

Benzodiazepine therapy

A global approach to the problems-II

Editor's Note:

This is the second of a three-part article. The author makes several controversial statements. The articles are published in the hope that readers who disagree will generate lively and worthwhile correspondence.

KEYWORDS: Drug Therapy; Benzodiazepines; Drug Dependence; Physician-patient Relations; Family Practice.

Summary

In this 3-part article, the author gives his observations of the good usage but also of the abuse of benzodiazepines as he experienced it in private family practice. He describes the prescribing habits of the doctor, the personality profile of the patient, the effects of the drug and the interrelationship between these. The paradox between the expected effect of benzodiazepine and the actual results, is well illustrated.

In Part I (June 1984), he showed that a thorough working knowledge of various pharmacokinetic and clinical parameters of the benzodiazepine derivatives is essential for efficient benzodiazepine therapy.

In Part II, he focusses on the prescribing doctor and his problems in deciding to commit his patient to the benzodiazepine alterative.

In Part III, he will describe the different types of patients, how they become part of the vicious cycle of this therapy and concludes with a few positive suggestions.



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2. CHARACTERISTICS OF THE PRESCRIBING DOCTOR

In another dissertation on the paradox inherent in medical practice today (unpublished), I postulated the theory that a compromise in the standard of medical practice was inevitable if the doctor was to survive in a system which is imperfectly structured. The doctor's prime commodity, 'Time', is not linked to the tariff system, as it should be, but instead, the number of patients that he sees in a day is the critical factor. As Krief¹ mentioned in his article 'le Syndrome de Bon Dieu'... "time is a major problem in medical practice. If it is not resolved, none of the other problems will be".

This I feel, is also the primary reason why the prescribing physician emerges as the villain of the piece in the establishment and perpetuation of the enormous abuse present with benzodiazepine usage in the world today. The physician is constantly fighting a losing battle with time, hoping to offer temporary and symptomatic relief, to buy temporary respite from the necessity of involvement with his patient's deep-seated conflicts.

This situation discourages patient involvement. It potentiates, instead, the wholesale prescription of the guaranteed temporary solution, the Universal Panacea, a Pill. This takes the pressure off the physician until the 'next time'. It will usually afford the patient a measure of relief, either until the prescription runs out, or until the problems become compounded. However, by introducing the patient into the 'vicious cycle of benzodiazepine usage' (see Part III), the physician is guaranteed a repeat visit by the patient: unless the patient's

problem has been identified, confronted and dealt with in psychoanalytical and supportive terms, there will be no cure. There will, instead, be only a gradual deterioration in the patient's condition, with repeat visits becoming increasingly frequent, if only to obtain another prescription for the now dependent patient.

However, the temporary resolution of both the patient's and the physician's conflict is not a bad compromise for all concerned, if one looks at the resulting situation superficially. Indeed, so long as there is an effective alternative available to both the physician and his troubled patient – palliation of the pressing emotional crises without necessitating the time-consuming commitment of involvement for the physician and the painful psychoanalytic journey for the patient – the choice rather to delay indefinitely the decision to institute a remedial programme by the prescription of an effective benzodiazepine will invariably take precedence.

The rationalisation by the physician of his course of action, in order to allay his own conscience, will usually be the socially accepted observation that a doctor is always so overworked and busy, dealing with life-saving essential situations, such as perforated appendices, coronary thromboses and caesarean sections, that those unfortunates who manifest with blatant neurotic, psychosocial and depressive symptomatology, need to take second place in the competition for his time and empathy.

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This psychorationalisation on the physician's part does certainly hold an element of practical truth, but does it give him the moral prerogative to throw his already emotionally compromised patient into the deep end of the cess-pool which is psychotropic misuse? It is not every physician who has the personality profile, the necessary insight and empathy, the inclination, the training, knowledge and freedom necessary to deal with deep-seated emotional problems. Admission of this fact should carry no shame. Referral to the correct paramedical personnel, such as a clinical psychologist, or to a psychiatrist, is the obvious mandatory alternative. The physician thereby recognises and avoids the trap described in the Peter Principle⁵, by admitting his incompetence to deal with these complex aspects of his patient's needs.

To encourage the commencement of a course of psychotropics, and to renew the prescription repeatedly without taking full responsibility for the patient and his emotional needs by having enough time and knowledge to deal with his problems, is immoral, since the consequences for the patient are often disastrous. This tendency by the medical profession supports the view held by Ivan Illich, who, in his book *Medical Nemesis*⁶ states that "clinical iatrogenesis produces defenceless patients who are the unfortunate victims of the undesirable side-effects of approved, mistaken, callous or

contra-indicated technical contact with the medical system". He includes in this category "not only the damages that doctors inflict with the intent of curing him, but also of exploiting him (the patient)". He summarises his theory by stating that "the medical establishment has become a major threat to health".

Dare the doctor commit his already emotionally compromised patient to psychotropic misuse?

It is fascinating to observe the consultation tactics of so many practitioners who are well known for their aversion to involvement with their patients on an emotional level. Their modus operandi is one of constant re-assurance with mildly matter-of-fact airiness or even constant joviality, conveying the impression that they, themselves, are not unduly concerned that any problem exists at all. Without acknowledgement of a problem, no involvement is necessary.

This approach benefits both the physician and the patient short term. He justifies termination of the interview without necessitating the deeper leading questions that demand asking if the floodgate to the patient's turmoil is to be opened. The patient is suitably confused by the doctor's attitude, to justify going back home to re-examine the evidence available in attempting to decide whether, in fact, there is a problem or not.

Without confrontation of the issues involved, logical analyses of their aetiology with stepwise, practical and pragmatic counterstrategy formulated to eliminate, where possible, the sources of anxiety, thereby defusing a roller-coaster acceleration into disaster, the patient will continue to destabilise. The patient's self-image and confidence becomes increasingly eroded, compounded by the fact that reliance on the medication is becoming frighteningly obvious to him. Social and professional insecurity, with the development of generalised situational destabilisation invariably follows; one arena of collapse is the catalyst for the next arena of collapse, and a series of self-perpetuated disasters compound the status of the severely compromised ego.

General collapse on all fronts occurs.

The physician should be aware of the vicious cycle of events which may be perpetuated by constant avoidance of the issues at stake, with the concomitant championing of the benzodiazepine alternative. The benzodiazepines inhibit the process of psychorationalisation and resolution in so many ways, not least of which is the minimising of the emotional impact of a situation by dulling the painful input of potentially sensitive stimuli. This represses the patient's need to get to grips with the problem, since we all tend to act on feelings, not on facts.

The patient delays the moment of truth, and resolution of the problem waits for another day. In all these considerations, the physician is usually a reliable source of positive re-inforcement

as far as the avoidance of confrontation is concerned. The extent to which benzodiazepines dull emotional pain, allows avoidance of the critical issues – the enemy (which is the anxiety provoking situational derangement), strides his rampant path – free, always close at hand, but never engaged in battle.

Benzodiazepines repress the patient's need to get to grips with the problems – it delays the moment of truth.

As described, the patient is developing fresh areas of conflict, with the gradual erosion of his social, business and interpersonal stability during this latent period of benzodiazepine-induced respite. When, eventually, one or other crisis demands the onset of confrontation and psychorationalisation, the patient's courage has become compromised to such an extent, that he has no emotional reserve or any other egotistical or logistical weaponry with which to fight. By prolonging the latent period before engagement of the issues at stake, the benzodiazepines have been given enough time to warp the patient's character into an impotent sarcophagus. It is as if 'their coping mechanisms have become atrophied during their long periods of drug therapy'².

The understanding of these basic progressions in any mental disorder or condition are absolutely mandatory if a physician is to be able to effectively counsel his patient and plant his rehabilitation before the patient has entrenched himself in a situation of no return.

In short, the physician needs a broader knowledge of the kinetics and progression of mental illness, neurosis and developmental crises as well as having practical approach in the management of these patients. An holistic approach is desirable.

Doctors, in general, are hopelessly impotent in dealing with most emotional crises. And it is no shame to admit it!

Gail Sheehy's book *Passages*⁷ highlights the predictable adult developmental phases and crises which were largely ignored by Freud and Piaget, and briefly dealt with by Erikson. A working knowledge of ideas such as these should be mandatory for any student completing his medical studies. Doctors, in general, are hopelessly impotent in dealing with most emotional crises. Small wonder, then, that the benzodiazepine alternative is so firmly entrenched in medical practice, and, tragically, universally accepted. It was noted that "a continuation of the yearly rate of increase in benzodiazepine usage could lead to the total tranquilisation of America by the turn of the century"⁸. It is all too easy, too effective and too expe-

cient short term to be ignored. It would take a physician of uncompromising integrity, unwavering conviction and one who is totally independent of the system to be able to resist the temptation of the benzodiazepine alternative.

This is certainly too much to ask of the average practitioner, whose bona fides are generally genuine. If he were to stand by his convictions, and offer time-consuming care to each patient with an emotional problem, he himself would acquire serious financial problems under the present tariff system, where the prime determinant of remuneration is the number of patients he sees in a day, and not the time he spends with them.

Barbara Gordon, in her book *I'm dancing as fast as I can*⁹ which details her unmonitored sudden withdrawal from benzodiazepine usage after 10 years of dependence with a psychotic withdrawal reaction, draws attention pertinently to the professional immorality of the psychiatrists consulted by her in her desperate search for some sort of emotional equilibrium. Her book was written primarily to highlight the poor standard and immorality of psychiatric care in the USA as experienced by her, and also to warn other benzodiazepine dependents as to the quality of help they may expect if they are unable to find a psychiatrist of unquestionable integrity and blameless motivation.

Medical students should be better prepared for the psychological and emotional problems that they will have to cope with in private practice.

To conclude that doctors today are, in general, hopelessly impotent in dealing with emotional crisis, is unequivocal. Awareness of the potential dangers of the benzodiazepine alternative¹⁰, familiarisation with the broader aspects of psychodynamics and psychorationalisation, a wider apprenticeship in the 'school of life'¹⁷ and an open mind when considering his own motivation are factors which may enable the physician to think twice before committing his patient to the benzodiazepine alternative. The biggest single remedial factor, of course, would be the linkage of the tariff to the unit of time spent with a patient, and to bring this remunerative system in line with the tariff as enjoyed by other professional disciplines.

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