Social Security). The number of prescriptions was similar in the previous three years. The decrease in the use of drugs for sleeping problems has not been balanced by an increase in the use of drugs as sedatives and tranquillizers — the number of prescriptions for sedatives and tranquillizers dropped from about 21 million in 1977 to 19 million in 1980.² These figures mean that at least one million adults in England take hypnotic drugs regularly and this is confirmed by epidemiological studies. However, this number is not increasing.^{3,4}

The 1920s saw a major controversy concerning the use of barbiturates for the treatment of insomnia.⁵ Barbiturates were then, and for the next 50 years, incriminated in numerous suicides and cases of accidental self-poisoning. Although bar-

biturates are still used, the advent of reliable and safer alternatives in the form of benzodiazepines, the zeal of certain doctors⁶ and the impact of the media, have all led to a reduction in their use. Barbiturates are now included in the list of controlled drugs in the clauses of the Misuse of Drugs Act.

Should general practitioners be happy when more than one million adults are regularly taking hypnotic drugs for insomnia? Although patients might regard a good night's sleep as important, there is no evidence that sleep deprivation is harmful. Studies of performance show that the only constant effect of sleep deprivation in man is sleepiness, with an increased tendency to take daytime naps.⁷ Moreover, sleep does not need to be fully made up. The major components of the sleep cycle, namely deep sleep, light sleep and rapid eye movement (REM) sleep may all be lost, but when sleep is allowed after several days of wakefulness, most of the deep sleep and about half of the REM sleep are reclaimed but virtually none of the light sleep. Apparently it is the deep sleep of the first five hours which we need, and volunteers have been trained to forgo the remainder with no ill effect.⁸

In general practice the situation may be different; doctors are not dealing with healthy volunteers deprived of sleep experimentally, but with distressed patients who regard insomnia as a major problem — it is interesting to note that 20% of the population consider themselves to be poor sleepers yet do not seek help. Patients usually have a discernible cause for their insomnia — a painful or uncomfortable illness, such as rheumatoid arthritis; a psychiatric illness, often depression; or a social problem, such as marital conflict.⁹ Patients presenting with sleep disturbances are predominantly female (the ratio of females to males is about 2:1), score highly for neuroticism on the Eysenck personality questionnaire and have often had major physical or mental illnesses in the past. Most patients presenting with insomnia are over 40 years of age and it is known that night-time sleep requirements decrease with increasing age while the tendency to take daytime naps increases;¹⁰ this should be a subject for patient education.¹¹

Barbiturate dependency has been a recognized problem for many years¹² but dependency on benzodiazepines has often been discounted as unlikely to be serious.¹³ Benzodiazepines have now largely replaced barbiturates on the repeat prescription list and as long ago as 1971 a controlled trial demonstrated that patients were as likely to become long-term users of nitrazepam as of amylobarbitone.¹⁴ The physical manifestations of serious physical dependency on barbiturates — mainly epileptic fits associated with withdrawal — are however virtually unknown with benzodiazepines and this has led to the assumption that dependency does not occur, or that if it does it is only of a mild psychological kind. A recent report of withdrawal from therapeutic doses of benzodiazepines has clearly demonstrated the wide spectrum of physical and psychological symptoms which can cause the patient to recommence use of the drug.¹⁵ The physical symptoms included paraesthesiae, pains in various parts of the body, ataxia, visual disturbance, gastrointestinal symptoms, feelings of weakness as with influenza, menorrhagia and changes in appetite. Psychological symptoms such as distortions of perception or delusions, feelings of persecution or of depersonalization, agoraphobia, depression, and of course a craving for the drug were common. Most patients suffered from insomnia as a withdrawal symptom for about four weeks.

Similar symptoms were reported among a group of general practice patients who were being helped to withdraw from hypnotic drugs by a psychologist, and among another group of general practice patients who had been long-term users of these drugs.^{16,17} As yet there are insufficient results to provide detailed characteristics of the patients who are prone to dependency¹⁸ and this is an area which warrants research. It is becoming apparent that the casual prescription of hypnotic drugs can be the start of a life-time habit which is difficult to break; unfortunately the first prescription is often issued to a patient in hospital, and this has a reinforcing effect. In one study 33% of the patients who were discharged from hospital were taking hypnotic drugs whereas only half this number were taking drugs on admission.¹⁹ In a study of long-term users of hypnotic drugs 21% of these patients had started taking these drugs after a period spent in hospital.³ Appraisal of patients after discharge from hospital should include a discussion on the use of hypnotic drugs if they have been prescribed.

It has been suggested that hypnotic drugs may lose their effectiveness after a period of time²⁰ but the evidence for this is inconclusive. Oswald and colleagues found that after 24 weeks of taking the hypnotic drugs lormetazepam or nitrazepam, the drugs still improved sleep.²¹ Giblin and Clift in a general practice study found that ceasing to take hypnotic drugs after long-term use was not detrimental to ultimate sleep patterns, implying that the drugs had little useful effect, although withdrawal was associated with temporary sleep disturbance.¹⁶ It seems that hypnotic drugs may be taken to prevent withdrawal symptoms and as long ago as 1965 Oswald and Priest showed that for five weeks after ceasing to take these drugs the patient was liable

to start taking them again to avoid withdrawal symptoms.²²

The hangover effect of hypnotic drugs is also a matter of concern and in one study of women it was found that a single night-time dose of flurazepam (15 mg) or temazepam (20 mg) altered their driving behaviour the next morning, a change which could increase the chance of an accident.²³ In the elderly, for whom hypnotic drugs are mainly prescribed, accumulation of temazepam and nitrazepam in the plasma has been shown to occur over a week of treatment and this was associated with a deterioration in reaction time.²⁴

It has become increasingly apparent that hypnotic drugs should play only a minimal role in the management of insomnia. Determining the actual cause of insomnia, whether it be organic or psychiatric or a social anxiety, can be highly effective²⁵ and the attachment of psychologists and social workers to general practices could revolutionize prescribing habits. Short-term use of a short-acting hypnotic drug like temazepam for a week or two may act as an adjuvant to other management but even then the patient should be warned of the danger of side effects and withdrawal symptoms and if a repeat prescription is requested this should necessitate a consultation as a fundamental problem may not have been adequately tackled.

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