

EDITORIAL

Psychotropic drug use: fallacies and a paradox<sup>1</sup>

Alarm is frequently expressed at the 'relentless march of the psychotropic drug juggernaut' (Trethowan, 1975). Indeed, in the judgement of some commentators apprehension is mounting towards startling proportions: 'Opinion is growing that in the use of psychotropic drugs we may be evolving a dangerous monster' (Harman, 1975). Such warnings relate chiefly to the prescription of the so-called minor tranquillizers in general practice. They are not new (Lennard *et al.*, 1970), nor do their sources lack authority; none the less the march still continues.

The trend may partly reflect the familiar human tendency to ignore unpleasant facts and unwelcome advice, or the effectiveness of commercial promotion, or other factors extrinsic to the merits of the case. But it cannot be assumed to be entirely unrelated to the quality of the arguments advanced; on the contrary, it will be suggested that the conventional arguments are sufficiently flawed to undermine an excellent case for more discriminating use of psychotropic drugs, and even to enhance their attractiveness to doctors and patients.

There are two pillars to what may be termed the standard case against these drugs: a moral judgement based on present-day attitudes towards distress and its alleviation, and a clinical opinion about the genesis of anxiety and its resolution. The moral standpoint is based on the belief that there has been a decline in public willingness to face and endure the psychic stress inevitable in day-to-day living. What seems to be envisaged is a latterday version of the expulsion from the Garden of Eden: modern man, having eaten of the synthetic apple, leaves behind an era of contented stoicism for one in which medication is expected to be an instant answer to all distress, problems, and frustrations. 'As more and more facets of ordinary human conduct, interactions, and conflicts are considered to be "medical" problems, physicians and subsequently patients become convinced that intervention through the medium of psycho-active drugs is desirable or required' (Lennard *et al.* 1970). Zealley (1975) spells out the theme even more clearly, and even dates the fall from a particular Act of Parliament: 'Since the implementation of the Mental Health Act there has been a steady change in the expectations of the man in the street. Increasingly, happiness is expected as a right. If he is unhappy, he assumes something is wrong with his chemistry, or with the world, or both. And the solution is all too often sought in a prescription from the doctor – a pill for every ill.'

However, contrary to these confident assertions, the evidence points to a notably conservative attitude towards tranquillizer use amongst a majority of the general public. A nationwide study in the U.S.A. (Mannheim *et al.* 1973) found a clear difference in respondents' attitudes to the use of medication to control anxiety sufficiently severe to threaten daily work or family life, of which the majority approved, and in attempts to influence normal functioning, of which over 80% disapproved. The similarity of rates of tranquillizer use in different countries (Balter *et al.* 1974) suggests that this attitude is not confined to the U.S.A., which fell near the middle of the nine European countries studied. Furthermore, the findings that less than 20% of respondents in any country had used an anti-anxiety or sedative drug during the past year, and less than 10% regularly for a month or more, coupled with the predominance of females above the age of 55 years, suggest that more subtle and complex factors than a recent, universal upsurge in hedonism need examination.

Equally, the absence of any examination of the historical assumptions implicit in the argument is surprising. Some recognition and assessment of the volume of use of other chemical sources of hoped-for tranquillity in the past, from alcohol to opiates, and not excluding the placebos that formed the major part of the materia medica of our forebears, would seem to be essential before any conclusions are drawn about present-day habits.

The same tendency for assumptions to hold sway, unexamined and unchallenged, is evident in the

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clinical arguments directed against tranquillizer use. Basic to these is the belief that use of these drugs is in opposition to the resolution of the causes of anxiety, whether these are external or internal, and thus perpetuates it in the long term: 'Clearly it is much simpler to ask one's doctor or specialist to change one's internal arrangements than to adjust those external circumstances that have brought about the distress' (Zealley, 1975). And, again: 'If the sufferer is given too ready a means to suppress his anxiety his motivation to try and resolve the conflict that underlies it may also be suppressed. In short, to overcome anxiety a patient must be allowed to experience it, albeit in tolerable doses' (Trethowan, 1975).

But do tranquillizers, in fact, inhibit the resolution of conflicts or the alteration of external circumstances? Certainly to suggest they do so by eradicating all anxiety, even 'tolerable doses', is not only to fly in the face of everyday clinical experience but to share belief in their magical potency; the very basis of their over-use. It is, however, possible that they do so in other ways: by diminishing the individual's willingness to pay the price for change, in terms of temporary apprehension, pain or frustration; by impairing his ability to assert himself; or by damaging cognitive performance and discrimination – all of which inadequacies are subsumed in the standard stereotype of 'tranquillization'. But studies of drug effects on human conflict resolution under natural conditions are conspicuously absent, and it is difficult to see how generalizations can be supported without them. Animal studies, for what they are worth, lend no support to the first suggested mechanism. Indeed, the effects of the benzodiazepines, the most commonly prescribed minor tranquillizers, are virtually the opposite of what it predicts: they attenuate the behavioural consequences of frustration, fear and punishment, and in conflict situations increase the animal's persistence in the face of pain or the threat of pain (Cook & Davidson, 1973).

Animal studies of the benzodiazepines' effects on aggression, relevant to the second possibility, are particularly noteworthy, since the stereotype of 'tranquillization' seems to have its roots materially in the famous 'taming' effect of these drugs on animals, and the consequent assumption that patients are rendered too passive to face up to their problems. But since the halcyon days when they were thought to be bringing close the laying down of the lion with the lamb it has become clear how difficult it is to define a psychotropic drug as anti-aggressive in animals, so complex are the mechanisms involved and so variable the results depending on the test model used (Valzelli, 1973).

In man also, the effects do not conform to the stereotype. Increased aggressiveness was early reported as a 'paradoxical reaction' (Ingram & Tinbury, 1960; Cohen, 1961; Maguire *et al.* 1972) but may also accompany the anxiolytic effects of these drugs as a direct action, depending to some extent on pre-existing anxiety levels in the individuals concerned (Gardos *et al.* 1968; DiMascio *et al.* 1969; Salzman *et al.* 1969) and on the group situation (Salzman *et al.* 1974). It has been suggested that 'for many patients the release of aggression may be socially or therapeutically beneficial, when channelled appropriately, and this may be considered as part of overall therapeutic movement' (DiMascio, 1973).

Human experimentation is somewhat easier in testing the third possibility: drug effects on performance and discrimination. Although the tests commonly used are not necessarily directly relevant to real-life situations, the evidence points to relatively minor impairment (Brimer *et al.* 1964; Holmberg & William-Olsson, 1963; Lawton & Cahn, 1963).

A recent trial of chlordiazepoxide, diazepam, mediazepam and amylobarbitone (Bond *et al.* 1974a) supports this view through the conclusion: 'In the doses taken, which were determined by the patients themselves and which were found by them to be optimal the drugs produced little behavioural impairment. However, the drug which produced *most* interference with performance, amylobarbitone, was the *least* effective clinically and physiologically.' Furthermore, since anxiety itself impairs performance (Bond *et al.* 1974b), it is possible that at some dosage levels, in some patients, performance may be actually improved.

These fallacies have in common with the moral argument that they tend to invest the drugs with an unwarranted aura of high potency: even if their supposed power is condemned, the effect remains.

But, in addition, conviction that they interfere with problem- and conflict-resolution is likely to discourage patients from attempting these tasks, and their doctors from bothering to support them in doing so. The use of medication as a simplistic alternative, rather than an adjunct, to other forms of treatment is thereby made more likely.

The paradox is thus that, by initiating a self-fulfilling prophecy, the attitudes and behaviour deplored may actually be encouraged. If 'tranquillizer' use is to be rationalized, the limitations of their power – for good or evil – need to be recognized; their actions in real-life situations investigated rather than assumed; and the reasons for their use examined open-mindedly. Moral turpitude should not automatically be ascribed to those who continue to seek from their doctors relief from distress.

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