Behavioural Psychotherapy, 1986, 14, 263–264

Correspondence

To the Editor,

Benzodiazepines and the behaviour therapist: managing withdrawal and the problems of concurrent treatment with these drugs. *Behaviour Psychotherapy*, 1986, 14, 1–12.

Edgar Miller's above review of benzodiazepines and behaviour therapy, with particular reference to the withdrawal problem, was an excellent and timely summary of the sparse information available in this field.

In this department, we have taken the view that psychologists have a duty to try and offer help to GPs with the considerable problems arising from the rapid disillusionment with BZs over the last few years, and we are in the process of setting up a programme of group support and behavioural management for BZ withdrawal.

Unfortunately, although over thirty local GPs initially agreed to collaborate, they have only come up with a total of 15 referrals of which only three patients have finally agreed to join the group. An article in the local newspaper yielded a somewhat better response, adding a further seven to eight patients, so that we now have a viable group, but this is still a pitifully small total in comparison with our estimate of perhaps 1000 BZ-dependent patients throughout the District. We can, of course, speculate about the reasons for this but are trying to investigate it more objectively.

Our programme is following Miller's general guidelines, but I would like to emphasize the following points in particular:

(1) Because of the time-scale of the withdrawal syndrome, each medication stage needs to last *at least* two weeks; weekly reductions could be disastrous in that a further reduction might easily be made just as the withdrawal symptons from the preceding reduction are about to emerge in their severest form, resulting in panic and redoubled medication.
(2) The importance of the Lader and Petursson double-blind studies is that they make it clear that when patients complain of difficulties coming off these drugs, their symptoms do almost invariably reflect a *genuine* withdrawal phenomenon, whether or not compounded by expectation effects.
(3) Nevertheless, recent media publicity has grossly exaggerated the likely

duration and severity of these symptoms, such that many patients now attribute almost *any* symptom occurring months or even years after coming off tranquillizers to withdrawal; this is a recipe for much anger with the medical profession (and sometimes a convenient state of helplessness) but not much insight.

(4) Some self-help booklets on this subject also over-emphasize withdrawal symptomatology, going into long and graphic descriptions of every conceivable symptom (and it seems there are many); other booklets take a somewhat "political" stance (consequently we decided to produce our own booklet, "Coming off Minor Tranquillizers", copies of which are available on request).

(5) Miller observes that sleep disturbance is generally very distressing, and therefore to be minimized by leaving the night-time dose of BZs intact until last; we would go further and say that sleep management should be a central component of the behavioural package.

(6) Anxiety management is difficult with patients on prn. medication, for whom reaching for a tablet to cope with fluctuations in anxiety is just too easy an option; we therefore insist on patients being transferred to a regular medication regime, which also facilitates a systematic approach to reduction (GPs, however, sometimes find this strategy difficult to understand, since the medical journals generally now advise them to offer medication to *new* patients on an intermittent prn. basis only).

Our programme is flexible and open-ended with four weeks of preliminary anxiety management followed by several months of group support and medication reduction, but we hope to be in a position to report initial findings by the summer of this year. Meanwhile, we would be very interested to hear from other people involved in similar projects elsewhere.

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