# "*Is this an elixir of quality of life?*": Patients' and doctors' perspectives about benzodiazepines

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## Introduction

Benzodiazepines (BZDs) are effective and safe for short-term symptomatic treatment of anxiety and insomnia [1,2]. Its chronic use has been associated with undesirable effects, tolerance and dependence [3]. The high rate of BZDs' long-term use among older Portuguese population is considered a public health problem [4]. Main goal of this poster is to characterize perspectives and attitudes of Portuguese doctors and chronic users of BZDs, regarding BZDs' risks and benefits, determinants of prescription and adequate clinical management.

## Methods

- Data were collected through **semi-structured focus groups (FG) with doctors and patients taking BZDs** (purposive, conceptually-driven sampling; two primary health centres and one hospital; facilitation by a moderator and a co-moderator; voluntary and confidential participation).
- Audiotaped records were fully transcribed. **Content analysis** followed **grounded theory principles** with **Charmaz's line-by-line open-coping strategy** [5]. MAXQDA12® was used for analysis.
- The study was approved by ethics committees: Lisbon Regional Health Administration and Portuguese Protection Data Authority. Signed consent forms were collected.
- Content analysis was done independently by two psychologists. Results were confronted with FG scripts, assuring that main pursuit questions were properly explored. Conceptual **triangulation** was enhanced by a narrative review of literature. Further **interpretative and significance validity** will be assured by open-access to the anonymized corpus, soon available at www.bedsproject.pt.

Main topics covered in the FG (Tables 1 and 2):

**Table 1.** Doctors' perspectives

- Determinants of initial prescription of BZD and management strategies for its prescription
- Perceived benefits and risks of the use of BZD
- Difficulties of negotiation with patients
- Training needs about BZD (and anxiety or sleep disorders' management alternatives)
- Key determinants of effective health education for anxiety/sleep- and benzodiazepine-related literacy promotion

**Table 2.** BZD users' perspectives

- Beliefs & concerns about benefits, risks or dosage of BZD
- Process/course of initiation and continuation of use of benzodiazepines
- Attempts (and determinants) of cessation of BZD use
- Reasons for relapse
- Need for information regarding anxiety, sleep disorders and BZD

## Results

Two FGs with 12 (7+6) patients and two FGs with 14 (6 + 8) doctors were conducted. Table 3 describes some characteristics of participants. Selected *verbatims* for both doctors and patients presented in Fig. 1.

**Table 3.** Participants' characteristics

| Patients | | N |
|---|---|---|
| Gender | Men | 6 |
| | Women | 6 |
| Age | 20 - 39 years | 1 |
| | 40 - 49 years | 1 |
| | 50 - 59 years | 3 |
| | 60 - 69 years | 5 |
| | 70 - 79 years | 2 |
| For how long taking BZD? | <6 months | 2 |
| | 6 - 11 months | 1 |
| | 1 - 5 years | 2 |
| | 6 - 10 years | 1 |
| | > 10 years | 6 |
| Why taking BZD?* | Anxiety | 6 |
| | Insomnia | 4 |
| | Somatization | 1 |
| | Anxiety and panic disorder | 1 |

| Doctors | | N |
|---|---|---|
| Gender | Men | 7 |
| | Women | 7 |
| Medical specialization | Family Physician | 9 |
| | Neurologist | 1 |
| | Psychiatrist | 2 |
| | Cardiologist** | 2 |

* *Main reason* ** *One of the cardiologists is also a geriatrician*

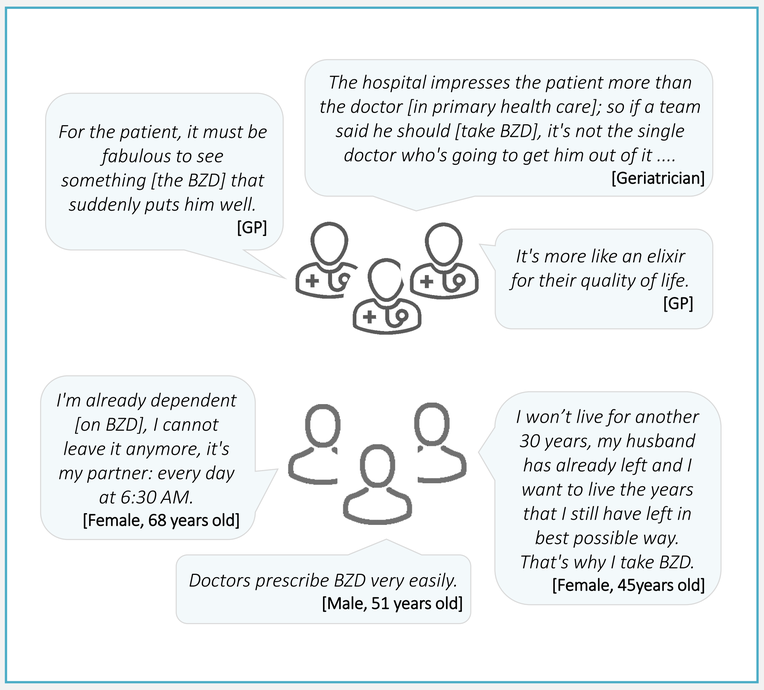


Figure 1. Selected *verbatims* (doctors and patients)

**Table 5.** Selected dimensions and categories for doctors

**Attitudes regarding BZD**

| Promoters of BZD's prescription | Inhibitors of BZD's prescription |
|---|---|
| - BZDs are effective for quick relieve of anxiety & insomnia<br>- BZDs have few adverse effects & small tolerance effect<br>- Older patients do not benefit from discontinuation<br>- Patients want to keep taking BZD (resistant to quit)<br>- Discontinuation is too difficult to manage (tends to fail) | - BZD as obstacle for treating the cause of symptoms<br>- Effective cessation programs are available<br>- Adverse effects of BZD<br>- Need to respect norms / good practice |

**Other determinants of BZD's prescriptions**

| Pat-doctor relationship | Organizational determinants | Prescription 'heritage' | Cultural determinants |
|---|---|---|---|
| - Prescription as 'act of empathy'<br>- Low self-efficacy for negotiating with patients<br>- Not enough 'holistic'-knowledge about patient | - Lack of time with patient<br>- Lack of info about: BZD indication, psychiatric diagnose<br>- Lack of access to mental care<br>- Difficult articulation with other health professionals | - Patients' "loyalty" with other doctors' prescription<br>- Patients' perception of importance if BZD was given at hospital | - BZD considered as safe & effective until recently<br>- Social 'normalization' for BZD prescription |

**Requirements for good clinical practice with BZD**

- Investing in the relationship with the patient
- Adequate follow-up when prescribing
- Negotiation of short-term prescription with patients
- Progressive discontinuation programs

**Training needs**

- Clinical case discussion
- How to promote collaborative work (other colleagues/units)
- Communication skills train (coping with resistant patients)

**Table 4.** Selected dimensions and categories for patients

| Knowledge/beliefs on BZD | Concerns about BZD | Where to look for information about BZD | Why taking BZD | Negotiation with doctors | Stopping BZD |
|---|---|---|---|---|---|
| - **Placebo/nocebo effect:** a) Knowing about side-effects induces negative effects, b) BZD has a placebo effect, c) Not believing in placebo effect, even with very low dosages<br>- **Negative effects:** a) Vague notion that every drug has side effects, b) Daytime sleepiness, lack of memory, less vitality, nightmares, c) Habituation effect, d) Feelings of dependence<br>- **Positive effects:** a) Better sleep, less anxiety, b) life easier | - Dependence<br>- Long term adverse effects of BZDs<br>- Lack of information about specific negative effects of BZDs | - Drugs leaflets (threatening; tend to be ignored)<br>- Internet (also perceived as misleading)<br>- Doctor or pharmacist are best sources<br>- Groups of patients (sharing experiences) | - **For the first time:** a) Complaints (insomnia, anxiety, depression), b) Stressful events of life/work, c) Advice/prescription of doctor (no patient initiative/knowledge)<br>- **Nowadays...:** a) It results, b) No negative effect; no worries, c) Feeling dependent, d) It is a habit/routine; just one more drug (among other ones), e) No alternatives (to get same positive effects), f) Easy to get (self-medication) | - Not easy to find correct posology (time of day, dosage)<br>- Self medication (changing posology without doctor's awareness)<br>- Afraid to follow the advice to stop the BZD | - **Why?:** a) Medical advice, b) Life conditions got better (e.g., less stress), c) Long term use already (being afraid of negative effects)<br>- **How?:** a) Alone (self-medication), b) Replacing by Diazepam, c) Progressive reduction of dosage<br>- **Perceived experience:** a) Feelings of anxiety, b) Several attempts, with relapses |

## Conclusion

To the best of our knowledge, this is the first qualitative study about opinions and attitudes of Portuguese doctors and patients regarding BZD. The results supported decisions for two other research components of the Benzodiazepine Discontinuation Study (BEDS) project, namely: a national-based survey regarding beliefs and attitudes of family physicians, and a non-controlled intervention study at primary healthcare level for assessing a BZD discontinuation program. Saturation of collected data is a main limitation, due to the restricted number of focus groups (though with a total of 26 participants). The level of expertise of participants and the sampling strategy, maximizing diversity/heterogeneity of opinions, allowed rich, in-depth and insightful discussions. Second focus groups per type of sample provided few new data, themes or codings. Moreover, triangulation with published research in this area revealed that main topics were properly covered while providing new country-specific information. Health professionals are aware of the need to reduce prescription and consumption of BZDs. However, different factors (organizational, structural, relational) contribute to lack of adherence to most adequate BZD's prescription. Data points out to the need for promoting better articulation between different medical specializations and with other health professionals. Also, patients can benefit from a more informed and active involvement on the decision for starting and ceasing BZD's intake. As expressed by one of the participants, inspired by Balint, *"the best anxiolytic is the therapeutic relationship"*.

## References

[1] Ashton H. Benzodiazepines: How They Work & How to Withdraw [Internet]. 2002 [cited 2015 Oct 8]. Available from: http://www.benzo.org.uk/manual/index.htm
[2] Kollen BJ, van der Veen WJ, Groenhof F, Donker GA, van der Meer K. Discontinuation of reimbursement of benzodiazepines in the Netherlands: does it make a difference? BMC Fam Pract. 2012;13(1):111
[3] Longo LP, Johnson B. Addiction: Part I. Benzodiazepines-side effects, abuse risk and alternatives. American Family Physician. 2000; 61(7):2121-8.
[4] Furtado C. Psicofármacos : Evolução do consumo em Portugal Continental (2000 – 2012). Infarmed, IP. 2014;1–21
[5] Charmaz K. Constructing Grounded Theory: a practical guide through qualitative analysis. London: Sage Publications, 2006

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