AN EXPLORATION OF HOW THERAPISTS VIEW THERAPEUTIC PROCESS IN RELATION TO CLIENTS WHO ARE TAKING BENZODIAZEPINES

by

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ABSTRACT

This qualitative inquiry explores how therapists view therapeutic process in relation to clients who are taking benzodiazepines. Benzodiazepines are drugs prescribed for the short term relief of the symptoms of anxiety and for insomnia. There are estimated to be over one million people dependent on benzodiazepines in the United Kingdom at present.

I conducted a survey of a sample of NHS psychotherapy services in England to ask what their policies were towards clients in therapy who also took benzodiazepines. I then conducted semi-structured interviews and audio-recorded twenty-six therapists from different therapeutic orientations, with experience of working with clients taking benzodiazepines in a variety of settings. I analysed these interviews using grounded theory, deriving forty-four propositions from the data.

I was specifically interested in the process of grieving and I propose that benzodiazepines suppress emotional processing and affect narrative competence in relation to grieving, which is thereby inhibited, prolonged or unresolved. I also identified that clients seemed to suffer a loss of lived experience for the time they were taking this medication. When comparing clients taking benzodiazepines with other clients, therapists needed to make adjustments to the therapeutic process because these clients were less able to respond to therapy.

Psychodynamically, I propose that there might be a series of triangular relationships between client, therapist, drug and doctor, involving dependency, power, seduction and ingratiation. Because the client's defences seem to be increased by benzodiazepine use, I suggest that their use might be incompatible with psychotherapy.

Therapists confirmed the survey's findings that the implications of benzodiazepine prescribing for clients in therapy are largely ignored and we make some recommendations that psychotropic medication issues be given greater prominence in the training and supervision of therapists.

LIST OF ABBREVIATIONS

BNF	British National Formulary
CBT	Cognitive-behavioural therapy
CNS	Central Nervous System
CSM	Committee on Safety of Medicines
DSM	Diagnostic and Statistical Manual
ECT	Electro-convulsive therapy
GABA	Gamma-aminobutyric acid
GP	General Practitioner
MIMS	Monthly Index of Medical Specialities
NHS	National Health Service
PTS	Post-traumatic stress
PTSD	Post-traumatic stress disorder
RCT	Random(ised) controlled trial
SSRI	Selective serotonin re-uptake inhibitor
TO	Transitional object

CHAPTER 1

INTRODUCTION

Emancipate yourself from mental slavery

None but ourselves can free our minds

Redemption Song 1980

Bob Marley (1945-81)

The Emancipation Act of 1833 in Jamaica did not bring about instant freedom because it could not change the hearts and minds of people overnight. Slaves were nominally freed but attitudes and methods of working the plantations survived emancipation in persistent ways. Mental slavery still persisted in the Jamaica that I knew in the 1970s and Bob Marley's words sum up for me the mental slavery that is not confined to Jamaica and still exists in many forms today. Attitudes, expectations, established methods and practices might still enslave our minds, preventing radical thinking and the discovery of new ideas about familiar problems.

I feel as passionately about dependence on benzodiazepines as a form of mental slavery as those who fought for social justice and the emancipation of slaves on the sugar plantations of Jamaica. The belief in harmless drugs and the pursuit of easy solutions to psychological problems seems as de-humanizing to me as the use of slaves was to the abolitionists. People's attitudes to pills or psychotherapy, or acceptance of established methods and practices may prevent them freeing their minds whether they are clients or psychotherapists.

What the research is about

The goal of this qualitative research inquiry is to explore how therapists view therapeutic process in relation to clients who are taking benzodiazepines. The question arises from my experience of being a therapist helping clients to withdraw from benzodiazepines after they had become dependent on them. This led me to wonder whether my experiences of working with benzodiazepine withdrawal were similar or not, to those of other therapists working in different settings.

I think that how the therapist views the client is very important, because the belief that the client is a responsible adult, capable of making responsible decisions and coming to the right solutions is a fundamental tenet of motivational interviewing (Prochaska & DiClemente 1984). In many approaches to problems concerned with drugs whether prescribed or illegal, contact between client and therapist is initially directed towards raising self-efficacy and self-esteem in the client. It echoes principles in counselling and psychotherapy with its humanistic value base, of respect for the client's autonomy and the centrality of the therapeutic relationship as being fundamental to change.

I started by asking myself four questions (Colaizzi 1978) in order to say what this research study is about. The first was what I want to discover through this inquiry, which I shall address first. Then, how my unique personality influenced my reasons for choosing this topic and that includes my personal and professional experience. The third of these questions asked what I value about research that led me to do it this way and how that has

influenced or biased what I have investigated. The fourth question to explore was what hidden gains there might be for me in doing it this way.

What I want to know

My interest in this subject comes out of my experience of working in a clinical psychology research team from 1986-89 investigating the problems of long-term benzodiazepine use and testing a psychological approach to drug withdrawal. The benzodiazepines are sedatives (anxiolytics and hypnotics) widely prescribed since 1961, for which the prescribing guidelines now limit them to short-term use (Appendix 1). It was widely assumed in 1986 that the main problem with these drugs was dependence, but clinical experience was alerting us to possible effects on the client's ability to use difference types of therapeutic intervention and to underlying psychological problems which went far beyond dependence itself.

Many of the people we saw there had made several unsuccessful attempts to withdraw from their medication and had frequently had a number of "treatments" for their dependence on benzodiazepines. Those who had received counselling or psychotherapy seemed to have gone round and round their problems without resolving them, or to have given up or been given up on. They had often made no reduction in their drug use in spite of considerable therapeutic input. Why had their attempts to withdraw been unsuccessful and why had their problems remained unresolved in spite of being in therapy?

Some people also seemed to have acquired further psychological difficulties since starting drug use. In particular we noticed they had difficulty connecting and retaining ideas, being emotionally cut off yet distressed, and being agoraphobic and unwilling to leave home unescorted. Most of their problems were at least as severe as the problems that first led them to seek medical help and in most cases much worse. Do clients taking benzodiazepines have additional psychological problems as a result of their drug use? Do other therapists notice this when the emphasis is not on drug withdrawal?

The Withdraw Project (Hamlin & Hammersley1989) was unique then in taking a psychological approach to benzodiazepine withdrawal and evaluating it. Benzodiazepine users are not a homogenous group and we deliberately sought to help and learn from as wide a variety of people as we could. Amongst the findings was the discovery that the most statistically important predictor of success in withdrawal terms, was the client's expectation of success expressed as confidence in their ability to withdraw. Confidence in themselves seemed to us to be a feature of self-efficacy that is directly supported by the therapist's confidence and belief in the client. I concluded that how the therapist views the client might be very significant in psychotherapy with clients taking benzodiazepines, and wondered whether other therapists thought so.

The social and political scene was significant since the media, especially Esther Rantzen's "That's Life" (1985) programme, were focussing the public's attention on the problems that were emerging for people who had taken benzodiazepines for a long time and had problems of withdrawal. I had begun to see that dependence was only part of the problem. Therapists

outside the field of addiction were asking questions about how to help clients withdraw in order to deal with underlying psychological problems that seemed to be mixed up with dependence on benzodiazepines. "What do other therapists think?" answers the first of Colaizzi's (1978) four questions about what I want to discover through this research.

Why I want to know

In answer to Colaizzi's second question about how my personality influenced my reasons for choosing this subject, I think that working successfully in this field requires a degree of subversiveness. I am dissatisfied with the established wisdom, or as I see it complacency, about combining therapy and benzodiazepines and being subversive is very useful when it comes to challenging this. In addition, as a therapist I feel like a detective trying to find out something elusive or secret or uncover what someone wants to remain hidden. I ask awkward questions sometimes, check things from first principles and examine issues in detail. I am also tenacious, determined and do not give up easily, rather as an investigative journalist might be who wants to get to the bottom of a story in order to expose it.

I am also angry at the deception and distortion of truth that has enabled drug companies to denigrate human beings through the slavery of addiction, by exploiting human distress for commercial gain. Some doctors have been diverted from their intention to treat suffering, into doing harm and creating iatrogenic illnesses. Although the problems of dependence have been brought to public attention from time to time, society at large appears to have colluded with the appalling scale of the problem in a form of mass denial. Although I

believe there are important social justice issues at stake that I want to understand better, I am realistic about how likely I am to change anything in the political arena.

Why I want to do research this way

The third of Colaizzi's (1978) questions was what I value about research, why I want to do it this way and how this may influence or bias what I investigate. If I want to know what other therapists think, qualitative research through interviewing and observation gets me closer to capturing each individual's point of view. It also allows me to examine the issues from within the constraints of the everyday life of therapists rather than from a distant or idealised viewpoint that is separated from the real world. I also want a lot of rich detail not just a few measures that may not add up to much of significance.

I want to involve other therapists actively in the research process as co-researchers because I think that this will deepen the level of the inquiry and produce findings that I could not discover in any other way. I have questioned the relevance of some research that compares outcomes of therapy often with pharmacological treatments and placebo, because therapists do not seem to value it. I think that my research will have some value if it influences the practice of other therapists as well as mine because we give much of our attention to reflecting on the therapeutic process.

In an era of social constructionist thinking, therapists who value subjectivity in their therapeutic work are challenging some of the assumptions made in the search for firm evidence of the effectiveness of the psychotherapies. Adopting a model borrowed from

medicine of the random controlled trial, with its emphasis on cause and effect, leaves out much that seems to be relevant to research into process, for example the context. At best, those methods are only one way of telling the story. If medication is introduced into the process of therapy, then its significance needs to be explored in both positivist and post-modern research agendas.

I feel strongly that research should produce something new, because I have read a great deal of probably well conducted research that seems disappointing and to have little new to say apart from advocating more research along similar lines but asking subtly different questions. I think that doing qualitative research from a different perspective can include subjective realities and differing contexts. I wanted to draw on my experience of learning from hundreds of clients describing their experience and thousands of therapeutic encounters as a way of learning and a method of research. Furthermore, it was this process of listening that taught me what there was to learn, since I did not and could not have known that in advance.

What I hope to get from it

When I addressed the fourth question (Colaizzi 1978) about what hidden gains there might be for me in doing this research and doing it this way, I found the prospect of uncovering "the hidden", both exciting and frightening. It was frightening to think that my experience would not be substantiated by the experience of others, that other therapists would not have noticed benzodiazepines as having any impact on the therapeutic process. I acknowledged that since we are always wanting to find what we are looking for, I might be much less

interested in finding what I did not want to find, evidence or views that conflicted with my hunches.

In thinking about the way I was choosing to do this research, I thought that there would be a gain even if it were not the expected one; disproving my hunches would also be a gain since it would challenge me to think again about my own experience of therapeutic encounters. I expected to be excited by this research, because in the previous research I had been involved with, such as The Withdraw Project, I had discovered that even the unexpected could be a stimulating experience. I also felt that I would gain more by doing research that does not discount the experiences of clients and therapists as "anecdotal", which might sit more easily with me as a therapist.

Personal background

In view of the fact that I started this introduction with a quotation from a Jamaican reggae musician and references to the emancipation of slaves, I want to explain the significance that these references have for me at a personal level. This locates me within the study in terms of what I bring to it, some of my personal and professional experiences and some of my values and beliefs. It explains some of the passion in my work and some of my passion about this topic, because passion can mean enthusiasm as well as suffering.

I read sociology as an undergraduate and during my second year, spent three months in Jamaica representing the National Association of Youth Clubs as a guest of the Jamaica Youth Clubs Council. I did some social research in a shanty town outside Montego Bay,

had my passport and money stolen, worked with my contemporaries, broke up knife and bottle fights, got mugged but fought back, had a wonderful time and loved the people and the country.

A few years later, I returned with my husband to live in Jamaica for eight years, where our children were born. I have a strong spiritual and religious background and in preparing for our work in Jamaica, I had my first experience of a psychiatric assessment to see if I had the mental stability to survive it. We were advised by our predecessors that "there is a real passion to be lived out there", and we found ourselves persecuted as a couple sometimes as well as fighting for justice for others with less power than us. The experience taught me about confronting with compassion, standing up for what I believe in while recognising that everyone makes mistakes and has blind spots. Life there required patience and persistence as well as a love for people, as social and political forces can resist necessary but uncomfortable change.

In Jamaica I had two other significant relationships that were therapeutic, one a retired priest and the other a nun, both of whom had wide experience of spiritual direction and their support and understanding was valuable to both of us when life was very tough. The Religious Orders provided us with a place to go for restoration and reflection when we left Jamaica for a break after three years. We have remained in contact with both our colleagues since, and I mourned the nun's untimely death a year or so ago with great sadness. My other experience of therapy was following the death of the last member I had known of my family

of origin some twenty years ago, when I had counselling and began a long association with CRUSE, the organisation for bereaved people.

Professional background

After graduating as a sociologist, I set up a county association of youth clubs, at a time when detached youth work with "unattached" young people was becoming fashionable. I started my counselling work before there were training courses, studying group dynamics in the era of 1960s "encounter groups". This was when I first encountered supervision and was fortunate to have a former senior education inspector with whom I discussed work and all the personal struggles I had over it. I worked on my own, often late at night, listened to young people with drug problems and love problems, and youth leaders too. I had enormous freedom, lots of bright ideas and a supportive committee who met once in two months to hear how the work was going. I made a few waves and in some ways was subversive, but survived by learning to be subversive more covertly, a lesson I still forget sometimes.

In Jamaica, I was a lecturer in religious studies and mathematics, training teachers of whom many were experienced but lacked formal education. I learned to start from where they were and to find the gaps in their understanding. Religious education had consisted in telling bible stories and I had the task of implementing the new syllabus, which was based on understanding children's religious thinking and the educational ideas of Piaget. At first my classes in biblical criticism and thematic teaching were received with polite scepticism, but gradually with more enthusiasm. When I confronted the college principle about not consulting me nor involving the students in the carol service, I was a lecturer in religious

studies who was the only lecturer exempted from taking assembly, an attempt perhaps to limit my subversiveness.

Mathematics was the class in which I met those who had given up hope or been given up on and they all had to pass to qualify. This was where believing in people's ability to free their minds and understand mathematics, worked the miracle of helping them to believe in themselves and become what they were capable of becoming. Later when I became an in-service tutor travelling to country towns to teach mathematics seminars I learned how reliability was valued, and because I always turned up so students would always wait for me. I inherited large numbers of assignments that had not been marked and, realising students would not receive credit for their work unless it was marked, I felt it was important to do it so that they got a fair deal. I empathised with those who felt abandoned without a tutor, so reliability and commitment to clients have been values central to my therapeutic work

The context of the study

I am involved in this area of benzodiazepines and psychotherapy by chance, not any great design. I had just finished a M.Ed. in Educational Psychology in 1986 and was expecting to continue my studies in education, when by chance I saw an advertisement for a group worker with the Withdraw Project in North Birmingham Health Authority. I knew nothing of benzodiazepines, had no recent experience of group work and admitted in the interview to not having any of the required therapeutic background, so I was surprised to get the job. I trained in both cognitive-behavioural therapy and transactional analysis, which were combined with a gradual withdrawal programme.

During my first year with the Project we sought a general practitioner's referral from anyone approaching us for help in withdrawing from benzodiazepines including information about the diagnosis, the medication, the length of time that it had been taken and any other medical problems or treatment. I looked up every drug, drug interaction, and medical condition, as well as the over-the-counter medication that the patient described on their questionnaires before seeing them for the first assessment interview, and gradually learned what I needed to know about benzodiazepines. I think that attention to details such as this and relating the information to my experience of the client has been important in forming my views about how benzodiazepines affect therapeutic process.

Our research assistant provided me with a selection of research papers to read at the start and I gradually read nearly every research paper we had. In addition, as our literature searches were up-dated each month, we discussed everything that might be relevant or useful to the Project. Questions about unusual withdrawal reactions, drugs during pregnancy, alternative treatments using beta-blockers, antidepressants, or anti-psychotics, in-patient fast withdrawal methods and whether to change from the existing drug to diazepam were all scrupulously and carefully explored using our own data and comparing it with other people's work.

The effect the Project had on me

I was entering the culture of clinical psychology with its emphasis on the scientist-practitioner model and on the whole gaining a lot from it. However I was less aware that I

was tacitly accepting many of the assumptions that belong to this approach. The group programme was based on a mixture of education and therapy and implicitly assumed that "the patients would be suffering deficits in cognitive ability" as a result of taking benzodiazepines. Transactional Analysis had been incorporated into the programme as a way of helping patients address their emotional numbing, over-nurturing of others and the loss of positive self-image. It was assumed that people needed an experience in the group and an opportunity to reflect on it for new learning to take place and that materials should be written specifically for a client group with "poor memory and attention deficits".

My understanding of and approach to research was being reinforced as I had started my undergraduate studies in sociology with its emphasis then on questionnaires, surveys and statistical analysis. I enjoyed statistics and quantitative methods and found myself teaching mathematics and statistics during my teaching career in Jamaica. Just before joining the Project, I had studied advanced experimental research in educational psychology and my birth as a psychologist shifted me towards the positivist empirical paradigm.

The questions the Project raised

I was also a reflective practitioner, a model that reflects more of my counselling background and I began to ask many questions and look for answers. There was also the opportunity to explore other drugs which appeared to present people with problems of dependence, assist withdrawal of barbiturates, antidepressants and antipsychotics, provide a consultancy service to doctors and therapists, and develop ongoing support and referral to other agencies. I wondered do other people think there may be problems with other psychotropic drugs?

I wondered why it was so difficult to find people who wanted to withdraw when television programmes and newspapers were full of the problem, general practitioners were under enormous pressure to address long-term benzodiazepine dependence through prescribing guidelines and threatened litigation. When we found people, they were desperate for help but issues such as shame about dependence, chronic agoraphobia, stigmatisation by being associated with a psychiatric hospital and fears about withdrawal seemed to make it difficult for people to approach us.

Drug workers who identify closely with their clients by adopting their language, casual dress or alternative life-style may not be able, once the client is abstinent, to do the deeper therapeutic work. Minimising distance at this early stage may make confrontation too difficult or damaging to the therapeutic alliance at the later stages of therapy. Does that apply to clients who are taking benzodiazepines who seek therapy elsewhere, I wonder? Are the strategies useful for benzodiazepine withdrawal counter-productive for therapy, by being too directive, too confrontational, too focussed on behavioural change or for some other reason?

When clients came for assessment interviews, I heard between 200 and 300 stories and realised that they had told the same stories many times before to people who had done as little with it as I was proposing to do, that is virtually nothing. They felt unheard and I believed that if I had heard these stories in a different setting, I might have been able to respond differently. Constantly I heard disclosures of sexual abuse, emotional deprivation,

relationship difficulties, discrimination, bereavement and loss for the first time because it had all been concealed under headings such as "nervous breakdown" or "inability to cope" or "endogenous depression" or "for no good reason". I knew that some people with similar stories found therapeutic help, but wondered what happened to those who were dependent on benzodiazepines. Did they not seek help or were they rejected as unsuitable?

The actual group process seemed to confirm my expectations that people were emotionally cut-off, found difficulty in concentrating, remembering and making connections between ideas, and I experienced the phenomenon of people repeatedly going over the same ground. Having a structure seemed to move the group on and help them not get bogged down in focussing exclusively on withdrawal problems and this required a lot of energy and humour that the group seemed to lack. These groups with a common issue provided both support and confrontation from their members in a way that, as the group therapist I could not. I have found it harder to do this work with individuals, and wonder whether that is because I had the group experience first or whether other therapists also experience this difficulty.

In listening to people's stories about their lives and how they made sense of the dependence on benzodiazepines, I was constantly aware of the metaphors that clients used to represent their drugs or the meanings they attached to taking them. Benzodiazepines had been called "mother's little helpers" by the media, or was it the pharmaceutical companies? They were promoted as harmless and when compared with the barbiturates that they replaced, they probably seemed relatively harmless at least when taken in overdose. But clients attributed a great deal to these drugs as tonics, crutches, friends, and their use as magic bullets, help to

cope and even negatively as jailers. The metaphors clients used provided me with important information about the symbolic place benzodiazepines occupied in the client's frame of reference and a route to enter into an understanding of their meanings. I was interested to know how other therapists viewed and used these metaphors.

This experience made me think again about the importance of maintaining therapeutic boundaries. Whatever style of therapy is practised, boundaries are usually set around whether telephone calls are permitted in between sessions, involvement of relatives or friends, asking for individual sessions while in a group, being in individual therapy elsewhere, and so on. With this group of clients, whenever the going got difficult, they had been able to take another tablet and I was asking them not to do that. I did not want them to put pressure on their doctors for more drugs either, so there had to be another way to contain this.

I accepted telephone calls monitoring them carefully and raising concerns about overuse with the client as a more respectful and therapeutic response than avoiding returning them. In this way I acknowledged that dependence on a therapist through which autonomy could be promoted was a step away from dependence on a substance. I also gave a considerable amount of advice. I wondered whether therapists in other settings find their boundaries challenged and how they respond. I imagined other therapists might not be comfortable with the "expert" role that may result from giving advice.

The Project had no medical practitioner and prescribing responsibility remained with the patient's general practitioner, so I was involved in a double contract, with the patient and with the doctor. By asking the doctor to continue to see the patient regularly and to continue to prescribe benzodiazepines without putting the patient under any pressure to reduce, I was hoping to foster a good relationship between them, which would continue after the person had stopped attending the group. The process, or a good therapeutic alliance, begun by me might be transferred to the doctor/ patient relationship.

I realised that just as I had to learn to speak the client's language, I also had to learn to speak the doctor's language, consciously adopting medical terminology, generic names for drugs rather than brand names, and writing short letters that they might read. I realised that the doctor might perceive me as more credible and trustworthy if my advice to both of them was reliable and accurate and if I contained the patient's anxiety by being dependable in a crisis and willing to talk to them by telephone. If I was asking the doctor not to refer elsewhere or prescribe further drugs, it was important to contain their anxiety about litigation for prescribing long-term. By advising them that co-operating with a Project such as ours, would be seen to be addressing the patient's drug dependence responsibly, we formed a collaborative approach to the problem.

Over a period of time I came to value the ways in which some of the doctors, both general practitioners and consultants, and I were able to give patients a consistent message and provide professional support for each other. Not all my experiences of contact with general practitioners have been positive, but I take the view that if I assume that they can be and will

be positive, it is much more likely to happen that way. I have supported several patients who had been removed from their doctor's lists for refusing to stop taking benzodiazepines and offered to help negotiate with their new doctor to maintain their prescription while the patient considered withdrawal. I knew that this could be frightening if people needed a regular prescription and that having to ask to go on another doctor's list could be a humiliating experience.

I became much more involved in these relationships than was customary for therapists then, and I wonder now what was good and what was bad about that. I wonder whether the rise in counselling in general practice since then has led to similar collaborative working for other therapists. I also wonder what difference it makes when there is a medical practitioner in a therapeutic service and prescribing is in-house, and whether the decision is perceived as the responsibility of one person and not necessarily the concern of each therapist.

Almost all the people who came to the Project had received psychological help of some kind before but had not found that anxiety management, life-skills training or short-term counselling made much difference, possibly because we only noticed measurable therapeutic change as the dosage of drugs was reduced. When clients completed a withdrawal group, they certainly knew how to withdraw, most had made some reductions but were by no means ready for therapy to address underlying issues even if they would be accepted by another therapist.

Because they were not yet abstinent, referral on to other therapeutic services was usually not accepted. It appeared that some therapeutic services were operating an exclusion policy for clients dependent on benzodiazepines even if it was not overt. So I wondered if therapeutic services have policies that exclude clients on benzodiazepines. If they do, where do these people get the help to withdraw, other than the few specialist tranquilliser services, so that they are eligible? Is this group of potential clients for therapy discriminated against?

When in 1989 Dr Hamlin and I set up Withdraw Workshops and trained over 300 therapists around the UK, I was increasingly interested in what other therapists both inside and outside the addiction field had to say. I began to build up a picture of individual therapists suspecting that benzodiazepines were affecting the therapeutic process, but also of colleagues who were proceeding unaware of the possibility and of no agency policy. The wide mixture of their backgrounds made for stimulating discussion and few left the consultations with any doubt that this was an important issue to take back to their workplaces. I continued for a number of years to run workshops for drugs teams and counselling courses and I wrote a book on counselling based on my experience (Hammersley 1995).

Other experience of research

I was involved in investigating the usefulness of a relaxation tape to be provided by general practitioners to anxious patients as an alternative to benzodiazepines. This experience taught me some of the problems that can be encountered with research that appears at first to be quite straightforward. The plan on paper is not always easy to put into practice. Small

mistakes can have enormous consequences and I have discovered again in doing this research how difficult or impossible it is to go back and put them right.

There were problems about interpreting the criteria for randomised allocation to treatment and control groups, problems about patient compliance and the measures that were used. I now wonder about the value of this kind of research because we learned nothing about the varied human stories that lay behind the consultation for which the same relaxation tape was to be an answer. The research assumed objectivity in its evaluative methodology, but for me it devalued the individual's personal and subjective experience. This view is a personal predisposition that has affected the way I have chosen to do this investigation.

Bereavement

Since I have focussed some of this exploration around bereavement, I will outline some of the experiences that have influenced or biased what I investigated. Since 1981, when I experienced a personal bereavement and was helped by talking about it to a number of people, I have been involved as a volunteer, counsellor, supervisor, trainer, committee member and adviser to a local branch of CRUSE Bereavement Care. Then in 1985 the subject of my master's degree dissertation was "Parental death in adolescence". The difficulties I experienced in conducting that investigation, when the permission to talk to adolescents through contact made with their schools was suddenly withdrawn, certainly made me cautious about attempting to contact clients for interviews through third parties.

Bereavement was the major reason reported by the research participants in the Withdraw Project; a fifth of them gave bereavement as the reason for the consultation that led to the first prescription for benzodiazepines. Participants' average time on benzodiazepines was ten years, but as some had started when they were first available in 1961, twenty-five years was also a possibility. During that time many people had experienced further bereavements, such as the ending of relationships, children leaving home or redundancy. Loss was certainly a major therapeutic issue to emerge in the withdrawal groups. As people reduced their dose of benzodiazepines they appeared to me to re-connect with their grief and start to mourn again often for losses sustained many years before. I wondered if others noticed this.

In 1988 I presented a paper on "Benzodiazepines following Bereavement" to the Second International Conference on Grief and Bereavement in Contemporary Society, outlining our concerns that benzodiazepines might in some way inhibit grieving. I showed how those who had been prescribed following a death compared with other clients taking benzodiazepines on a good number of the measures we used. It appeared to us that those who had been bereaved did much better initially (perhaps suggesting no underlying pathology in medical terms) but that they seemed to "plateau" for a while during the life of the group. They seemed to reconnect with their grief, but after grieving to do as well as others when it came to reducing their dependence on drugs. Perhaps another interpretation is that the drugs helped them in some way, but those present at the conference discussion thought that the drugs had been inhibiting grieving.

In January 1988, the Committee on Safety of Medicines had issued its guidelines to doctors about limiting prescribing of benzodiazepines to 2 to 4 weeks and included a warning that benzodiazepines were thought to interfere with grieving. This followed a similar statement from the Royal College of Psychiatrists (1987) and since I was presenting the paper at this conference, I contacted the authors to ask them if they had any evidence upon which they had based their statement. I was told it was a consensus view and like us, they did not know of any research in this area.

In 1991 I presented a paper on "Issues of loss in relation to benzodiazepines" at a symposium "Benzodiazepines into the 1990s" in London, at which I outlined some of the losses which result from taking benzodiazepines. Loss may be a reason for benzodiazepine prescribing, which then results in other losses, emotions, cognitive functions, independence due to agoraphobia, and loss of connection with lived experience during the time people take the drugs. I had also become aware that people experience loss of a sense of self, loss of self-efficacy, loss of self-esteem and loss of relationship. In these ways, I have been presenting ideas and theories for debate with others with their own particular perspectives.

Contacting clients

In order to provide some evidence to the Committee on Safety of Medicine about a benzodiazepine, I approached North Birmingham Health Authority for access to the notes that I had written while working at the Withdraw Project. I had the approval of the Project Director who had previously been assured that she could continue to have access to the research data. The request was turned down on the grounds that patients had not given their

consent to this scrutiny of their records. As a result of this earlier experience, I concluded that it was unlikely that I would be given permission to contact clients I had seen at the Project for this research.

I had also been meeting with MIND organisers and social workers at the mental health centre in my town to discuss the feasibility of collaborating together to provide a benzodiazepine withdrawal group. However my status as an independent practitioner was a problem for some people since it is thought to be tainted by money, and it became clear that without the support of the local general practitioners, the social workers would be unable to proceed. I was invited to a group session to discuss some of the concerns people had about benzodiazepines, but we agreed to leave it at that. So it seemed unlikely that I could contact potential client participants through MIND.

My therapeutic approach

I am a counselling psychologist and have been in independent practice since 1989. Although as I have indicated I have practised both cognitive-behavioural therapy and transactional analysis, my preferred orientation is psychodynamic. I have been most influenced by the writings of Kohut (1971, 1977) for his concepts of self, narcissistic injury, object love, and his ideas on the therapeutic use of relationship. Winnicott's (1971, 1986) ideas about maternal love and transitional objects led me also to be strongly influenced by Bowlby (1969, 1988) and Stern (1985) amongst others. Cashdan (1988) has influenced me strongly more recently in terms of therapeutic practice.

I still see clients taking benzodiazepines, but more often antidepressants. Some are willing and able to come off their drugs quite quickly and therapy has progressed in the usual way. Occasionally, when people realise what might be involved, they prefer to continue with drugs and leave me and may go elsewhere. I often do not know what happens to them, but I am quite comfortable with that. Sometimes when working with a client during the drug withdrawal phase the process seems uncomplicated, but then there have been difficulties moving into a different phase of the therapeutic relationship in order to deal with underlying issues. I wonder if other therapists know when people are taking benzodiazepines, and if they do, if they notice any difference.

Object relations

Object relations defines the individual's inner world as basically the residue of the individual's relations with people upon whom he was dependent for the satisfaction of primitive needs in infancy and the early stages of maturation (Horner 1984). The inner world determines in a fundamental way the individual's relations with people in the external world. Object relations is seen as one of the functions of the ego. Psychological health and psychopathology can both be understood in terms of the organising and integrating functions of object relations development.

The client in psychotherapy replicates his early object relations with the therapist through the transference and since there are a variety of theories, so there is no one form of therapy (Cashdan 1988). However the therapeutic relationship is seen as central and is dependent on the formation of a therapeutic alliance. This includes the full-scale therapeutic rapport and

all elements favourable to the therapy, the patient's motivation, positive transference and the rational relationship (Horner1984).

Horner states the criteria she has found useful in evaluating the strength of the therapeutic alliance as, motivation, acknowledgement of the false-self, capacity for attachment to the real person of the therapist (non-transferential), capacity for self-confrontation, capacity for confrontation by the therapist, ability to endure disappointment or frustration, and ability to tolerate feelings of anger towards the therapist. I use these criteria as a template for the evaluation of the therapeutic alliance.

Object relations theory provides a framework for the exploration of transitional objects (the benzodiazepines) and metaphors used for them. "The analyst's work consists in a *metaphorical* (his italics) replacement of the deficiencies of maternal care, either through accepting the analysand's dependence or through accepting his need for fusion within the symbolic interplay – for the analyst does not represent the mother, he is the mother" (Green 1978 p.176). I believe that ingesting benzodiazepines is a form of fusion with the transitional object (TO).

It has been argued that the transitional object is an external object identified and in part created by a dependent person, usually a child, and the transitional object both represents themselves and the person on whom they are dependent but from whom they have been separated. Within this view, the transitional object is wholly within the control of the dependent person/child and cannot be given by a therapist to a patient or offered as a

substitute. It is thought that if a patient consumes it, this is usually without the knowledge of the therapist. While this view seems to fit generally with Winnicott's (1971) "summary of special qualities in the relationship" (p5), Winnicott himself widens the subject out to include religious feelings and drug addiction among others.

He gives as an example, the wafer in the Blessed Sacrament which is symbolic of the body of Christ, which may be understood by a Roman Catholic that it is the body and for the Protestant as a substitute or reminder but not the actual body itself. In both cases Winnicott states it is a symbol. What is important here is that the body or the symbolic representation of it is given by Christ, or a priest as His representative, to be consumed. From the clinical description of two brothers, Winnicott states that a rabbit adopted by the first child as a "comforter" did not have the true quality of a transitional object, but that the soft green jersey and red tie adopted by the second child as a "soother" was a typical example of a transitional object. "It was a sedative which always worked" (p7).

Flew (1978) in discussing Winnicott's view of transubstantiation, makes the point that Winnicott believed that the transitional object had a variable meaning and that the religious dogma can be seen as a compromise formation between illusion and reality. He draws on Winnicott's papers to describe the paradox that the child creates the object by choosing it but that the object was there, waiting to be created. If a child reaches out to his mother's left ear, then the ear is a subjective object that happened to be there to be discovered (Winnicott 1986). Perhaps in a similar way medication is created as a transitional object by the patient, although it is already there, waiting to be discovered as such.

A study by Arthern & Madill (1999) into therapists' views of how transitional objects work, states that little is known of their specific introduction by adult clients or therapists within psychotherapy. However this study makes it clear that therapists give transitional objects of the therapists' own choice to clients, some with a verbal component and some soft objects depending on the orientation of the therapist. They make the point that it is not just the object itself that is significant, but also the process whereby it is given or received or both. The process of embodiment, by which the elements of the therapeutic relationship were encapsulated within the physical presence of the T.O. is compared with Winnicott's explanation of the symbolism in the Blessed Sacrament.

Cashdan (1988) describes object relations therapy as focussing on the relationship and on the client's projective identifications, which he defines as behavioural offshoots of fantasies from pathological object relations. The four major forms of projective identification are dependency, power, sexuality and ingratiation, and these show themselves as the major themes of helplessness, issues of control, seduction and self-sacrifice. These are common themes commented on in therapy with clients taking benzodiazepines.

Attachment theory

Attachment theory is a variant of object relations theory, but the important issue is not sex as Freud thought, but security. The individual is a person relating to other persons and his relationship to the world is governed by internal working models, which include affective, cognitive and behavioural elements. Attachment relationships (especially the therapeutic relationship) are defined by three key features; proximity seeking to a preferred figure, the

secure-base effect and separation protest (Holmes 1993). The therapeutic process has three components, attunement, autobiographical competence and affective processing.

Within this model, psychotherapy provides a "good enough" attachment figure, consistently available, at the right spatial distance, to allow the client to experience through the relationship a secure-base effect. The client must be able to engage cognitively and affectively with the therapist. The client must experience empathic attunement, be able to access and understand past and present events and relationships and make connections between them, and be able to process the feelings and emotions which are released.

Structure of the thesis

In chapter 2 I describe how I intended to conduct this inquiry and my reasons for making the choices I did. Chapter 3 contains reviews of the literature on the effects of benzodiazepines and literature from the fields of addiction and psychotherapy that seemed relevant to the question in some way. Chapter 4 is an account of a survey I conducted of NHS psychotherapy services and their policies on combining psychotherapy and benzodiazepines. In chapter 5 I describe how I contacted and interviewed a number of experienced psychotherapists for their views about therapeutic process with clients taking benzodiazepines, and analysed the data using grounded theory.

Chapter 6 contains the information gathered as field notes during the interviews about the therapists themselves, their observations about how they thought their clients were affected by benzodiazepines and the metaphors clients used in therapy, in table form. It also includes

data in table form (6.18) of 25 cases that therapists described of a client in therapy who withdrew from benzodiazepines. The next four chapters include the forty-four propositions that I derived from the data and fourteen outcome propositions, which are discussed in more detail in the discussion chapter.

Chapters 7 and 8 describe the participants' views on how they thought the grieving process might be affected and differences they observed in the therapy between these clients and their other clients. Therapists' views on psychodynamic meanings and their theories about combining therapy with benzodiazepines are contained in chapter 9 and some implications are outlined in chapter 10. The final chapter, 11, contains a discussion of the findings, a personal reflection on the process, my learning about the topic and the research process and an evaluation.

While it may be more usual in qualitative research using interviews and grounded theory, for the review of the literature to follow the collection of data in order that the researcher can "bracket off" their own preconceptions and assumptions, it was not realistically possible for me to start this research by "unknowing" what I already knew of the research literature on benzodiazepines. I have tried to analyse and interpret the data with that in mind. I have also written a more extensive chapter on methodology than might be expected or wanted. I have taken the suggestion of McLeod (2001) that good qualitative research requires an informed awareness of philosophical perspectives because qualitative research does not constitute a fixed, agreed method.

I have outlined how I approached this inquiry by asking myself four questions about what, why, how and for what gain I wanted to undertake it. In addition I have located myself in the study by saying something about my personal and professional involvement with the topic area and my values and beliefs. Reflecting on my experience raised a number of questions for me about how other therapists view the therapeutic process with clients who are taking benzodiazepines. This thesis is about how I discovered some answers, what I learned from doing it and the impact the process had upon me.

CHAPTER 2

METHODOLOGY

Why qualitative research?

Qualitative research is a field of inquiry in its own right with interconnected sets of terms, concepts and assumptions which cross over disciplines, fields and subjects areas (Denzin & Lincoln 2000). It is an activity that locates the observer in the world, who then uses a set of interpretive and material practices to make the world visible. That world consists of a series of representations, which include field notes, interviews, photographs, recordings and memos, as well as the more abstract forms of narratives, language and meanings. It "involves an interpretive, naturalistic approach to the world... (so) qualitative researchers study phenomena in their natural settings, attempting to make sense of, or interpret phenomena in terms of the meanings people bring to them." (p3)

The purpose of inquiry is to enhance knowledge (McLeod 2001) and it is important to elaborate on what is meant by knowledge and knowing. The type of inquiry produces a type of knowledge with which it is closely related, and this is different from other types of knowledge and methods of inquiry. Lynch (1996) in discussing counselling research and the development of different research methodologies over the past thirty years identifies three different perspectives on the nature of reality and knowledge. Qualitative inquiry assumes that the world is constructed; that it is a complex, multi-faceted, layered representation, which can be viewed from different perspectives. In particular our personal,

social and relational view of the world is constructed through and by language, actions and the ways in which the world is physically shaped.

Qualitative methods are used for an in-depth description of a programme, practice or setting (Mertens 1998), which are multi-method, interpretive, naturalistic and attempt to understand or interpret phenomena in terms of the meanings people bring to them. They allow for complexity, context, exploration, discovery and inductive logic, because the researcher acts without imposing pre-existing expectations on the phenomena but begins with observations and allows the categories of analysis to emerge from the data. The ontological assumption that multiple realities exist that are time and context dependent leads to qualitative methods to gain an understanding of the constructions held by people in particular contexts.

The basis for choosing qualitative methods is the researcher's view of the world, the nature of the research questions and for practical reasons that are associated with the method. They are appropriate in Mertens' (1998) view when the focus of the research is on a process or its participants, when there are individual outcomes, detailed information is needed, the focus is on diversity or unique qualities. The intention is to understand the process theory, so it is suitable for exploring participants' beliefs about the nature of a problem and how a process may lead to desired outcomes. Counselling and psychotherapy are based on humanistic values and so qualitative methods are likely to be more acceptable to participants. Main strategies for data collection include ethnographic studies which lend themselves to exploring cultures and communities, case studies which lend themselves to the study of individuals and interviews which lend themselves to the study of diverse views.

There are various qualitative methodologies which all seek to understand the world of reality, addressing different facets of the task. Phenomenology and grounded theory focus on the meanings, through which people construct their reality, ethnography which has a cultural emphasis focuses on how reality is constructed through rituals and social practices. Discourse focuses on how reality is constructed through language, talk and narrative and hermeneutics explores historical and cultural meanings through which reality is experienced (McLeod 2001).

Juxtaposed to qualitative inquiry is quantitative inquiry, which has been the dominant and traditional methodology of science. This view sees reality as simplifiable and knowable and not dependent on any subjective interpretation. Research in this tradition has a long history and focuses on rejecting the null hypothesis, objective data collection, reliability and validity (Maykut & Morehouse 1994). It is also concerned with linear causal relationships rather than interconnected and interdependent ones. Heron (1996) critiques the use of conventional clinical trials in the counselling and psychotherapy field as House (1996) questions the ontological and epistemological assumptions of symptom-oriented objective evaluation studies.

Historical and philosophical background

There are two main paradigms in research, the Positivist and the Interpretive-Constructionist, although in recent years the development of critical theory and related ideological positions, (Guba & Lincoln 1994) has led to the emergence of a third group

which Mertens (1988) has called the Emancipatory paradigm. Maykut & Morehouse (1994) define a paradigm as a set of overarching and interconnected assumptions about the nature of reality. Guba & Lincoln (1994) identify three questions which define a paradigm: The ontological question asks about the nature of reality, the epistemological question asks about the nature of knowledge and the relationship between the knower and the would be known, and the methodological question asks about how the potential knower goes about obtaining the desired knowledge and understanding.

Positivism as the dominant paradigm was based on rational empiricism from Aristotle, Bacon, Locke, Comte and Kant. It assumes the social world can be studied in the same way as the natural world, that the method is value-free and cause can be determined (Mertens 1998). Positivism, a term first coined by Comte in 1830s, was synonymous with science and meant objective, based on measurable variables and provable propositions and was most concerned with explanation, proof and prediction of observable events (Maykut & Morehouse 1994). So the ontological position of positivism is that there is one reality which is knowable within probability. The epistemological belief is in the objectivity of the researcher who observes in a dispassionate manner and the methodology is primarily quantitative, measurable and analysable statistically where what is observed and measured is decontextualised.

Phenomenology focuses on understanding the meaning events have for the people being studied, and includes qualitative research, grounded theory, naturalistic inquiry and ethnography (Maykut & Morehouse 1994). It sees the individual and his or her world as co-

constructed. Naturalistic Inquiry is elaborate in detail, and comprehensive in scope, with a philosophic basis, techniques and methods that are based on the new paradigm (Lincoln & Guba 1985). If knowledge can be separated into parts and examined, the knower and the known are separate, but if knowledge is constructed, the knower cannot be separate from what is known. That reality is multiple and constructed is a postulate of the phenomenological approach and propositions are discovered through careful inspection of the patterns that emerge from the data.

The first of three research issues of phenomenology is a focus on words rather than numbers because words are how people interpret the world and it is the researcher's task to capture the process of interpretation. This requires an empathic understanding of the feelings, motives and thoughts of others. If we create our world with words, presenting the results of research to the participants in the same manner includes them in the discovery. The second issue is that phenomenology embraces a subjective or perspectival rather than an objective point of view. The third is that it focuses on discovery rather than proof because it is the observation of people and events and the discernment of patterns that lead to the forming of hypotheses, so discovery comes before proof.

Central to qualitative research is the posture or way of being of the researcher which allows the researcher to be at one with the people being investigated. This posture of understanding from and empathic rather than a sympathetic position was called "indwelling" by Polanyi (1967). The qualitative researcher is viewed as a participant observer, an in-depth interviewer who then removes him/herself from the situation in order to reflect and rethink

the meanings. In this way the researcher becomes a "human-as-instrument" for the collection and analysis of the data, because only humans can be sufficiently flexible in order to capture the complexity and subtlety of changing situations. This draws on the researcher's skills, experience, background, knowledge and biases in the primary process of data collection, so that in the immediacy of the situation, the researcher can use an opportunity for clarification or explore idiosyncratic responses. Polanyi agrees with using the researcher as the instrument in this way, because of the complexity of people compared with the simplicity of inanimate objects.

Maykut & Morehouse (1994) consider the person of the researcher further in drawing on the ideas of Arendt (1958) who makes the point that human plurality has characteristics of equality and distinction (perhaps separateness). If we were not equal, we could not understand others, and if we were not distinct (separate) we should not need to. We create "webs of meaning" and are brought into existing webs of meaning, because equality allows us access to others' experiences of their world but we cannot assume our understanding is the same as theirs. This allows the inquirer to see differences in similar situations and similarities in different situations.

Qualitative inquiry begins with hunches or tacit knowledge, what we know and cannot say, and is different from articulated knowledge (Polanyi 1967). Explicit knowledge, which follows tacit knowledge, is of another kind and can be subjected to critical reflection which tacit knowledge cannot. What at first may seem meaningless becomes meaningful as the researcher participates in looking for what is unknown and uses the context to provide clues

to understand the phenomenon. This requires a tolerance for ambiguity, uncertainty and vagueness and avoids premature closure. Sometimes the listener hears an alternative meaning more clearly than the teller does, or the teller becomes aware of an alternative meaning in the telling.

This connection between the knower and the known, the teller and the listener, must be a dynamic and mutual relationship, a dialogue, because the teller is a person to be understood not a thing (Bakhtin 1986). There is an interaction within the narrative, which can deal with changes of intention, beliefs, desires and commitments. The meaning emerges from the narrative, what is embedded in the stories of their lived experience, as what the two participants can agree upon as a working basis. In this way the story as told, changes and becomes a new story created by the interaction.

Interpretive-Constructionism

The Interpretive-Constructionist paradigm is based on Husserl's phenomenology and Dilthey's study of interpretive understanding, hermeneutics or meanings (Mertens 1998). It assumes knowledge is socially constructed, the product of the values of the researcher and cannot be independent of them. The concept of objectivity is replaced by confirmability (Guba & Lincoln 1989), and that data, interpretations and outcomes are embedded in contexts and people apart from the researcher, so they are not just figments of the imagination of the researcher. Phenomenology includes qualitative research and grounded theory, naturalistic inquiry, ethnography and sees the individual and his or her world as co-constructed, that reality consists of multiple, socially constructed realities. The

epistemological belief is that there is an interactive and corresponding link between researcher and participants, that the values are made explicit and that the findings are co-created. The methodology is primarily qualitative hermeneutical and the contextual factors are described rather than assumed to be eliminated.

Whereas, those involved in the quantitative research tradition may have a belief in one way of objectively knowing reality, it follows that there is only one scientific method against which to evaluate good science. Qualitative inquiry is based upon a different philosophical stance, that is that reality is constructed, so there must be many alternative understandings of reality and a pluralism of ways of going about it. Denzin & Lincoln (1994) described five different stages in the evolution of qualitative research, and now (Denzin & Lincoln 2000) refer to the "seven moments of qualitative research" (p12) as a historical overview of the way these methods have developed and relate to each other.

The first stage, the traditional period, in the early part of the 20th century consisted of typically anthropological fieldwork where much authority was vested in the researcher to represent the subject of the research. The second stage or modernist phase from the 1940s to the 1970s formalised methods such as grounded theory, phenomenological and ethnographic studies in order to show that qualitative research could be as rigorous and valid as positivist research. The third phase of "the moment of blurred genres" (p15) represented a coming together of the humanities and the social sciences in a hermeneutic interpretation of texts, where the voice of the researcher began to appear as researchers turned away from the battle against positivism. The fourth moment, the crisis of representation, arose as a consequence

of the blurring of genres as researchers struggled to rethink basic issues around how they could capture the lived experiences of participants unless through the writing of the researchers themselves. This led to experimentation with new forms of writing such as poems, images and drama which were distinct from the fieldwork notes themselves.

The fifth moment, the post-modern period, is characterised by action-orientated, participatory and politically focussed research. The sixth, (post-experimental) moment of fictional ethnography and multimedia texts connects writers with a more post-modern relativism. However as each stage evolves out of the previous one, it does not replace it and sweep it away but the previous stages form part of the plurality of methods available to the qualitative researcher. The seventh moment is the future where social science may be more responsive to the communities in which we do our work, a civic sociology may evolve embracing all the disciplines, where the moral imperatives cannot be ignored (Lincoln & Denzin 2000).

Ethics and politics

Asking a research question implies the existence of a problem and highlights the researcher's personal motives and values. Without these ideas there would be no subject matter for the inquiry and the researcher would bring no personal knowledge of the field. There are therefore infinite possibilities for research that reflect the cultural values with which the researcher approaches reality. Research is not value free, not only in the formation of the question being asked, the manner in which the investigation is conducted but also in the uses or potential uses to which it is applied. Qualitative research effects both

the researcher and the participants as well as the wider society in which it is conducted. Professional codes of ethics or conduct provide a format for moral principles, which should be an integral part of research planning and implementation.

Mertens (1998) specifies three ethical principles of beneficence, respect and justice. Firstly beneficence, which refers to maximising good outcomes, secondly respect for autonomy, courtesy, privacy and confidentiality and thirdly, justice so that those who benefit bear the risk and that research is non-exploitative. However this is not as straightforward as it seems. Christians (2000) asserts that the social science tradition with its commitment to individual autonomy insists that informed consent must include the two conditions of voluntary participation and full and open information. Clearly it assumes that researchers design research free of active deception, but it is impossible to be free of all ambiguity particularly when the research process is evolving and deception by omission is sometimes inevitable.

Preserving privacy and confidentiality includes protecting the identities and research locations of the participants since the principle of non-maleficence means that no one should suffer harm or embarrassment. In many ways this is more important than beneficence but the possible benefit of the many may be weighed against the possible negative experience of the few (Shillito-Clarke 1996). A further principle of fidelity is significant in qualitative research where disclosure of private knowledge to the researcher is the most likely source of harm. The researcher has to prove to be a trustworthy recipient of what may be politically sensitive information and although pseudonyms and disguises are used in writing, identities

may well be recognisable to insiders. What the researcher sees as innocent, may be seen by participants as betrayal.

When government agencies, education or health authorities are studied, there are questions about what ought to be left unexposed and this is in many ways a political choice. The researcher is expected to ensure the accuracy of data, and fabrications, fraudulent materials and omissions are viewed as both non-scientific and unethical. Fine & Sandstrom (1988) give an example of the problems of whether to challenge racist remarks or drug dependency and risk losing the trust of participants. Is tolerating behaviour supporting it and if it goes unchallenged, is the researcher doing no harm?

Christians (2000) gives an alternative view from the perspective of a feminist communitarianism ethics, which sees interpretive discourse as authentically sufficient when it fulfils three conditions of representing multiple voices, enhancing moral discernment and promoting social formation. If or when the researcher-participant relationship is reciprocal, invasion of privacy, informed consent and deception are non-issues. However McLeod (2001) raises the problem when publishing or disseminating the research of the effect on the participant as reader. He cites Josselson's (1996) comments on the dread, guilt and shame that may accompany turning ones back on participants and talking about them publicly, as "work we must do in anguish" (p70).

Qualitative research in counselling and psychotherapy

A phenomenological and hermeneutic approach is described by Howard (1991), Toukmanian & Rennie (1992) which focuses on the experiences of the individual client, meaning, and intentionality and uses qualitative and descriptive methods. Garfield & Bergin (1994) note the changing attitudes towards the nature of science and the trend towards qualitative research in psychotherapy. They state that therapists are not influenced by quantitative research "because it does not capture the essential phenomena that the clinician perceives" (p.14). While not discarding traditional methods Bergin & Garfield (1994) propose more flexible techniques for getting at the complexity of the phenomena therapists encounter.

A more critical view of qualitative research in psychology (Morgan 1996) accepts methods such as case studies and description as long as the study is repeatable. McLeod (1994) and Sherrard (1997) advocate triangulation, that is more than one type of analysis and additional sources of information as well as seeking counter instances of the phenomena, alternative explanations and checks with respondents. Stevenson & Cooper (1997) suggest that what constitutes good research is researcher reflexivity, that is the extent to which the researcher reflects on the process of the research and how this may make explicit the researcher's understandings.

McLeod (2001) asserts that hermeneutics and phenomenology, although they may appear opposite and alternative ways of doing things, have an underlying affinity since they are both concerned with understanding and opposed to positivism. Hermeneutics is concerned

with the interpretation of texts (frequently religious) in a culturally and historically informed way from within a tradition. This approach requires the existence of publicly accessible data and involves a moving back and forth between the parts and the whole of the text, which is referred to as the hermeneutic circle. The researcher uses empathy as a means of understanding the emotional, interpersonal, cultural and historical context of the person who created the text. Its focus as an approach is towards achieving a comprehensive and coherent interpretation, a reading that encompasses all the text.

The researcher is speaking from within a tradition, such as counselling and psychotherapy, informed by the values, beliefs and prejudices of that tradition. There is a respect for innovation and creativity, which goes beyond the meaning and requires an act of discovery. As a result of this both the text and its author and the researcher are changed and this is how new knowledge is created and made known. It is this coming together to create new meanings which is referred to as a fusion of horizons.

Phenomenology aims to produce an exhaustive description of the phenomena of every day experiences rather than an interpretation, and thereby arrive at an understanding of the thing itself – the essential phenomenon. Colaizzi (1978) sees the phenomenological researcher as engaged in creative insight, that is intuition. Using phenomenological methods the researcher immerses himself or herself in the material until the essence of the meaning becomes clear. The researcher "brackets" in some way their previous knowledge and assumptions and suspends the taken-for-granted attitude (McLeod 1996).

McLeod (2001) makes a case for hermeneutics and phenomenology, brought together by Heidegger, as the core of the qualitative research method in counselling and psychotherapy. Phenomenology does not embed its knowledge in a social context, while hermeneutics is all about context. The underlying affinity is found in the process of asking questions which involve making assumptions, and the process of describing the phenomenon reveals what had previously been hidden, that is it is revelatory. The implications for qualitative research in counselling and psychotherapy are that both strategies must be used and it is the task of the researcher to find the right balance in a particular case.

Grounded theory

Grounded theory as a method of analysis was founded by Glasser & Strauss (1967) and developed by Strauss & Corbin (1990) as a non-linear, interactional method of theory building since the researcher moves back and forth with the data, and it is sometimes called the constant comparative method for that reason. Strauss & Corbin (1994) define it as " a general methodology for developing theory that is grounded in data systematically gathered and analysed". The emergent theory can be seen to be grounded in the current data collection and analysis.

The key features of grounded theory (Mertens 1998) are the researcher's constant interaction with the data, questioning, comparing and thinking about meanings, using theoretical sampling methods and systematic coding procedures. There is a gradation of types of coding from open coding as the researcher looks for key words or phrases that recur in the text. The second stage of axial coding is used to build a model that includes the context,

conditions, action or interactional strategies that describe the phenomena and the consequences of these actions. At this stage of thematic analysis or concept development the analysis is complete. Selective coding involves the process of selecting a core category and relating the other categories to it, to develop theory that is validated by grounding it in the data.

In the final stage of writing Stainback & Stainback (1988) recommend a deep and valid description for a well-grounded theory. They advocate the researcher should seek contextual meaning to understand the social and cultural context of the situation in which the statements were made. The problem that arises is whose voice is represented in the written report? There is a conflict between faithfully representing the differing voices and the writer's interpretation of them, which is sometimes resolved by going back to check with the originators of the data. In phenomenological research Tesch (1990) draws attention to seeking the individual's perceptions since subjective experience is at the centre. Holstein & Gubrium (1994) stress the philosophical basis of phenomenology as the way the individual interprets the world around them, and that the researcher does not make assumptions about an objective reality that is separate from the individual. It is difficult to hold the tension between these seemingly conflicting aims.

Charmaz (2000) while acknowledging that grounded research was developed by Glasser & Strauss (1967) to counter the dominant view that quantitative studies provided the only form of scientific inquiry, points out that it is seen by post-modernists and post-structuralists as having obvious and subtle positivist premises. Strauss & Corbin (1990) come close to

traditional positivism through assumptions of objective external reality, neutral observers and manageable research problems. They encourage unbiased data collection, technical procedures, espouse verification and give voice to respondents representing them as accurately as possible. While acknowledging how respondents' views differ from their own views and art as well as science, they nevertheless discourage the researcher's subjective interpretation.

Charmaz (2000) proposes a "constructivist grounded theory" which takes the middle ground between post-modernism and positivism and "celebrates first hand knowledge of empirical worlds" (p510). She advocates this approach for accessible methods, the relativism of multiple social realities, the mutual creation of knowledge and an interpretive understanding of subjects' meanings. Grounded theory methods should be used as flexible, heuristic strategies rather than formulaic procedures because grounded theory need not be rigid or prescriptive, and a focus on meaning furthers interpretive understanding when these strategies are used without positivist assumptions.

McLeod (2001) writes for the researcher in counselling and psychotherapy and advocates using grounded theory alongside phenomenology and hermeneutics as a method for analysing data which helps researchers discover new ways of making sense of the social world. However he points out that it downplays collaborative working and fits better with a traditional view that the work of analysis is best done alone. Maykut & Morehouse (1994) whose focus is on educational research go to considerable lengths to describe strategies for collaborative analytic methods using grounded theory. In fact McLeod points out that there

are four, five or more different ways of doing it and that it fits with Denzin & Lincoln's (1994) description of a bricoleur and produces a particular kind of knowledge which suits and works for researchers in this field.

Bricolage

McLeod (1996) refers to the qualitative researcher who pieces together the solution to a specific problem in a situation as a "bricoleur", what Denzin & Lincoln (2000) call a Quilt Maker who assembles images as the maker of a film montage. They are jacks-of-all-trades of many kinds, interpretive, narrative, and the solution is an emergent construction, which is essentially pragmatic, strategic and self-reflexive. This is immediately attractive to the counselling and psychotherapy researcher because the effective therapist is required to integrate understandings of the personal, cultural and historical and find meaning in complexity. Denzin & Lincoln suggest it is a way to come to terms with a confusing array of methodological genres since the researcher must negotiate their own personal route through the terrain and cobble together stories rather than grand theories.

The method is adaptable to circumstances, allows the researcher flexibility, the opportunity to improvise and a blurring of genres between science and art (McLeod 2001). It fits broadly within the Human Inquiry method (Reason & Rowan 1981) which assembles the contributions of many people who oppose positivist science. The key epistemological principles include an acceptance of subjectivity or disciplined reflexivity, that knowledge leads to action and outcomes that make a difference, and that knowledge is collective and relationally shared with co-researchers. Knowledge is a cyclical process, which moves from

experience, reflection and theories to action, and respects the whole person, their spiritual, emotional, relational and embodied dimensions. The end point may not be a paper or a book but poetry, drama, film or art.

The fundamental assumption behind Human Inquiry is the humanistic trust in creativity, integrity and the truth-making capacity of the person and the sense-making capacity of the group. McLeod warns of its limitations with clients in counselling and psychotherapy research because of the blurring of the boundaries and the tendency of the research group to become a therapy group. If such a group were set up by clients to fulfil their own inquiry goals, the boundaries would be more clear-cut and manageable. A further difficulty is that Denzin & Lincoln (1994) intended bricolage to be subversive since it throws established or intended methods into the air and that may make it difficult for novice researchers.

In some ways the concept of bricolage encourages the researcher to find their own way through the process making decisions at each stage while justifying them, because although there are protocols for constructing and conducting interviews and a number of methods of analysis, none of them can be exactly applied in practice and in all contexts. Inevitably, difficult decisions have to be made, plans have to be altered and directions changed. What is important is that the researcher knows what they are doing at some level and has something to say at the end of the process; that there is as it were, a quilt.

Collecting data

While there is no correct way of collecting data, a number of writers give some general methodological guidelines, characteristics or principles which can be used by the researcher as a starting point. The more prescriptive they seem, the more they undermine the principle that the design emerges during the process and that decisions are made as the research progresses so that important leads can be pursued. The research question itself, what is practically possible in terms of time and cost and the preferences of the researcher all play a part in the decision about how to collect data. A research focus on the views of a particular group of dispersed people indicates that individual interviews may be chosen as a method rather than other methods such as a case study, focus group or observation.

Mertens (1988) gives general guidelines on the researcher-as-instrument, speaking for the other, focusing on an area of inquiry, exploring research sites, choosing a sample, gaining permission, protecting confidentiality, negotiating entry, entering the field and the role of the researcher. More detailed guidelines are given by Maykut & Morehouse (1994) about a purposive sample where each participant expands the variability of the sample. Mertens (1988) says that the researcher seeks a saturation point when there is repetition of material, confirmation of previously collected material, when negative cases can be sought to enrich the emergent model and explain the variation and diverse patterns.

In theory the goal is to choose a carefully selected group of people who represent a range of experience of the phenomenon, using the researcher's working knowledge of the context. Contact with one participant may lead to contact with others in a snowball technique, so that

sampling is emergent and sequential (Lincoln & Guba 1985). Glaser & Strauss (1967) call it theoretical sampling because it allows the researcher to build broader theoretical insights in the on-going process of data collection. On the question of sample size, which cannot be decided in advance, Glaser & Strauss (1967) advocate continuing until we reach saturation point and Lincoln & Guba (1985) say you can reach saturation point with as few as twelve and probably no more than twenty. However in practice this decision may have to be balanced against considerations of time, money and availability of participants.

Once the decision to conduct interviews with a sample of participants has been made, the researcher has to consider how to get access to the setting, understand the language and culture, decide how to present oneself, locate an informant, gain trust, establish rapport and collect any empirical materials (Fontana & Frey 2000). The researcher also has to consider how the interview is to be framed, whether structured or unstructured, any ethical consideration, how great a part to play in the interview, how much to prompt, probe or disclose, and how it will be interpreted. Since certain types of interviewing are better suited to particular situations, Fontana & Frey say the researcher must be aware of the implications, pitfalls, and problems of the kind of interview they choose.

Maykut & Morehouse (1994) see in-depth interviewing as a conversation with a purpose, a form of discourse shaped by asking and answering questions, so it is the joint product of interviewer and interviewee, what and how they talk about the topic. It should move beyond surface talk to a rich discussion of thoughts and feelings. Once rapport and trust are established, what is most skilful is deep and genuine curiosity about understanding another's

experience. So the structure, whether the questions were developed before the interview, are open-ended and so forth is less important for the quality of the material than the depth of engagement. Mischler (1986) advocates seeing the interviewees as collaborators telling their own stories, and the balance of power being shared as the important factors in conducting the interview.

Analysing data

Strauss & Corbin (1990) take the researcher through the process of breaking down the data into units, looking for connections and patterns and building concepts out of these interpretations. Concepts are related to each other into statements of relationships, which form the theory that is then checked back with the text so that the theory is fully grounded in the data. The researcher is encouraged to interpret, use procedures flexibly, continually be asking questions, challenging decisions and assumptions and reflect on the procedures and their logic. In data analysis Tesch (1990) identifies principles and practices which expand these ideas of a systematic and comprehensive but not rigid analytic process which occurs throughout the data collection process as well as with the reading of all the data at once before dividing it up into smaller units. The data system is developed inductively from the data and the main analytic process is comparison to build categories, define similarities and find contrary evidence. This is not a mechanistic process since triangulation requires convergence from a variety of data sources under a variety of conditions, in order to produce a higher order synthesis in the form of a descriptive picture of patterns and themes or substantive theory.

Miles & Huberman (1994) outline three main approaches to qualitative analysis of which interpretivism is one, and highlight the conflict between the phenomenologists who are careful and dubious about condensing the material. They do not use coding but assume that through continual reading of the source material, one can capture the essence of the account and reach practical understanding rather than laws. However, interpretivists insist that researchers are not detached, but bring their own understandings, convictions and conceptual orientations and are members of a particular culture at a specific historical moment. What they hear and observe in the field affects them and so if the researcher does not use pre-established instruments it will be difficult to separate external information from what they themselves have contributed. There are common features of analytic methods which include affixing codes, noting reflections, identifying patterns and themes, taking the patterns into the next wave of data analysis, elaborating a small set of generalisations and confronting those generalisations with a formalised body of knowledge in the form of constructs or theories.

There is clearly a conflict between following a systematic and precise set of procedures, for example as set out by Miles & Huberman (1994), and taking time to allow realisations to emerge as a process of discovery. The advantage of the former is that there appears more certainty through reliance on rigorous technique; the advantage of the latter is that a more individual perspective of the phenomenon is allowed to emerge which might have been otherwise excluded. For the counselling and psychotherapy researcher McLeod (2001) states that grounded theory works and enables work which is rigorous, plausible and

applicable and that there is not one unique way of doing it which alone guarantees that it is systematic and rigorous but there are many.

McLeod further concludes that this fits with Denzin & Lincoln's (2000) description of the researcher as bricoleur and produces a particular kind of knowledge. It generates theory but it is atheoretical and researchers should not think too much about one counselling and psychotherapy tradition or the community within which they operate. The categories should be pragmatic, not ideological nor too case-based. For the counselling and psychotherapy researcher who is also a practitioner, this fits with the position that whatever the theory or approach used, in the moment one has to trust oneself and the process. Therefore it is the researcher who must be rigorous and systematic in attitude and approach not just the method.

Research design

Focus on benzodiazepines

My original proposal included all psychotropic medication and it did not take me long to realise that this was hopelessly unrealistic. There are many different groups of drugs, taken by a wide variety of different people, for many different reasons in many different settings. People may take several drugs at once, change what they take, or stop and start different drugs to alleviate unwanted effects. It seemed wise to attempt something simpler and more manageable, within an area where I had more personal experience and where there was a consensus about how the drugs should be prescribed. With benzodiazepines, use for anxiety and insomnia is limited to 2 to 4 weeks (Appendix 1) and although I thought it unlikely that

I might indirectly influence someone to stop taking their drugs through conducting this research, I was unlikely to do any harm which was an ethical consideration.

Research paradigm

I have chosen to do this investigation using the alternative, interpretive-constructionist paradigm and a qualitative research methodology, because I believe it to be best suited to answer the research question. The first stage of the design was to conduct a survey of NHS psychotherapy services about their policies in relation to therapy with clients taking benzodiazepines. This was a trawling method to collect background information that might serve the purpose of identifying questions and issues to be explored at greater depth at the interview stage and to recruit possible interviewees. Recruiting a group of therapists as co-researchers to interview was the second stage of the design, which allowed for the context of the therapists, their settings and practice to be included as well as providing more data for detailed analysis.

Because I was seeking a range of diverse views, I have chosen an emergent design for the interviews which does not fully specify who the participants shall be as a non-emergent design would. I intended to build a varied sample of people as the process of data collection progressed in order to allow for the exploration of features that emerged during the process which seemed to me to be worth pursuing and which I could not anticipate. This might lead to a broadening out or indeed a narrowing down of what I considered important in response to hearing and considering the views of participants.

Criteria for selecting interviewees

There were three criteria for selecting interviewees based upon seeking therapists who had experience of the phenomenon that I was investigating, could make comparisons between clients when taking benzodiazepines and not taking them, and whose training had prepared them to reflect on the therapeutic process. The criteria were made known in all the information given out in the recruitment process. They were:

1. Trained in a style of therapy which uses the relationship,
2. Have experience of working with clients taking benzodiazepines,
3. Have worked with a client taking benzodiazepines, who stopped.

Reasons for not interviewing clients

There are a number of ethical concerns that I have considered about interviewing clients as participants, particularly that taking part should not cause harm to them, their current or past relationship with their therapists, the doctor/ patient relationship, nor impact adversely on their personal and family relationships. I considered contacting clients through their therapists so that any issues raised by being interviewed could be discussed with them. However this does not address a potential problem for people who are no longer in therapy. I was also aware of the difficulty I had experienced previously finding participants through a third party who might change their mind.

I was advised that first person accounts of people who were taking benzodiazepines might be confused, or those of people who had previously taken them might be unreliable.

Because I could not know how the person had been or their diagnosis before they took them, this might undermine the value of what they were saying. I have accepted the evidence for retrograde facilitation, that benzodiazepines facilitate memory of events before the drugs were taken by suppressing the processing of events in long-term memory while the drugs are being taken. This might include the period of time in therapy.

Nevertheless, I think that it is a matter of social justice that the views of clients should be heard at some time. In addition I accept that clients may prefer to state their views to a researcher who has themselves taken benzodiazepines, rather than through a professional however well intentioned, and I have some sympathy with that viewpoint. It is inevitable that the views of clients would be interpreted from a particular perspective, which is not necessarily the client's perspective. In view of some of the questions I have raised about therapy offered to clients on benzodiazepines, I think that clients may have some very negative experiences and comments to make which might more easily be said to a researcher with whom they feel greater empathy. I recognise that this is an area for further research and that collaboration with other researchers might help solve some of the problems of finding client participants.

Ethical issues

As a member of the British Psychological Society, I have designed this research to comply with the Code of Conduct of the Society (1993), in relation to obtaining consent, confidentiality, and personal conduct. In terms of the principle of beneficence, that is to maximise good outcomes and secure the well-being of participants, I have tried to respect

their privacy and confidentiality by not disclosing information that could identify them. I considered whether I could include clients in this investigation and any potential harm that might be caused by taking part. All the participants were given the right to choose whether to participate when the purpose of the investigation was outlined to them when first contacted and before the interviews, and were free to withdraw their consent. In line with the principle of justice, I considered how to compensate participants for their contribution, and I stayed on site to discuss their work, run a training session and gave copies of client leaflets, when invited. As a trustworthy recipient of the information they supplied, I have tried to present an accurate account and agreed to publish in some form the outcomes of this investigation.

Data analysis

I chose grounded theory (the constant comparative method) as the method of data analysis since this is a suitable method for analysing interviews. The analysis describes and interprets how therapists view the therapeutic process in relation to clients who are taking benzodiazepines.

Provisions for trustworthiness

I shall try to be open about the purpose of the study, the procedures I adopted, which specific people and settings were sampled, how I collected and analysed the data and the findings. I hope that this will allow readers to have some confidence in the findings of this research, as the views of other therapists not just my own. Lincoln & Guba (1985) describe four aspects of the research process, which contribute to trustworthiness and I have

considered how far I could meet them. First, in using multiple methods of data collection, I conducted a survey of NHS institutions to ask them about their policies and conducted face-to-face interviews with therapists. I further collected research papers, reports, service descriptions and suggestions of other people to approach as interviewees from participants, and reviewed the relevant literature in the fields of benzodiazepines, addiction and psychotherapy.

Secondly, I have built an audit trail consisting of a researcher's journal of how participants were sought, all the communications by letter and telephone with participants and all those attempts to find participants that led to a dead end. The journal has a section which is a record of face-to face and telephone supervision and all the written correspondence and feedback given in supervision. The paper record includes the methods used to locate NHS therapy facilities, the original replies to the survey questionnaire, the original field notes of interviewees and their settings and the original transcripts. The techniques that were used to analyse the data using grounded theory and the colour-coding system described in the section on analysing data can be identified as marked on the transcripts. The third aspect deals with working in a team in order to minimise bias, but I had to conduct this study alone so I have attempted to use multiple methods and keep clear dated records of the procedures.

The fourth aspect suggested by Lincoln & Guba (1985) is to ask participants whether I have accurately described their experience. One option is to show participants the report in the early stages of preparation and listen to their responses but not necessarily to change it or alternatively to agree not to publish anything participants do not find truthful. I decided that

the scale of this study was too large to make these options realistic, but I have sought feedback by presenting a paper on the results of the NHS survey at an international conference of counselling psychologists and publishing an article in a journal. I presented a workshop on the views of therapists at a national conference of psychologists and I gave a talk and discussion on benzodiazepine metaphors at an AGM that consisted of clients and therapists in a voluntary agency.

Mischler (1990) advises researchers to make the methodology visible, but states that the ultimate test is whether we believe the findings strongly enough to act on them. A number of participants at the end of the interview stated that the experience of discussing and reflecting on their practice with me had made them review their assumptions and theories about their clients and benzodiazepines. In informal contacts since then, particularly since some participants have also attended paper presentations and workshops, participants have said that they have implemented some of their own findings resulting from participating in the research.

CHAPTER 3

REVIEW OF THE LITERATURE

Sources

The Withdraw Project, North Birmingham Health Authority (1985-89) had a full-time research assistant who checked the medical, addiction and clinical psychology journals in the library of the University of Birmingham on a monthly basis. This extensive archive provided a broad range of papers relevant to benzodiazepine withdrawal. In addition, a co-operative relationship between the Project and the West Midland Centre for Adverse Drug Reaction Reporting at the Queen Elizabeth Hospital, Birmingham, ensured that any relevant papers were brought to my attention. This co-operation has continued between the former Director of the Centre, an adviser to medical databases, and myself on the basis of personal communication.

Databases

1. CLINPSYC search made in 1994. Key words were Psychotherapy, Pharmacotherapy, Drug Treatments.
2. The Institute for the Study of Drug Dependence search made in 1995, world-wide for the last five years. Key words were Psychotherapy, Benzodiazepines.
3. The Counselling in Primary Care Trust search was made in 1996. Key words were Drug Treatment, Therapy.
4. Internet searches of the American Psychiatric Association and other web-sites using search engines 1997/8.

Journals

The journals of The British Psychological Society and The British Association for Counselling were read for papers and references from 1994 onwards.

Co-researchers

Some of the therapists who were interviewed are active researchers in the field of benzodiazepines or have written papers and they shared their work. The investigator was alert to co-researchers recommending books and articles, which were included in the search.

The uses of benzodiazepines

This group of psychotropic drugs was introduced in 1961 as a safer alternative to barbiturates, and was widely prescribed in general practice throughout the following 20 to 30 years, for the treatment of anxiety and insomnia (Medawar 1992). Twice as many women as men were prescribed them, perhaps because they were more likely than men to discuss problems with their friends, visit physicians and request drugs, (Cooperstock 1979). Physicians were more likely to offer tranquillisers to women than men with the same symptoms, and for both sexes, age and work status were correlated with their use. It was assumed that the drugs helped vulnerable people to cope better with living.

These drugs are sedatives and enhance the effect of GABA, the inhibitory neuro-transmitter. A study by Kleinknecht and Donaldson (1975) observed the effects of diazepam on reflex speed, critical flicker fusion threshold, attention and vigilance, decision making, learning and memory, and psychomotor performance. They concluded,

"in all functions except simple reflexive responding, some indications of impaired performances were reported." (p.399)

They add that there appears to be an interaction between diazepam and alcohol, (they mutually potentiate) and that diazepam made people underestimate the passage of time, and in the simulated driving test, subjects had an inability to estimate the effects of diazepam and hence compensate for its influence. At this time most studies did not investigate long-term use; subjects being given diazepam for 2 to 3 days before the tests were administered.

Outside the laboratory, unwanted effects of benzodiazepines were noted. Zisook and De Vaul (1977) identified three serious effects as dependency, hostile-aggressive feelings and behaviour, and thirdly suicidal depression. They noted that the behavioural effects are attenuated by the physician's awareness and acknowledgement of the effects. Once the patient has the information, they can make sense of their experience. However, adverse effects were frequently denied at this time, and the advantages of the drugs were considered to outweigh the risks.

Bancroft (1979) gave the indications for medication when patients present in an emotional crisis. First, benzodiazepines can be used to lower arousal, which might seriously impair the ability to solve problems or make decisions, and hence promote "coping". Second, hypnotics improve sleep and hence facilitate problem solving. Later research has challenged the myths of the benefits of "a good night's sleep" and sedation improving "coping", but these ideas are still widespread and may represent the prevailing

medical view of how drugs should be used as an adjunct to therapy (Lader et al 1992b), The British National Formulary (BMA & RPS 1998).

The effects of benzodiazepines

Priest (1980) claimed that benzodiazepines were a major advance in medicine because they were so effective in acting on anxiety and insomnia. While psychoses involved a severe distortion of reality as in delusions and hallucinations, neuroses involved normal day-to-day reactions such as obsessive-compulsive disorders, hysteria, anxiety states and depressive illnesses. He points out that psychotics suffer from neurotic symptoms and that benzodiazepines are rarely fatal when taken alone. Psychological dependence was acknowledged in some patients but physical dependence was thought to be rare.

The report of The Committee of the Review of Medicines (1980) considered the efficacy for indications other than anxiety and insomnia, long-term efficacy in all indications, residual effects particularly day-time sedation, possible dependence potential, withdrawal symptoms, implications of differing properties for clinical practice and their use with the elderly. The use of benzodiazepines as anticonvulsants, muscle relaxants, or as pre-medication in surgery is accepted medical use.

It concluded that there was no difference between anxiolytics and hypnotics in efficacy, few beneficial effects after 4 months of continuous use and recommended that their prescription be limited to short-term use. It also recommended that benzodiazepines should be withdrawn gradually, a recommendation which continued to be ignored during the 1980's when concern about dependence precipitated much abrupt withdrawal by both patients and physicians.

Dependence has been the main objection to benzodiazepines within medicine and little attention was paid to the view that the assumptions behind prescribing needed to be reviewed. Koumjian (1981) pointed out that drug treatment of anxiety redefines social problems as medical problems, and by providing a treatment for symptoms of stress, it discourages attempts to change society, which might be a more appropriate strategy. The attitudes and beliefs, which support the medicalisation of anxiety, are firstly the individualisation of anxiety, secondly a reductional view of non-specific or psychosomatic symptoms and thirdly a belief that diazepam reduces anxiety. Psychotherapy might be construed as a form of social control also, but with the emphasis on an internal rather than external locus of control, it could be viewed as a form of taking responsibility or self-control.

The effects of diazepam		
Tolerance	Addiction	Drowsiness
Slurred speech	Spotty memory	Muscular inco-ordination
Excitement	Hostility	Hallucinations
Delusions	Depressed Feelings	Suicidal ideas
Headache	Dizziness	Decreased Libido
Dry mouth	Constipation	Slow Urination
The withdrawal symptoms of diazepam		
Anxiety	Depression	Tremors
Sweating	Cramps	Dizziness
Nausea	Vomiting	Weakness
Seizures	Paranoia	Panic
Psychosis		

Table 3.1. (Koumjian 1981)

It is clear that cognitive, affective and behavioural effects of benzodiazepines were noted both with their use and in withdrawal.

Much of the research interest from 1980 onward focussed around withdrawal phenomena but throws light on how people are affected by benzodiazepines. Petursson and Lader (1981) withdrew benzodiazepines from 16 long-term users and all showed symptoms of anxiety, dysphoria, and some showed affective and perceptual changes. Attempts to assist withdrawal by prescribing propanolol (Tyrer et al 1981) show that the propanolol did not affect the drop-out rate perhaps because it does not attenuate psychological symptoms. Increasingly, people became aware that benzodiazepines caused anxiety (Morgan & Oswald 1982).

Schopf (1983) identified withdrawal phenomena of anxiety, dysphoria and disturbances of sensory perceptions, and recommended that benzodiazepines should be restricted to patients in whom non-medical methods have failed. Realistically, at this time, non-medical methods had barely been tried. Again, perceptual changes were noted by Tyrer et al (1983) who withdrew 41 outpatients from diazepam over 3 months. They also comment on passive-dependent traits in patients as if these might belong to the patient but now can be seen to be just as likely to have been an effect of benzodiazepines.

Alternative treatments for anxiety were combined in a number of studies (Cormack & Sinnott 1983, Ashton 1984) where the emphasis was on finding successful strategies for withdrawal and a reduction of symptoms. Gradually the prescribing of benzodiazepines was discouraged from 3.1% of the population taking them for more than 12 months (Balter et al 1984). This gives an estimate of 1.5 million people who were long-term users in 1984, after the Committee on the Review of Medicines (1980) had recommended use be restricted to the short-term. Furthermore, it was not efficacy,

which was leading to continued use, but perhaps people's physical and psychological dependence on drugs.

While Medawar (1984) was pointing out that all benzodiazepines sedate and that is how they treat anxiety, he also points out that "there can be no such thing as a non-sedating sedative - an anti-anxiety agent which does not in some way impair alertness". (p.123) The work, which made a significant impact, was Ashton's (1984) paper which made the point that chronic use was associated with adverse effects and which described a withdrawal syndrome including perceptual distortion, paranoia, depersonalisation, visual disturbance, and other physical symptoms.

These adverse effects were unreality and depersonalisation, poor memory and concentration, perceptual distortions, hallucinations, obsessions, paranoid thoughts. "Symptoms of prolonged use are said to include loss of concentration and memory, decline in psychomotor performance, depression and emotional anaesthesia." (p.1139) "Several patients remarked that they could not cry." (p.1138)

Behavioural effects include agoraphobia, being withdrawn, passivity, lethargy, reduced social activity and avoidance. "Eleven of the twelve patients developed agoraphobia while taking benzodiazepines. Six were completely unable to go out of the house alone and others had to overcome feelings of panic to do so." (p.1138) The emotional effects include blocking, panic, fatigue, depression, excitability, phobias, rage and craving.

Other withdrawal studies identified cognitive and affective effects of benzodiazepines. Busto et al (1986) studied 163 patients who were referred taking benzodiazepines. Of

those taking only benzodiazepines (N=92), 16% reported problems such as memory impairment. Presumably the others were not aware that their memory was impaired. Hamlin (1988) showed that the 111 patients, who were withdrawn following a psychological treatment, had very high levels of both anxiety and depression following chronic use. These high levels only reduced as the benzodiazepines were reduced suggesting that the drugs had a blocking effect on the therapy.

Studies, which investigated the effects of benzodiazepines on cognitive and affective functioning, confirm the findings of withdrawal studies. Angus and Romney (1984) found that patients taking routine doses of diazepam for a minimum of 5 days did more poorly on both short-term and long-term memory tests than they had done prior to medication. Short-term memory was most severely affected.

They warn against combining psychotherapy and minor tranquillisers because of the growing body of evidence that diazepam does impair memory. Its use as an adjunct to therapies emphasising learning should be reconsidered, since diazepam slows down the very learning that is supposed to take place.

Mac et al (1985) tested the effect of lorazepam on memory in a double-blind study and showed that recall was reduced 2 hours after ingestion. Lister (1985) showed that the greatest effect was on long-term episodic memory, which would mean an impairment in the acquisition of new information. The amnesia is related to the sedative effects. Patients suffering from learning impairments may not be aware of their deficits. Although patients perceive the sedative effect, they rate their mental abilities no differently after than before drug administration.

Similar points about the effects of benzodiazepines on therapy are made by Curran (1986) in a review of 90 studies of research on benzodiazepines and memory, only 2 of which studied a patient population. She says that anterograde amnesia, drug-induced amnesia, could impair day-to-day functioning but that "for psychotherapies which involve learning, the use of drugs which impair the patient's memory may be counter-productive" (p.180). The effects are retrograde facilitation, that is an enhancement of memory for events, which occurred prior to the use of drugs, when the drugs are withdrawn, and anterograde amnesia. "The more demands a task places on memory, the more likely the drug will affect performance" (p.196) This is likely to have implications for therapy.

Some people have suggested that the memory impairment may build up over a period of long-term use. Curran says that memory impairments were aggrevated by repeated dosing with flurazepam, suggesting that even one or two doses may have an adverse effect on memory. Three mechanisms of action are proposed: (1) impaired consolidation, (2) state-dependent learning, (3) sedation. "Remembering was a function both of the meaningfulness of what is to be remembered and the drug". (p.207) The subjective awareness of drug effects on memory show that people are unaware of impairment despite it being objectively measured.

Golombok et al (1988) showed that patients taking high doses for long periods perform poorly on tasks involving visual-spatial ability and sustained attention, compared with a group who had stopped taking and a matched group who had never taken them or who had taken them in the past short-term. They state "furthermore... they are not aware of

their reduced ability... patients who withdraw... report improved concentration and increased sensory appreciation, and only after withdrawal do they realise that they have been functioning below par" (p.373). Golombok et al cite further studies (Lader 1983), (File and Pellows 1987) as showing that cognitive functioning (the ability to learn new material) is impaired, after short-term and chronic use.

A study by Catalan et al (1988) showed that 3.6% of patients in a health centre received a script for psychotropic drugs. They were mainly elderly and female. They showed greater psychological morbidity in patients on long-term benzodiazepines and antidepressants, 43% compared to 8% of controls. Drug users 23%, had higher rates of attempted suicide, than controls, 4%. They conclude that for patients who were psychologically unwell, cognitive-behavioural treatments might have been more effective, and for those who were well, they might not have needed drugs at all.

A large (N=9003) random representative UK sample of adults (Ashton and Golding 1989) showed 4.2% of females and 2.1% males reported current use of benzodiazepines. Increased probability of use was associated with females, older age, more psychological symptoms and physical ill-health, lower socio-economic status, unemployment, current smoking, less participation in active leisure pursuits. Assuming the 18+years population is 40 million (1983 census) and 3% of the population uses benzodiazepines, there were in 1989, 1.2 million long-term users of benzodiazepines.

Ashton and Golding identified cognitive effects as difficulty in concentrating and worrying. In addition to the behavioural effect of insomnia, they commented that "the strong association between tranquilliser/hypnotic use and lack of participation in

physically active leisure pursuits was striking." Emotionally, people reported always feeling tired, boredom, lonely or under strain.

Morgan et al (1988) studied a randomly selected, nationally representative sample (N=1020) of elderly people aged 65+years and found that 16% reported using hypnotics, mostly benzodiazepines, and that a quarter of these had taken them for more than 10 years. They estimate that 10-15% of the elderly population take a hypnotic at night, that is about 0.8 to 1 million people in Britain. There has been considerable concern over the excessive use of benzodiazepines amongst older people.

Another study (Association of Community Health Councils for England and Wales 1989) has noted double vision, poor memory and concentration and mental confusion as cognitive effects. Behavioural effects were loss of control over movements, difficulty pronouncing words, impaired psychomotor performance, antisocial and aggressive behaviour, shop-lifting, outbursts of rage, violence, sexual offences and baby-battering. Emotional effects noted were a complete dulling of the emotions, suppressed feelings, inhibited or protracted grief and outbursts of rage.

Medawar (1992) in a wide-ranging review of the benzodiazepines cites The Committee on Safety of Medicines (1988) for concern about the psychological effects of benzodiazepines on adjustment to loss and bereavement. The Royal College of Psychiatrists (1987) makes the same recommendations but explain that the harm is due to memory loss. Amnesia is mentioned, as is adjustment to trauma, which may be severely inhibited by benzodiazepines. Ashton (1984) is cited both for impairment of mind,

memory and mood due to the blunting of emotions or emotional anaesthesia. Other effects relate to reduced psychomotor performance (Smiley 1987).

Medawar (1992) in discussing alternatives to benzodiazepines makes three further points, which are significant for this study. First, that the benzodiazepines are exceptional because the side-effects mimic the condition for which they are prescribed. There was a tendency to treat every-day problems and all ills. Second, "the real harm is done when this relatively high level of ignorance (of short- and long-term effects) is not reflected in drug control policies, and in marketing and **clinical practice**" (p.214) (my emphasis) Third, "of particular concern is the extent of unconscious bias; the degree of scientific illiteracy; and the overwhelming weight of over-optimistic and uncritical product assessments" (p.214)

Risse et al (1990) in a study of eight patients with combat-induced PTSD, found that the major effects of benzodiazepines was the reduction of speed of repetitive movements, impaired acquisition of new material, impaired anterograde amnesia in recall tasks and delayed retrieval. They say "The use of benzodiazepines to treat stress and bereavement reactions has suppressed traumatic memories, including those of childhood sexual abuse and previous acts of violence, that can be vividly evoked upon withdrawal many years later". (p.35)

They also believe that benzodiazepines may delay the normal PTS reaction, which might have been dealt with in counselling. Memory for information acquired pre-drug was not impaired and may even have been improved (retrograde facilitation) because of reduced interference from information acquired post-drug intake. Anterograde amnesia is

common with all benzodiazepines and since most sensitive tasks involve increased complexity, delay in recall occurs because of increased demand on memory.

Breggin (1991) states that memory dysfunction due to amnesia can interfere with psychotherapy but does not really discuss why or how. However he agrees that "brain-disabling treatments render patients less able to evaluate their own dysfunction." (p.249). Bixler et al (1991) compared triazolam, temazepam and placebo in a double-blind parallel group study, and found that triazolam was associated with next-day memory impairment and amnesia. Impairment of delayed recall was also worse in the triazolam group. Amnesia increased with continued use and intermittent use. Confusion and memory impairment were the most common manifestations while hallucinations and delusions the least.

Curran (1991) suggests that benzodiazepines would impede episodic learning in cognitive-behavioural therapy and that a client may actually forget what she/he did during a therapy session. If this were the case, it would certainly contribute negatively to outcome. She further suggests that sedative effects might lead to the client compensating by increasing their efforts. However this idea conflicts with the evidence that clients would be unaware of the sedative effects and the implications of that.

Another cognitive process, which is important in therapy, seems to be affected by benzodiazepines. It is the ability to make connections between two things and context association. People taking benzodiazepines seem to be able to hold conflicting views without being aware of it and clinical experience suggests that these clients in therapy are more difficult to paradox. Along with Curran's evidence that repeated doses do not lead

to tolerance of episodic memory impairment, these have implications for conjoint use of benzodiazepines in therapy.

Less has been available to judge the effects of benzodiazepines on mood (affect) and behaviour. However Lader (1992a) showed that diazepam decreases hostility, complaining and unusual behaviour as rated by staff. But the subjects themselves were poor at judging the extent of these adverse effects on mood and social functioning. What might seem a desirable outcome to some might represent an adverse effect to others.

Salzman (1992) lists the side-effects of benzodiazepines as sedation, dysco-ordination, altered memory and cognitive function, and affect dysregulation. Benzodiazepines can increase passivity but have a paradoxical effect of disinhibition and increased excitement. The effects on memory are listed as: acute amnesia and chronic insidious impairment, (1) acquisition (2) retention (3) consolidation (4) retrieval.

Salzman says that benzodiazepines impair memory at the consolidation stage without impairment of stages (1) and (2). He makes a further distinction between episodic memory where remembering requires active work and semantic memory which does not require active work. Benzodiazepines do not impair semantic memory but do impair episodic memory.

Curran et al (1993) make the point about the retrograde facilitation effect of benzodiazepines. In Curran et al (1994) they show that alprazolam was given to subjects for 8 weeks and 5 to 8 weeks after medication was stopped, patients' memory was still impaired (episodic memory). There was limited evidence for drug-psychotherapy

interactions but they suggest that the debate is wider than memory impairments. It also raises the question of whether exposure and relaxation constitute a wide enough or sufficient definition of "psychotherapy".

Bishop and Curran (1995) in an analysis of implicit and explicit memory, comment that although much of the sedative effects of a drug are expressed in a subject's behaviour, they may not be a part of a subject's awareness and therefore cannot be expressed explicitly. They further show that lorazepam disrupted performance on both explicit and implicit memory tasks, induced motor sedation and impaired focussed attention.

Weingartner et al (1995) showed that triazolam facilitates retrieval from memory of information presented just before administration of the drug. Bond et al (1995) confirmed clinical reports of disinhibition of aggression. The subjects' increased aggressive behaviour was not matched by increased angry feelings. They suggest that this is like the effects of alcohol and it reflects a lack of insight.

However it may be more to do with the emotional numbing of benzodiazepines cutting people off from angry feelings perhaps re-inforcing psychodynamic defences. However in the study the patients maintained that the drug calms them down. Three factors emerged in benzodiazepine-linked aggression. They were (1) it occurs in response to provocation, (2) it is recognised by others not the patients themselves, and (3) it is more likely to occur with higher doses.

Addiction and dependence

The addiction literature focuses on both the substance which is used or abused and on the treatment of the underlying problems and consequences of the drug use. Although it addresses the use of alcohol, and illegal substances, many of the drugs' effects are similar to benzodiazepines and the theoretical approach may have valid points to consider, particularly when therapy is to be combined with drug use.

Trotter (1995) writes about the treatment of adult survivors of sexual abuse, which is frequently associated with substance use both prescribed, self-prescribed and illegal. Trotter advises that in dealing with non-addicted survivors who drink or self-medicate, they should be warned they need to abstain during the course of treatment, (therapy for childhood sexual abuse) because "chemical use slows down necessary memory acquisition and interferes with affect regulation." (p.107)

Washton (1995) stresses the importance for mental health professionals in becoming familiar with substance abuse, because the use of brain modifying chemicals can severely exacerbate and complicate pre-existing mental conditions, or can induce behavioural disturbance in people with no pre-existing mental illness. Mental conditions could include psychological problems, and although it refers primarily to illegal substances or alcohol, it may be equally true for prescribed substances such as benzodiazepines. Addressing the non-specialist therapist, Washton advises them to always consider the possible involvement of substance use when assessing a patient's presenting problem.

Murphy and Khantzian (1995) in reviewing theories, which focus on a genetic marker or predisposition to substance abuse, note the importance of environmental factors. However substance abuse does not denote psychological problems but a biological system programmed to respond in a certain way to chemical agents. Indeed, these researchers suggest that the psychopathology associated with substance abuse is a consequence, not a cause, of chronic substance use, and that much of this psychopathology disappears with successful treatment; a finding consistent with many benzodiazepine withdrawal programmes.

Rawson (1995) in addressing the issue of whether psychotherapy is effective for substance abusers says little about benzodiazepine use, and effectiveness here is defined as decrease in drug use. However in addressing psychotherapy for alcohol abuse (similar to benzodiazepines in effects) Rawson makes the following points: (1) that it cannot be a passive/reflective process, (2) there must be a focus on drug use, (3) the therapist must be active/directive in promoting behaviour (drug use) change.

Rawson cites Levy (1987) on psychodynamic techniques, which require an awareness of the central nature of alcohol use on all aspects of the psychotherapeutic process. These are: (1) to be alert to dependence/withdrawal issues, (2) the use of defences such as denial and projection, (3) that giving advice is essential, particularly strategies for achieving abstinence, coping without and relapse prevention.

Levy states that because alcohol "influences all aspects of the therapeutic relationship and therapy process, any efforts to conduct psychotherapy with alcoholics without a central focus on this issue will result in an unproductive therapy experience" (Rawson

1995 p.67). This viewpoint suggests that a similar awareness might be needed for clients taking benzodiazepines.

Kaufman (1994) makes the point that "the vast majority of psychotherapists...advocate the establishment and continuation of abstinence as a prerequisite for on-going psychotherapy." (p.90) In discussing the use of benzodiazepines for anxiety and depression, he warns that they are cross-tolerant and similar to alcohol in lowering inhibitions. Kaufman does not consider the effects of sedatives on psychotherapy.

The question of whether therapy should precede or follow abstinence from benzodiazepines is addressed by Hamlin and Hammersley (1989) who advocated an integrated approach to benzodiazepine withdrawal which addressed both physical and psychological aspects of long-term use, from the perspective of the client's implicit hope of a better quality of life. Psychological therapy was used while the client was withdrawing (and still taking medication) in order to aid withdrawal. The assumption was that the underlying issues, which were identified, could be worked through later in deeper therapy aided by abstinence.

The therapeutic aim from the assessment onwards, was to challenge the tacit acceptance of medication as a valid solution to social or psychological difficulties. It particularly addressed the client's ambivalence about their drug use, challenging beliefs about long-term efficacy as well as the client's denial of responsibility for continued drug use, and projections onto the drug, the doctor or manufacturers of benzodiazepines. In this project, allowance was made for the sedative effects and psychodynamic meanings of benzodiazepines and the style of therapy adjusted accordingly.

Hammersley and Beeley (1996) raise the issues that medication and counselling are often incompatible approaches because clients need to be in touch with their symptoms as they are the means of access to the underlying problem. Medication affects the scope and depth of counselling, attributions of change can be made to the drug rather than owned by the client, and client and therapist can get "stuck" if drug effects both physical and psychological are not acknowledged. Significantly, the authors discuss the effect of medication on the therapeutic alliance, whatever the model of therapy used.

Two further projects concerned with benzodiazepine withdrawal using a psychological approach addressed problems of what therapy can achieve before and after withdrawal. Dillon (1991) used personal construct therapy with elderly long-term users, and noted that the drugs enabled them to be "how they would like to be" but at the same time prevented them from addressing the underlying cause of their intense distressing emotions. Personal construct therapy brought into awareness the meaning the pill had for the user, but insight and awareness were not sufficient for behaviour change. Those who reduced their drugs noted their thinking had become clearer.

Armstrong (1996) describes the approach of CITA, the Council for Involuntary Tranquilliser Addiction, who also make a distinction about the kind of therapy which is offered to aid withdrawal and the deeper approaches which follow abstinence. She notes that counselling is a wasted resource for those blocked off by the effects of benzodiazepine use until withdrawal takes place. Until then, it is difficult to know what

problems have been suppressed; often long-delayed grieving may take place and the true personality may emerge.

The psychodynamic perspective

In discussing counter-transference issues Kaufman (1994) describes therapists who continue to treat someone in psychotherapy who is actively dependent on drugs as over-involved and "enabling". The patient is enabled to continue drug and alcohol abuse because of a lack of confrontation. The most enabling behaviour is when doctors continue to prescribe habituating medications, to patients who are extremely skilful in these manipulations and physicians may not be aware that they are being manipulated. He describes a case history of Anita (p171) where he prescribes antidepressants out of awareness, to a drug-dependent client, as an example of therapist's splitting.

Ghodse (1995) says that the patient must use the relationship to identify and alter intra-psychic processes using techniques of insight, restructuring of belief systems and cognitive reframing. Drugs impair general awareness, the ability to concentrate and attend to the assessment interview, with impairment of short-term memory and amnesiac periods. Classic analytic psychotherapy is unsuited to drug-dependent patients because they are difficult to engage and their mental state is adversely affected.

For those dependent on sedative/hypnotics, "it has been suggested that the supportive relationship that develops between patient and therapist becomes a substitute for drug use, just as drug dependency may be a substitute for certain aspects of important interpersonal relationships." (p.172) This suggests important psychodynamic and object-relationship functions for both benzodiazepine use and psychotherapy.

Levin (1995) explores this connection further and cites Kohut (1977) in stating that the addict craves the drug because it seems capable of curing the central defect in his self, and becomes a substitute for the self-object which failed him. By ingesting the drug, he symbolically compels the mirroring self-object to soothe him. Or he compels the idealised self-object to submit to his merging into it and thus partakes of its magical power. In either case it provides him with self-esteem which he lacks, a feeling of being accepted and thus self-confidence. Or he creates an experience of merger with a source of power and feels stronger and more worthwhile.

The effects of the drug are therefore to increase the feeling of being alive or a certainty that he exists in the world. But tragically these attempts cannot succeed since no psychic structure is built and the defect in the self remains. In therapy, the patient's transference to the drug is replaced by transference to the therapist, and that transference unlike the one to the drug, is used to promote growth. Clearly the benzodiazepine-taking client's transferences (that is the unconscious hopes, desires and fears) to their drugs and to their therapist require examination.

The meaning of client's transference to their drugs may be contained in the images and metaphors which clients use to describe their tranquillisers and tranquilliser use. Montague (1991) reviews work done in this field (Helman 1981), (Lennard and Cooperstock 1980), (Montague 1988a), (Montague 1988b), (Morgan 1983), (Rhodes 1984), (Szasz 1974), and lists metaphors of both tranquillisers and their use:

Tranquillisers as:	**Tranquilliser use as:**
magic bullet / placebo	vacation/break/escape
tool/vehicle/computer programme	artificial paradise
passport/ ticket	moral weakness
pacifier/consoler/comforter	normal daily event
helper/missing mate/friend	(afternoon tea)
enslaver/straitjacket	military mobilisation
crutch/prop/support/band-aid	turkish bath/relaxing setting
lock/vice/prison	Social image
Life-line/life enhancer	Social control
Stand-by/ security	Fog/barrier/imprisonment
Resource	Evil necessity
Food/fuel/tonic	Plague/scourge
hero/army/police	Zombification

Table 3.2. (Montague 1991 p.54)

Barkin (1978) defines Winnicott's (1971, 1986) concept of transitional object as what mothers allow and expect their infants to become "addicted" to, the first not-me possession, an attachment. The nature of the transitional object, he says, is related to its origins in the early stages of life, that is oral eroticism. It "represents the idealised maternal imago or part object breast and the mother's supportive tension-regulating functions". (p.527) One of the paradoxes in the functioning of the TO is that it promotes autonomy while re-establishing symbiosis; the symbiosis with the therapist may promote autonomy but attachment to a drug of dependence as TO clearly does not.

Levy (1993) sees medication as a means to separate from symbiotic relatedness on the part of the client and it also satisfies the regressive yearnings of the therapist. He states, "Whenever medications are used during psychotherapy, their meaning and usefulness to patient and therapist must be continuously scrutinised to prevent medications becoming a vehicle for the unconscious avoidance of the therapeutic task". (p.200)

Hausner (1993) identifies three dynamics in the patient's transference to the drug, the soothing effect, the placebo effect, and compliance. The patient-therapist relationship recapitulates the original dyad in object relations theory and therefore the medication is the transitional object which marks the interface or border between them. Hausner's work like Levy's assumes that the therapist is also the prescriber.

He goes on to explore the doctor/therapist's countertransferences as:

(1) the doctor identifies with the anxiety in the patient, prescribes and feels soothed,

(2) the doctor fears loss of control if the patient is disturbed, regressed or distressed,

(3) the fear that something terrible might happen,

(4) the means of maintaining a union,

(5) means of distancing the patient / demarcation of boundaries,

(6) a defence against intrusion / symbiosis,

(7) emotionally disengaging from the patient, and

(8) to mollify the patient to reduce the labour of the therapeutic task.

"When the therapist.... substitutes a potential transitional object (medication) for the object itself (himself or herself), the source of well-being and security may become

invested in the medication, with attendant displacement, distortion, and potential undermining of the therapeutic process itself". (Hausner 1993 p.104)

Nevins (1993) points to the psychological meaning of medication as

(1) a sanction of punishment for misdeeds,

(2) confirmation of deficiency and inferiority,

(3) the assumption of another burden,

(4) a sign of personal powerlessness and helplessness,

(5) re-inforcement of passive tendencies,

(6) a pardon,

(7) concrete embodiment of hope and support,

(8) flight,

(9) replacement of human relationships.

He sees the medical countertransference, the preference for "organic" above psychological medicine, as being about the preference for a dead patient rather than a live one. He identifies three types of intervention as firstly, suggestion: the symptom is an invading enemy to be expunged in battle; hypotheses, which the physician uses, are experienced as unquestioned truth (literalism). Examples include: drugs correct disturbances in brain chemistry, chemicals make connections work better, ...find their way to receptor where they fit, blocking off... analogies with a diabetic's need for insulin.

The second type of intervention is manipulation, which uses the emotional systems existing in the patient to remove obstructive trends: a conviction that something wrong has happened and reparation is necessary. The third type of intervention, inexact

interpretations, conveys to the patient that biologic mechanisms provide the exclusive explanation of symptoms and treatments: you can see I am blind; I don't know what is the matter with you; go and be likewise; how could you know what is the matter with you?

Goldhamer (1993) says that on the one hand the patient may have fantasies of being poisoned, manipulated, coerced or seduced by the omnipotent parent-doctor, while on the other side is a desire for a magical cure. The patient wants to be loved and understood as a dependent child and the medication is a gift signalling concern and understanding of the patient's suffering. The gift may provoke ambivalent feelings of being dismissed or rejected as too sick to control his own behaviour, and the pills are an alternative to listening to him.

He lists ten therapist (doctor) issues as:

(1) inability to tolerate the slow pace of therapy,

(2) need to prove omnipotence,

(3) inability to tolerate sameness and anger,

(4) treatment for therapist's anxiety,

(5) frustration at passive role in therapy,

(6) desire to be active,

(7) assertion of authority,

(8) expression of desire to please the patient,

(9) desire to be loved and admired,

(10) alternative to time and attention.

He gives as an example of the desire to be active:

"This is illustrated in the well-known phenomenon of the physician who listens to his patient's somatic complaints, cannot make a diagnosis of a physical illness, but feels he must do something for the patient, and so prescribes a tranquilliser." (p.219)

Block (1979) noted that the chronic neurotic was often prescribed benzodiazepines, whose pharmacological value are dubious, but that the symbolic value is to serve as a bridge (transitional object) between therapist and patient as a tangible reflection of the therapist's interest and caring. Block (1979) comments that "such a basis for prescribing drugs is obviously not sound..." (p.209) but it perhaps illuminates the dynamics of the doctor / patient relationship and therapists' reluctance to challenge or sever the bridge, when the roles are split.

Comparing therapy and medication

Chouinard et al (1982) described a double-blind controlled study of 50 patients with generalised anxiety or panic attacks lasting 8 weeks. Alprazolam was compared with placebo, and 18 patients received short-term behaviour therapy from week 5. The findings show that alprazolam controls symptoms better than placebo and behaviour therapy was not shown to make any significant difference.

The Nottingham study of neurotic disorder (Tyrer & Murphy 1988) compared diazepam, dothiepin, placebo, cognitive-behavioural therapy and self-help given for 6 weeks and withdrawn for 10 weeks, and concludes that diazepam was less effective than dothiepin, cognitive-behaviour therapy and self-help. It also comments that "simple" counselling is as effective as drug treatment, without apparently including counselling in the research design.

There are several studies (Lindsay et al 1987), (Power et al 1989), (Power et al 1990) which show that cognitive therapy is more effective and longer-lasting than benzodiazepines in the treatment of generalised anxiety disorder. Lindsay et al (1987) found lorazepam produced a more rapid initial response than did CBT, but that patients treated with medication were reluctant to stop and were particularly likely to relapse when withdrawn.

Fisher and Greenberg (1989) compare psychosocial and drug treatments in terms of outcome and conclude that psychotherapy methods are equal or superior to the outcomes obtained with medication. However they are clearly taking a different view by discussing psychological distress rather than neurotic disorders, a paradigmatic shift. In discussing cost-effectiveness they include physical and emotional costs as well as economic ones, and assert that psychotherapy does not necessarily involve a longer duration of treatment and that in the long term there is greater improvement and fewer relapses.

They highlight the difference between the two approaches by stating that psychotherapy unlike medication cannot be delivered as a contextless agent and that the active agents include the interpersonal relationship. This undermines assumptions about manualised treatment packages removing therapist variables in psychotherapy research. Perhaps the assumption that medication can be delivered in a contextless form needs to be challenged too.

Three studies, which address different aspects of benzodiazepine dependence, show that brief counselling is as effective as benzodiazepines (Hamlin 1993), or that this is so in the early stages of treatment but that as therapy progresses, the effectiveness of benzodiazepines declines whereas psychological treatment maintains (Hackman 1993). Salzman and Watsky (1993) point out that anxiety may be a signal of underlying psychic conflict and indicate the need for psychotherapeutic intervention rather than simple symptom reduction.

Combining therapy with medication

Klerman et al (1994) assume a medical model and discuss whether medication facilitates psychotherapy and note the converse possibility that medication gains efficacy only in combination with psychotherapy. They identify the negative effects of combined treatments as medication adversely affecting the psychotherapeutic relationship, medication-induced reduction of symptoms reducing motivation, and that medication undermines defences providing symptom substitution in order to maintain a balance between conflicts and defences.

On the other hand, the negative effect of therapy on medication is that therapy is unnecessary, irrelevant or at best, neutral. It says the concept of chemical imbalance has been established in the public's mind and medication is assumed to correct this. Secondly, symptoms may be aggrevated by probing and uncovering of defences. They conclude that it is not appropriate for psychotherapists to resist diagnostic classifications and pharmacotherapeutic approaches and that patients should receive treatments that have been validated by research and are appropriate to their disorders.

They warn researchers that medication has a profound impact on brain processes and psychological and neurological functions related to: sensation, perception, memory, cognition, psychomotor activity, speech and language, information processing, sleep and biological rhythms, central and peripheral autonomic nervous systems regulation and functioning, memory and other psychological and physiologic processes. This can be viewed as either a good thing or a bad thing depending on the stance taken.

Psychotherapists are warned that many patients receive a combination of medication and therapy often inadvertently, since they take them without their therapist's knowledge. This latter point is acknowledged by Sexton (1996) who comments that stuckness in the therapy is often paralleled by the patient who is "stuck" on their medication without the therapist being aware of it.

Hayward et al (1989) ask whether benzodiazepines facilitate or hinder psychological treatments, limiting their investigation to cognitive-behavioural therapy as the only form of psychological treatment. They propose theoretical arguments for facilitation in that benzodiazepines promote more rapid exposure for phobias, assuming that the concept of phobias is valid and/or useful, which it might be for CBT.

Against this they suggest that benzodiazepines may reduce motivation for psychological treatments by giving an illusion of improvement, interfere with the development of tolerance to stress, make state-dependent learning difficult to generalise, promote the attribution of improvement to the drugs, and patients may forget what they have learned in sessions. It may be useful to see what evidence exists to back up any of these theories.

Rosin and Köhler (1991) in exploring psychodynamic aspects of psychopharmacology suggest that drugs reduce the intensity and alter the quality of the observation of inner and outer experience. "Unfortunately there are no reliable rules for the combination of psychotherapy and psychiatric pharmacotherapy up till now." (p.133-4) Stone and Rodenhauser (1991) surveyed 143 group psychotherapists to determine their attitude towards inclusion of medicated patients. More than two-thirds accepted them and thought that they did not interfere with the group process. They did not consider whether medication affected the effectiveness of the group treatment for the patient.

Kahn (1993) suggests that most research assumes that psychotherapy and drugs work additively on different aspects of illness, psychotherapy for social functioning and medication for abnormal mood and thought content. It is probably a widely held view, which would explain how medication and psychotherapy are so frequently combined. However it assumes that mood and thinking is abnormal and not related to the rest of psychological functioning.

Kahn refers to the Boston-New Haven Collaborative Study of Depression which tested the hierarchical view that psychotherapy is superior to drugs. Four negative hypotheses are identified: (1) that drugs are a negative placebo, increasing dependency and prolonging psychopathology, (2) that drug relief of symptoms could reduce motivation for therapy, (3) that drugs could eliminate one symptom but create others by substitution if underlying conflicts remain intact, and (4) that drugs could decrease self-esteem by suggesting people are not interesting enough or not suited to, or capable of, insight-oriented work.

Schachter (1993) from a medical /psychiatric and analytic perspective, looks at the treatment of patients with severe depression, psychosis and mania. Most authors consider that psychotherapy and medication can be combined to allow psychotherapy and give examples of using drugs sensitively and intermittently to support extreme distress and symptoms, reducing the drugs to allow therapy.

Five points are not addressed. Firstly and quite commonly, the authors fail to distinguish between one group of drugs and another and treat them all the same when clearly they are not. Secondly the authors still hold an underlying disease model which undermines a psychoanalytic understanding. Thirdly, none consider the direct effects of the drugs only the transferential and counter-transferential issues, and there are direct effect as the previous literature shows.

The fourth point is that enhanced therapeutic accessibility with antidepressants which occurs with severely depressed patients is seized upon, whereas decreased therapeutic accessibility is largely unnoticed and ignored or ascribed to the "illness". Lastly, if analysis fails, there is a tendency to resort to medication for symptom control, rather than considering other forms or styles of therapy.

Ostow (1993) recognises the two treatment modalities and defines them essentially as psychosis needing medication and neuroses needing psychotherapy. He then describes two situations where he advocates combining treatments: (1) treating depression with antidepressants and following soon with psychotherapy, and (2) for the control of excessive affect in borderline, manic and attention deficit disorder patients.

He notices that the patients display rigidity in analysis, that the analytic process is affected, nominal compliance, superficial insight and limited behaviour change with combined treatment patients. He suggests that medication seems to affect the depth at which therapy operates. He is surprised by this but offers no explanation.

Recent developments in offering counselling in general practice have raised a question about whether access to counselling reduces psychotropic prescribing rates. Of course one is offered to patients and the other is behaviour of doctors so no relationship might exist. Fletcher et al (1995) compared psychotropic prescribing rates between practices which employed counsellors on-site and those who referred for counselling elsewhere. Lower levels of psychotropic prescribing were found in those practices which referred elsewhere, suggesting that accessibility of on-site counselling does not reduce prescribing rates, and the authors conclude that attention needs to be addressed to the attitudes and perceptions of the doctors.

A similar study (Sibbald et al 1996) found no difference in prescribing rates between practices with and without counsellors, except that practices with counsellors prescribe more costly non-CNS drugs than those without. Possible explanations suggest numbers are so small as to show no significant difference, or that counselling is used as an adjunct to prescribing, or the quality of the counselling may not be high. It could also be related to doctor's counter-transference issues such as feeling threatened or inadequate.

Therapy alone

Roth and Fonagy (1996) reviewed psychotherapy research and concluded that for the treatment of anxiety disorders, (1) psychological treatments produce highest effects

followed by combinations, (2) antidepressants alone have a higher effect than benzodiazepines alone, (3) benzodiazepines alone have only short-term effects, (4) few studies give follow-up data, (5) discuss the possibility that benzodiazepines interfere with state-dependent learning.

They comment on the poor quality of the research into counselling, which includes social work, being seen by a psychiatrist, non-directive counselling, problem-oriented counselling. Counsellors included psychiatrists, social workers, physicians, psychiatric nurses, nurse practitioners, and health visitors with 3 weeks training. Only three studies (Holden et al 1989), (Klerman et al 1987), (Raphael 1977) show improvement, that is efficacy of counselling over controls.

Roth and Fonagy suggest that Holden's study which used health visitors as counsellors was effective because it was with a specific client group, women depressed after the birth of a child. It could also have been effective because the counselling addressed the underlying issue of what the depression was about. Klerman et al used a specific therapeutic approach, albeit with untrained but supervised nurses, and success was measured by reduction of symptoms. Raphael (1977) studied bereaved patients using trained therapists and psychodynamic/exploratory therapy focussed on bereavement. At 13 months follow-up 77% of counselled patients had good outcomes compared to 41% of controls.

Parry (1996) in a review of NHS psychotherapy services states that the clinical effectiveness of therapy depends on the capacity of the patient to engage in a therapeutic alliance, and that where that capacity is reduced, the skill level of the therapist is most

crucial. Secondly, that there is a need for research on the effectiveness of psychoanalytic therapies including the need for valid and reliable technologies to measure psychodynamic aspects of change in addition to symptoms and behaviour change.

Thirdly, most outcome research is based on a comparison of two forms of treatment and its apparent simplicity can mask the complexity of variables, which determine outcome such as the capacity to form a therapeutic alliance. Fourth, clinical consensus is seen as a valid research measure. Fifth, it concurs with Roth and Fonagy that there is little evidence to support the effectiveness of counselling in primary care despite high user satisfaction. Sixth, that for all therapies, short-term symptomatic relief is not a significant measure of improvement. Seventh, people with neurotic disorders are not effectively treated by medication and counselling; they need eclectic and formal psychotherapies. Benzodiazepines in combination with psychological treatments add little to efficacy and may reduce the impact of psychological treatment. Finally, "Psychotherapy is not well understood by professionals in psychiatry and medicine generally...the culture of symptom suppression and containment affects the approach of all those professionally involved and is likely to spill over to the wider public". (p.95)

Gutheil (1982) comments that in understanding the use of medication in a psychotherapeutic context, it is necessary to explore the doctor-patient relationship. The psychiatrist has an authoritarian attitude and an enhanced belief in the biological-medical heritage, while the patient becomes dependent, reliant on magical thinking, and assumes a passive compliant role as in other fields of medicine. An authoritarian attitude sees medication as concrete, specific, precise and straightforward, what Gutheil calls "The delusion of precision." (p.322)

A small study of patients using benzodiazepines after bereavement (Warner and King 1997) sent a brief multiple-choice questionnaire to 132 bereaved next-of-kin of patients who died in a 3 month period. Of the 109 responses, 7 had taken benzodiazepines and found them helpful. There was no consideration of the concept of helpfulness or discussion of the process of bereavement. The self-awareness of the bereaved relatives was not considered nor the effects of medication on cognition affecting responses. The authors conclude, "before we accept the view that short-term tranquillisers are not helpful in bereavement, more evidence about their efficacy is needed." (p.15)

Karasu (1982) explores the possibility of an integrative model for psychotherapy and pharmacotherapy, focussing on differential efficacy, the methodological problems inherent in this and the therapeutic process of how each works. He highlights the unique nature of the interpersonal relationship between therapist and patient which is substantially different from the traditional physician / patient relationship in medicine.

In suggesting a model that puts psychotherapy at the end of treating neuroses rather than psychoses, he comments on how drugs affect therapeutic process. He suggests that drugs confound therapeutic transference, reduce the ability to respond affectively to psychotherapy explanations, that they unwittingly mask feelings necessary for the resolution of conflicts and undercut the need to suffer through re-eliciting of repressed events.

Psychotherapy literature

Balint's (1964) research project on doctors doing psychotherapy identifies some of the dynamics present in the doctor / patient relationship. He refers to the "collusion of anonymity" in referring to a specialist which increases the doctor's confidence in himself and the patient's confidence in the doctor. The giving of advice, reassurance and sometimes prescribing all make the doctor feel better, useful and helpful.

Guntrip (1971) makes the point that Freud saw a medical training as far from the best for understanding human beings. Psychiatry looks for the physical causes of psychological problems and treats them like any other illness. The situation is worsened because doctors are not denied an approach to the field of neurosis, but have a false and positively harmful attitude towards it.

Guntrip allows that more psychiatrists today look for psychological causes of emotional "illness" but reports one of his patients with an anxiety attack discharged as "absolutely nothing wrong" which could not have occurred if her life history had been considered. He sees Freud's failure to abandon the traditional assumptions of science as leading to the confused and illegitimate mixture of biology and psychodynamics.

Szasz (1972) suggests that the notion of mental illness is used chiefly to obscure and explain away problems in personal and social relationships. He says that psychiatry is a science defined by its subject matter, mental illness, and if there is no such thing as mental illness, what then? Szasz challenges some of the false assumptions such as neurosis, disease and treatment and lays the foundation for a process-theory of personal conduct. He says that a scientist is most properly understood by what he does. He

suggests that psychiatrists categorise symptoms and then remove them as if they had no meaning.

Frank (1979) explores the nature of psychotherapy and says it is concerned with the content of the symptoms and their meaning for the patient's life. He stresses the primacy of communication as the medium of healing which depends more on the personal influence of the therapist than medical and surgical procedures. Therefore, he says, the personality of the therapist is crucial to psychotherapy and has to be fully experienced by the patient.

Orlinsky et al (1994) regard the quality of the patient's participation in therapy as the most important determinant of outcome. The therapeutic bond, especially as perceived by the patient is importantly involved in mediating process-outcome links. Orlinsky differentiates between those process variables, which are associated with outcome and those, which are not and clearly identifies the quality of the therapeutic relationship as central.

An example of the way in which counselling can be discounted in order to promote the superiority of drugs shows how traditional attitudes still hold sway in medicine. Priest et al (1996) report on the results of an opinion poll for the defeat depression campaign. Of 2003 people interviewed in 143 locations in Britain, 91% thought that depressed people should be offered counselling, whereas 16% thought people should be given antidepressants. The authors do not mention counselling in the list of "key messages" arising from the study but focus on the need to educate the public on the benefits of pharmacological treatments.

Smail (1996) in exploring what makes change possible draws attention to the conventional psychiatric approach, that recognising that distress is expressed through our bodies, it makes sense therefore to interfere directly at this level by changing our embodiment. That may seem fair enough, but it is the investigative side of psychotherapy that reveals that people's problems have their origin in past and present relationships and experiences in the world around them, which may be stored in their memories, rather than originating in their bodies. "Physical treatments are acceptable in the same way that having a drink when you feel down is acceptable, but taken as solutions to life's problems they are unsatisfactory in the same way that staying permanently drunk would be." (p.9)

Loose (1998) challenges the disease model of addictions because there is no scientific or clinical evidence that the concept is valid. It is part of a belief system supported by addicts, experts and the public and although the concept is an illusion, it is sometimes a useful one. Loose states that in medical discourse, symptoms represent a disease, so treating a symptom may sometimes mean treating a disease, but this is not always a sufficient approach to treating addictions.

However psychoanalysis (psychotherapy) is based on a subjective narrative or truth. Psychotherapy is not about a disease but about human subjects. When the subjective element of the cause of the suffering has been eliminated, then the symptoms can disperse. This is a fundamental difference between these two different discourses of meaning.

Mahrer (1998) makes a very critical analysis of psychotherapy in a list of eleven embarrassing problems for psychotherapy. Point ten is that research makes virtually no difference to the field of practice. Perhaps recent trends in counselling psychology to integrate research with practice will help that particular embarrassing problem to be addressed. Research needs to influence practice as much as practice needs to inform research and its methodology.

Mahrer's eleventh point refers to the problem that psychotherapy rests on a foundation of absolute truths: mental illness, biological basis of psychological variables, success strengthens responses, brain determines behaviour, universal basic needs, therapists diagnose and then apply a treatment, the relationship is the pre-requisite for change, clients seek relief of problems and distress. These "absolute truths" are some of the assumptions, which underpin both psychiatry and psychotherapy. Each side may feel more comfortable with some rather than others; it is not safe to assume that their assumptions are the same.

A critique

While random controlled trials were an appropriate way to determine the effects of benzodiazepines, this methodology has its limitations. In addition to problems raised in the previous chapter, the research shows there was a considerable interest in cognitive effects but under-reporting of affective, behavioural and relatedness effects. This reflects the researchers' assumptions that they were only looking for adverse effects, as they would have defined them. After all people were taking benzodiazepines to change their mood; that was what was desired. Since the researchers were not aware of their

relationship with their "subjects", how the subjects related to others might not be considered important.

"Dedicated researchers in every field tend to find what they are seeking in order to confirm their theories..." (McDougall 1995, p235). If people only see what is important to them to see, then what appears unimportant is important in order to disconfirm our cherished theories. This applies to me as much as other researchers. Again, the starting point of this research has been that in human experience, reality is subjectively constructed.

The fact that subjects were unaware of some of the effects benzodiazepines were having on them adds another level and dimension to the parallel processes of "unknowing". Incorrect attributions, confusion between what is a drug effect and what is a symptom or the underlying problem have been legion in this field. Dependence potential was at first denied and is now thought by some to be the only problem, or possibly to do with the patient's personality. Most of these studies would have been relying on the subject's subjective experience of the effects of the drugs (symptoms and side effects) to report them. Quantifying this data later lends a spurious objectivity.

Secondly, what is a wanted effect for one person is an unwanted effect for another. There are really no such things as "side-effects". What is wanted in the doctor's surgery may be unwanted in the therapists consulting room, because they have different objectives and ways of working (Hammersley 1995). Failure to recognise this different viewpoint leads each side to be frustrated by the ignorance and intransigence of the

other. This study is not about a comparison between two models; it is exploring the views of psychotherapists about the psychotherapeutic process.

The addiction literature relies heavily on the domain of illegal drug and alcohol use, where rapid and early abstinence is achievable if therapeutically costly. There is a tendency to focus on abstinence as the objective rather than the underlying psychotherapeutic issues, if they are acknowledged at all. This is not advised with benzodiazepine dependence and therapists may have to allow for drug effects for months or years through the early stages of therapy. However therapists in the addiction field do have a lot of experience of working with clients who use a substance and can frequently discriminate between what is the drug and what is the client. In this field at least, the drugs are not ignored.

Psychodynamic issues are not acknowledged by all therapists but that does not mean that they do not exist in every session, just as they do in every medical consultation too. Much of the literature reviewed here originates in the United States of America where the therapist is also the prescriber. Translating this to a United Kingdom context where the roles are frequently separated may help to make the issues more visible. Alternatively, the joint role allows medical therapists to challenge themselves about their real motives and recognise the different paradigms they have to bridge.

The literature on comparisons between and combinations of benzodiazepines and therapy is of limited value because of the different paradigms. It does not make sense to assume that all therapy must last for a fixed period of time, be a once-for-all event, be measured by symptom reduction when that is not considered a valid objective of therapy and so

forth. Most studies use cognitive behavioural therapy, for psychiatrically defined groups, who are seen as homogenous, and ignore the quality of the therapeutic alliance. It is the methodology of the random controlled trial applied inappropriately.

Finally, the therapeutic literature is still struggling to define what therapy is, let alone how it works. The outcome studies show surprisingly good results considering untrained counsellors, poorly defined goals and the short-term nature of it. Yet studies in general practice, with well-trained counsellors do not seem to have demonstrated their effectiveness as alternatives to prescribing. Is that because doctors do not trust counselling or because of a lack of awareness of the psychodynamics of prescribing? Client surveys for counselling show high satisfaction among clients (Seligman 1995) but the view that counselling is therefore effective may be as unreliable as the studies on benzodiazepine efficacy. Perhaps a case of finding what you are looking for.

CHAPTER 4

THE SURVEY

Aims and objectives

In view of the fact that there is very little research evidence reported in the relevant literature which is directly about the effects of benzodiazepines on clients in psychotherapy, much has been indirectly inferred from addiction, psychotherapy and medical literature which mentions the issue in passing. An additional source of information might therefore be what psychotherapy practitioners in the field actually do or purport to do and their reasons. As this was to be a survey of limited scope at an organisation level, the field of investigation chosen was National Health Service psychotherapy services in England. The Health Service setting was important because firstly, it was assumed that practitioners would be more likely to be aware of benzodiazepine prescribing guidelines and limitations of the drugs' effectiveness, and secondly it was assumed that statutory services would be more likely to have established formal or informal policies for admission to psychotherapy.

The survey was not intended to be a representative sample since that would be beyond the scope of this research, but rather to give an indication of opinion and practice across a broad area geographically, across disciplines and across therapeutic orientations. It would therefore provide a background of knowledge, attitudes and practice for more in-depth investigation with individual psychotherapists. Also it was hoped that the survey might identify individuals who were willing to take part, in the interviews to follow.

Method

Selecting NHS services

The Midlands Health Point information service provided lists of NHS organisations, using "psychotherapy" and "mental health" as search words. It was clear that "psychotherapy" as a selector provided a more appropriate list of organisations and this word was used in subsequent searches. The Midlands service provided addresses and telephone contacts for the other seven regional health information services. All eight regions supplied lists of psychotherapy services.

The term "psychotherapy" is used in the NHS to refer to a wide range of services of a psychological nature. In some settings, the title of psychotherapist is reserved for analytically trained psychiatrists, and in others it is used generically for all practitioners of broadly psychological therapy of whatever training, with many variations in between. Some entries on lists indicated what kind of therapy was offered but not by whom, others provided less information.

Selection of survey participants

The list of agencies varied considerably in length and scope and because the task of writing to them all would be too expensive and time consuming, I decided that it would be more useful to target the agencies that might provide information about policies by making a selection. My selection of the services to be included in the survey was inevitably arbitrary, but I chose to include all those agencies which were eligible because they stated that they offered counselling and/or psychotherapy. Those agencies describing their services primarily as behaviour modification, psycho-educational groups

or social skills training were excluded. My reason for this was my assumption that benzodiazepines are more likely to interfere with the process of the former treatment than the latter. In addition, I was interested in exploring the psychotherapeutic process and hoped that some survey participants might agree to be interviewed, so I was looking for therapists who would fulfil the selection criteria for interviewees.

The selection was also influenced by the fact that the list for London and the south east of England was much longer but less detailed. Where the London/south east list gave lists of hospitals without any details about the unit, services offered, or addresses, they were not included. A more representative sample would have included more London based services but this was not intended to be a representative sample in that way. Instead, I chose a similar number of services from each of the eight NHS regions in order to get a country-wide perspective. In total, thirty-nine services were selected.

The questionnaire

The questionnaire (Appendix 3) was designed to elicit as high a degree of response as possible by being short and clear with respondents required to tick boxes for their replies. The questionnaire left space for further comments. It was sent to the clinical director of the service, with a covering letter (Appendix 2) and a stamped envelope for return.

There were three questions:

1. Do you have a policy about patient's or client's use of benzodiazepines or similar drugs, whilst engaged in psychotherapy?
2. Could you describe the policy briefly? (or enclose a copy if you prefer)
3. Could you give the rationale behind your policy or no policy?

Results

Number of Questionnaires sent out	39
Replies received	22
Response rate	56%

Discussion

The majority of services that replied did not have a policy and of those that did, it was a fairly informal one. Much seems to be left to the discretion of the therapist to raise the issue with the client, supervisor or prescriber. If it is assumed that the client and prescriber might be less aware of the importance of client accessibility to the therapeutic process, much depends on the therapist's knowledge and willingness to share it.

The therapists might acquire knowledge through training but the subject of counselling and therapy with clients on medication has only recently appeared in advanced counselling courses, for example those sponsored by the Counselling in Primary Care Trust. Much therapeutic work in the NHS is unsupervised because it is not a requirement for psychotherapists of every professional background and would also be limited by the initial training of the supervisor not having included the topic. It could be considered a specialist area but is not one recognised by many psychotherapy services.

Responses to questionnaire

Question 1: Do you have a policy?	
Yes (2 informal)	5
No	16
Policy decided elsewhere	1
Question 2: What is your policy? (Analysed by response to Qu.1.)	
Policy is decided elsewhere (N=1)	
It is decided on an individual basis in supervision	
Benzodiazepines are reduced or withdrawn in conjunction with a consultant psychiatrist for practical reasons	
Yes, we have a policy (N=5)	
It is negotiated individually by the therapist	2
Benzodiazepines are reduced or withdrawn	2
It is discussed with the referrer or prescriber	1
No, we do not have a policy (N=16)	
It is at the discretion of the therapist	7
It has not been considered	2
We do not influence prescribing	1
We may develop guidelines	1
Left blank	5
Question 3: What is the rationale?	
Yes Responses	
Professional boundaries	1
Psychotherapy model	1
Use antidepressants / refer to specialist services	1
Believe the two approaches are incompatible	1

Table 4.1.

Question 3: What is the rationale? (continued)
Other Comments
Reducing or withdrawing benzodiazepines might be a goal of therapy but only if set by the client. We would be concerned about accepting a client for therapy if the thinking was severely affected by medication. With our highly dysfunctional patients, rigid, inflexible policies are not realistic. For some patients, the two approaches would be incompatible; for others it may help contain them in therapy. Practical issues of how much control we have over prescribers.
No Responses
Those taking benzodiazepines are still disabled by their symptoms. One patient in 5 years needs benzodiazepines long-term. Combing the approaches increases the benefit - GP or psychiatrist managed the medication. We do not influence medication. The two are complimentary approaches. There is no good evidence that benzodiazepines interfere with therapy in general, but there are some individual cases where it seems clear they do. We would not insist on withdrawal before being offered psychotherapy. Benzodiazepines are helpful in the short-term but we hope they stop taking them during therapy. We take an interest in medication before starting psychotherapy, but decide on an individual basis. We discuss appropriateness of the referral and may wait for the client to stop taking drugs or work with them while on. Psychiatrists are trying to wean people off. Heavy use of benzodiazepines would certainly impede progress and may be a contra-indication to treatment (i.e.psychotherapy). It needs to be actively addressed at the beginning as potentially destructive and against understanding. I promote discussion of drug use. Benzodiazepines have widespread inhibitory effects and influence memory and thinking. It would mean having a policy on other drugs, ie. Antidepressants, alcohol, cannabis, major tranquillisers etc. Combination of professional boundaries, practical issues and not having considered the matter. A policy has not been considered.

Table 4.2.

Some replies suggest that services cater for different populations; those with severe mental health problems and those who function better psychologically. That could account for an assumption that all clients would be receiving medication and therapeutic interventions would necessarily be more superficial. This may also account for replies that suggest that some people are helped by benzodiazepines short-term and some are helped long-term. 'Help' may refer to the suppression of symptoms, which fits a medical model.

However, assertions are made that combining approaches increases the benefit or that the two approaches are complimentary or that there is no evidence to the contrary. When a psychological model is used, evidence shows that benzodiazepines do not increase the benefit (Parry 1996). "Trials of benzodiazepines in combination with psychological treatments suggest that at best these add little to efficacy, and at worst may reduce the impact of psychological treatment" (p49).

Some replies show inconsistency such as believing that benzodiazepines are helpful but hoping the client will stop taking them. Alternatively some replies indicate a belief that benzodiazepines are a hindrance but do not actively advocate withdrawal. References to a higher authority such as psychiatry may indicate an avoidance of conflict by challenging that authority. Doing nothing may seem a safer option leaving all the responsibility to the client without compromising professional relationships for the therapist.

Practical obstacles such as difficulties of control over prescribers are not insurmountable if therapeutic outcome were seen as important enough. Presumably prescribers would

not knowingly sabotage the therapy for which they are referring their patients. It appears unusual for a NHS psychotherapy service not to address the client's use of alcohol, cannabis or major tranquillisers and therefore not to address their use of benzodiazepines.

There are clear statements by two respondents; one has a policy and sees the two approaches as incompatible because thinking is affected by medication. One consultant psychiatrist was the best informed about widespread inhibitory effects and the influence on memory and thinking. They are very much in the minority and are unusual in being proactive in discussing the issue and explaining their reasons to clients.

Questions raised by the survey

1. Why has the evidence on combining benzodiazepines and psychotherapy not become widely known and resulted in the development of policies?
2. What theory and research on medication from a psychological perspective is included in psychotherapy training courses?
3. What supervision input do therapists receive for this issue? Should more challenging supervision be required for NHS psychotherapists?
4. How can a client be expected to think critically and take responsibility for him/herself if thinking is impaired by the drug?
5. How can a client make a decision if information, opinions and advice are avoided by psychotherapists?
6. Does research in this area need to focus on process rather than outcome in order to describe and explain the interaction between benzodiazepines and psychotherapy?

7. Is there a confusion between the assumptions of the medical and psychological models?
8. Are psychotherapists in the NHS competent enough?
9. What are the therapists' (and others') transferences to benzodiazepines and to medicated clients?
10. Is there a parallel process between the avoidance of psychological distress on the part of the medicated client and the avoidance of conflict on the part of therapists in medical (NHS) settings? Both are wanting not to know, not to feel and not to do something.

Conclusions

Further research is clearly needed to address some of these issues and perhaps different ones. It seems that any further involvement of other psychotherapists should not focus exclusively on those working in NHS settings. Perhaps therapists working outside the NHS psychotherapy services, such as in general practice, addiction services and psychology departments for example, would have a range of different perspectives.

Secondly, it seems fair to assume that more can be learned from experienced psychotherapists whatever their background; they should be competent, properly trained, and supervised so that they are reflective and critical about their work, and they should all have had experience of working with clients taking benzodiazepines alone.

Thirdly, therapists who could assist the investigation further need to be able to comment on the therapeutic process, to be aware of and use the relationship or therapeutic alliance regardless of which therapeutic orientation they prefer. They need to be able to comment

on transference and counter-transference issues since these are clearly significant in explaining what occurs or does not occur in the process.

CHAPTER 5

DATA COLLECTION AND ANALYSIS

Building a sample

In practice building a sample of therapists and devising an interview format go together, so I chose to ask a therapist I knew if she would be my first interviewee and I could pilot the interview with her. This had the advantage that I felt less nervous with someone I already had a degree of rapport with and I felt that if the interview went wrong in any way or I didn't get useful material I could go back and try again. She agreed to ask her colleagues in her team and another mental health team if they would be willing to be interviewed. I intended to use a snowball technique amongst other methods to develop networks and find a variety of different participants that way.

I used a mixed strategy for extending the sample, in the early stages casting the net as widely as possible, and later looking for omissions and being active in seeking participants with different backgrounds or settings. The interviews all took place over a period of one year. My course director offered to put up a notice in the School, circulate details at a conference he was attending, to mention it in the newsletter and gave me the names of two people who worked as psychotherapists in psychiatric settings. One of those agreed to take part and found a colleague who also participated. The other psychotherapist did not take part because he did not fulfil the criteria of having experience of working with clients taking benzodiazepines, but he gave me the name of the consultant psychiatrist who ran the clinic

he worked in. I wrote to her hoping that she would offer to be interviewed or ask her colleagues but she declined.

I was an associate member of a psychology department, so I wrote to the Head of Psychology who agreed to circulate a letter to all the psychologists in the service, which produced several responses. When I attended conferences of the BAC and the BPS, I circulated notices and left details on notice boards (Appendix 4). Two counselling psychologists who offered to take part as a result of notices at conferences asked the members of their department and one asked the counsellors in general practice she worked with, for people willing to participate.

I wrote letters for publication in "Counselling", the journal of the British Association for Counselling, "Counselling Psychology Review", the journal of the BPS Division of Counselling Psychology, "Counselling in Medical Settings News" of BAC, the "Psychotherapy Section Newsletter", "The Psychologist" (BPS), "Counselling News" and the "Newsletter of Counselling in Primary Care Trust" (Appendix 5).

I had two replies from therapists in Scotland and wondered whether it was feasible to travel that far to interview them. As an alternative, I wondered whether I could ask them to record their responses on a tape and send it to me, and how that might differ from data I obtained in a face-to-face interview. I asked them both if they would be willing to do that and one declined because although he was interested in the subject of the research, he had no experience in this field. The other therapist agreed so I sent an interview guide and tape but

she did not return it. I made discreet inquiries through a third party to see whether I could follow it up, but was advised that she might not welcome being pressured to take part, so I let it drop.

I was concerned that I had not located any psychiatrist/ psychotherapists to be part of the sample and began to think of ways that I might include them. Several psychiatrists known to me before were not therapists themselves and those I had known in drug withdrawal agencies were largely working in the same way as the other therapists. My supervisor offered to write letters to accompany mine and sent them on to a university department of general practice, a professor of psychotherapy and the university counselling service. I was very hopeful that because of his links with people and the institution that I might gain access to another network which would include medical or psychiatric practitioners. I also wrote to the Royal College of Psychiatrists to inquire whether they would help me with contacts. None of these strategies produced any participants and I began to consider whether shared professional backgrounds made access easier for me in psychology, counselling and psychotherapy settings but my lack of it kept me out of medical and psychiatric settings.

I began to get more letters in response to my letters to journals and was building up a sample who were also putting me in touch with further therapists, so the snowball technique was working. I had found some therapists working as counsellors in general practice and I felt it had been important to include them. I decided to approach some of the agencies that work with people who want to withdraw from benzodiazepines. I contacted a voluntary organisation that offered counselling and had a telephone help-line and arranged to

interview two therapists. A social worker whom I had known slightly who had worked with women dependent on tranquillisers and a specialist centre offering therapy to women agreed to be interviewed, which I thought might give a different perspective. I had advised someone making a video on benzodiazepine withdrawal and having a copy of the video, I thought that I would contact two branches of MIND who had been running a benzodiazepine counselling service. MIND has played a very significant part in problems associated with benzodiazepine dependence and the organisation has a strong client focus. One MIND groups' counsellors agreed to be interviewed.

I was pleased to be contacted by a therapist who works in a drug agency that specialises in illegal drug use because benzodiazepines are also misused in large quantities alongside drugs such as heroin, crack, and marijuana. He counselled clients taking benzodiazepines chaotically and in large doses sometimes stopping and starting again, as is frequently the case when supply may be limited or stopped suddenly. He also had special knowledge of working collaboratively with general practitioners and I wondered what different perspectives I might gain there. My previous experience at the Withdraw Project had included having colleagues who worked with illicit drug users and we had frequently discussed some of the differences between these clients and those who were prescribed benzodiazepines.

One of the limitations of this strategy for building a sample is that I relied heavily on existing contacts, and networks of people who may hold views similar to mine or to each other. In addition, I have been part of the field of benzodiazepine dependence and had

previously held discussions with, taught or supervised some of the participants. Others had heard me speak or had read material I had written or were using material I had devised, so it is impossible to separate out my influence and how I biased the sample. On the other hand, being connected to the field made developing rapport and trust much easier and I was warmly welcomed and had to concentrate on developing some distance in perspective so that it did not become a comfortable chat between like minded people.

The most obvious omission is of medically trained therapists who might have contributed much about contextual issues, particularly in terms of ethical, legal and professional implications. I think they might also have contributed to my understanding of some of the psychodynamic issues that emerged, particularly if they had had an analytic training, as this therapeutic approach is probably under-represented in the sample. I think that London and the south east of England might have been a better base to work from, for the greater availability of potential participants. Another omission is of sufficient negative cases, but in some ways they were probably excluded by the criteria I devised. It might in fact lead to asking a different research question altogether to be addressed in a different way. Inevitably there must be more omissions that I do not know about.

Profiles of the therapists

A: a female social worker who manages a mental health hostel for clients many of whom take a lot of medication and are gradually withdrawing from benzodiazepines. She has worked with clients on benzodiazepines for 14 years and uses a person centred approach to therapy. I have had previous contact with the team as a group supervisor.

B: a female clinical and counselling psychologist who works in a NHS psychotherapy service and independently. She estimates that 25% of her clients are taking benzodiazepines out of her caseload of approximately 30 clients. She has worked with clients taking benzodiazepines for 9 years and uses psychodynamic therapy.

C: a male clinical psychologist who works with elderly patients with physical health problems. He estimates that 20% of his patients are taking benzodiazepines and about 35% take antidepressants. He has worked in this field for 11 years and uses cognitive-behavioural therapy and Transactional Analysis. He attended a training course on benzodiazepine withdrawal that I ran 10 years before with the Withdraw Project director.

D: a male clinical psychologist who works half his hours in hospital and half in a community setting. He has 45 people on his caseload of whom 50% are taking benzodiazepines. He has worked with clients taking benzodiazepines for 10 years and uses a systemic approach to therapy.

E: a female clinical psychologist who has worked in a NHS Trust for 7 years using humanistic and cognitive-behavioural therapy. She has a caseload of 50 to 55 patients of whom 10% are taking benzodiazepines. She is a colleague of therapist B.

F: a female clinical psychologist who specialises in psychopharmacology and who has 22 years experience of working in this field. She previously ran benzodiazepine withdrawal

groups in a hospital setting using cognitive-behavioural therapy. She has published a number of papers and books on the subject and gave me copies of her 6 most recent publications after the interview.

G: a male counsellor with a background in hypnotherapy who works for a voluntary organisation specialising in benzodiazepine withdrawal. All his clients take benzodiazepines and are withdrawing and he has worked in the field for 4 years using mostly a person-centred approach.

H: a female counsellor with a nursing background who is a colleague of therapist G. She has 10 years experience in benzodiazepine withdrawal and uses a mixture of Rational Emotive Therapy and Neuro-Linguistic Programming.

I: a female counselling and clinical psychologist who works in a unit for elderly people, some with serious mental illness. She has worked with benzodiazepine problems for 10 years and did some research on using Personal Construct Therapy with clients withdrawing from benzodiazepines, of which she gave me a copy. She integrates this approach with Person Centred Therapy.

J: a female counselling psychologist who works in a psychology department of a hospital and 4 general practices with counsellors. She has 70% of her 20 clients taking benzodiazepines and has worked in this field for 3 years. She uses a psychodynamic and existential therapy approach.

K: a male counselling psychologist who is a colleague of therapist J in the hospital setting but he also works in a community mental health team and sees EAP clients privately. He uses an existential approach to therapy, has worked for four years in these settings and has 20% of his 22 clients taking benzodiazepines. I have served on professional committees with K.

L: a male clinical psychologist who works in a psychology department, a community mental health team and a hospital burns unit. His caseload of 20 clients has 10% taking benzodiazepines. He has worked with benzodiazepines for 3 years using a psychodynamic approach and cognitive therapy sometimes.

M: a female counsellor who has worked in general practice for 2 years and is usually seeing one or two clients taking benzodiazepines because the practice discourages their use. She became aware of problems with benzodiazepines from my work and wrote her dissertation on the subject of which she gave me a copy. She uses an integrated approach of psychodynamic, person centred and cognitive behavioural therapy.

N: a male clinical psychologist who manages an addiction service and has had 12 years experience in benzodiazepine problems. He uses cognitive behavioural therapy and has a caseload of 17 clients of whom a third are withdrawing from benzodiazepines. He had previous contact with the Withdraw Project and was familiar with our approach and findings.

O: a female psychodynamic psychotherapist with a background as a psychiatric nurse who runs a therapy service for women. She has worked with clients taking benzodiazepines for 7 years and received referrals of clients who had been through withdrawal programmes elsewhere.

P: a female counselling psychologist who works part-time in general practice using object relations therapy. She has seen a few clients taking benzodiazepines and worked with them long-term for 3 years. She has also experience of seeing clients in the workplace for counselling. I was her supervisor during part of her training.

Q: a female social worker who previously worked in a drug and alcohol team and was involved in benzodiazepine withdrawal. She has worked in the field for 10 years using a broad-based person centred approach. About one third of her clients were taking benzodiazepines now and she specialises in offering a therapy service to women. She attended a training course I ran on benzodiazepine withdrawal about 10 years ago

R: a female psychotherapist working in the person centred tradition who has 10 years experience of benzodiazepine problems and about one third of whose clients are taking them. She works in private practice but has a background in the NHS. I was her trainer at the Withdraw Project.

S: a female counsellor who works for a MIND group withdrawing all her clients from benzodiazepines using a gestalt approach. She has 20 years experience with benzodiazepines and does both individual and group work.

T: a female counsellor who is a colleague of therapist S at the same MIND group. She has 21 years experience of benzodiazepines including taking them herself and becoming dependent. Many of her clients take antipsychotics and antidepressants and she also staffs the telephone help-line. She uses a mixture of person centred therapy and psychosynthesis.

U: a female counsellor who is a colleague of therapists S and T who uses a client centred approach and has worked with people withdrawing from benzodiazepines for7 years. About 50% of her caseload take benzodiazepines and she also runs therapy groups.

V: a female health promotion specialist with a background as a nurse specialist in benzodiazepine withdrawal, she manages a unit of 12 volunteer counsellors. She has 12 years experience and all her clients are taking prescribed drugs. I was invited to stay after the interview and meet the volunteers for whom I ran a training session in benzodiazepine withdrawal and discussed the research I was now doing.

W: a female counsellor who worked in 3 general practices in a part of the country that has the highest rate of benzodiazepine prescribing. She ran special benzodiazepine withdrawal clinics with 74 patients who were being seen regularly in two of the practices. She has

worked in this field for 4 years and uses focussed person centred therapy, cognitive behavioural and psychodynamic therapy.

X: a female psychodynamic/ analytic therapist who works in general practice and privately. She told me on the telephone that the 6 doctors really "believe in prescribing benzodiazepines in spite of the BMJ articles". She has 10 years experience and comes from an educational background. Most of the patients in the practice are on antidepressants and about 12% of her clients are taking benzodiazepines.

Y: a female counsellor who works in general practice as a counsellor and as a teacher privately. When she informed the doctors I was coming, she told me they wanted to know if I was working for a drug company. She has 6 years experience of working with clients taking benzodiazepines using a person centred approach. When she started, 40% of the patients were taking benzodiazepines whereas now it is 10%. She also runs groups.

Z: is a male addiction worker/ counsellor who manages a drug project in a large city. He has 10 years experience in drug work and uses Transactional Analysis and gestalt therapy integrated with person centred therapy. About 20% of his clients take benzodiazepines some of which are obtained illegally and taken chaotically often with heroin.

The decision to stop interviewing

I made this decision before I had completed all these interviews because I felt I was reaching saturation point where material I was now collecting, repeated or confirmed previously

collected material. In addition the availability of potential interviewees was drying up and I had to consider whether devising new strategies to open up access to more therapists would contribute to greater diversity. I had spent about one year conducting these interviews and two years on the research so far, so there were considerations of time, cost and the distances I had travelled to consider, as well as my preference to give my attention to analysing more systematically the data I had. I decided to stop, acknowledging some of the omissions, because I felt I now had enough data to address the research question.

Devising the interview

I devised the interview by thinking about the general areas of interest that might get our conversation going and the background information about the therapist themselves, the setting they worked in, what their experience consisted of and which therapeutic approach they used. So I devised quite a detailed interview structure to see what I needed and what was useful and what I could leave out as too restricting to try out a few times to see what worked and what did not. I had experience of using a semi-structured interview as an assessment instrument at the Withdraw Project and found that as I became familiar with it, I could use it flexibly taking my lead from the client much as I do now. I worked with specific questions at the beginning to open-ended ones later on.

I tried the draft version on the first three interviewees and found a balance between having a form that I could conveniently tick and recording the actual word or phrase used. My preference is to try to catch a few words verbatim and I do write in first sessions with clients now, without any structure other than what is in my head. I cut out most of the structure

after the first three interviews finding that people took up the openings easily and it could become a real conversation with a purpose. I found that I could use what I have learned as a therapist about rapport, trust, engaging with the person and the subject of the conversation, because I was genuinely interested in the subject and what they thought about it. Much of the prompting, probes and clarification I left to my intuitive judgement in the moment.

The first part of the interview (Appendix 6) was not recorded because it was establishing trust and rapport, and discussing the purpose of the research interview and issues of confidentiality. We agreed that taking part in the interview and the recording of part of it gave implicit consent to its use for the purposes of the research. I refer to the first part of the interview when I recorded responses in writing as field notes and these were more closed questions. The second half consisted of more open-ended questions that went deeper and explored the feelings, values, beliefs and meanings of their experience. This latter section was tape-recorded using a standard stereo-tape recorder with internal multi-directional microphone that was relatively unobtrusive and efficient.

I noticed that these first experiences felt very similar to my first few attempts at assessment interviews when I started at the Withdraw Project. Not knowing the interview schedule well, I would break the flow to relocate myself back with the interview questions, keeping one eye on the time, listening carefully yet be thinking about what was not being said. I was asking questions to go deeper yet not wanting to go too far in one direction to the exclusion of others. At the Project, at first I did not know when to offer a place in a group nor whether the client was suited to it. It is difficult to assess unless you keep in mind what you are

assessing for and in a way since this research was open ended, I did not know at first whether I had got good material from the interview. I did not begin to feel I knew where I was going until after the third interview, but fortunately found the interviewees very accepting of my hesitation and unfamiliarity and they talked freely without much prompting.

Conducting the interviews

What I was aiming for was collaboration between me and the interviewees in our mutual exploration of a subject that we were both interested in. It needed to be started off by my questions but gradually I heard interviewees asking questions themselves and being surprised sometimes at what they heard themselves saying. I thought that this was a good sign and that the power to direct the flow of the conversation was being shared. There were moments of empathic understanding that resulted in bursts of laughter and moments of sadness and anger that were also shared. I have indicated that I stayed sometimes for a prolonged period of engagement, which I think contributed, by sharing meals, research papers, training sessions and discussion, to my gaining a better understanding of participants in their own settings. I had stated in my invitation letters that I hoped the interview process would be mutually beneficial and many therapists said it was.

After the first three sessions with an improved interview format, it felt to me as if I clicked and started to enjoy the interview process, began to hear patterns of recurring words and phrases, began to understand what they were saying and to recognise things that I have thought or felt too. At the same time there were new ideas and thoughts and concerns being raised which engaged me with thinking and reflecting on differences after the interview,

particularly the impact that the context and setting has on the process of therapy. I reflected on how each therapist was using their own approach to working with these clients and telling me their stories. I was very interested in the replies that described what the interviewees thought about what was happening in the process of therapy from their own perspectives. I had my own thoughts and insights and had to decide whether to write notes for myself after each interview or not.

I decided not to do so partly for the practical reason that I was acquiring a large amount of paper to process, and partly because it fixed my thinking too early in the process and brought too much closure. I wanted to hold my impressions inside, so that what happened in later interviews could evoke memories of what had occurred in previous ones, and I could make the connection internally. I was much more likely to use that than a written record. In this way the collection of previous data could shape my response in the present interview as well as new data shaping my interpretation of the past one. I do much the same with clinical supervision, writing things down only when and if I feel ready to do so, and trusting that it will still be usefully applied if I do not write anything.

Implications of these choices

Firstly, what emerged was a mixture of a series of closed questions in the first part of the interview followed by open-ended questions in the second part, but undoubtedly the first part of the interview influenced the second. I made the choice to manually record the first part and mechanically record the second part so the first part has omissions based on what I selected as important. Any question can be heard as an expectation on the part of the

respondent and I expect that participants were wondering what I wanted or expected them to say. Given that I was known in a variety of ways to several participants, and might have represented an authority, they may have been influenced in what they were prepared to disclose, or willing to disclose more because of an expectation that we would agree.

Not returning to check with participants after the interview may have missed their second thoughts and deeper reflections which might have provided a far richer source of material. There could have been a trade-off between doing this and interviewing fewer participants in the first place. Alternatively, using a group to address these questions might have allowed me to observe the interaction of ideas between several therapists particularly if the group was diverse. So the kind of interview I chose has inevitable limitations and other methods would have different ones. The choice I made reflects my preferences, experience as an interviewer and particular stance in relation to being part of the field and not separate from it.

Transcribing the interviews

I had the interviews transcribed by a professional secretary whom I trust, because she is skilled in this and I am not. She sent me back two or three tapes as they were transcribed so I could read and reflect on the interviews, processing what was emerging from them while I was still conducting interviews. I had to listen to the tapes to fill in gaps of softly or rapidly spoken words and of course the technical language in some cases. This was quite boring and I found that listening to and checking the tapes in this way was not nearly as useful as just reading the transcripts, which brought the encounter alive for me. Perhaps that is a

personal preference because I can hear the person speaking from what is written as I may do when I know the author of something that is written. However I think there is also the reason that in listening you hear only what is being said and have to move on, but when reading, something else on the page can catch your eye or you can stop and turn back to what was said earlier on. I think this experience influenced me in the method I chose for analysing the data more fully later.

Analysing the data

I had decided during the process of reading the transcripts to do the analysis manually and not use a computer programme. The reasons for this were partly practical in that the computer I used then was out-of-date and there was no software that would work on it, but also the other computer available was elsewhere and not easily accessible. My main reason was a preference for a hands-on approach, which allowed me to move through transcripts and between them in order to find my own way of analysing them rather than using a prepared package. I think this had the advantage of allowing me to learn how to do this by myself and in my own way. It has the disadvantage that you can make mistakes and have to go back and find a better way which is also useful learning. There may be no right or wrong way of doing this, but clearly with hindsight there might be better or worse ways of doing it, but I think people find the way that suits them best.

I decided that I would use the format of the four main areas of questioning and deal with each question segment in turn. This would allow me to handle a manageable amount of data at one time while still being able to maintain an overview. While writing a previous

dissertation, I had devised a system for using index cards on which I recorded data, quotations, and my ideas from reading papers or books that I wanted to include in the various chapters. I colour coded each card in one corner to indicate which chapter it was relevant to, often several. In that way I could select all the cards relevant to the chapter I was writing and put them in the order I wanted to use them and write from the ordered cards. I have read about cutting up the transcript and putting each unit of meaning onto a card and this may be useful when there are several researchers analysing data but I chose to use my colour coding system.

By the time I came to analyse the transcripts in a systematic way, I had already read them through several times and gained impressions and ideas about what might be significant about patterns of words and phrases, and fed that into the next interviews several times. This generally fits with a system of open coding (Strauss & Corbin 1990) and I felt ready to move to finding common constructs quite soon. The fact that I seemed to do this quickly suggests that since I already had my own ideas about the phenomenon from my own experience, I must be imposing those assumptions on the data. This is inevitable (Patton 1990) and I recognise that my prejudices, viewpoints and assumptions must have influenced my choices and interpretations of sections of the text. However my intention was to try to be tuned in to others and empathise with their viewpoints and to assume the mental position peripheral to both the insider and outsider perspective as described by Wax (1991). So I was alert to suggestions of different viewpoints as well as what the interviewee might be missing.

I then analysed the first segment of the transcripts, which related to the question I had asked about bereavement. This segment was coded in the margin using black ink, with the constructs that I identified (axial coding). One advantage of this method was that when the interviewee went back to make a comment "out of place as it were", the colour coding system covered this by marking all constructs related to bereavement in black ink wherever they appeared in the transcript. I then compared all the constructs with the same label to see if they fitted together and seemed to be related bearing in mind that each interviewee was talking in their own therapeutic language about the process of their clients' bereavements as they observed and understood it. I also considered whether any of the constructs were different although they were described by the same word and this involved trying to decide in the context of the whole interview what the interviewee meant, as far as I could.

When I felt reasonably satisfied with this analysis and the decisions I had made, I went on to collate these constructs. First, I listed under the name of each interviewee all the constructs I had identified in their script, and then reversing the process I listed under each construct, all the therapists who had mentioned it. I then checked whether I had used all the data in this segment of the transcript to see whether there was anything that did not fit in any of the constructs and made decisions about whether they could be subsumed in existing constructs, whether I needed new constructs or whether constructs needed to be shuffled. I then had a reference list for each construct that made it possible to identify it in the appropriate transcript by the construct name in black in the right-hand margin of the script.

The next stage was to identify the theoretical propositions related to bereavement and the client's internal process and check those against findings from elsewhere or previously identified in the literature review. Where there were negative instances, that is views that did not fit with the proposition, the proposition had to be more tentative, as what "most" but not "all" therapists believed. This led on to preparing for writing when the process became very similar to the coded card system I had employed previously, in that I could organise the references to the scripts in the order than I wanted to include them in the text. It was a very methodical system that seemed to work well and I felt I had control over managing the data and the process of analysis, which provided me with a systematic way of writing. However there was a further stage to the analysis in organising and writing up the findings. I prefer to organise my thoughts into a series of subheadings and write from those, so this fitted in with my preferred writing technique.

I used much the same process for analysing the data in the segment of the transcripts that related to difference, using red as the coding colour, then purple to indicate the analysis for theories about the process, and professional issues. One advantage of doing the analysis this way is that the paper copy of the transcript remained intact throughout and this allowed me to refer back to what had previously been said or check whether a point was being repeated. I was able to pour over large amounts of data simultaneously. The person of the therapist remained known to me by using the real name on the transcript, which allowed me to understand their meaning in relation to them, the context of their work and practice. Since no one else had access to the transcripts I did not regard this as compromising confidentiality.

The field notes that were made at the start of the interview provided a useful cross check mechanism for clarification, elaboration and some detail. It was from the field notes that I analysed the data on metaphors and the therapists' experiences of clients withdrawing from benzodiazepines. Clearly I had to find ways to condense this material and there is more detail that I can return to at another time. In these ways I tried to find an analytical procedure that involved examining the meaning of people's words and inductively deriving findings in a systematic manner.

Outcome propositions

The third level of analysis and interpretation, following the identification of themes that emerged from the data and the formulation of propositional statements (Lincoln & Guba 1985), was to look at the relationships and patterns across categories (Maykut & Morehouse 1994). They advise the researcher to examine all the propositions, to consider their relative importance and to see which propositions stand alone. Putting two or more propositions together forms "outcome propositions" that are overarching summaries of a number of propositions. The development of theory requires the highest level of interpretation and abstraction from the data in order to arrive at organising concepts and tenets of theory. Much of this level of analysis was done during the writing up and required a re-thinking of the data during the process.

CHAPTER 6

FINDINGS

The twenty-six psychotherapists who were individually described in chapter 5, were interviewed according to the interview schedule (appendix 6) and their answers to the first five questions were recorded manually. This chapter contains data about the group of therapists as a whole and their collated views from the first part of the interview. A discussion of these findings and the following four chapters which derive from the second part of the interviews is included in chapter 11. Tables 1-5 describe the group of interviewees.

THE THERAPISTS / CO-RESEARCHERS

Gender	
Female	19
Male	7

Table 6.1.

Professional Background	
Psychologist	11
Counsellor	7
Nurse	3
Teacher	2
Social Worker	2
Doctor	1

Table 6.2.

Practitioner Category	
Addiction Specialist	9
Counsellor / Psychotherapist	7
Clinical Psychologist	7
Counselling Psychologist	3

Table 6.3.

Work Setting	
Addiction service	9
Psychology department	7
General practice	5
Private practice	4
Community mental health team	3
Hospital	3
Unit for older people	2

Table 6.4.

Therapeutic Approach	
Person centred	13
Cognitive-behavioural	9
Psychodynamic	8
Integrative	3
Transactional Analysis	2
NLP/Hypnotherapy	2
Existential	2
Gestalt	2
Personal Construct	1
Systemic	1
Analytic	1
Psychosynthesis	1

Table 6.5.

Tables 6-8 give details of the interviewees' experience of working with clients taking benzodiazepines, in response to question 2 (appendix 6).

Experience with Clients on Bzs	
	Years
Mean	8
Range	3-18

Table 6.6.

Proportion of Clients on Bzs	
	%
Mean	45
Range	5-100

Table 6.7.

Size of Case Load	
	No. of clients
Mean	26
Range	3-74

Table 6.8

Tables 9-13 show how therapists noticed their clients being affected by benzodiazepines, and are the responses to question 3 (appendix 6).

EFFECTS ON CLIENTS

Cognitive Effects noted by Therapists (compared with other clients)	
Poor concentration / focussing	8
Poor memory	7
Slowed thinking processes	5
Lack of clarity / muddled	5
Disconnection	3
Difficulty linking thoughts	3
Difficulty thinking things through	3
Lose thread in dialogue	2
Rigidity in thinking	2
Doubt own competence	2
Not psychologically-minded	2
Loss of confidence ' self-efficacy	2
Lack of self-awareness	2
Unaware of listener's difficulty in comprehension	2
Denial	2
Rationalisation	2
Attention problems	1
Don't listen / don't hear	1
Difficulty problem-solving	1
Narrow focus to thinking	1
Cognitive impairment	1
Irrational	1
Negative attitudes	1
No higher executive function	1
Cannot initiate or organise themselves	1
Inaccessible	1
Dulling of perceptions (visual-spatial ability)	1

Table 6.9.

Behavioural Effects noted by Therapists			
(Compared with others clients)			
Passivity	12	Avoidance of risk	1
Agoraphobia	6	Reduced social activity	1
Drowsiness	5	Tense	1
Agitation	5	Stay on edge of groups	1
Social withdrawal	4	Rigid behaviour	1
Absences from therapy	4	Drop out of therapy	1
Avoidance	3	Secretive about drug use	1
Bizarre / erratic behaviour	3	Stuckness	1
Rituals / obsessional behaviour	2	Ambivalence about therapy	1
Inability to cry	2	Demanding	1
Difficult to engage in therapy	2	Ingratiation / seduction	1
Psychosomatic symptoms	1	Victim behaviour	1
Insomnia	1	Enmeshed behaviour	1
Entrenched in medication habit	1		

Table 6.10.

Emotional Effects noted by Therapists			
(Compared with other clients)			
Emotionally numb	14	Loss of interest	1
Flattened emotions	10	Unempathic	1
Increased anxiety	10	Dissociation	1
Very unhappy / sadness	6	Phobias	1
Panic	5	Loss of libido	1
Mood swings	4	Loss of identity	1
Simmering anger	4	Irritable outbursts	1
Increased depression	3	Low confidence	1
Suppressed feelings	3	Indifference to themselves	1
Disinhibition of emotions	3	Strengthened defences	1
Excitability	2	Fear of insomnia	1
Poor motivation	2	Damned up / repressed	1
Vulnerable	2	On another planet	1
Suppressed dreaming	2	Discounting own feelings	1
Boredom	2	Self-centred / focused	1
Shame	1		
Men turn feelings into symptoms and side-effects			

Table 6.11.

Dependence Effects noted by Therapists (Compared with other clients)			
Dependent relationships	7	Fear of unknown	1
Belief in needing drugs	6	Avoidance of feelings	1
Reluctance to reduce/stop drugs	5	Ambivalence about drug use	1
Dependence on other substances	4	Fear of dependence	1
Psychological dependence on drugs	4	Wanting symptoms removed	1
Attribution of therapy gains to drugs	3	Protection of supplier	1
Aware of addiction	3	Wrong attribution of symptoms	1
Use external locus of control	2	Hoarding drugs	1
Belief in efficacy of drugs	2	Ambivalence re: attending therapy	1
Denial of problem with drugs	2	Ambivalence re: Problems & therapy	1
Tolerance / less effective	2	Unable to take control	1
Unsuccessful attempts to withdraw	1	Given up on life	1
Inverted attachments	1		
Dependence / power dynamics with doctors			

Table 6.12

Effects On Relationships noted by Therapists (Compared with other clients)			
Infantilised	5	Affect marriages/hell for partner	1
Adopted sick role	4	Intolerance/escaping anger	1
Dependent relationships	2	Formalised interaction	1
Hazy view of relationships	2	Change is stifled	1
Stop people changing relationships	2	Emotional distance from parent	1
Symbiotic relationships exacerbated	2	Unaware of impact on others	1
Isolated	2	Loss of parenting experience	1
Increased dependence on therapist	2	Slippery	1
Inaccessible in therapy	2	Wanting me to fix it	1
Difficulty in relating to others	1	Loss of libido / can't relate either	1
Sexual dysfunction	1	Stay in dead relationship	1
Not a whole person	1	Secondary gains	1
Persistent moaning	1	Adult dependent on mother	1
Avoid dealing with problems in relationships	1	Withdrawn	1
Not self-nurturing / excess nurture of others	1		

Table 6.13.

Tables 14-17 show what therapists thought were their clients' beliefs about benzodiazepines and attitudes to therapy, in response to question 4 (appendix 6).

Clients' Beliefs about Benzodiazepines	
Assistance / reassurance	11
Necessity	9
Medical treatment / tonic	7
Do nothing / no problem	7
Plague / scourge	7
Addiction	4
Overpowering / zombifying	4
Remove nerves / suffering	3
Moral weakness	2
Social control	2
Solution	2

Table 6.14

Clients' Metaphors for Benzodiazepines	
Crutch / prop / glue	18
Pacifier / soother / comforter	14
Seducer / enslaver / straitjacket	9
Helper / friend	7
Trap / prison / punishment	7
Food / fuel / tonic	7
Magic bullet / spell	6
Life-line / life enhancer	6
Resource / solution	6
Tool / switch	4
Security	4
Hero / saviour / guard	4
Passport / escape	2
Thief / murderer	2

Table 6.15.

Use of Metaphors in Therapy	
Do you use metaphors in therapy?	
Yes	20
No	5
Maybe	1
Used:	
As a reflection	9
In stories and fantasy	5
To promote change	5
For exploration	3
To access meanings	2

Table 6.16

Client's Beliefs about Therapy	
Better alternative to prescription	12
Saviour / magician / expert	11
Therapy is discounted	9
Crutch / support	6
Fear / worry about dependence	6
Understanding / uncovering problems	5
Worse alternative to prescription	4
Unsure	3

Table 6.17

Table 18 (overleaf) shows the responses to question 5 (appendix 6), when therapists were asked to describe what happened when a client withdrew from benzodiazepines.

Effects of Benzodiazepine Withdrawal on Psychotherapy

Multiple Case Studies

Therapist	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	
Difficulties with Withdrawal					x	x				x	x		x		x	x							x		x	X	11
Decision by Client (Th/GP)	C/ Th	C/ Th	C/ Th	C/ GP	C	C	C	C/ GP	C	C	GP		C/ Th	GP	C/ GP	C	C	C	C	C/ Th	C	C	C	C/ GP	C/ Th	GP	22
Withdrawal integrated with therapy	x	x			x	x	x	x	x	x			x	x	x		x	x		x	x	x	x	x	x	X	20
Emergent issue: Loss			x						x	x			x	x			x			x						X	8
Emergent Issue: Relationship	x		x			x				x	x		x	x	x		x			x	x	x		x	X		14
Emergent Issue: Abuse								x		X																X	3
Problem extinguished	x		x	x	x		x		x	x						x	x	x		x	x	x	x		X		15
Increased self-efficacy	x		x	x	x	x	x	x	x							x	x	x		x	x	x	x	x	X	X	18
Increased alertness	x			x			x		x						x	x	x	x	x	x	x	x	x	x	x	X	16
Increased access emotionality	x						x		x	x	x		x		x	x	x	x	x	x	X						13
Increased self-awareness			x				x								x		x	x			x	x	x			X	9
Improved therapeutic access	x	x	x				x	x	x	x	x		x		x	x	x	x	x	x	x	x	x	x	x	X	21

Note: Therapist 12 had not worked consistently with a client who withdrew from benzodiazepines

Table 6.18.

CHAPTER 7

THE EFFECT ON GRIEVING

How do benzodiazepines affect grieving?

During the interviews, I asked interviewees whether they thought benzodiazepines affected their client's grieving. Twenty-four therapists out of twenty-six said they believed they had noticed this and two expressed some uncertainty.

Effects on the client

Proposition 1 : Clients who are grieving seem to be emotionally numbed.

Fifteen therapists described emotions being suppressed, blocked, dulled, removed, distorted, lost, disconnected, flattened, inhibited, numbed or the client being "turned into a zombie". They clearly thought that emotional accessibility was necessary for grief work and that work would be slowed down or obstructed in some way if the client was not in touch with their emotions. There seem to be two aspects to this, firstly that the client needs to be aware of their feelings and secondly, be able to express them.

> "They (benzodiazepines) suppress things for them so that they don't deal with grief... they suppress emotions, they anaesthetise emotions... (clients) sometimes seeming to be not in touch with emotions and other times not being able to express emotions.... seeming sad or tearful but in an unproductive way."

The theme of benzodiazepines anaesthetising emotions, is taken up again by a therapist who likens the client to one in a coma or asleep. This fits with their role as pre-medication before surgery (Committee on Review of Medicines 1980) and their

acknowledged amnesic properties which mean that patients do not later recall unpleasant experiences during biopsies or minor surgery.

> "I had a client who was her mother's carer and when her mother died she'd lost her identity in life. She was given benzodiazepines and then years later she still hadn't gone through the grieving process. It's like they're in a coma... like they're asleep."

One therapist commented on the client not realising they had feelings that might need to be expressed to their therapist. They believe that if feelings can be contained then they do not need to be expressed. Holding in avoids letting out.

> "It seems to not exactly block people expressing feelings... they actually don't have the feelings so much. They can contain them and then they don't need to talk about them."

> "It masks it. It dulls it. It takes the edge off. It doesn't allow them to experience the depth of pain. It doesn't take it away, it just dulls it."

> "I think it has a blocking effect on the emotions. When they feel it, they're able to take a tablet and cut off, because that's a word I use a lot with people... cut off."

"Cut off" is a phrase that frequently occurs when therapists are describing clients taking benzodiazepines. Sometimes the metaphor is "masking" the emotions, sometimes "dampening". It is easy to see how this enables clients to feel more in control and this is especially true when a funeral is seen as a time for a "stiff upper lip" or "being in control" or "coping". Therapists also believed that the feelings had not gone away or been lost but were merely deferred.

Proposition 2: Benzodiazepines may be used to avoid the pain of grief.

Five therapists mentioned that benzodiazepines are an avoidance of pain. This is in part a suppression of emotion but it is also an indication of how benzodiazepines are used to support a psychological defence. One reason for avoiding grief work is that relatives may not approve or may encourage avoidance as a sign of "getting over it" or "coping well." This seems particularly the case for young people who are encouraged to get on with life, have another baby, or remarry to replace the loved partner.

> "They were trying to avoid the pain. They used this as avoidance instead of encountering the pain, going through the pain. They weren't feeling it because they could take these tablets and hence they went on and on taking them."

> "People who back away from difficult challenges or difficult emotions... its a kind of avoidance of painful emotions."

> "It enables people to focus on the daily tasks and focus on putting energy into getting through that, feeling that if they can get through that, they can get through it all and are doing very well. In a kind of wider existential way it helps them to avoid the pain of loss and grief."

Proposition 3 : Clients seem to be detached from the reality of their loss.

Eight therapists commented on the cognitive effects, the ways in which benzodiazepines helped people "not to know" what had happened. They refer to being out of touch with reality, concealed thinking, memory problems, confusion, disconnection, detachment, lack of engagement, not understanding fully and clouded thinking. An early psychological defence following bereavement is denial and it seems as if benzodiazepines reinforce it and that it persists while the drugs are being taken.

"I remember one woman in her 70s who said, "as long as I'm taking these, I don't have to think that Joe isn't here anymore. They didn't have to think... although those thoughts come up, they got blocked out with the next tablet."

"You're living life in a sort of bubble... detached from what really is happening to you, rather than being part of it. You're detached from it, so how can you fully experience it?"

Several therapists commented on the client's inability to process ideas and make connections, particularly between thoughts and feelings. There is a lack of integration and sometimes a discontinuity of thought. This fits with the evidence that people taking benzodiazepines experience cognitive deficits but these therapists are putting that into another language which relates to their own experience.

"I think the client would be in turmoil... some messages would be coming in but they wouldn't be able to process them, so it's very confusing. They don't take the death fully on board... I can't see them actually grieving... there is a kind of distance... they're not connecting."

"She wasn't really thinking realistically about the impact on anybody else at all.... she could talk about that in a cognitive way but didn't seem to be experiencing it and integrating it with her own experience."

"I think it slowed the grief; she would have shown greater progress if her thinking had not been clouded and I think the drug was clouding her thinking."

Proposition 4 : Benzodiazepines seem to make it difficult to remember events.

There were a few comments about amnesia but many therapists merely implied it as if it was quite common and hardly worth mentioning. It is an effect of benzodiazepines but whether it is desirable or not depends on the viewpoint. It may be considered desirable not to remember an unpleasant medical procedure, whereas therapists might regard it as

desirable to remember what occurred leading up to and at the time of death, what was said and by whom, and the events surrounding the funeral. This viewpoint is supported by the assumption in grief counselling that the bereaved need to recount all their painful memories, sometimes many times in order to find a resolution of the painful feelings.

> "Her husband contracted cancer, and she was given diazepam before his death supposedly to help with his illness. She could not remember the details of his death afterwards. It seems as if the part that you were given it for has gone missing."

> "We know that benzodiazepines are used as premeds, to take away your memory of operations, so if that's a function that is recognised, obviously it is going to block memory."

While benzodiazepines interfere with cognitive processing, they seem to keep clear, memories of the events before they were taken by preventing consolidation of new learning. So memories before drug use are often vivid when the client finally withdraws from the drug. This is called retrograde facilitation and has been identified by a number of studies (Curran 1986, Risse et al 1990, Curran et al 1993, Weingartner et al 1995).

This may mean that if benzodiazepines are prescribed soon after a death, ostensibly to help people not to cry during the funeral, the events of the funeral, words of condolence, letters of sympathy, visits and support are not fully experienced by the bereaved person and after they stop the drugs cannot be recalled to console them. On the other hand, the latter stages of illness, events surrounding accidents, operations and hospitals are left as vivid memories which have been relatively unprocessed, especially if the person was in shock.

"The memories were clear (of the events) before the death, but not clear after the death."

Proposition 5: Therapists noticed sleep and dreaming were affected.

Three therapists mentioned sleep and dreaming. Clearly since benzodiazepines are sedatives, clients taking them may not have thought that this was a problem. They do not usually realise that drug-induced sleep is different from natural sleep and that REM (rapid eye movement) sleep when dreaming occurs is suppressed. Many people believe that they are entitled to "a good night's sleep" or that it is a remedy for psychological distress. Wakefulness is seen as unhealthy and is one of the main reasons for clients requesting medication after a death. It is probably one of the most difficult requests for a doctor to resist. There is some evidence that this short-term prescribing leads to long-term use (Morgan et al 1988).

"The drug was giving them drug-induced sleep rather than natural sleep. My understanding is that we work out a lot of our emotions through our dreams and through our sleep. They weren't dreaming and they didn't want to dream because the dreams weren't very nice. The dreams were going back through the deaths, through the reality of the loss and it seems that the drug stopped that."

"I am particularly interested in dreams and I think the dreaming is much more helpful when you're not on sleeping pills. It actually suppresses dreaming."

"She was on something like 2.5mg lorazepam three times a day and she had a very bad time withdrawing and also with the re-emergence of dreams. Sometimes they find it quite frightening that they're having these vivid dreams and they've forgotten, if it's been years since they've had a normal night's sleep, and often refer to them as nightmares. If you ask them about what they remember about their dreams, they don't have a particularly nightmarish quality at all. The experience of dreaming itself was what was frightening."

Effects on the grief process

Proposition 6 : Therapists noticed that grief seemed to be inhibited.

In reviewing the process of grieving, some clients appear not to start grieving at all. If benzodiazepines are prescribed in the first few days after a death when the person is still in shock, the client may not start to grieve and remain in the stage of denial. Not everyone might consider this a problem until they appear in therapy when therapists may uncover this detail in the client's history and relate it to the presenting problem in the formulation. Sometimes a number of people have assessed the client and identified that they have not grieved a loss.

> "I met a man who was very heavily dependent on benzodiazepines, who had started taking them two years before when his father died in rather difficult circumstances. His father was in another country and he went to this country to look after him for two or three months. He was forced to return here and then his father died very shortly afterwards. My perception was that there was an awful lot of guilt involved in this. After two years he didn't really appear to have started his grieving. I think his guilt and other aspects of his grief were unconscious and were remaining unconscious."

> "There was no grief, and that was disclosed after a couple of years of being in a (withdrawal) group. When the woman felt as though she wanted to share that in the group, this was the beginning of her grieving. I define it as awareness; she became aware at last of her severe grief and was acknowledging now what had happened."

> "The people that I've seen here have been on benzodiazepines after a traumatic event. I find that I'm seeing people five or ten years later who have not grieved, possibly because they have not given themselves time and space. I would say a

good 50% have been given tablets to cope with the event and I think that it was a blocking mechanism."

One factor that seems to restart the grief process again is the reduction of the dose of benzodiazepines to a level where feelings emerge once more. It seems as if withdrawal itself is sufficient to disinhibit the grieving, which can then take place normally. Many people seem able to complete their grief once it has restarted.

"Someone who lost a partner approximately ten years before, who had reduced benzodiazepines to a very low dose, suddenly began to feel, over a period of weeks, more and more emotional. They started thinking about the loved one and it disturbed them as they did not understand why this would happen as the person has passed away many years before. I was taken aback because I was not prepared for this response, but through speaking to colleagues and my own experience, I've found it is something that happens time and time again. I've come across it several times and colleagues also many more times; it's universally agreed that this happens. It's like repression."

"It's like whatever they are suffering, they are held in a kind of time warp, and then years later they're still in the same place. Then if they withdraw, its like the death has just happened. The time between the death and coming off drugs is just lost."

Proposition 7: Grieving seems to be prolonged when clients are taking benzodiazepines.

One effect that therapists identified was that grieving was in some way prolonged or protracted. They described how the process was suppressed, slowed, protracted, halted or prolonged and that some clients continually cried but without experiencing relief. One property of benzodiazepines is that they are depressants; in long-term users in the

Withdraw Project we identified a very high incidence of clinical depression. Depression is also a common withdrawal effect of benzodiazepines and a reason for restarting the drugs in those who have not been warned to expect and prepare for it in other ways. This double bind is further complicated by the fact that depression is a normal part of the grieving process.

Both clients and therapists can easily get caught up in trying to unravel the primary cause of depression not always aware that identifying the cause is unnecessary since the remedy remains the same, withdrawing the drugs. Doctors can get caught up in further complicating this by attempting to prescribe antidepressants on the assumption that depression is caused by a chemical imbalance, an over-simplification itself. Withdrawing benzodiazepines carefully and properly and allowing the grief process to continue normally will alleviate all three "causes".

> "They (benzodiazepines) seem to prolong the grieving. They seem to hold them in that state rather than helping them to move on. I saw a great number of people and they'd been on benzodiazepines not just for a couple of nights, but for years, and it seems that they hadn't actually moved very far in their grief at all. It (taking benzodiazepines) really seems to prolong the agony, I would say."

> "I can think of another gentleman who was so incapacitated by grief and anger, he couldn't talk about anything else. But he couldn't internalise it to move forward either."

> "She seems to have bad bouts, constant bouts, (of grieving) and she's wondering why it's still attacking her, why it's still happening. There seems to be confusion about why she's doing this process again. She's confused about the grieving process and has read books on it wanting to know for herself. She was active in trying to seek her own salvation, but she was still out of touch in some ways.

There was some part of her pushing forward, wanting life again, and there is still a great chunk of her out of touch."

"I was relating it to me again. I wasn't allowed as a child to grieve... I was punished for crying so grew up not to cry in front of people and not cry a lot anyway. But on benzodiazepines I would cry, but I don't think I got relief."

Proposition 8 : Therapists observed their clients not progressing but getting "stuck".

A similar concept which therapists described is the idea of stuckness in the therapy. They described it in these terms as well as describing a process of going round and round, not making any progress. As a supervisor or trainer, I am most often prompted to ask whether the client is taking benzodiazepines by a description of the client being stuck. Often I hear that the client appears to be doing all the rights things and the therapist hopes they are doing all the right things but forgot to check on the client's medication, what and how they are taking it.

It appears to be an unconscious form of self-sabotage, with the client completely unaware of the significance of their drug use, so failing to tell the therapist. On occasions clients are only concerned with whether a drug is addictive or not and they have not considered that the occasional sleeping tablet has any relevance to their therapy. This often mirrors their doctor's casual reassurance that taking benzodiazepines occasionally is harmless, because the doctor is only focussing on the effects on sleep not the whole range of effects.

"Oh, very stuck, very stuck, unable to move on. And they felt unable to move on in life, in actually regaining any part of their lives. That bit in the grieving when people start to re-invest in their lives seemed to come very, very slowly if at all."

"Well, they (benzodiazepines) probably influence the whole process, to think about it, to reflect on it, to integrate thinking, letting the person have the feelings that go with their loss. It's the same thing you see in therapy, that they go round and round the same thing without it having any effect."

"So instead of working through the anger, accepting it and moving on, they've actually stopped; they're still at the beginning of the horror. Different people get stuck at different stages. Some people might work through the first stage and then take benzodiazepines and get stuck at a different stage, but more often than not they are stuck right at the beginning."

"I would say that I have noticed the benzodiazepines interfering with grieving, in the sense of her being stuck and showing very little progress for long periods of time. I saw very little progress in that time which was very frustrating for me, and I thought it was very inappropriate prescribing that had got her into this. She had been on benzodiazepines following the bereavement for three years."

Proposition 9 : Therapists discovered people whose grief seemed unresolved.

Some therapists comment on the effects of benzodiazepines on the grief process in terms of grief being unresolved after many years. These comments reflect my own experience and the findings of the Withdraw Project, of the numbers of clients whose unresolved grief emerged only when they reduced their benzodiazepine doses. My work as a supervisor for CRUSE has brought issues of unresolved grief to my attention on many occasions and medication is nearly always a major contributory factor. It appears that grief work can be left undone for many years.

"Thirty years after the death, she'd never really let him go; she'd never worked through the grief."

Often therapists notice that there are two kinds of crying, searching crying which is chronic and persistent and letting-go crying which consists of a few very deep heart-rending sobs. It is this latter kind of crying which seems to represent the real letting go, part of the process of resolution.

> "And they could feel sadness, but it was not a good grief; it was more like sadness. Not deep as grief in those circumstances should have been. There was a sadness and there were tears, but... not desolate tears, but sadness tears for them in their loneliness, but not for the whole of the situation really."

One therapist who told me she had taken benzodiazepines herself was able to reflect on her own experience as well as the experience she observed and was reported to her by her clients.

> "Sure, and about myself, I think I still haven't grieved for my past properly yet."

Proposition 10 : Clients appear to grieve for the years of lost life-experience.

Among the therapists who specialise in working with clients who are dependent on benzodiazepines, several mentioned that in addition to the unresolved losses in people's lives before or while taking the drugs, people also grieve for the years of life-experience which have been lost and cannot be regained.

> "And another thing is the lost years, the lost years during the drug taking. I've not known a client yet who hasn't grieved for the lost years and the lost time spent."

> "It was quite a theme really, I would say. The one thing that I recall most was this enormous sense of loss in terms of whole chunks of their lives had been lost.

They describe being on the drugs as like living life in a fog. That was quite a common experience; it was like not being fully alive, if you like."

"There is also grief around what has been missed from the client's life as well.... but also grief around the fact that they have been like that a great part of their lives, and they haven't experienced what they could have experienced."

"This lady was put on them (benzodiazepines) when she had what I presume was post-natal depression, so she'd been on them for 20 to 30 years. .... and had all this missed life; times just lost really."

This awareness of how they have been affected by their drug use frequently leads to both anger and guilt. Benzodiazepine users express anger with doctors, pharmaceutical companies, their family and themselves and can feel ashamed at having been deluded by the false promises and false reassurances made about benzodiazepines. Very difficult feelings of guilt and shame may also surface.

"They're usually angry with the prescriber; angry about what was lost. "I've lost relationships; I've lost a family; I lost my children growing up." There's a lot of anger. I've got a man at the moment who's lost his business because of it; he's literally lost his business and that was a huge loss."

Comments contrary to the propositions

The first therapist whose comments did not fit with the general consensus referred to a particular setting of working on an acute ward of a psychiatric hospital with clients with a schizoaffective disorder. In this context the priority may be to establish containment of extreme distress and benzodiazepines may be used to sedate patients and alleviate acute distress. So the context of therapeutic work and the client's wider psychological distress are significant factors in how therapists view their clients who are grieving. "But it is like

taking aspirin to relieve a headache, because you then have to deal with the causes of the headache." The use of benzodiazepines in the short term for extreme distress is widely accepted and should not affect grieving later on.

The second therapist was working in general practice in a bereavement project. She said she had not really considered the possibility that sleeping tablets might make an impact on the bereavement work, so she said that her theory was based on ignorance and was only a personal view. She then described benzodiazepines as anaesthetising pain, interfering with sleep and dreaming, and concealing thinking. It appears that both the contextual factors of decisions having already been made by the doctors to prescribe and then refer to the project, and the specific focus of the therapeutic work encouraged the therapist not to question the prescribing. In this case the therapist does not think she has a view perhaps because she is not expected to have one by other people.

A problem common in NHS settings is that a number of people make assessments for treatment, which is to be carried out by someone else, often lower down the medical hierarchy. Although the assessor does not have the requisite knowledge of the treatment process, assessments may be accepted without question. This point is raised again in considering other methods I used to collect data and in the chapter that examines psychodynamic issues.

Comparison with other data sources

The other method I used to collect data was the survey of NHS psychotherapy services. This suggests a quite remarkable lack of interest and awareness of the potential problems that benzodiazepine use might present to clients receiving psychotherapy. Of course the

evidence represents only the views of those who completed the survey and any others they consulted, and might not be a fair or representative viewpoint. One comment referred to benzodiazepines having widespread inhibitory effects, influencing memory and thinking, but bereavement as a presenting or contributory problem was not mentioned.

Other data is available from scrutiny of the documents that I reviewed in a previous chapter and I have developed a number of outcome propositions (Maykut & Morehouse 1994) against which this documentary evidence will be compared. If the interviews, my observations, the survey findings and the documents show the same pattern, then convergence should show that the phenomenon is being understood from several different ways of knowing. It is clear that the survey findings show neither convergence nor divergence, which is a disappointing outcome and may reflect its methodological limitations.

Outcome propositions

1 : Benzodiazepines suppress emotional processing which is a feature of grieving.

The sedative properties of benzodiazepines and the lowering of arousal in an emotional crisis were identified by Bancroft (1979), emotional anaesthesia is mentioned by Ashton (1984) who also comments that patients in her study "could not cry", and were depressed. Depression may be seen as a defence against loss and is mentioned as an effect of benzodiazepines by Zisook & De Vaul (1977), Koumjian (1981), Hamlin (1988). The Association of Community Health Councils for England and Wales (1989) report that benzodiazepines dull the emotions and suppress feelings, mood is altered (Lader 1992a), and feelings suppressed (Salzman 1992). These effects are likely to go

unnoticed and unreported in research studies because emotional numbing is one reason that benzodiazepines are prescribed and may be considered a desirable effect rather than an unwanted effect.

2: Impaired thinking, concentration and memory limits narrative competence in grief work.

There is much wider agreement in the literature on benzodiazepines that the cognitive effects are disabling. Kleinknecht & Donaldson (1975) identify deficits in attention, decision-making and learning, with Lader (1992b) suggesting the opposite that sedation may improve coping. Difficulty with attention and concentration was noted by Golombok et al (1988), concentration by Ashton & Golding (1989) and focussed attention (Bishop & Curran 1995). Problems associated with processing or learning have been identified by Curran (1986), Lader (1983), File & Pellows (1987), and with episodic memory by Curran (1991) and Salzman (1992).

Problems of memory are identified by Koumjian (1981), Ashton (1984), Busto et al (1986), Angus & Romney (1984), Mac et al (1985), Association of Community Health Councils (1989), Risse et al (1990), Bixler et al (1991), Salzman (1992), Curran et al (1994) and Bishop & Curran (1995). Amnesia as a cognitive deficit is mentioned by Lister (1985), Risse et al (1990), Bixler et al (1991), Breggin (1991), and lack of insight by Bond et al (1995).

3: The process of grieving is inhibited, prolonged or unresolved by benzodiazepine use.

Fewer studies comment on this but the Committee on Safety of Medicines (1988) and the Royal College of Psychiatrists (1987) must be considered authoritative statements. The

Association of Community Health Councils (1989) mentions benzodiazepines as leading to inhibited or protracted grief and Risse et al (1990) state that they are unsuitable for bereavement and inhibit adjustment to trauma.

4: After withdrawal, clients grieve and realise what experience was lost while taking benzodiazepines.

The delay in grieving is mentioned by Hamlin (1988) and Armstrong (1996). Ashton (1984) notes the sense of unreality and depersonalisation experienced by her patients. Bond et al (1995) suggests that benzodiazepines reinforce psychodynamic defences.

CHAPTER 8

DIFFERENCE IN THERAPY

Is therapy combined with benzodiazepines different?

Therapists were asked to compare their work with clients taking benzodiazepines with those who were not. In this way they were invited to use their other clients as a comparison with those who were taking benzodiazepines during the therapy. The person of the therapist, their way of working, skills, training and experience remained the same, but in some cases the context varied. Some therapists saw clients on benzodiazepines in one agency and clients who were abstinent in another, had different supervisors for different clients, or had worked with clients taking benzodiazepines in the past but less so now or the reverse. Twenty-four therapists believed that therapy was different with clients taking benzodiazepines from therapy with clients who were abstinent.

The client's process

Proposition 11 : Clients taking benzodiazepines appear more difficult to engage.

In the introduction, I gave an account of some of the problems we encountered at the Withdraw Project in finding and engaging clients. They were not queuing up to come and see us and we had a direct telephone line to the Project so that people did not have to make their call through the hospital switchboard. All the measures we took were designed to get people to come to see us and return for a place in a withdrawal group. One side effect of benzodiazepines, which is common with long-term use, is agoraphobia and this is difficult to combat at several levels. In addition clients may appear to have no distress or be overwhelmed by it.

"Well, certainly I feel you cannot counsel someone on benzodiazepines non-directively. If you try, you're likely to get extremely stuck. In fact, you may not even get to being stuck. They're very likely not to turn up, or to turn up once and not come back. They just vote with their feet and there's a lot going on such as agoraphobia, and they just can't handle it."

"As a counsellor I'm allowed in only so long as I collude with their internal world. The minute I start to challenge or question that world as a true reflection of reality, then I will be rejected. I'm the counsellor but I'm there to befriend them, not to counsel (they think). It's almost as if I'm not there to be a therapist."

Proposition 12 : Clients' motivation for therapy is reduced when taking benzodiazepines.

This proposition is related to the former one about engagement but it is different in that it relates to the way the client views therapy. The client has already received a treatment for their problem and probably knows that benzodiazepines make an immediate and noticeable difference. If the client has been taking them for a long time and they have been effective in some way, then it is not surprising if the client is reluctant to consider a change of strategy with the disruption that will mean. Like all work with clients who are dependent on a substance, work with clients taking benzodiazepines may benefit from a motivational approach.

"There is a reduced motivation to do psychological work because they invest the drug with the power to make them better."

"I think that while on them (benzodiazepines), they're not interested in making connections. It's not the ability, it's the desire... a motivational thing."

"The motivational stuff is important. Some people from early on give you clues that they don't really want to be there and they don't really want to give up the drugs. In fact what they'd like you to do, is help them get back to where they were before the GP started messing around (withdrawing benzodiazepines)."

Proposition 13 : Their problems seem less accessible when clients take benzodiazepines.

In addition to problems making contact with the client who may not be strongly motivated towards therapy, therapists can encounter a lot of distress on the surface that seems to be unconnected with the client's problem. If clients have never before considered what their symptoms were about or looked beneath the diagnosis they were given, they may not understand themselves at all. I have asked many people to explain to me what a "nervous breakdown" meant or how they knew they were " a born worrier" and they are surprised first that I don't know, and secondly that they don't know themselves. They had received treatments and education about how to get better but did not really know what their problem was about or what contributed to causing their symptoms.

"I think they can actually appear less distressed on the surface until you actually start to work... but I think they are very good at hiding what the real issues are."

"About 50% who went through the programme came out still taking them benzodiazepines). They were just not achieving anything so in my research we looked at this group into which a lot of work had gone, from the nursing staff and psychologists... It hadn't even touched them."

Therapists seem to be aware that one effect of the drugs is to block emotional accessibility, the numbed off "zombie" effect, and that clients are less receptive to any kind of intervention.

> "Therapy is very different and I think it is about access. People on benzodiazepines cannot access those emotions; it's like there is a dam in place."

> "Therapy is less effective. There is the feeling of not going forward together, the feeling of marching on the spot. There's the feeling with them of not being able to be totally in touch with their own feelings and we don't know the depth of their misery."

Proposition 14 : Benzodiazepines seem to prevent the therapy going deeper.

It is probably inevitable if the client's problems and emotions are less accessible, then the therapy will not go deep to reach the nub of the problem. In addition benzodiazepines' cognitive effects limit information processing at every level and this must contribute to the problem of going deeper. Several therapists were aware of needing to realise this in order not to attempt the impossible. One therapist spoke about abstention from benzodiazepines being a pre-requisite for deeper long-term work. A client centred therapist said that working in this tradition meant working at the client's level and with benzodiazepines, being much more aware of where the client is. A cognitive behavioural therapist noticed much the same.

> "When somebody's taking benzodiazepines, they are unable to work at a level that would eventually work towards emotional and mental understanding and change."

> "It's very, very different if people are actually on benzodiazepines. There's not a lot (of therapy) that you can do. It is certainly considerably dose-related."

"You're very lucky if people are on large doses of benzodiazepines, they very often don't even work at that here-and-now level, even with cognitive-behavioural therapy."

"Therapy is less effective in some ways. It's more shallow. It cannot be challenging; I can't go in for the jugular any time! There's no hitting the inner knowledge that we have; there seems to be no way I can touch that."

Proposition 15 : Clients' potential for insight seems limited by benzodiazepines.

Sometimes the therapist becomes aware that the client is not making real progress and this may be closely connected to the depth of therapy. Some of the studies about benzodiazepines point out the problems associated with learning at the level of consolidation, and this may be what is referred to as a difficulty making the connections necessary for insight. Other studies show that people taking benzodiazepines are not aware that they are affected in this way. It seems likely that this is an effect that benzodiazepines have indirectly on therapy.

"People on benzodiazepines are slower for insight. I think they're slower at grasping it, making connections, the "penny dropping" feeling."

"It feels as though the client isn't connected to what they're talking about. It's a sort of internal incongruity... they can talk about it but its not coming from the right place. I think that they are not learning. It's as if the next time, they haven't bothered to reflect on it. It's partly to do with insight and partly to do with the fact that they can't reflect on what they're working on. It's as though it doesn't attach to anything so they can't use it."

"I think that benzodiazepines block awareness and insights. And it's not just the ability to go inside and make connections; it's the desire."

Proposition 16 : Therapeutic work with clients taking benzodiazepines seems slower and harder.

Since benzodiazepines are sedatives and slow the client down in a variety of ways, it is reasonable to assume that they also slow the therapy down.

> "I have been aware that things may be slowed down; that there's an impaired capacity to retain what has been discussed from session to session."

> "Yes there is a marked difference. I have to go very, very slowly; the steps are minute."

> "You must change how you think people should move forward and allow people to move at their own pace... very small tasks."

If a therapist is aware that the work has been slowed down or progress is not up to their expectations, they may put more effort into the work of trying to reach the client or the problem. It is easy for the therapist to over-compensate for what the client is unable to do and "Rescue" the client. Therapeutic work with clients taking benzodiazepines can be quite exhausting.

> "I think it's harder work. A therapist has to work harder to try and connect things up because the client isn't doing that."

> "It's harder because you get less understanding of your problem as a counsellor of trying to follow some of their thinking. It is much harder to follow the client's thinking because it is so confused at times, and they don't realise you won't understand what they are talking about."

Proposition 17 : Clients depend on the drugs rather than the therapist or themselves.

The dependence on benzodiazepines is not just a physical one but also gradually over time, people can become psychologically dependent too. Many of the studies that explore this refer to the loss of self-efficacy and the shift from an internal to an external locus of control.

> "I think for some clients, it would mean they don't have any sense of being able to survive not sleeping for a few nights or cope with it from their own resources, and they immediately resort to something external."

> "They hadn't moved on from being a victim; they were still not seeing that they had the capacity within themselves to change."

> "They assume that things are hopeless and can't be changed, but with the expectation that somebody else or something else (the drug) would change them; their own powerlessness."

The dependence on a therapist is really a shift away from dependence on drugs and the therapist is working to restore self-reliance by transferring power to the client. The psychodynamic meanings of this are taken up in a later chapter.

> "I think the thing that stands out for me is they were depending on it, and how it can feel safer than depending on the therapist or the therapy."

> "How can we work together to understand what's helpful or not if we're trying to produce some change? How do we know if it's to do with the effects of the pill or the effects of the therapy?"

Proposition 18 : Clients have unrealistic expectations about benzodiazepines.

In addition to attributing power to the drugs, clients often have many misunderstandings and myths about their drugs that result from over-simplified explanations. If they consult their doctors seeking reassurance, they may well be offered reassurance even if it is not strictly true or in their best interests. There is a form of "kindness" on the part of doctors that allows their patients to hold onto the myths and the doctors and therapists can start to believe the myths themselves. One such myth is that the client has an illness with an organic cause that drugs "correct" and they are not responsible for their illness.

> "It was different because of the attributions. You had to be very aware of it because you don't want to put the client down by saying that's wrong information about the drugs. We have to work with it and understand where the client is coming from. It's a sort of mythology if you like and it was not easy to deal with ... having the prescriber hovering in the background."

> "The sense they made of their symptoms is that there is something wrong with them, and these drugs are holding them together, helping them to be what they'd like to be but aren't."

> "They are described as "people-pleaser" drugs, aren't they? To make them acceptable to everyone else, women get prescribed so they can cope with their husbands beating them up."

The patient has a large investment in believing the myths that are offered to them by doctors who are powerful authority figures. The expectation of the doctor is that they know what is wrong with the patient and their role is to cure the patient with medication. This may pose difficulty for therapists who have to hold onto the client's current view of themselves while proposing a change in that view.

"He told her she would be fine to stay on as long as she wanted. So if the doctor says it doesn't matter, why is it important (to come off)?"

"I've never found it helpful (prescribing during therapy), because it gives a double message to the client. We've defined their difficulties in psychological language, and a doctor has viewed their problem as needing medication."

"The client says, "Oh, I was put on something." The doctors in that practice are not prepared to work with me. I will say, "I'm aware your doctor put you on this, so we need to look at how this will affect us in here."""

Proposition 19 : The client may view the therapist differently.

Clients may view their therapist as the person who is going to help them understand themselves and resolve their problems in some way, but if they have not taken drugs they have not had an alternative. If clients have had unrealistic expectations of benzodiazepines, especially believing in the drug's power to change them, it follows that they are less likely to invest their hopes in the power of therapy. Therapists can pick up a sense that the client does not really need or want the therapist or therapy. However when the drug is given up all the hopes are invested, sometimes unrealistically, in the therapist.

"This particular medication is affecting the person's mind and it has been prescribed for that reason. But it will affect the way that person reasons and thinks and feels and perceives what you are there for."

""Because I'm actually feeling a lot better, I don't need you." And so I go from "saviour" to "not needed" in quite a quick space of time."

"(After she was off her drugs), I was her protector; I was the one who would lead her to the light; I would show her the way forward. I was questioned by the GP which didn't help; his view was that I was wasting my time. I was convinced I wasn't and I think the long-term outcome has proved I was right. But the clients

were very needy; maybe that's how they got into the drug situation in the first place."

Proposition 20 : Benzodiazepines can reinforce psychological defences.

There are a number of ways that clients can keep things out, so that they do not have to be aware of them. Denial, avoidance and anger can all serve this purpose and benzodiazepines are effective ways to suppress thinking and emotions.

"They're just not in touch with their suffering. It's a kind of denial."

"When you think of exposure treatment for anxiety, taking benzodiazepines would be seen as an avoidance behaviour together with other avoidance behaviours."

"I think the client's defences are increased in a way; one woman's dominant psychic defence is anger..."

A number of therapists indicated that they saw benzodiazepines as a form of resistance to therapy that allowed clients not to own things, or defend against the therapist's intrusion, or provide a rationalisation for ending therapy.

"Everything is "you this, you that" and I have endeavoured to get him to personalise statements, but there is just enormous resistance, absolutely enormous resistance."

"People go away and disconnect things and you have to start again almost, and I think drugs accentuate that sometimes. In a way, people can use drugs as an alternative to therapy or even as an attack on therapy."

"People say, "I don't even know what I'm doing here", and "there are a lot of people and I know you have a long waiting list", and "am I wasting your time?" I would interpret that as a defence mechanism, resistance."

The unwillingness to take responsibility for emotions is understandable because their doctors have been willing to prescribe drugs to remove them. Therapists commented on intellectualisation as a defence. A number of other points were made about how drugs reinforce the clients' dependence needs, which can then be expressed as a desperation to be dependent on the therapist. Often it is when the drug is given up that its function as reinforcing a defence becomes clearer. A longing to be at the centre of the therapist's attention may indicate regression following early narcissistic injury. Turning the problem into a physical rather than a psychological one indicates somatization.

"They're more dependent and know it. "Stay with me because I need you...I'm not sure why I need you...But I know I need you..." It's a need rather than a want. I think it's because they feel so helpless and out of control."

"They want to be the centre of focus and attention. It's like the earth and the sun...they are the centre of the universe and other people are just being totally unreasonable around them."

"I asked her if she thought what we'd been talking about (a physical condition) might have been related to how she was feeling. "Oh no, no, no...the doctor says I've got irritable bowel syndrome and it's nothing to do with what we've been talking about.""

The therapist's process

Proposition 21 : The focus of therapy has to be on drugs initially.

This is an obvious difference in that there is a secondary problem to the counselling which other clients may not have. In specialist addiction services the focus on drugs is

seen as the main focus but there is considerable agreement that the drug issues have to come first before other issues can really be dealt with. Not all therapists will have been trained in this way but many told me they had discovered through experience that working with an understanding of the drug issues was important.

> "With people taking benzodiazepines, coming off becomes the focus of the work to start with, so that is different because they are bringing a very concrete problem into the therapy."

> "You do the patient a greater service, helping them to withdraw from the drug, and then suggest that they embark on counselling. It needs to be focussed on the drug."

> "I'm assuming that if I'm working with somebody on benzodiazepines, they've agreed that the ultimate aim should be to come off them, so quite a bit of the session would be taken up with where they are in that process."

Proposition 22 : The style of therapy has to be adjusted.

The main issue in dealing with medication is that the therapist has to give advice or guidance, but certainly they feel they have to be much more directive than they would be with other clients. This may be because the myths about benzodiazepines need to be confronted, or clients need accurate advice about appropriate rates of reduction, or they need to be forewarned about withdrawal symptoms or alternative ways of dealing with those symptoms rather than returning to drug use.

> "I feel that it was my place to advise the patient about the medication. I would be giving advice and guidance and explaining what is going on, explaining the way drugs work."

> "People taking benzodiazepines need a lot of support and guidance. And it needed me to be the one who was setting out what we should do next, and I had to write down the next stage in their reduction because they couldn't hold it in their head. With people who were quite heavily dosed, I would find that week after week we would go through very similar or practically the same conversation."

A number of therapists had realised that they had to adjust their way of working with these clients and commented on how this impinged on the assumptions about therapy from different traditions and orientations. A directive approach is seen as more congruent with cognitive behavioural therapy than with person centred therapy or psychodynamic therapy.

> "I think it's probably harder for people who work in a person-centred or psychodynamic way, because it's to do with being comfortable with being directive. There's no way you can work with people on drugs without being directive. The counsellor has to set the agenda when they believe that the client should set the agenda."

> "I think behavioural approaches seem to be the best at that stage, because I don't think you can do the deeper psychological work until the basics and the safety are sorted out. It can't be done without the basic foundations which I think cognitive-behavioural work gives them."

Proposition 23 : There is often a question over who is in control of the process.

Being directive, advising and guiding are all ways that therapists can be in control of the process but this may be different from the way in which they may attempt to have a more equal balance of power with other clients. If there is an assumption on the part of the therapist that withdrawing from medication will allow therapy to take place, that may

override the client's former assumption that the decision to take benzodiazepines was really up to them. There are other participants in the process such as the doctor and the drug itself that may be exerting some control over the process.

> "I keep trying to hand the control back to them, but these clients are very helpless. We will struggle through it together. It's much more accompanying them; I don't tease them and I use less humour because they just wouldn't respond. There's no lightness about them."

> "There's more potential in these circumstances for therapy to be sabotaged (by prescribing). I don't think doctors were knowingly trying to sabotage the kind of relationship you have with the client but it wasn't very helpful and you have to deal with it very diplomatically."

> "If I had a client who took hypnotics every now and then for insomnia, that would be different. First of all, why does he resort to drugs in this particular instance? What does he think the drugs are doing? If it was more than just a few times, then I would have to bring in the possible effects on the therapy."

Proposition 24 : These clients seem to be more demanding and challenge boundaries.

Therapists often feel drained by these clients who are more demanding in some ways as if they are having all the energy sucked out of them, and can see very little change. A number of therapists commented on how frequently benzodiazepine withdrawal groups seem to want to spend time complaining and that the therapist can absorb a lot of covert criticism. The constant negativity, going over and over the same ground has been the undoing of some self-help groups, who lacked someone to keep the focus and boundaries intact. The constant demands of telephone calls and requests for support can overwhelm group organisers.

"Their relationship with me is dependence but it is more than it would be normally. Whereas everybody comes in and grabs at you until they realise, these clients are more....sometimes I feel there is a quality of teasing you...I'm not sure that it's clingy but it's not entirely honest because it's more gutting."

"What's different is trying to keep myself on track with the therapy. It's hard when they're down, when you've struggled for a year and a half and there feels to be little movement forward. They demand a deeper level of energy but they don't seem to receive energy."

"I think there was a danger of me colluding with them, partly because of my fear of rejection, and therefore I lower or raise my threshold to challenge. In other words, I would challenge less often or allow escape on a challenge, which I don't think I would allow with other clients."

Proposition 25 : Therapists feel more frustration when the client is stuck.

Therapists can feel very weary with how long this process can take and if they are more used to working in brief and focussed ways this can be very frustrating. It is time consuming work since withdrawal from benzodiazepines is done gradually at the client's pace. In between reductions, clients seem to need time to adjust to the psychological changes that have occurred and also time to contemplate the next reduction. They can appear to be stuck with reducing the dose or stuck in the process of change and therapists can feel helpless themselves.

"I spend a lot of time trying to split them from the drug."

"I end up getting a bit lost in it and wondering what they're getting, what they're doing, and I sometimes wonder if that is their experience. A sort of frustration that we're not doing anything here."

"Well, it can make me feel quite angry and frustrated, that instead of bringing their feelings back to me, they've just taken a tablet. Then I have to try and make sense of my own feelings and find a way of using them that's helpful to the client, rather than getting annoyed with them."

"I feel very strongly anti people being on anti-depressants and tranquillisers and I feel sometimes that's made it quite difficult for me. Although I would never tell a client to come off drugs, I sometimes feel they may pick up my feelings about it."

Proposition 26 : Therapists may deny or avoid problems with benzodiazepines.

For a variety of reasons therapists may wish that the problems associated with clients taking benzodiazepines would go away or not be there in the first place. It may be too difficult to confront other therapists, doctors and clients so the problem is ignored. The survey of NHS psychotherapy services suggests that this may be the case. One way of dealing with this is to be ignorant of the problem.

"I really couldn't say because when you are doing that sort of therapy, the medication they are on tends not to really be discussed, and I don't really think about it unless it's very obviously affecting them in some way. That doesn't tend to be the case when they've been on medication for a long time. So, I'm afraid I don't have anything to say about it."

"I know people who were involved in research (on benzodiazepines) and I talked to them about it; I wasn't actually involved directly. No I haven't done much reading. I have to say I haven't been really interested."

Another strategy is to avoid the problem by leaving it to someone else, the centre, the doctor, and to find a good reason for doing so. It may be fear of incompetence or it may also be fear of the client's response that is the reason the therapist avoids raising the topic with the client.

"I think counsellors actually don't want to have to deal with this because they don't know how to, are frightened of dabbling in that area and feel very vulnerable. They'd rather leave that to the doctor because it's their business, and "What about undermining the doctor-patient relationship?""

"I have to be careful; what I say is filtered. I'm thinking, "I am not going to be able to penetrate this", and also if I tried, it feels as if I would produce more anxiety; they would retract."

Proposition 27 : The therapist experiences more role conflict.

Several therapists spoke about feeling very uncomfortable with an expert role and being knowledgeable about medication although they could see that it would be useful knowledge to have. It is particularly difficult to raise the issue in a team where others may not support a tentative viewpoint and therapists risk feeling demolished. The medical profession's assumed superiority can be difficult to challenge when the referral is from a general practitioner but it might be even harder if that medical professional is the manager of the service. Prescribing is such an accepted practice in some settings that therapists fear colleagues would be amazed if they questioned it.

"Asking the counsellor to set the agenda when they believe the client should set the agenda is not such a problem for cognitive-behavioural therapists, but the difficulty for person-centred counsellors is their extreme reluctance to be in any way an expert. And giving information; sometimes you can swing it round a bit and help them see they are empowering the client and it becomes more acceptable."

"A clinical psychologist (supervisor), having set beliefs as I have set beliefs and we're rigid in our own ways, saying, "Well, I think it would be very helpful if this

person who is suicidal were on tablets." And me saying, "Well actually I think it would be better for them to stay with me and work through the pain." And then having to go away and wonder if I am right."

"I recently made some sort of resistant gesture in the mental health team. We have a unified intake system and discuss referrals once a week. It's a very frustrating process because there's a tendency to diagnose, accept the GPs perceptions... There's a sort of team approach, "Oh well, they're asking for psychological treatment, give them one." And I said, "Hang on, the GP prescribed something so they've already had a medical approach.""

Proposition 28 : Therapists experience the drug's effects.

Therapists can feel confused, muddled, and that they are not able to make connections or are in other ways limited in their thinking. They may experience flatness, lethargy or dullness emotionally or feel blocked and that their potency is affected. Sometimes, therapists seem able to hold conflicting views about the drugs almost without being aware that they are doing so. There are some examples of this kind of dissonance here.

"Like I said, it's about feeling stifled and a feeling that my potency is interfered with. My effectiveness is blocked. I think feeling stuck in ...a flatness. I suppose it feels like lethargy; it's bizarre really."

"I don't think benzodiazepines and therapy are incompatible... I don't know of any evidence that combining them increases positive outcome... I think they can undermine therapy because of the investment that's made in the drug."

"I think it's to do with the drug getting in the way. I would see the drug as an obstacle, and there would be a case for saying that this person is not suitable for counselling while they're taking that kind of drug. But then now, we are using counselling to withdraw the drug."

Proposition 29 : Benzodiazepines seem to undermine the therapeutic alliance.

A number of therapists made the point that prescribing and referring for therapy gives a mixed message; that medication is needed and that the client can sort out the underlying problem. They are also aware that their own ambivalence and reluctance to make a clear statement about their own beliefs or preference adds to this. Then the client may want therapy but also want benzodiazepines just as much. The problem is whether benzodiazepines and therapy are incompatible and if they are, why counselling is used to assist withdrawal. Clearly some counselling works while clients are still taking benzodiazepines, but it is not easy to explain to the client why they need to withdraw from the drugs in order for counselling to continue. It seems to be that what therapists want to offer to clients is the best of therapy.

> "I feel quite strongly that therapy is different because I feel that we're not in there together. I feel that we deal with a lot of things, but it's not the core. Because I work in a time-limited psychodynamic way, I'm really addressing the relationship constantly, and I feel we are not addressing core issues when the tablets are there."

> Soon after they either end or just don't come back, so either way it's premature. I'll usually be sitting there knowing that as far as two people can, you've got a common understanding of where you're at. With these people (on benzodiazepines) I often don't.

> "I believe that there are energies that pass between people and that that energy is effectively blocked with benzodiazepines. The transference is totally different."

> "They're far more draining, and there's a feeling of sadness within me because they can't take what you can do for them. I would give so much that they could take it off and go with it, but at the end of the day, you give it and they can't use it."

Comments contrary to the propositions

Two therapists stated that they were ambivalent about whether therapy was different with clients taking benzodiazepines or not. One of these two had specialised in benzodiazepine withdrawal and had clearly enjoyed that work and found it very rewarding. She had earlier commented on the way she saw benzodiazepines interfered with grieving.

> Therapist: It's actually quite difficult for me to say whether it's different or not.
> Interviewer: As you work in a person-centred way, do you need them to be fully present in the relationship with you and fully in touch with their internal reality?
> Therapist: Thinking about it logically in those terms you'd think, yes, but obviously if they're not fully able to... but then a lot of people I've worked with because of their feelings for other reasons... and you'd think that that would interfere, and yet... I just felt that for me, working with benzodiazepine users was probably a very rewarding experience.

The second therapist had a nursing background before therapy training, and worked in a medical setting in a general hospital with clients prescribed benzodiazepines pre- or post-operatively, so the context may be influential here.

> Interviewer: Is therapy different in any way?
> Therapist: I don't think it is really, no, because that reflects the limits of my vision... I think frustration is not an uncommon feeling with these clients, because I don't feel I'm being effective. I feel it's inhibiting. It feels quite oppressive, in a sense. I feel stifled.

Comparison with other data sources

The data collected from the survey of NHS psychotherapy services is minimal on the issue of whether the therapists view their clients taking benzodiazepines differently. There are some replies that indicate that whether the client is taking medication or not is seen as irrelevant, while some replies indicate that therapists are taking it into consideration at the beginning, and that implies that they think it will affect therapy in some way. What they say they do about it is sometimes inconsistent or even contradictory. However these answers come from being asked to give the rationale for not having a policy and it is important not to read too much into them.

As before I have developed some outcome propositions (Maykut & Morehouse 1994), which summarise the propositions in this chapter and I shall compare these outcome propositions against the documentary evidence reviewed earlier to see if there is convergence. Although these outcome propositions were derived from the propositions, the two which relate to the therapists' views about the client's process mirror the two which relate to the therapists' views about their own process. This seems to indicate some consistency of viewpoint.

Outcome propositions

5: The client taking benzodiazepines is less able to respond to therapy.

The documentary evidence in the previous chapter, which supported propositions about emotional numbing, cognitive processing deficits and disengagement, also applies to this outcome proposition. However since therapists views which have formed this proposition are derived from their comparison of clients taking benzodiazepines with

those who were not, it seems that all clients taking benzodiazepines, not just those who are bereaved, are less able to respond to therapy for these reasons.

Furthermore in the addiction literature, substance use is believed to slow down necessary memory acquisition and interferes with affect regulation (Trotter 1995), complicates pre-existing conditions (Washton 1995) and is a cause of psychopathology not a consequence of it (Murphy & Khantzian (1995). Kaufman (1994) makes the case for the client's abstinence as a prerequisite for therapy, Hammersley & Beeley (1996) that the symptoms are the means of access to the problem, and Dillon (1991) that the client is prevented by benzodiazepines from addressing the cause of their distress. Armstrong (1996) warns that counselling is wasted until withdrawal takes place.

In the psychodynamic literature, Ghodse (1995) states drugs impair awareness, concentration, attention and memory necessary for therapy and that clients are difficult to engage in analysis. Klerman et al (1994) identify effects on the alliance and reduced motivation as reasons clients cannot respond, a point picked up by Kahn (1993) as well as drugs decreasing self-esteem. Ostow (1993) noticed that patients show superficial insight and limited behaviour change, while Parry (1996) considers that benzodiazepines reduce the impact of psychological treatment. Karasu (1982) suggests drugs reduce the client's ability to respond to psychotherapy and unwittingly mask feelings.

6: Clients have a positive transference to benzodiazepines.

Drug dependency is seen as a substitute for important personal relationships (Ghodse 1995), a substitute for the self-object (Kohut 1977) or a source of power (Levin 1995). Many sources explore the meanings of the client's transferences to tranquillisers through

the metaphors (Montague 1991, Helman 1981, Lennard & Cooperstock 1980, Montague 1988a, 1988b, Morgan 1983, Rhodes 1984, Szasz 1974). Barkin (1978) refers to oral eroticism of transitional objects, Levy (1993) as a means of separation from symbiotic relatedness and Hausner (1993) to the drugs having soothing effects.

Nevins (1993) points out the psychological meanings of medication, which are transferential, while Goldhamer (1993) sees the drugs as a gift of a magical cure, and Block (1979) that drugs represent the doctor's interest and caring. The psychodynamics and meanings of benzodiazepines are returned to in a later chapter.

7: Therapists need to make adjustments for clients taking benzodiazepines.

In reflecting on their experience of the therapeutic process, therapists believe they need to make adjustments and Rawson (1995) suggests that therapy cannot be passive, the focus should be on drug use and the therapist must be directive. Levy (1987) says therapists must be alert to dependence, look out for defences and give advice. Hamlin & Hammersley (1989) advocate an integrated approach to drug withdrawal incorporating it in therapy and Parry (1996) states that given the client's reduced capacity to engage, the skill of the therapist is crucial.

8: Therapists have a negative countertransference to clients taking benzodiazepines.

Kaufman (1994) refers to therapists splitting drugs and therapy, while Ghodse (1995) points out that the therapeutic alliance is a substitute for drug use. Levy (1993) says that drugs can support the avoidance of the therapeutic task and satisfy therapist's regressive yearnings, but Hausner (1993) gives examples of how drugs can undermine the process.

Sexton (1996) refers to getting stuck with the patient who is stuck on their drugs and Schachter (1993) to the tendency to resort to medication if therapy fails.

CHAPTER 9

MEANINGS AND THEORIES

Psychodynamic Meanings

Many therapists commented on the roles and expectations between the doctor, therapist and client and how these can be played out unconsciously, replicating early interpersonal and family dynamics. Transactional Analysis, (Stewart & Joines 1987) highlights these dynamics in its game theory, showing especially how games can be played in triangular fashion around the Drama Triangle of Victim, Rescuer, Persecutor roles. These roles are played out of awareness and there is no suggestion of conscious intent. The drug, in this case a benzodiazepine, is also sometimes the unacknowledged third party in the dynamic relationship, just as "the illness" may have been a third "person" in the client's personal relationship with a partner or parent.

Another way of looking at the underlying dynamics in these triangular relationships is to use the concept of projective identification (Cashdan 1988), in order to categorise the interpersonal processes that are being unconsciously enacted. Cashdan suggests four main projective identifications, dependency, power, sexuality and ingratiation. I have chosen to replace sexuality with seduction because this seems to me to fit better with the world of drug addiction and advertising that I think forms the wider contextual framework for these micro-processes. Whereas in object relations therapy, the projective identification has a relational stance or role adopted by the client in the relationship with the therapist, in analysing what occurs in these therapeutic processes, I believe that all the participants can at some time adopt each of these relational stances.

Proposition 30: Doctor, therapist and client are involved in a triangular relationship.

One scenario may be the client in the Victim role, the therapist in the Persecutor role who is making the client do painful work and the doctor in the Rescuer role, who can take away the pain. This can then lead to the doctor unconsciously undermining the therapy by prescribing sometimes for what seems unrelated, such as insomnia. This highlights the importance of all three participants acknowledging that therapy can sometimes be painful, difficult or disturbing.

> "Well, it can be about the client's relationship with the GP. The day after the therapy session they always go to the GP and say they need valium or a sleeping tablet, which might be quite a significant way of having someone else who's there. Most GPs are men; clients can set up a sort of parental thing, a triad between me and the male doctor."

> "The therapy setting had a triangular aspect to it in that there was a prescriber there as well as the client and psychologist.... What I found difficult to deal with was having the prescriber in the background... hovering. I don't think people were knowingly trying to sabotage... It affects the kind of relationship you have with the client. You have to deal with it very diplomatically."

> "The client says, "Who are you to tell me that I should look at something?" The GP does reinforce that for me. I think it occurs when the triangle of the three of us is not addressed in the assessment and ongoing in a collaborative way, that I feel the GP and I have played off against each other."

Once therapy has started, the third party role formerly occupied by the doctor can be replaced by the drug, which has been his "parting gift" to his patient and for which they may unconsciously have agreed the patient can secretly return. The monthly medical consultation for a repeat prescription provides an opportunity for the client to disclose to

the doctor that the therapist is trying to make them dispose of the "gift". Even if the doctor does not want to sabotage the therapy, and can tolerate this discounting of the gift, he or she has to re-prescribe inevitably reinforcing the message contained in prescribing. Issues of dependence, power, transitional objects, resistance and splitting can all emerge.

> "The drug is like another person in the dynamics. It's like dependence; he does depend on the drug; he can't imagine his life without it. The drugs have become a prop and the thought of having that prop taken away; they are going to collapse. And I'm the person that's there saying, "I want you to give this thing up." So he could feel quite angry with me about that if he wants to resist what I'm saying. And I could become like the bad parent and the drug might become like the good parent... something like that. I do need to think about the kind of relationship he has with the drug and the relationship he has with me, and his family, and the doctor..."

> "And it could also be symbolic in that drug taking maintains a relationship between you and your doctor who perhaps could be seen as a transferential object in themselves. There is a secondary gain whereby benzodiazepines enable other sorts of relationships, for example between oneself and one's partner, or it enables you to have your GP regularly monitoring you."

Proposition 31: Dependency is a dynamic of the relationships.

The relational stance of dependency is one of helplessness, in which the person is expressing fears about their ability to cope. The self-object is bad, inept, a failure, worthless and weak and the metacommunication is "I can't survive". This induces a response of caretaking on the part of the other person in the relationship. The patient seeing a doctor may utter words such as these about not being able to cope and the doctor takes responsibility for resolving the feelings of helplessness by prescribing a drug. The doctor's response may be seen as over-enabling, or in transactional analysis terms, the Victim has found a Rescuer. As games proceed along these collusive dynamic lines until

the switch occurs and the game ends, the doctor moves around the drama triangle from Rescuer to Persecutor. The therapist may also have feelings of dislike and want to push the client away in response to the client's projections of dependency.

> "I think many prescribers probably have a stereotypical view about long-term benzodiazepine takers. "If you take them off (referring to older people), they're going to have a greater dependency on us perhaps. They're going to be in the surgery much, much more." So they've perceived it as basically a hassle both in terms of the patient and in terms of the impact that might have on themselves."

> "I feel that when they're on benzodiazepines, they're very childlike, and very needy for the basics in life."

> "They're more dependent and they know it. Sometimes I feel that there is a quality of teasing you... I'm not sure that it's clingy but it's not entirely honest because it's more gutting. "Stay with me because I need you... I'm not sure why I need you..." It's a need rather than a want. I think it's because they feel so helpless and out of control that they can't even see a handle on the control."

Prescribing benzodiazepines deals with the client's dependency needs directly by giving them a transitional object on which they can depend, to substitute for the good-object doctor so that they can separate. Very little was said in these interviews about the doctor's feelings of dependence in the prescribing dynamics, although it is commented upon later to some extent in the implications. However, it may be that doctors are distressed by their own dependency and countertransference feelings and reduce their anxiety by prescribing for the patient, giving them a transitional object in the same way that a mother may leave a toy with a child she is leaving. Therapists were aware that the client had transferred dependence needs onto the drug, and clung to it perhaps because it was safer than dependence on a bad-object therapist.

"There are those who take benzodiazepines where the symbolic nature of it is in evidence, as a way of nurturing themselves while they're taking the medication. Perhaps it's a tonic; it's a way of doing positive things for themselves. Perhaps their own experiences were that when they were distressed or in need, they were given something as opposed to helped or acknowledged. You know, "Open your mouth, shove this down, and don't bother me again", type of approach."

"This lady who carries her tablets around, told me her mother still carries a tablet around with her. In fact she said her mother's sister had been prescribed benzodiazepines and she carries around a tablet that she still has. Actually taking the tablet away was quite frightening, as if you were okay as long as you physically have it with you. The difference is that they'll say, "I need them" but will not acknowledge the negative, that they might actually be doing some harm. So they have to keep the tablet good, if they've been in a world which is as miserable as not having a parent."

The therapist is also a potential good-object on to whom the dependency needs may be transferred, so that the drug can be given up, and more can be received through the therapeutic relationship than could ever be accomplished by a drug. However the client is often reluctant to do that and holds onto the drug as a transitional object even though it is not being taken. Its mere presence is soothing.

"I have a client at the moment who is fairly agoraphobic and obsessional. Many years ago he was taking diazepam 2mg tablets. He carries them around now but I don't think he's taken any for about five years or more. I've chosen not to confront that, but at some stage if he doesn't decide to give them up then I will have to decide to confront what he's doing."

"The issue is the dependency that they can't survive without it. You don't want to leave them and either they continue with the drug or they have to come off later unsupported, which they don't believe they can do. So it's a support mechanism

as well. At the time she was on the drug any event however trivial, was blown up out of all proportion as evidence of her inability to cope. Being on the drug made her feel that she couldn't cope because she needed to live with the drug."

The client's ability to take control of the transitional object, as a child controls or sometimes scolds a doll, is a very important feature of it and it gives the person a sense of being strong rather than weak, independent rather than needy. The client cannot control access to the therapist anymore than they could control the parent who left them and therefore attachment to the therapist is a risk. The therapist who identifies that the drug is a "crutch" is aware that the client will need to lean on her as a prelude to learning to stand on their own feet.

"They are very dependent people but at the same time there's a great reluctance to become dependent on me. Some people substitute dependence on you for their drugs very easily, but in my experience that's an achievement that has not been an easy step for the client to make. It's much safer to be dependent on a drug because you have control over it but you can't control another person. It is an unwillingness to risk attachment."

"With some clients one might interpret the level of defences that are involved in taking medication to blunt emotional reactions, and what it is symbolising, and whether it is resistance. Is the therapy ever complete if the client is taking drugs? I would be left with a degree of dissatisfaction because my agenda would be to hope that someone could sustain themselves without that kind of crutch. And whether even if the drug were relinquished, the dependency would be displaced onto myself or on to something else."

Therapists also have feelings of vulnerability and helplessness in the relationship with a dependent client, and this is sometimes expressed as insecurity over their role in relation to drug withdrawal. The client is frightened and the therapist is frightened and

sometimes therapists are also looking to the doctor to take responsibility for decisions about the therapy. Not knowing anything about drugs is an example of dependency.

> "The patient is a little bit frightened very often. The sort of person who chooses to come is usually aware of what drugs do to them.... But look, it's a speciality... the reality is that I'm very unprotected but I'm supposed to say to the doctor, "Please take them off so that we can work together better." I'm very often very worried...."

> "Supervising other therapists, they resent me raising the question of benzodiazepines. Because they're actually frightened of dabbling in that area and they don't feel competent to do so and they don't like my suggestion that they should. I think they immediately feel vulnerable because they haven't picked it up and they feel they are being told they should know something about this. They actually don't want to deal with this because they don't know how to and its a threatening area. They'd rather leave that to the doctor because it's their business and it brings up all kinds of issues."

> "I find that a lot of counsellors feel, "I'm here to work with your psychological stuff. That's another issue. That's not part of what I'm here for". The other thing is that people are quite frightened sometimes of people on medication. They feel this is a great responsibility and I'm only a counsellor and perhaps I shouldn't be seeing them if they're on medication as well. Forgetting that the doctor isn't a counsellor when he prescribes!"

Proposition 32: Power is a dynamic of the relationships.

The relational stance in the power dynamic is one of control, in which the patient having expressed fears about being out of control unconsciously invites someone more powerful to take control. The patient is seen as fragile or fragmenting and the metacommunication is "You can't survive" and this leads to prescribing, controlling symptoms, and doing as

the doctor says. The patient may feel incompetent, inadequate or unable to take care of themselves, and complies with the wishes of the omnipotent doctor. An important feature of transitional objects is that the person is in control of them, thus giving the client a sense of control. The potential for a battle of wills between competing views about therapy and benzodiazepines may lead to conflict between doctor and therapist which may not be overtly expressed.

Splitting

Where there is more than one person helping someone, there is potential for splitting, and where both doctor and therapist are involved with a client, one can be a good-object and the other a bad-object. Earlier I referred to the doctor as the good-object parent who responds to the helplessness of the patient by prescribing a drug as a transitional object. However that relationship can go sour when the doctor realises that the patient has become dependent on the drug. The doctor can remain a Rescuer by reassuring the patient that they are not really dependent but really need the drug. Alternatively, the players can move round the Drama Triangle so that the doctor is no longer the Rescuer but the Persecutor who is telling the patient that the drug must be given up.

> "They can go to the GP who will give them something, whereas the therapist isn't physically giving them anything. So they are comparing a more giving parent with a more pain-inducing parent, splitting. Then its important to communicate with the GP and try to minimise the split, otherwise it can get completely out of hand and the client can always set the GP up to sabotage the therapy.

> "I had a client fairly recently who went off in the middle of therapy to get a prescription for hypnotics. He hadn't really thought at all about the significance of this, and it hadn't occurred to him that not sleeping was anything to do with what we were doing together. When we talked about it, it was okay and he

stopped taking them. He just thought he wasn't sleeping and the doctor would give him some tablets.

The client can also realise that they have become dependent on the drug and become very angry with the doctor and turn him or her into a bad-object and be searching for a better "parent" by entering therapy. The therapist can be a good-object who promises more by offering a relationship in which the client may perceive an opportunity to become dependent once more. If the client enters therapy not realising they are dependent on a drug, the therapist may become bad, a Persecutor who is threatening to remove them from the drug. In several ways good and bad objects may be split so that doctor and therapist are seen on opposing sides. Both doctors and therapists can engage with this transferential drama by competing to be the patient's good object.

And that means that they're splitting the picture into good and bad. A little bit of anger at the doctor who's dumped them on you, who couldn't care, but generally it's my fault not their fault and they've got me anyway. I'm an inadequate doctor, somebody who deals with mad people.

"They're not totally incompatible, but in a sense they are working against each other. If you're saying to a client, "Well, you must feel your feelings" and the doctor's saying, "There, let me give you something to take away these nasty symptoms", then you've got two really polarised positions.

Several therapists spoke about their awareness of the importance of dealing with the client's dependence issues without allowing splitting and the power balance, by keeping up contacts and communication with the prescriber. Certainly where therapist and doctor both realise the danger they can take steps to prevent splitting. One important way that splitting is avoided is by both doctor and therapist having a clear understanding of the

boundaries in their professional relationship and an agreement about whose responsibility it is to advise the client on withdrawal.

> "I'm thinking of one GP my client used to go to, asking for medication. He did occasionally give medication, but more often he would tell her to come and talk about it in therapy, and that's what the therapy was for. We did speak on the phone several times and I think the client felt much safer in some ways. She didn't particularly like it but when she saw that she couldn't actually split us completely, and we were going to stand together in a way it was like having parents who are consistent."

> "But look at me. There I am working in a practice and you make me feel very aware that I haven't really found out enough about medicines. You're quite right there is a split, and it needs bridging."

> "So it would be a question about boundaries, and would it be viable to maintain sufficient boundaries for therapy to take place? Or is this person so involved with medical professionals and would it cause too much conflict?"

> "If they haven't taken it on board that they're going to experience some mild discomfort, there's a tendency to run to the GP. I've even had one person hospitalised with a possible heart attack. One lady went to the GP and the GP went and upped the dose even though I'd negotiated with the GP on taking this person through a withdrawal programme."

Proposition 33: Seduction is a dynamic of the relationships.

The relational stance of seduction (also sexuality) is eroticism, in which the person expresses desire, wanting or addiction. Dependence on benzodiazepines is not usually classified as addiction because the dependent client does not usually engage in the drug-seeking behaviour and increasing the dosage that characterises addiction to illegal drugs. The client who is seeking instant gratification from the drug is seduced because the metacommunication is "I will make you whole". The doctor's promise of wholeness is

contained in the concepts of making the patient better and cure. At another level the message to the patient is "You need me" or "you need my drugs to make you better".

In the wider context, the pharmaceutical companies have put enormous amounts of money and time into persuading doctors to prescribe their products even where the need for the drug has barely been established. They seduce the doctor with promises that the drug will satisfy their patients' demands and the doctor may be sucked in to the client's projections that way. Oral eroticism may be involved in the fact that the transitional object is consumed thus allowing fusion or merger with the good-object. Doctors who tempt patients with drugs and who offer drugs as an alternative to therapy when it is difficult may be acting into a projective identification of seduction.

> "There is a reduced motivation to do psychological work because they invest the drug with the power to make them better. Psychological work is much more painful, and if one can get immediate gratification, we all take that option at times if the pain is unbearable."

> "There are people who firmly believe that benzodiazepines have a continued and specific effect that is desirable, and the way they feel and cope with their problems reflects on some external locus of control attributable to the drugs. When they present in therapy, you are on a hiding to nothing because their desire is for you to provide them with some external stop-gap."

> "They have unrealistic expectations because the tablet was a cure-all and instant. I have a lot of men say to me, "Well, I'd really rather just take a pill. I've been here for 6-10 weeks and I don't feel that you've given me anything; you haven't done anything."

One way that therapists can engage in seduction is by trying to persuade the client to come off benzodiazepines with an implicit promise to make the client whole after the

drugs have failed to do so. Therapists may encounter a great deal or resistance on the part of clients and offered views about preferring to adopt a motivational approach or empower the client to make decisions. It does not make a difference whether the drugs are being offered or withdrawal is suggested, persuasion by doctor or therapist may be seen as seduction and resisted.

> "They are described as people-pleaser drugs aren't they, to make one acceptable to everyone else. Women get prescribed and say they can cope with their husbands beating them up, if that's coping. I can't see that I'd have ever started training (unless I'd come off). I'm also prepared to fail. I'm strong enough in myself to feel that I don't have to be the good girl and get it right all the time anymore."

> "I think, for some people I might have to work with them a little while before I could address coming off, in order to build a relationship, engage with them. Engaging is more difficult, building a relationship is equally difficult. I would have to put more effort into motivating people."

> "How I see my role is to enable them to make a decision for themselves. So I suppose I really have got a neutral attitude to it, because I think it's counter-productive to try to persuade people to do things that they don't want to do. It affects the therapeutic relationship negatively so I don't do it. I wouldn't see my role as persuading them or motivating them to do anything."

> "If somebody's on benzodiazepines and their attitude is, "this is the only way to go" then I think psychological methods are more difficult and might not be possible. They can resist the psychological intervention while they have that as a prop, especially if it's reinforced by repeat prescriptions."

Proposition 34: Ingratiation is a dynamic of the relationships.

The relational stance of ingratiation is one of self-sacrifice in which a person is willing to suppress or deny their needs for the benefit of others. Over-enabling and over-

accommodating the client may involve ingratiation. This is the Rescuer role in transactional analysis where resentment is suppressed but the Rescuer expects to be paid back with appreciation. The metacommunication is "You owe me" in return for being willing to give the other person whatever they want. Clients have sometimes drained themselves in the service of others by being over-nurturing and have difficulty nurturing themselves except by taking drugs. Doctors, therapists and clients can find it difficult to say No.

> "The doctors only want to know if it's going to hurt their pockets. I think their policy if anything, is, "What do you want? You feel like this? Okay." It is unrecognised ingratiation."

> "Someone comes in very distressed and a tranquilliser will make a difference immediately. It would be a way of the prescriber scoring points with the patient, that the patient comes along with a high expectation of the doctor, and the doctor can give them a prescription that's going to immediately make them feel better. I think there needs to be some understanding about doctors feeling that they have to ingratiate themselves with the patient and the doctor wants to be seen as giving good service to the patient, and the patient would feel let down if he weren't given one."

> "I feel that if a person has been taking benzodiazepines for some time, they are more vulnerable than they otherwise would have been. They want to please the counsellor and it may not be the ideal we are aiming for, but the reality is they will say "yes" when maybe they mean "no" more often."

Proposition 35: Benzodiazepine use seems to increase resistance in therapy.

Throughout the interviews, therapists have commented on the way that they observe clients appearing vulnerable yet apparently well defended, but that this was not seen as psychological stability. The defences were seen as a problem for the therapist because

the client seemed to be locked away, the problem difficult to discern and the client expressing hopelessness. It is important to recognise that many long-term benzodiazepine users are depressed. Therapists' countertransferences included feelings of frustration, being stuck, blocked and encountering obstacles.

> "It can make me feel quite angry and frustrated that instead of bringing their feelings back to me, they've just taken a tablet; they haven't really stayed with their feelings. So it's as if something's been lost that can't always be reclaimed."

> "The counsellors come to supervision feeling that their client hasn't moved forward, that they're not doing anything. The counsellors feel stuck, de-skilled and debilitated because they're sucking all their energy out of them and they can see no changes."

> "I think it's to do with the drugs getting in the way. I would see the drug as an obstacle. And in some cases there would actually be a case for saying that this patient is not suitable for counselling while they're taking that kind of drug."

Sometimes other defences such as over-compliance, playing games and sabotage are remarked upon. The comment about the compliant behaviour of benzodiazepine users when compared with illegal drug users resonates with my work at the Withdraw Project. We were experimenting with using TA ego-grams with both groups and found that benzodiazepine users scored high in –AC (negative adapted Child ego-state), whereas illegal drug users were high in –RC (negative rebellious Child ego-state). These comments seem to confirm that experience. In over-compliance anger is suppressed, whereas in rebellious behaviour it is acted out.

> "I think they were much easier to engage than some of the illicit drug users and some of the people using alcohol. Unlike that group (illicit users) for whom

you'd book appointments and they wouldn't turn up, once you'd started to engage with them (benzodiazepine users), they'd turn up on a regular basis."

"We are playing games all the time and if you don't collude with the game then you will be smacked down in one way or another. And those who collude are wonderful and those who don't are evil and the enemy and to be destroyed almost. There's a hate that came through towards everyone. I think there was a danger of me colluding partly because of my fear of rejection."

"I can think of two people that I had difficulty with. One was trying to sabotage the group into playing all sorts of games. But I think in a sense she hadn't moved on from being a victim and there was a need for her to be understood in that position."

Another defence that therapists encounter seems to be vagueness. That makes it very difficult to get hold of what the client is saying, even if the client is aware of it themselves. The therapist can feel blocked and angry.

"A lot of people say, "Well, I don't even know what I'm doing here," and "there are a lot of people and I know you have a long waiting list," and "am I wasting your time?" I interpret it as a defence mechanism, resistance. "What about you? What's gone on in between?" "Oh, I was put on something."

"I end up getting a bit lost in it and wondering what... why they're getting... what they're doing... what can we do? And I sometimes wonder if that's their experience, a sort of frustration that we're not doing anything here. Not wanting to upset people or force them to look at things. It can feel like it because I'm being directive and feeling that I'm not getting anywhere. I'm trying to bust down a wall, sort of demolish a wall, and I'm trying too hard to get through."

Several comments relate to the ownership of feelings and the efforts therapists make to get clients to connect with and own what they feel. The defence is intellectualisation but this appears to change as drugs are reduced.

> "There is an inability or unwillingness to take responsibility for their emotions. With one client in particular, everything is "you this... you that..." I have endeavoured to get him to personalise statements in "I" and there is just enormous resistance, absolutely enormous resistance. A lack of owning I suppose."

> "As they reduce the drugs, the language changes and rather than intellectualising and speaking from the mouth they start to speak from the tummy. Instead of, "it hurts" they say, "I hurt". You say to clients, "Try to own this."

There are examples of these defences in previous extracts, but the two that follow are further illustrations. The first extract is a description of a client who lacks insight and cannot understand her child's behaviour that mirrors it. Agoraphobia and panic are very common experiences for people taking benzodiazepines, and may relate to issues of dependence and symbiosis, fear of separation and merger. Panic may mask suppressed feelings of anger. The second example is of a person who feels defeated, uses vague statements of misery, which the therapist finds irritating. It is not surprising that the therapist is glad when this client leaves because he or she feels as disempowered as the client and can find nothing to work with.

> "They're stuck in the house, frightened of going out, they have panic attacks all the time, can't cope with little life-problems. There's a knock-on effect with what is going on with the children, where children are acting out what's wrong with mum. And yet mother can't see that what she's doing is affecting the child. She can't understand why her child is kicking the teachers to bits in school or why this kid is playing truant. She can't see that it might be connected to the way that she

is, and that she hasn't been boundaried in herself and so therefore hasn't given her children boundaries."

"They're the sort of people who come up with, "Why look at that? Can't change it. What's the point of that?" Things are hopeless and can't be changed, but with an expectation that somebody else would change them. They are powerless and need someone outside to fix this. Lots of people say, "I want answers from you. I want advice," and you can work with that. But the vagueness... not knowing what they're coming for... irritating. I'm glad she goes. It's a hopelessness almost. It's a giving up on... I've tried and tried..."

Theories about the interaction

Therapists were asked whether they had a theory about the interaction between benzodiazepines and psychotherapy. Most had not studied the subject formally in their training unless they had done post-qualification training in addictions, and the input from supervisors had been minimal. Therefore they were reflecting on their therapeutic experience and on their earlier answers in the interview, in order to formulate theory

Proposition 36: The use of benzodiazepines undermines the therapeutic alliance.

Many therapists spoke about how benzodiazepines undermine therapy because the client cannot think or feel properly, but there are some other points that are relevant too. One viewpoint is that therapy cannot be considered complete if the client is still using drugs and that it is a wasted resource if the client is unable to benefit fully which is important to those therapists who work in the NHS. There is also a viewpoint that they are fundamentally different approaches.

"My main thought is that you can't come to the end of therapy with someone who is on benzodiazepines; it's not going to be resolved. There seems to be an

emotional "stuckness" at an age much younger than their current years. I don't know if it's actually when they started taking them, but its a kind of emotional regression."

"When I was on pills, twice I went to therapists for about five sessions and left because I couldn't handle it, didn't want it or didn't like the therapist. I was in analysis for two years but couldn't use it. Pills don't cure the cause; therapy tends to get to the root of the trouble."

"I just think that you're wasting scarce resources by trying to counsel somebody while they're taking benzodiazepines and that actually you could be quite cruel to them. When they are only running on a few cylinders, they could make decisions they could seriously regret. I think there needs to be a period of consolidation, because you cannot have your mind pickled one day and the next day be fine and able to go off to university."

"Every time somebody takes a tablet, that detracts from the therapy, and if they keep doing that they are eroding the therapy. It seems like a battle between two different approaches; the medical one, which is about getting rid of symptoms and the other which is about trying to find meanings."

Proposition 37: Therapists are ambivalent about whether benzodiazepines and therapy are compatible.

Therapists seem undecided about whether the two approaches are compatible, but they are not comfortable with the idea either, even questioning the ethics of combining them. These responses are in some ways similar to the responses given by therapists in the survey on policies. In view of the considerable amount of disquiet over the cognitive and numbing effects of benzodiazepines on people, I wonder whether the real problem is that they do not want to say that they have reservations. Throughout the interviews

therapists were quite openly talking about incompatibility but seemed to reverse or deny the possibility when asked about their own theory.

> "I don't see my role as either to suggest that it's a good thing or a bad thing that they're on them.... The most I would say is that doctors don't like to prescribe them because they seem to be addictive.... I suppose the person needs to be psychologically present in order to make use of therapy, and it might interfere with emotional processing or grieving.... If you had the feeling that someone was quite doped up, then you feel that you are not relating to the real person."

> "Are drugs and therapy compatible? I personally can't say, give an absolute, but I feel uncomfortable attempting that. If someone came to me and said this is what I want to do, I would be very clear with them about my reservations.... But I think that if backed into a corner, I guess I'd say I wouldn't refuse, but I wouldn't be happy about it. I have actually said to people and doctors.... I think it presents an ethical problem for counsellors.... I would make it very clear to the client that the drug would be a barrier to them being able to get in touch on the very real level."

A few are much clearer about saying that they think they are incompatible because benzodiazepines stop the therapist reaching the client.

> "The interaction is a negative thing. Benzodiazepines stop you getting to the client and therefore reduce the effectiveness of the work."

> "I think they conflict. Benzodiazepines tend to render feelings unconscious which conflicts with my theory of therapy whereby difficult feelings are made conscious, understood and expressed."

Some therapists are prepared to say that the two approaches can be combined and are not incompatible, but then go on to undermine their arguments.

"I find benzodiazepines, prescribed properly, very helpful, very beneficial to people. They should be used short-term in times of crisis if their personal resources are dangerously low and they need that extra prop.... I've never thought about the interaction of benzodiazepines and therapy... If you believe your pill is going to be the answer, then that's very significant.... If you take a psychodynamic approach, when somebody is defending against unpleasant emotions, and the therapy is to try and help that person get in touch with those things, then therapy is going to take much longer."

"I don't think they are incompatible. I don't know of any research evidence that suggests that combining them increases the likelihood of positive outcome.... I think they can undermine therapy because of the investment that's made in the drug.... A very brief stay in hospital can provide some room for rethinking about where to go from here, but if you prolong the stay you start affecting people's lives and a lot of problems arise. You could use that as an analogy for medication, that you're removing people from their natural state."

Proposition 38: Psychotherapy may require benzodiazepine withdrawal.

Many therapists had attempted to combine psychotherapy with benzodiazepine withdrawal and found that benzodiazepine withdrawal needs to precede the deeper work.

"I think the two can go hand in hand if there is a withdrawal programme. With one client, at the time I thought I was helping him but looking back nothing really changed. There is a difference between understanding and insight; he could accept what I was saying, but I don't think he could actually relate it directly to himself."

"I think if someone is taking benzodiazepines regularly, I wouldn't embark on long-term therapy if they didn't want to address that as part of the process. It depends on whether you persevere and get them off and go on working. If they didn't come off, it would affect the outcome and the psychotherapy wouldn't have been particularly effective."

"Although you do most of the work after they have come off, I still felt that you could do some useful work while they were still on the drugs. We'd touch on things... do things like loss... and it was almost like a rehearsal."

"If a person attributes their lack of sleep to bereavement, and you work with the bereavement in addition to the reduction in benzodiazepines, as they work through the bereavement they engage in new relationships, develop a new sense of self, a reconstituted self in which hypnotics play no part. Perhaps the extent of the dependency is only obvious after you've come away from circumstances and see them in retrospect, and then you understand the effect they've been having on you; its retrospective insight."

Comparison with other data sources

In the responses to the survey questionnaire, of the five NHS psychotherapy services that had a policy, only one believed that the two approaches are incompatible. On the other hand, some without a policy thought that "combining approaches increases the benefit" or that "the two are complementary approaches". Ambivalence is expressed by putting the two views together such as, "there is no good evidence that benzodiazepines interfere with therapy in general, but there are individual cases where it seems clear they do", and "use of benzodiazepines would certainly impede progress and may be a contra-indication for psychotherapy".

The propositions derived from the data analysis have been combined and summarised in four outcome propositions (Maykut & Morehouse 1994), that are examined against the relevant literature for convergence.

Outcome Propositions

9: Therapy with clients taking benzodiazepines involves people in a series of triangular relationships.

Kaufman (1994) describes over-enabling behaviour and a lack of confrontation as countertransference issues in drug and alcohol use, for the prescriber and therapist and how patients who are drug dependent can manipulate their physicians. Balint (1964) identified similar over-enabling behaviour including prescribing. Goldhamer (1993) highlights the triangular relationship between the patient, the doctor and the pill. In addition to a reluctance to challenge drug use with the patient, therapists may be reluctant to challenge doctors (Block 1979), the triangular relationship between doctor, therapist and drug.

10: Benzodiazepine use contributes to dynamic issues of dependency, power, seduction and ingratiation.

Ghodse (1995) identified conflict between dependence on therapist or drug, Kohut (1977) sees the drug as a substitute for early object relations failures, Levin (1995) sees the drug as performing mirroring, merging, enhancing false self-esteem and confidence. Winnicott's (1971, 1986) concept of the transitional object supports this, while Gutheil (1982) identifies issues of dependence and power in the relationship. Hausner (1993) sees the drug as having soothing, placebo and compliance dynamics in the transference, while Nevins (1993) identifies a number of psychological meanings in medication which confirm the patient in the victim role.

Montague's (1991) list includes metaphors that relate to dependence such as, "pacifier, consoler, comforter" and "food, fuel and tonic", as well as more powerful images of

tranquillisers as "passports and tickets" and "hero, army and police". Seduction is implicit in drug dependence, but is expressed in this list as "enslaver" and "moral weakness and evil necessity". Ingratiation as a dynamic is expressed by the phrase "people pleaser drugs", and in this list by the reference to "social control".

11: The client's defences against therapy are increased by benzodiazepine use.

Levy (1993) identifies that drugs can help the client to avoid the therapeutic task, and Sexton (1996) referred to the frustration experienced by therapists when clients appear "stuck", that is unwilling to move. Rigidity in analysis (Ostow 1993) seems to be related to this and Montague (1991) touches on a similar theme in the metaphor for tranquilliser as "straitjacket" and "lock, vice, prison", and tranquilliser use as an "artificial paradise".

12: Long-term benzodiazepine use may be incompatible with psychotherapy.

A number of writers seem to suggest that analytic psychotherapy is incompatible with drug dependent patients (Ghodse 1995), may undermine the psychotherapeutic process (Hausner 1993), and that medication adversely affects the psychotherapeutic relationship (Klerman et al 1994). While Hayward et al (1989) suggest benzodiazepines may assist behavioural trials in CBT, they do not address psychodynamic aspects such as the impact on the observation of inner and outer experience (Rosin & Köhler 1991). Kahn (1993) identifies four ways in which drugs could be incompatible with psychotherapy, Schachter (1993) makes clear prescribing must be sensitive and intermittent in order to allow therapy, and Ostow (1993) says that medication affects the depth at which therapy operates.

Parry (1996) suggests an impact on the therapeutic alliance and that benzodiazepines may reduce the impact of psychological treatment. Karasu (1982) while exploring the possibility of integrating psychotherapy with pharmacotherapy says that drugs confound the therapeutic process and Guntrip (1971) sees the mixture of biology and psychodynamics as confused and illegitimate.

CHAPTER 10

IMPLICATIONS

Therapists were asked for their views about training and supervision for psychotherapists and invited to draw conclusions about the implications. They all commented on a number of issues and implications.

Proposition 39: Training does not adequately prepare therapists for working with clients taking benzodiazepines.

They were asked whether their initial training had included anything relevant to psychotherapy with clients taking benzodiazepines. Some had received no information or training in working with clients taking medication, some had received some general information about psychotropic medication and some had received specific training in benzodiazepine withdrawal, post-qualification. The majority expressed the view that their training had not prepared them for working with clients taking benzodiazepines and that they would have found the subject useful.

> "Absolutely not! It was such a trite comment, "You can't counsel people on drugs", which if you are working in a GP practice is not terribly helpful since most of them come to me on drugs."

> "If it came into earlier training, I think one of the useful effects would be that it was an accepted part of counselling. One of the things I have come up against again and again, (as a trainer) is that counsellors think they can get away without it, and that its not their job, that's not what they're trained to do."

One way of learning about the issues, is to do so on the job in an addiction service, dealing with alcohol issues in social work practice or because the therapist is involved in research.

> "There seems to be very little known about benzodiazepines, given the outside world in general. It didn't come up in training; but it's a special part of working here, and I know from my own personal experience."

> "I had a sort of generic social work training in which we touched very little on drugs, although I have done some practical training in alcohol. On my psychotherapy training, I think we had one afternoon."

> "In training I had some input but since qualifying, no. I had a research job for three years with depression and I became very familiar with drugs at that time."

When considering what they had been taught about medication, the same picture emerged of teaching oneself by using references such as the BNF, or picking up knowledge through experience. There are some suggestions that what is taught is often a list of symptoms and medical approaches rather than anything specifically from a psychotherapeutic viewpoint. Not teaching about medication possibly because tutors themselves may know nothing about it is seen as a glaring omission.

> "Part of our training involved a module on psychopharmacology, but I don't think there has been anything helpful in my training; it's been my experience really."

> "I had training in drugs, but I haven't done much with it. I did have a course on the symptoms of depression, but most of it I did myself by looking up the BNF. Because I trained in a medical environment, what one gets taught is more about the kind of treatment you get if you're hospitalised, you know ECT or severe antidepressant drug treatment."

"I have to say I've had very little training. At the time I trained, I can remember interesting stuff about alcohol that planted the seed for addiction, but I can't remember much about psychotropic medication. It is a gap, because once you start, you get into placements, you start seeing clients, whichever field of psychology you are in, it's bread and butter stuff."

"Because my degree was in social psychology and health studies, part of my degree was about addictions and we covered depression and drugs, so it was in the back of my mind, but not in relation to therapy because it was dealing with specifics like depression."

"There was one day on the postgraduate course that I've just completed. We were asked what we wanted from the course and it was something I asked for. As I suggested it and wanted to write a paper on it, I was asked to do a presentation to the class because the lecturer didn't really know anything about it either."

When it came to whether therapists knew how to help clients reduce and withdraw from benzodiazepines, clearly some did because they worked in specialist agencies. They suggest that specific training is necessary so therapists understand the drug and do not have unrealistic ideas about how long withdrawal can take.

"I did a separate couple of days for benzodiazepine work. I'm glad I did because I would never have known what to do otherwise. The thought of actually trying to work with somebody on benzodiazepines and not understand what they're going through just horrifies me. There was not enough specific training, not enough formalised supervision, not enough medical input. I felt that in order to understand the process that these people were going through, I needed to understand the drug. I needed to understand the effect it had on the body. I did get that from my training, but a couple of days is not enough."

"The counsellors who come and work for me do diplomas in counselling on an academic course and have very idealistic ideas about helping people in ten or

twelve sessions. So within the training that I offer them, I do a lot of work on just how debilitating benzodiazepines make people and how slow it can be."

"I was a nurse first and I got involved because I was doing a course to become a tutor. Doing a project on benzodiazepines in 1985 was the launching point. I had been to two workshops with people then in the field and in the end we just thought we'd start our own organisation."

Proposition 40: Therapists require appropriate supervision to address medication and therapy.

Supervision both during training and throughout professional practice is a requirement for psychotherapists and work with clients taking benzodiazepines should have been discussed in supervision sessions. Therapists were asked what had been helpful or unhelpful to them in supervision. The supervisor's knowledge about medication and own experience of working with clients taking benzodiazepines is important.

"We have supervision here with a psychotherapist who also has knowledge and experience of drugs. It is absolutely essential that he knows about the drugs because that's what most of the clients talk about in the early stages. He's a tremendously insightful person, he has great ideas and it helps that he is sympathetic to work with clients taking drugs."

"Well, I think the supervisor has also got a full picture of the client. He's not just approaching it in the psychological counselling but he actually knows about the physical addiction and the association between is important. It's very important."

"I had monthly supervision, and I also had access by phone and used it a couple of times for clients I felt stuck with. What was helpful was somebody else's experience of working with clients on benzodiazepines; he was the guy who trained me to work with benzodiazepines."

However more than that, an understanding of the complexity of psychodynamic issues is highlighted.

> "Yes, she has been helpful to a point. I've only recently come to recognise that my supervisor is not terribly good at affirmations and sometimes I feel that after these clients I could do with it. Her strength is in the theory, but I don't think she understands working with benzodiazepines and I've tried to explain it to her, that you aren't getting the relationship rewards that you would normally get."

> "It was very helpful because I had a client who was tying me up in knots and I was encouraged to challenge her more. It was supportive because it was such hard work and I also remember the warning about not being drawn into persecuting the client because I felt exhausted and frustrated."

Sixteen therapists felt that their own supervision had been lacking in some way. Either they had difficulty in finding experienced and knowledgeable supervisors, or had problems in having a supervisor provided who knew about psychotherapy or medication but not both.

> "Not to any great extent other than recognition that a person might be taking medication and that wasn't helpful. But not an actual exploration of what the effects of medication might be."

> "Elsewhere I have other supervision and benzodiazepines would not be specifically mentioned. There seems to be very little known about benzodiazepines in the outside world."

> "I've had a psychiatrist as a supervisor at one point. He gave me a lot of factual stuff but it was not really process-oriented which is where I am going. He had no therapeutic training. I think that with none of my supervisors has it really been

focussed on. I don't formulate it well enough to bring it but also because its not picked up."

This comment reflects the view that if the therapist does not raise the issue, the supervisor may not do so either. One or two commented that both they and the supervisor seemed to ignore the drugs, and one or two felt that they knew more about the subject than the supervisor did. There are comments about self-learning and getting factual information from other professionals. There are no comments on the parallel process of "not knowing", and few about other psychodynamic influences.

"I have to say no. I don't know if that's the fault of the supervisor or the fault of myself because I never actually brought the question. It never entered the conversation or part of the supervision."

"Well, usually I've been in the position of knowing more about it than the supervisors in the jobs that I've had. I've picked up knowledge about benzodiazepines from various sources over the years."

"When I went on the counselling course, I had supervisors who were qualified in counselling but not anyone who specialised in the benzodiazepine field. On the benzodiazepine front there was lots of self-learning."

It may be more difficult to cope with a supervisor who is appointed to oversee work and who takes an opposite point of view. This comment is from a counselling psychologist and describes her difficulty in receiving supervision from a psychologist where a different theoretical stance is taken.

"My supervisor throughout my three years training has been a clinical psychologist who was pro-medication. It was unhelpful which is why I've had to

seek outside supervision. The supervisor suggested that the client should be on tablets and we were in conflict with each other."

The process of being interviewed seemed to provoke some therapists to reflect on their experience and discover something new.

"Well, I wouldn't say I'd had any really. I mean at times medication has been taken up as part of the dynamics in supervision, but there wouldn't be any specific input I don't think. It's interesting, because talking to you I realise that it is something I feel dissatisfied about. But it does seem striking because I'm not just talking about one supervisor, but several.

"None at all! It's been very helpful talking to you today. And so it would be to have someone who could advise me, to help me look at the dynamics of the relationship, to use metaphors more, and to think about the triangulation that might be occurring with the doctor."

Proposition 41: Therapists need to be alert to issues about assessment, contracting and the context of therapy.

Several comments were made about issues that should concern other therapists who are assessing people who are taking benzodiazepines for psychotherapy. The first point is that the issue of medication/ benzodiazepine prescription needs to be raised with the client in the first meeting so that both therapist and client can explore their views about it. This allows the therapist to give important information to the client so that they gain the client's informed consent if withdrawal is proposed. Any ambivalence on the part of the client about continuing or withdrawing from medication can be discussed and if the client wishes to continue drug use, their wishes can be respected and realistic goals can be set.

"If a client came to me and they were on some form of drug that altered their perception of things, or that made them dopey or that detached them in some way, then I would need to know that. And I think that has to be an important part of the assessment, and every counsellor should have their BNF handy and look it up."

"At the stage of assessment I would want to know if people were on medication. It has implications for liaison with other professionals, if someone is a suicide risk, and it would give me some idea where the person stood in terms of motivation in relation to psychotherapy."

"If they're seeking therapy, part of them at least wants to not rely on medication. The other side of that is often people have been given benzodiazepines because they keep pestering doctors and the doctor doesn't know what to do with them."

"And I remember having a very moving session when she said, "But it helps me. Who are you to tell me what I should or shouldn't do? If you take these drugs away, what would I be left with?" And that was a very humbling experience in remembering that what I think is right about these matters is not necessarily what some other people would think. So I've adopted what might seem a non-committed position, but it doesn't mean my views have changed about it, but I appreciate that people will only relinquish something if they're ready to."

The point is made that drug agencies too, need to address both issues of drugs and psychotherapy so that they are not split.

"I think any psychologist working with clients using benzodiazepines needs to be aware of how they could affect the person's ability to make use of therapy. Psychology can be a bit polarised. People in the addictions field are well informed on all the purely substance issues; what are the different drugs, how they interact, what their half-life is; and more mainstream psychologists are into therapy and the therapeutic relationship and don't always take account of the drug. We need to marry the two together more."

> "You have to be aware that you're dealing with two problems or a combination of a psychological and a physical problem. You have also to be quite aware of doctors and other people getting in the way of that and causing physical problems by prescribing."

The setting in which the counselling takes place has important implications for therapists, particularly general practice counsellors who may be assessing clients for very short-term work. There are questions raised about the suitability of these clients for short-term counselling particularly if benzodiazepine withdrawal is being contemplated. It cannot be considered ethical for drug-dependent clients to be offered too little time to withdraw from medication safely and for therapists to feel under pressure to do it.

> "People engaging in counselling should be more aware. I think that in general practice, a lot of time is wasted working with people who are on drugs, that could more usefully be spent getting them off or working with somebody who wasn't."

> "If a counsellor gets a referral from a GP who is the counsellor's employer, for six weeks' counselling for anxiety and personal problems, and they've been on a waiting list. If they were on benzodiazepines, after the six weeks they've addressed certain issues and maybe that person finishes the counselling a little better. Well, you've done your job, but is that client's quality of life necessarily enhanced?"

> "My big fear is around a quick fix; therapeutic six trips and you should be okay. The counsellor may be being ordered to get them off within x amount of sessions, and what happens to the client after that? They're in bits, I know they are."

The alternative situation is that many people who are long-term users of benzodiazepines, have been around the medical referral system for quite a long time. When less-recognised symptoms occur, patients can be subjected to a whole range of

diagnostic tests before someone considers that the drugs may be a cause of the symptoms. Therapists may encounter feelings of frustration or despair due to what is sometimes called the "revolving door syndrome".

> "I do think you have to be aware when you are dealing with this group of people that they have been through an awful lot of people before you. They will have had numerous doctors, they will have been in numerous other situations and you are the end of a very long line. And we get a lot of that person's perceptions and baggage about people in such a position. So you have to be aware of the attitudes they have towards them. So you're another one, or the opposite, hoping against hope that the magic's going to happen."

Particular groups of people are more likely to be prescribed benzodiazepines and this can be something that other therapists may be alert to. Older people, women and survivors of childhood sexual abuse are among this group.

> "Clinical psychologists are inevitably referred these clients, but its mainly now those working with older adults who come across these issues. Just over 80% of all prescriptions for benzodiazepines are given to people over 65. The prescription rate for benzodiazepines given as anxiolytics has steadily declined but the rate for hypnotics has changed virtually not at all."

> "I'm not sold on the whole notion of benzodiazepines at all because I've seen the devastating effects on people.... It's an interesting field, women and drug abuse; 80% of women who misuse drugs or alcohol have been sexually abused as children. And so often women use drugs to self-medicate or get their doctors to medicate them. I think childhood abuse presents itself in fragmented memories... or they have half memories. Its interesting, the way people describe being on benzodiazepines is like being in a bubble, and its like people with memories of child abuse... they're almost alike... did it really happen?"

Very little is known about the effect a mother's use of benzodiazepines has upon her relationship with her children. It seems as if there is object-loss, a lack of mirroring and a change in the psychodynamic roles within the family.

> "I've had clients who've had mothers who were on diazepam from way back, who talk about their mothers being cut off from emotion. When she came home from school, her mother used to be sat in front of the TV all day, whatever was on it. And not disciplining them, not being unkind just leaving them to it, letting them get on with it. It helped her to look at why her mother was like that; it made her feel better to think it might not have been her, it might have been the drugs that were making her like that."

> "One woman had been prescribed Prozac and wanted to know if it would have the same effect on her that diazepam had had on her mother, and it was only then that I made the connection that her mother had taken diazepam for years. Her brother had some sort of physical disability when he was little and she felt she'd had to be the "responsible" person. The other client felt that her brother had always been the one who was special and it felt like both of them had had to take over some of the mothering roles in the family because their mothers weren't in a position to be mothers themselves."

Proposition 42: Clients need to be aware of the implications of combining approaches.
Therapists feel that clients need to be better informed about benzodiazepines, their side effects and about withdrawal as well as the problems of combining them with therapy.

> "I'd like for there to be more education, for people to be a lot more aware than they are about the side effects of any drug at all, psychotropic or not."

> They need to know how it's interfering with the process, in order to understand and recognise their responsibility for continuing to take the drug.

"Some people want to get off when they're well into their 70s and 80s and if they want to, I'll take them through. It's hard to face, to have to live with some of that panic that they live with, if they have withdrawal symptoms when they're cutting down, but often there's a determination which you may not have with someone younger."

"They might be being ordered off the drugs, and very often are, with no thought at all given to the impact on them of withdrawal. So it's absolutely essential that the counsellor is fully aware of that."

At the same time therapists are thinking that the client needs to understand what therapy involves, how it is different from taking drugs and that the client will be expected to play a much more active role in order to promote change.

"At the start, people see therapy as another treatment like drugs. It's something the doctor suggests to you and therefore it wouldn't matter to have two treatments. But if people do think like that, its just more of what the doctor ordered. So we need to be educating people about what therapy is about."

"My feeling now is that if somebody's been prescribed medication for treatment, then either they stick with that or we try and replace that with a psychological treatment."

"I stress this with my clients. It's all very well coming along each week for an hour and doing the work, but if you go out of that door and don't think about what's been said and what you've felt for the rest of the week, then we could go on for years and years and not get anywhere. Because change, which is what I think counselling is about, can't be achieved unless that person actually does something about it."

Therapists also suggest that clients need to be aware of some of the psychodynamic issues implicit in taking medication, that it can feel good to receive a gift which

symbolises the doctor's care, or that there are attractions in adopting the "sick role" in the family. In contrast, there may be unexpected disadvantages in the loss of life experience even if for some, there is joy in a life restored.

> "The clients feel cared for as opposed to dumped. "The GP has given me these tablets"; what else can I do with this patient?"
>
> "Another issue for some clients is that the prescription for benzodiazepines in some sense makes them sick and they want that. I've certainly had clients who get some sick benefits and really want to be on something to keep that going."
>
> "They (the clients) lose a good chunk of their lives. I would think it would always have implications for the rest of their lives, where that piece of life went to, what was the confusion about trusting their own discernment."
>
> "I had a young man say, "You've given us back our mother". She'd been on 7mg of lorazepam a day; imagine!"

Proposition 43: Doctors are criticised for poor prescribing practice, lack of psychological awareness, discounting the value of psychotherapy and the misuse of power.

Much of the problem about dependence on benzodiazepines starts with the initial prescription, perhaps the patient who expects them and the doctor who reciprocates. In general practice where the doctor has little time and few alternatives, it is easy to see that doing nothing might seem very unsympathetic and uncaring. However many warnings are given about benzodiazepines only being given for a short time, what happens in practice is that this often leads to long term prescribing. This is especially the case when hypnotics are prescribed in hospital and continued afterwards.

"Some GPs will prescribe benzodiazepines to just anyone who walks through their door and complains a bit of being emotionally stressed. Whereas there are those who will only prescribe to very distressed people. So I don't think there's any rhyme or reason except the individual idiosyncrasies of the prescriber."

"If you've got a "heartsink" patient the easiest thing is to give them a prescription or get them out of the door. I can understand why that happens. I'm not being totally unsympathetic to the GP, but it's a short-termism that doesn't actually help anyone in the long-term."

"I'm not a GP but we assume that you've got to prescribe something. Maybe you think you have. In some of the GP practices that I work with, there are very promising signs of preventative measures before medication is prescribed. It's still very much a minority."

"I think it's the young doctors coming out of training into general practice and psychiatry who can look at other ways. Because so many people start in hospital taking a sleeping pill and then when they get out, they continue taking them."

Once the doctor and patient develop a drug habit, it is much more difficult to change and look for alternatives, and doctors can feel responsible and attempt to withdraw people from their medication sometimes unsuccessfully. Some of the therapists specialise in benzodiazepine dependence so they will have considerable experience of the client who is reluctant to stop their drug use as well as clients who are angry with the doctor for not warning them about the problems they might encounter.

"He'd developed a habit through prescription; very trusting of GPs; wouldn't think about stopping unless doctor told him to. When these issues were pointed out to him, he became very angry that he wasn't given information about it. Many prescribers probably have a similar stereotypical view about long-term

benzodiazepine takers, that if you take them off (referring to older people), they're going to have a greater dependency on us perhaps. So they perceive it as a hassle to get them off both for the patient and themselves."

"I feel that not enough importance has been put on people who are taking them by GPs. I don't think, in my experience, many of them are aware of the problem. They are just giving out repeat prescriptions. It quite clearly says in MIMS that they shouldn't be prescribed for more than 3-4 weeks, yet doctors are continuing to give them out, knowing that people have been on them for years."

"He told her she would be fine to stay on as long as she wanted. We talked to him about it and he said it was up to her really what she did... he put all the onus on her really rather than offering her any support. So if the doctor says it doesn't matter, why is it that important?"

"People who are on benzodiazepines long-term are often at loggerheads with the various medics who have tried to persuade them to come off, and I think the fact that benzodiazepines continue to be prescribed is a sign that the professionals have given up trying."

One difficulty is that the doctor is trained to diagnose and prescribe and some may not have much psychological awareness. They may not understand what psychological therapy is or how it works, so it may be discounted. Attitudes are slowly changing, but too slowly for some of those who commented.

"Some of them do see things psychologically, but they are doctors and don't always see the whole framework. I wish we could have meetings about our patients; they also wish we could. It's very difficult because it isn't addressed in medical schools and it's very hard to reach doctors later in their career."

"The psychiatrist is very interested in helping him withdraw from alcohol and benzodiazepines, but the main problem is diagnosis. I suggested he needed a

group during the day to complement what I was doing once a week, but he wouldn't have been offered anything because she could see he needed a therapeutic community and that is not available. The therapy group in the hospital is psychodynamic and wouldn't be suitable for somebody on benzodiazepines. There is an enormous lack of awareness on the part of the medical profession in general."

"A lot of GP's time is taken up by people presenting the doctors with psychological problems, and I know psychotherapy isn't necessarily a cheap option, but I would prefer it if GPs used the therapy option first before going on to prescribing drugs."

"There are some consultants who think their bit is the only bit that's of any worth. The rest are psychologically friendly but they either don't understand what psychology's about or they have their own time frame. They have this 12-week period in which people are packaged in, assessed, got some kind of package going and then discharged. Therapy doesn't fit that model."

Therapists from whatever professional background are very aware of the difference in their power in relation to the doctor. Some are counsellors employed by doctors and that has implications for those who might challenge the approach of prescribing for psychological problems. On the other hand there are clinical psychologists who have adopted an approach similar to medicine and they might prefer to maintain an alliance with those who are powerful.

"There's a transference issue about drugs being powerful and doctors being powerful. There's a lot of envy because I had that knowledge, that mysterious knowledge that they don't have, and therefore I can hold my own with a doctor."

"It's very difficult for the counsellor to challenge the GP! How do you challenge your boss when he's paying your salary and you need to take this money home?"

"What choice is there? The choice is not informed if they are already taking the drugs. I think the implication for medics is a lowering of their power particularly in the psychological forum, which is very deeply entrenched in the minds of British society. I have some psychological colleagues who are very medically orientated and the "diagnose/prescription" type of approach being weakened would undermine a lot of professional colleagues' confidence."

"The doctors are not always sympathetic, because with this litigation stuff, they're not going to own up to that. The GPs and psychiatrists who dish them out, or worse still don't acknowledge the effects of them, still hold enormous power and that power's being abused. For the people who've been abused, although everyone else might validate their feelings, the main prescribing authorities refuse to do that. It's my belief that acknowledging that fact would be enormously helpful with finding ways forward."

Proposition 44: What applies to benzodiazepines may apply to antidepressants and other psychotropic drugs.

In discussing some of the wider implications, therapists were asked about their views on other psychotropic medication, primarily antidepressants. There is considerable evidence that people can become physically and psychologically dependent on antidepressants (Int. Drug Therapy News 1984, Dilsaver 1989) which could have implications for therapists working with them. Of course the psychodynamic patterns could be similar whatever the drug. Much of the enthusiastic prescribing of benzodiazepines in the 1960s is being replicated now with the enthusiasm for SSRIs, (selective serotonin re-uptake inhibitors) particularly Prozac.

"We don't come across problems in the same way as tranquillisers. You still get prescribing practices which are highly ill-advised, and the best you can do is relay that to the client and check out whether the doctor's actually told them what they are taking. We see more antidepressant abuse with the illicit drug user."

"She'd come off the benzodiazepines and felt very good about herself. When she started to come off the antidepressants it was a problem. It's partly because she attributed her main vulnerabilities to the depressive aspects of herself rather than to the anxiety aspects of herself, so she was more dependent on the antidepressant."

"I think antidepressants are an equally difficult but different ball-game. I think they are completely wrongly used. There are people who should be on them that aren't and there are many, many people on them that shouldn't be. I think doctors use whichever is the fashionable one at the moment. I recognise that some clients get in the most terrible states of depression and that sometimes an antidepressant can help, can help them get off the benzodiazepines as long as you make sure you get them off the antidepressant soon afterwards."

Many of the reasons for prescribing antidepressants are the same as for benzodiazepines, such as an instant solution so that the patient is immediately gratified, or because the doctor feels obliged to do something. Nevertheless the messages of prescribing around chemical imbalances, illnesses for which the patient is not responsible and so forth are reinforced.

"A lot of what I've said could apply to antidepressants and obviously people have different reactions and effects and they are taking them in a different way. But I think the dynamics in relation to therapy can be similar. You see a lot of women here who have been given antidepressants and at the same time it is suggested that they seek counselling. They GPs feel they have to give them something now, whereas they will probably have to wait for counselling, but that seems a bit of a mixed message."

"If a person is on antidepressants, the reason they are on is important, whether it is because they feel suicidal or using antidepressants instead of benzodiazepines which is common. Antidepressants are not a major area of concern. I'm not a GP but the idea that you've got to prescribe something is still there."

"In my private practice I work long-term and the only medication that people have been on has been some antidepressant, latterly Prozac. The implication would relate to the meaning that's attributed to them and whether this meaning would in any way undermine the therapy. That would apply to any drug and I include in that alcohol."

Prozac was certainly in the forefront of therapists' thinking and many expressed their concerns about the denial of potential dependence, the effects of indirect marketing on public attitudes, the ease with which it is obtained and unwanted side effects.

"Now we're getting a lot of people on Prozac, and although they say it is not supposed to make people dependent, in my experience it does. Like Charles Medawar says, any drug that affects people psychologically, there is an addictive component. I have noticed it affects therapy but not as much as benzodiazepines. It's affecting feelings again and not allowing people to get in touch with their true feelings.... I think if people are on antidepressants, you can still counsel some of them. Every drug is different, but if it does have an effect on the mind, it must have an effect on therapy."

"Prozac is very much to the fore at the moment as being the new wonder drug because of TV appearances, and so they do tend to ask for Prozac very quickly. The doctors are getting the message about not prescribing antidepressants first, but the fact that people are becoming wise to the idea of counselling means I have more people on the waiting list, so they have Prozac. So it's working backwards again; we've got the full circle. I did stop them for a while and had the patients straight in and that worked wonderfully."

"A lot of our clients take antidepressants in order to come off benzodiazepines. It seems to help some and we encourage them to come off benzodiazepines first and then antidepressants. I'm worried about the prescribing of Prozac at the moment. Any mood-altering drug can be addictive and can cause damage in some ways... it is certainly a mental inhibitor. The medical profession is just switching from benzodiazepines to Prozac and it frightens me."

"I think there are times when the person is so depressed that you need to motivate them to actually get the counselling, and I think that's when it's useful. I think it's very, very bad news to put anyone who's been on benzodiazepines on an SSRI but particularly Prozac because it produces insomnia and anxiety is heightened. Either they (SSRIs) don't work at all for a client, and if they do work they just don't want to come off them. They're dependent psychologically purely because they like the effect and that makes it difficult."

Antipsychotic drugs or neuroleptics are usually prescribed in hospital or for more serious mental health problems, but in low doses they may be prescribed in place of benzodiazepines and antidepressants. The question of how the drug may impact on therapy with these clients is rarely considered as the drugs are frequently assumed to be necessary.

"I had a conversation with a psychiatrist who was saying that it would be easier to work with somebody psychologically if she wasn't so stuffed with neuroleptics. Another issue with antidepressants is that people wonder whether they have made progress or is it just the antidepressant. There's less fear that they affect cognitive functioning of the client in the here and now in terms of being psychologically absent. I rarely hear people complain that they don't feel themselves on antidepressants, whereas on benzodiazepines you will hear people say that."

"My experience with clients on benzodiazepines has got implications because very often we get people here on cocktails of medication and it's very difficult to sift out what causes what. I think it makes you aware of the effects. Someone will say, "I'm only on a small dose of chlorpromazine or something".... again we're thinking about how much effect that's going to have."

"Drugs have a place. There once was a time I'd never have said that, but they do. All drugs occasionally, but there's a difference between that and the vast quantities that get shovelled around. Every other person you meet seems to have

been prescribed this wonder drug. The cycle has started again. People now know about Prozac like they do about aspirin. I should imagine that 20 years from now there'll be somebody else sitting in these two chairs discussing Prozac."

Comparison with other data sources

The survey of NHS psychotherapy services contributes very little information about whether their clients are taking other psychotropic medication while in therapy. One service, which has a policy about prescribing, indicated that their clients take antidepressants. There was a suggestion that medication may be used to help contain clients in therapy and that could refer to antidepressants too. Two services indicated that medication and therapy are compatible approaches but whether that refers only to benzodiazepines is not clear. The idea that a service does not have a policy about antidepressants, alcohol, cannabis and antipsychotic drugs seems very surprising in one way but also very believable.

Outcome Propositions

13: Medication is a neglected area in therapeutic training and supervision.

It is very difficult to substantiate this outcome proposition (Maykut & Morehouse 1994) with reference to any literature that I have reviewed. Even if I were to review the syllabus of a selection of training courses in counselling and psychotherapy, it is still a matter of opinion whether this topic is of sufficient importance for it to be included. What is included is presumably what potential trainees, potential employees and accrediting agencies think is important to include. The sponsoring of advanced courses in counselling in medical settings by the Counselling in Primary Care Trust in six major centres gave some emphasis to the topic but not all those courses have continued. What

would be more significant would be that the topic was included on all basic training courses and this would have to be justified, perhaps in order to exclude something else.

Similarly, there is nothing in the literature review to substantiate the view that medication is a neglected area of supervision, but the two issues go together. If it is not a topic on training courses, and it has not been in the past, then supervisors themselves probably did not learn anything about it in their initial training. A number of therapists indicated that what they knew had resulted from being self-taught, attending short courses of the kind that I used to run and consultation with colleagues. My own knowledge is self-taught and I have indicated there is little research in this field. At best, it remains the view of the majority of the therapists I interviewed.

14: The implications of benzodiazepine prescribing for clients in therapy are largely ignored.

If an issue is ignored it is very difficult to find much evidence for it! However, patients/clients are dependent on their doctors and therapists for accurate information, and it appears that doctors who prescribe benzodiazepines beyond the guidelines set out in the British National Formulary do not tell their patients. In addition, if psychotherapy services do not have a policy about this issue it is unlikely that the subject is given much publicity. The survey responses indicated that in some cases it was left up to the individual therapist or the client to ask.

Following the statement by the Committee on Safety of Medicines (1988) that benzodiazepines might interfere with grieving, the British National Formulary published a warning about benzodiazepine hypnotics to that effect for a number of editions. (It is

updated and published every six months.) My latest version of the BNF (September 1998) has omitted that warning and no mention is made of bereavement at all. "Counselling" is only mentioned as a possible way to assist benzodiazepine withdrawal. I did not notice the change over the last few years.

In the Review of NHS Psychotherapy Services (Parry 1996), attention was given to the issue of combining approaches. The review states that benzodiazepines in combination with psychological treatments add little to efficacy and may reduce the impact of psychological treatments. However, in the Department of Health's evidence based clinical practice guideline on treatment choice in psychological therapies and counselling (Department of Health 2001), the group assert that "there is no reason why medication and psychotherapy should not be used together" (p1). The contributing organisations include the British Association for Counselling and Psychotherapy, British Confederation of Psychotherapists, British Psychological Society, Royal College of General Practitioners, Royal College of Psychiatrists and UK Council for Psychotherapy.

I suspect that this is an over-generalisation but it is a dangerous one because it allows people to suppose that all medication has the same impact on psychotherapy as well as to suppose that all psychotherapy is the same. I am very surprised that these organisations appear to hold this view especially as I am a member of some of them, and I do not think they conducted any survey of opinion to draw up a statement of clinical consensus. I believe that this issue should be reconsidered in greater detail, and could be an area for further research.

CHAPTER 11

DISCUSSION

Design and method

In choosing a plurality of methods for this investigation, the design to some extent evolved not only out of a qualitative, phenomenological approach, but also for practical and ethical reasons. The problem of two paradigms, medical treatment and psychotherapy, was partially resolved by acknowledging the value of RCTs in the medical literature, while using a qualitative approach for the survey and interviewing psychotherapists. However, for a number of reasons the two paradigms continued to pull me in opposite directions, as I shall describe in more detail later.

The selection of the participants was led by the three selection criteria and by who was willing to be interviewed. It inevitably meant that they were not a representative group, and because of my involvement in the field I had known some of them before. It was ethical considerations, which led to the exclusion in this study of clients, but their views are important and might be investigated as a cross-reference in the future.

I concede that statistical analyses can produce much more certain results, but they are often irrelevant to the important issues at stake. I decided that statistics which were derived from the limited descriptive data in the findings of part one of the interview, would have contributed nothing more than was immediately apparent. It was my impression that the professional background, practitioner category, work setting and therapeutic approach was not significant in the way participants answered the questions.

I did not really address the question of the efficacy of psychotherapy. Random controlled trials do not show much benefit of psychotherapy, but their use to address the subject has been much criticised. Meta-analysis techniques and satisfaction surveys both have their detractors, but I decided that the proof of the efficacy of psychotherapy was irrelevant to this study.

I chose to follow no particular method for analysing the interviews, except to find common themes, by immersing myself in the material of the transcripts. It is a subjective analysis of subjective opinions, but I followed Sherrard's (1997) advice using triangulation and considering alternative explanations for the results. I also asked myself what alternative results I might have obtained if I had asked different questions based on an assumption that benzodiazepines are helpful or compatible with or enhance therapy.

Following Bancroft's (1979) indications for benzodiazepines, I would have asked therapists for examples of client's improved problem-solving skills, decision-making and coping skills. I might also have asked for examples of hypnotics improving sleep and hence facilitating problem solving. My reading and reviewing of the literature led me to conclude I would be unlikely to find this evidence, and in my clinical experience of about 500 clients taking benzodiazepines, I have never observed it either. These claims belong to the 1970s and would not be made today. I might still have asked what effects of benzodiazepines therapists had noticed and about metaphors since those questions are more neutral.

In choosing to ask therapists about their actual clinical work, as they normally practice it with no special techniques or limitations about drug use, or time scales, the research imposed no external influence on their therapeutic practice by being entirely retrospective. This helps to make the results more easily generalisable. However the research interviews probably had a prospective effect in that the co-researchers have probably been changed by them as I have.

Analysis of part 1 of the interview

Therapists / co-researchers

In chapter 6, tables 1 to 4 show the gender ratio, professional background, practitioner category and work setting of the twenty-six therapists who contributed their views. Tables 5 to 8 show their therapeutic orientations, years of experience working with clients taking benzodiazepines, the proportion of their clients who take benzodiazepines and the size of their case loads. To what extent did this group meet the selection criteria set out in the research design?

I had to decide whether to accept a therapist still in training with extensive practical experience especially with benzodiazepines, whether clinical psychology training focuses sufficiently on the therapeutic relationship and process and whether a distinction should be made between those therapists who have seen two or three clients over a long period and those whose total experience is with benzodiazepine-dependent clients. These issues were discussed over the telephone with therapists and once accepted, their interview data was included.

The group closely fits the criteria of training and experience for this research. They were all trained in a style of therapy that uses the therapeutic relationship, all had worked with clients on benzodiazepines and all except one had worked with a client who had withdrawn. This therapist did not contribute to the multiple case-study analysis on the before-and-after-withdrawal comparison contained in figure 18, in chapter 6.

There were no psychiatrically trained therapists included in the group. The reason for this was that the enquiries to the Royal College of Psychiatrists and to a University training course for medical psychotherapists did not produce offers to take part. If they had been included, and fulfilled all the other criteria, might they have contributed a different viewpoint? That possibility has to be accepted. However there is a strong possibility that since professional background seems not to have produced differences of opinion among those who did participate, and psychiatrists would be well informed about the effectiveness and limitations of benzodiazepines, their views might have coincided with the other therapists.

Further questions arise about whether this group of therapists lacked training in the medical model, pharmacology, and that the client's diagnosis was unknown. If we accept that all the psychologists, nurses and the doctor, and two of the social workers who had worked in mental health had received training or were experienced in using the medical model, then at least 65% of the therapists had a knowledge of it. Secondly, the chartered psychologists and addiction specialists would have a moderate to excellent understanding of the pharmacology of benzodiazepines, at least 73% of the participants.

The clients' diagnoses might have been known by the therapists but were not disclosed to me, as it did not seem relevant to the purpose of this study. However as psychotherapists they would have made a psychological formulation about each client and during the course of the therapy, would have added to, subtracted from or corrected and modified it in the light of experience. Generally speaking, these therapists worked with people for whom a diagnosis of a neurotic rather than a psychotic diagnosis would have been made. That is, that their clients would not have had an enduring and severe mental health problem.

However, much of this study's credibility relies on the therapist/co-researchers. They are professionally trained (some of them at the top of their respective professions), worked in their preferred way, with clients for as long as seemed in their judgement to be appropriate, and had between them a wealth of significant experience. This is in marked contrast to studies using untrained "counsellors", using manualised techniques which they did not choose, without regard to the suitability of the treatment intervention for the client and without responsiveness and variation of the treatment protocol.

The survey

There is also a marked contrast with the responses from the NHS survey. The survey involved no contact or discussion between respondents and me and highlighted the importance of interaction between us, because I could not follow up replies to clarify the meaning. The interviews allowed me to develop rapport, and encourage the respondents to search their experience deeply, speculate, express suspicions and doubts, formulate their own theories and join in the research process more fully. The two groups are quite different, were used differently and produced very different results. Conducting the

survey was useful in showing how official policy or lack of it might mask what therapists themselves know but may not get asked.

Therapists' views on the effects of benzodiazepines

In chapter 6, therapists perceptions of the effects of benzodiazepines were reported in tables 9 to 13, listing cognitive, behavioural, emotional, dependence and relational effects. There is strong convergence between the cognitive, behavioural and emotional effects and the side-effects and withdrawal effects reported in the medical/psychological research literature (triangulation). Their views on dependence effects converge strongly with the addiction literature, and their views on relational effects converge strongly with the psychotherapeutic literature.

The therapists are consistent in their view that the effects of benzodiazepines have a negative impact on the client' ability to engage in the therapeutic process. This view is consistent across, therapists, orientations, professional background, work setting, length of time working with these clients and proportion of work with these clients. Tables 9 to 13 illustrate how and why they believe benzodiazepines have this effect.

The effects of benzodiazepines have been known for many years and reservations expressed about their efficacy for psychological problems (Committee on Review of Medicines 1980, Committee on Safety of Medicines 1988, Parry 1996). However, the effects on the therapeutic process have been less considered, but can be deduced from the known effects on patients and what are assumed to be the psychological requirements for therapy.

Therapists' views on clients' metaphors

Tables 14 and 15 in chapter 6, illustrate the therapists' views of the clients' beliefs about benzodiazepines (Tranquilliser Use as) and their metaphors for benzodiazepines. These results compare very closely with the findings of Montague (1991). Many of the therapists (of all orientations) used their clients' metaphors in therapy to explore psychodynamic meanings and transferences to benzodiazepines (Table 16) and to the therapy / therapist (Table 17). This is consistent with psychodynamic interpretations reviewed in the literature.

Therapists' case studies on a client who has withdrawn.

Table 18 records the results of 25 independently conducted case-studies on the effects on therapy brought about by the withdrawal of benzodiazepines, and asked therapists to compare one client while he or she was taking benzodiazepines with how they seemed when they were abstinent. In the majority of cases, the decision to withdraw was voluntary for the client and was integrated with therapy. These two conditions reflect current best practice in specialist benzodiazepine withdrawal services.

It appears that as the drug was withdrawn, underlying issues emerged such as loss, relationship difficulties and abuse which seem to have been suppressed by benzodiazepines. Some therapists mention in the descriptive part of the interviews, evidence of retrograde facilitation, frequently of loss or abuse. This seems to indicate that the underlying problem became more accessible to therapy. The problem that the client had brought to therapy was extinguished in 15 out of 25 cases suggesting that in part, at least, the problem might have been caused or reinforced by benzodiazepine. On the other hand the problem may have been worked through after withdrawal.

Four factors were mentioned as increasing with benzodiazepine withdrawal, all of which I consider to be significantly associated with effective psychotherapy, either as pre-conditions or consequences. They are, increased self-efficacy, increased alertness, increased access to emotionality and increased self-awareness. Being able to think, feel, have a sense of self and be able to make an impact on others should improve therapeutic accessibility as well as being potential goals. Twenty-one out of twenty-five therapists reported improved therapeutic access that they attributed to withdrawal.

Critique of interpretation of part 1 findings.

It is important to consider alternative explanations for these findings. The cognitive, behavioural, emotional, dependence and relational effects (Tables 9 to 13) which the therapists attributed to the drugs might to some extent be attributable to client factors or therapist factors or researcher's bias.

Client factors might be that this group of clients who become long-term users of benzodiazepines, have poorer cognitive skills, lower educational level, are less emotionally mature, greater defences, greater psychopathology, weaker coping strategies, fewer social skills for example or have an addictive/ dependent personality. This might explain why therapists perceive them in this way. In other words they are a fairly homogenous group who are observably different from other clients, regardless of their benzodiazepine use.

A counter to this argument is that research on benzodiazepine-dependent clients who were being withdrawn, (Hamlin 1988) showed they were not a homogenous group and

that all these aspects of the clients improved following withdrawal, which seems to confirm the original interpretation of this evidence. The before and after effect in the multiple case-studies is a check on this. Further, the therapists were comparing their benzodiazepine clients with their other clients as a control group. It seems unlikely that there would be such consistency and that none of them would have realised that the clients taking benzodiazepines were so different.

Secondly, the therapist factors could include their negative attitude to clients taking drugs, negative transference towards clients preferring drugs to therapy, or their expectations and beliefs. They may have lacked the necessary therapeutic skill, lacked experience or the therapy may have had an adverse effect. Some therapists may have an over-involvement in drug issues especially amongst addiction specialists or felt antipathy towards medical treatment.

While there is probably an element of truth in this challenge to the acceptance of therapists interpretations, since they may have had a negative attitude towards drug use, therapists are trained to identify what belongs to the client and what belongs to them. They engage in personal therapy and self-development throughout a rigorous training and achieve a higher than normal level of self-awareness. Many work in medical settings and are not antipathetic towards the medical model, rather preferring a different model to explain psychological problems, as in fact many medical practitioners do.

They will have seen these clients over many hours of therapy, testing their hypotheses about the client and the process with the client and in consultation with their supervisor. In these interviews they were giving considered opinions about their therapeutic

experiences, retrospectively with the benefit of hindsight, not making superficial judgements, instant assessments or giving fleeting impressions.

Therapists tended to express positive attitudes towards clients on benzodiazepines and towards working with them. The addiction specialists had chosen to work with this particular client group. Several spoke of finding the work particularly challenging, but also particularly rewarding. They exhibited considerable empathy towards clients' suffering and struggle to become drug-free and recognised the demands on time, patience and the personal security of the therapist.

Thirdly, I might have influenced the results both during the interview and outside it. Factors which might have influenced the results in advance of the interview include having been involved in therapeutic work and research into benzodiazepine withdrawal, my own stance towards the subject, my influence over the design and conduct of the interview, expectations from the literature, teaching, training, supervision, and co-operative links with therapist / co-researchers in the past and the authorship of books and papers on the subject area under investigation.

My attitudes and assumptions certainly existed and since they could not be avoided, have to be acknowledged. Both therapists and I were aware of this problem which results from being part of the field under enquiry. The positive aspects of this involvement were utilised to promote the rapport and co-operation in the interview in order to elicit detailed qualitative material.

I might have influenced the results during the interview by my expectations, by asking leading questions and prompting replies, through psychodynamic aspects of the relationship between the interviewees and me, by collusion with an anti-medical stance, selectively ignoring unwanted responses, finding what I expected to find. These dangers have to be weighed against the advantages of my participating actively in the interview.

There were probably some factors during the interview that influenced the results. However much both parties try to act with integrity and impartiality, unconscious psychodynamic processes were part of it. There is inevitably a desire to please on both sides, produce interesting material or stimulating questions for a colleague, and a common assumption that if something is being investigated then there is something to be discovered. Taking part in these research interviews either as investigator or therapist / co-researcher indicated an interest and therefore a viewpoint.

Tables 14 and 15 which relate to clients' beliefs about and metaphors for benzodiazepines, and tables 16 and 17 which relate to how therapists use metaphors with clients and the clients' beliefs about therapy are primarily descriptive, so no alternative interpretation is called for. What can be questioned is the significance that is attached to these descriptions. I propose that the replies have a psychodynamic significance and therefore comparisons can be made with other psychodynamic interpretations, which emerged, in the latter part of the interview.

Table 18 reports the 25 multiple case-studies illustrating therapists views on the effects of withdrawal. Eleven therapists stated that there were difficulties in withdrawal but no details or reasons are given. There are probably a variety of factors such as some clients

withdrawing too abruptly or under duress, physical or psychological dependence. However what about the fourteen clients for whom the therapists reported no difficulty. Was this because the client was receiving help by being in therapy or because the client had few problems? Several of the therapists were working specifically to promote benzodiazepine withdrawal and it can be assumed that they were skilled at reduction problems. It is however a secondary source not a first-hand account. What if the client was tolerant to the drug and no longer noticed an effect? Would that invalidate an apparent improvement due to withdrawal of the drug?

The limitation of these case studies is that the therapists were describing their clients and only loosely fitting their accounts into the suggested framework. The looser the framework, the less exact the account, yet the greater freedom allowed all cases to be fitted into it regardless of therapists' different case conceptualisations. Hence some may have omitted to mention some factors, selecting what was significant for them. However the addiction therapists while describing only one client who had withdrawn, nevertheless have withdrawn hundreds of clients from benzodiazepines and seen these effects.

These clients varied in terms of the stage they have reached in therapy, and how long beforehand they completed their withdrawal. The "recovery time" after withdrawal, during which the client may still feel vulnerable or fragile and still occasionally experience pseudo-withdrawal effects, is closely related to the number of years that a person has been taking the drug. There is no predictable time when a person starts to improve, or buried issues emerge or problems are resolved. It is possible that some clients had no emergent issue, and if there was no extinction of the problem, to wonder why they were in therapy

in the first place. I devised the framework following the interview, not in order to define it.

Improved therapeutic access is presumably the purpose of withdrawal, so therapists could have been seeing what they expected and wished to see. Just as they may have had clients with a strong desire to reward their therapists to ensure continued availability. All these limitations have to be acknowledged as a possibility. These results are strongly suggestive but cannot be conclusive.

Analysis of part 2 of the interview.

Chapters 7, 8, 9 and 10 contain the analysis of the second (transcribed) part of the interviews. Each chapter contains short quotations from the transcripts collected together under propositions. The selection and editing of the comments is my interpretation of what was said in the interview and I tried to remain faithful to the intention of the therapist by looking at each comment within its context. Editing focussed on producing a clear, concise and accurate comment while remaining respectful of the first person account. The propositions are summarised under a number of outcome propositions in each chapter and these form the major findings of the study.

Consensus can be falsified by omitting contradictory material, so I gave importance to using all the comments relevant to each theme, and noting comments that were contrary to the propositions. The following exceptions were made because what was discussed was not relevant to the subject of the research.

1. Material about work of a non-psychotherapeutic nature.
2. Shared professional issues.

3. Information about a benzodiazepine withdrawal service.
4. Latest research findings of respondent and research colleagues.
5. Detailed case material of benzodiazepine withdrawal.
6. Personal experience of benzodiazepine use.

Sometimes, comments that were included under one heading could have been included under another, and the choice represents my interpretation, but I tried not to use any comment twice.

The effect on grieving

Outcome propositions

1. Benzodiazepines suppress the emotional processing which is a feature of grieving.
2. Loss of memory of events affects narrative competence.
3. The process of grieving is inhibited, prolonged or unresolved.
4. After withdrawal, clients realise what experiences they lost while taking benzodiazepines.

There was a consensus that benzodiazepines interfere with grieving and this confirms the official position within medicine (Committee on Safety of Medicine 1988, Royal College of Psychiatrists 1987) if not actual practice. Perhaps some doctors and patients would see interfering with grieving as a good outcome. However, among psychotherapists the assumption is that grieving is a normal, health, and restorative process, which should not be interfered with, but rather facilitated.

The effects on the client can be linked directly with the effects of the drug, for example, emotional numbing, anaesthetising pain, detachment from reality, amnesia and hypnotic

effects. The effects on the grief process were the inhibition of grief, prolonged or protracted grief (Association of Community Health Councils 1989, Risse et al 1990), stuckness, unresolved grief and a grieving for the years (of life experience lost) taking benzodiazepines.

The effects of the drug on cognitive and affective processing (Royal College of Psychiatrists 1987), passivity of behaviour and reduced social interaction provide a theoretical explanation for this phenomenon. In addition, an effect on the therapeutic process would undermine the work of therapists addressing grief issues with clients. If as has been shown, therapists believe that benzodiazepines affect the process of therapy both by directly changing the client or indirectly by changing the process, then they affect the outcome of therapy and the client is unable to grieve fully.

This is consistent with the grief tasks model of grieving (Worden 1982) which involve acceptance of the reality of the loss, experiencing the pain of grief, adjustment to changed circumstances and withdrawal and re-investment of emotional energy. Warner & King's (1997) brief survey which focussed on superficial outcome measures without consideration of the process issues illustrates the problems of confusing the effectiveness of benzodiazepines with their efficacy.

I believe that loss is one of the fundamental issues in psychotherapy, because attachment is a fundamental dynamic in human relationships (Parkes et al 1991) and is what forms our sense of self. I view anxiety as the anticipation of loss, anger as protest about loss, depression as a defence against loss. For intraverts, psychological annihilation is represented by loss of control, while for extraverts it is represented by abandonment.

Psychotherapy starts by offering a temporary secure base through the attachment to the therapist, that one day must be terminated and the experience of loss processed in order to promote future resilience.

The responses given to the question I posed about loss focus very directly on the client's internal process during therapy and how benzodiazepines seem to affect it. I propose that it is the sedative effects of benzodiazepines that are the cause and that other drugs with similar sedative properties that act on the neurotransmitters would also slow down psychological processes. This might include alcohol, some antidepressant and antipsychotic sedatives.

It follows logically that all processing is inhibited or slowed and that not just grief experiences but all experiences might be affected. If grief work remains unresolved, then all therapeutic work might remain unresolved. This leads me to believe that benzodiazepines interfere significantly with psychotherapy by affecting the client's internal process.

Difference in Therapy

Outcome propositions

5. The client taking benzodiazepines is less able to respond to therapy.
6. Benzodiazepines can be viewed as the third party in the alliance.
7. Therapists need to make adjustments for clients taking benzodiazepines.
8. The therapeutic alliance parallels the client's relationship with their drugs.

In describing the client's process, therapists commented on several ways in which these clients seem less responsive than their other clients seem. These included accessibility, engagement, depth of working, potential for insight, deficits in concentration, processing, consolidation and recall. This is confirmed by reference to the literature (Angus & Romney 1984, Mac et al 1985, Curran 1986, Golombok et al 1988, Lader 1983, File & Pellow 1987, Ashton & Golding 1989, Association of Community Health Councils 1989, Hayward et al 1989, Risse et al 1990, Breggin 1991, Bixler et al 1991, Curran 1991, Salzman 1992, Curran et al 1994, Bishop & Curran 1995, Weingartner et al 1995, Trotter 1995).

Deficits in affective processing would also affect the client's process, noted in the literature (Angus & Romney 1984, Association of Community Health Councils 1989, Lader 1992a, Salzman 1992). Greater psychological morbidity (Catalan et al 1988), evidence that substances can exacerbate psychological conditions (Washton 1995) and evidence that psychopathology is a consequence not a cause of benzodiazepine use (Murphy & Khantzian 1995) further contribute to effects on the client's ability to function in therapy.

In describing the therapeutic process, therapists commented that it was slower, harder, delayed, and that the client's lack of self-awareness and disconnectedness hindered the process as noted by Rosin & Köhler (1991). Psychodynamic issues such as motivation (Hayward et al 1989), attributions and transferential issues were also identified. All of these can be attributed to the indirect effects of benzodiazepines on the therapeutic alliance (Karasu 1982, Fisher & Greenberg 1989, Levy 1993, Ostow 1993, Klerman et al

1994, Ghodse 1995, Sexton 1996, Parry 1996). Therapists had to make allowances for these effects with clients who were taking benzodiazepines because they were different.

Transferential issues about the clients' beliefs about the drugs and their transferences to them illustrate one way in which the therapy can be undermined if the emotional investment is elsewhere. This is recognised in the literature on the metaphors for benzodiazepines and their use, (Helman 1981, Lennard & Cooperstock 1980, Montague 1991, Montague 1988a, Montague 1988b, Morgan 1983, Rhodes 1984, Szasz 1974).

Benzodiazepines are seen as reinforcing the client's defences in ways that some psychotherapists do not regard as helpful. They are seen as a substitute for the self-object which failed the client in early life (Kohut 1977, Levin 1995). Other therapists referred to drugs as transitional objects on which the client had become dependent which links with earlier views (Barkin 1978, Block 1979, Hausner 1993).

It is important to recognise that the alternative model, the medical model, might view increasing defences as desirable but this is sometimes understood to refer to doctor's countertransferences, (Nevins 1993, Goldhamer 1993, Kaufman 1994). The key issue here is how increasing defences fits a psychotherapeutic strategy.

In their comments on the process, therapists make the point that benzodiazepines have to become the first focus of the therapy regardless of whether the client or therapist wants them to (Levy 1987, Rawson 1995). In one sense there is a pre-therapy stage which has to undo the medical treatment that preceded it (Kaufman 1994, Armstrong 1996). This requires an adjustment to the style of therapy towards being educational, directive and

behaviourally focussed (Hamlin & Hammersley 1989, Dillon 1991, Hammersley & Beeley 1996). There is also a recognition that higher dose levels require patience, written instructions and constant repetition due to memory difficulty. This clearly indicates an effect due to benzodiazepines and fits with Lambert & Hill's (1994) points supporting the link between process and outcome.

The psychodynamic issues of the counter-transference are included in this chapter to highlight differences in counter-transferences between clients on benzodiazepines and those who are not. Therapists report feelings of frustration because if the benzodiazepine use is not changing, then neither is the client. This fits with research into benzodiazepine withdrawal (Hamlin1998) which showed that clients made very little improvement in therapy until dose levels came down.

There is a parallel process between the avoidance of difficulty on the part of clients through their drug use and the avoidance of difficulty on the part of therapists in confronting doctors over their drug prescribing. A more comfortable position for both is denial and some therapists were very aware and disclosing of this. The recognition of their own defences seems to have been an important stage in the professional development of these experienced therapists.

A further difference seems to be that therapists identify stronger dependence needs on the part of clients who take benzodiazepines. This may be experienced as greater demands on the therapist and a tendency to push against boundary restraints. The opposite polarity is also noted of the undemanding client who might keep the therapist at a distance. This might be attributed to a shift from dependence on benzodiazepines to dependence on the

therapist or a resistance to this. Attachment theory might describe these differences as ambivalent attachment and avoidant attachment, both of which are insecure.

Other parallels identified include experiencing the client's lethargy, holding incompatible views without experiencing cognitive dissonance and the therapist seeing the drug as an obstacle to therapy instead of therapy to remove the obstacle. One difference in working with benzodiazepine-dependent clients is that it can produce role-conflict as well as conflict with others, colleagues as well as doctors.

Finally they comment on the way in which they perceive the therapeutic alliance to be indirectly affected. The concept within therapy of the "mixed message" is seen as very important and clearly prescribing and psychotherapy involves just such mixed messages. Prescribing benzodiazepines involves symptomatic treatment, external locus of control and burying the underlying issues, whereas psychotherapy involves symptomatic exploration, internal locus of control and uncovering underlying issues.

I think that therapy with clients who take benzodiazepines has to be different and that view is based on my experience in the Withdraw Project and since. I also think that when therapists reflect on their experience of the process of therapy they come to think so too. The client's ability to respond is constrained and therapy has to be adjusted to take account of that, maybe by going more slowly but certainly by agreeing either to withdraw from the drugs or set very limited goals.

The psychotherapeutic frame contains more than the two people, client and therapist. Also present is the doctor who got in first and left his or her legacy of the drugs, but the

drugs do not facilitate the process and have to be thrown out like a baby cuckoo who is taking up too much room in the nest. Benzodiazepines undermine therapy sometimes very subtly, by providing a safe haven to which the client can retreat when confronted. Therapists too can use drugs as a safe haven to retreat to when feeling that they are reaching the limits of their resources. Throwing the drugs out removes the false comforter (transitional object) to which both client and therapist may be clinging and both are exposed.

Psychodynamic issues

Outcome propositions

9. Therapy with clients taking benzodiazepines involves people in a series of triangular relationships.
10. Benzodiazepine use contributes to dynamic issues of dependency, power, seduction and ingratiation.
11. The client's defences against therapy are increased by benzodiazepine use.

Chapter 9 takes up the theme of psychodynamic issues and how these impact on the therapeutic alliance. Therapists explore their views of the triad relationship between the doctor, the therapist and patient. The most reported dynamic is splitting, the dangers of which can be reduced by close collaboration between doctor and therapist. A major problem is that most doctors, especially in general practice, might be unaware of the concept or would fail to understand it's significance.

Much of the literature that discusses this problem refers to the United States of America where the psychotherapist and prescriber are one and the same person. In that case there is potential for internal splitting by the doctor / therapist, which might produce problems

for the patient who receives a mixed message. In this study, the split refers to an external one between a prescriber and a separate therapist, producing internal confusion for the patient who has inconsistent messages from his trusted authority figures and cannot keep both objects "good".

Many of the comments refer to therapists' experiences of being undermined or sabotaged by doctors who prescribe during therapy without reference to the therapy or therapist. Of course patients usually initiate this, but therapists feel less angry with them. They hold the doctor responsible for his actions of responding to his counter-transference feelings by ingratiation, over-enabling, distancing and occasionally punishing. Not all clients disclose the fact that they are receiving therapy or allow contact with the prescriber by the therapist.

In this triadic relationship, the patient's transferences to the doctor and therapist, and the therapist's transferences to the patient and the doctor, and the doctor's transferences to the patient are all commented upon. What is missing, is any comment by therapists that they are aware of the doctor's transferences to them, the therapist. Probably they are not. While the therapist fears the doctor's power to prescribe, the doctor may fear the therapist's power to interpret. What goes unacknowledged is that the therapy is "correcting" the doctor's treatment or in some way showing up its inadequacies. The doctor understandably might feel defensive.

The second area which is explored psychodynamically is the therapist-client relationship, but this is still a triadic one for the doctor is replaced or represented in the triad by the drug, his gift or sometimes his poison. Some of the therapists seemed quite reluctant to

"throw the drug out" of the relationship and establish a dyad, perhaps concerned about whether they could replace all that the drug represented for the client.

There are several comments about the splitting between "psychological stuff" and drugs, which are seen to belong to another realm and subject therefore to another authority. Some therapists who have training and supervisory roles describe strong resistance on the part of some therapists elsewhere, to teaching about drugs and discussion of their work to include drug issues because they find it threatening.

The therapeutic alliance is affected by psychodynamic forces, which if ignored threaten the therapy in some way. However there is a very difficult dilemma for the therapist who wishes to interpret what is going on in the process or bring the issue out into the open, because clients taking benzodiazepines seem less able to use interpretations of the transference in the relationship.

This may relate to what has been identified as a reduced capacity for insight, or difficulty making connections both cognitively and affectively. This may in part explain why patients are deemed unsuitable for analytic or psychodynamic therapy while taking benzodiazepines. Therapists of other orientations may find a way of maintaining the alliance sufficiently to facilitate withdrawal.

Symbolic relationships

Dependence is a central issue with this group of clients and therapists were more concerned to explore it at a psychological level that merely at a physiological one. It is

one way of explaining why they continued to take the drug after the week or so that the guidelines permit. The sedative effects are experienced as soothing and calming and the client no longer has to think for himself and take responsibility for his environment, relationships or actions. He is allowed to regress.

The drug performs those functions for the client which once a parent might have performed, but probably performed inadequately. So the drug becomes a transitional object for the client performing soothing and nurturing functions in the absence of a good object / parent figure. Sometimes the drug is seen as a punishment or discipline, which might relate to unconscious feelings of badness or deficiency and a need for correction. Statements that drugs correct chemical imbalances feed directly into these unconscious fantasies.

The list of metaphors for benzodiazepines and their uses illustrates the underlying expectations of and roles that the drugs perform for the client that the therapist has to replace. It is only when the transference is shifted from the drug to the therapist, that the real healing work can take place, the infantile needs and hurt can be brought out in the therapy. Many therapists described this moment, when the pain is "owned" by the use of the first person.

Therapists from every therapeutic orientation were able to relate to this idea and to discuss the underlying dynamics in their own language. Many of them described how they use the metaphors in the therapy and work with them to produce a shift in the transference. They also used the idea of transitional object regardless of their main orientation suggesting it is a useful concept in work with clients taking benzodiazepines.

Theories about the interaction

Outcome proposition

12. Long-term benzodiazepine use may be incompatible with psychotherapy.

Many therapists at first denied knowing any theory, considered themselves ignorant, and were thinking about this question for the first time. As the interviewer, I was also finding my way for the first time into the exploratory process. I was judging how far to keep a respectful distance and how far to engage in the conversation. I gradually found my way to a facilitative style designed to get respondents to say everything they had to say. I was sometimes pushing, challenging and searching them, but respecting that the interview was about their experiences, theories, values and conclusions. I realised that is not a bad position for a therapist / researcher to take since it is what therapy is like (Gupta 1998).

Linking process with outcome

Rowan's (1992) case for integrating outcome and process issues and involving talking about people, to people and with people, has been attempted here. It is also theory that emerges from clinical phenomena and according to Garfield & Bergin (1994) is more likely to find acceptance with therapists. Following House (1996) each therapist was asked for their theory and each response was given due consideration. What was unexpected was such unanimity of view.

Considering this material from the perspective of Roth and Fonagy's (1996) three major factors associated with outcome, the therapists have provided evidence for all three. Firstly, the client characteristics of capacity for thinking, readiness, motivation and adjustment can be seen to be impaired by benzodiazepines. Secondly, the therapist's skill

in monitoring and maintaining the therapeutic alliance is put under strain if not undermined by the client's use of benzodiazepines.

Thirdly, this evidence emerges from actual clinical practice, and the interpretation put upon what happened in the therapy by the therapist who was actually there. It relies on a consensus of their clinical judgement and their credibility as experienced psychotherapists in this field. Roth and Fonagy make the point that clinical judgement is necessary in the interpretation of research findings and the evidence and interpretations of the therapists corresponds with my own clinical experience.

I believe that if the process of therapy is impaired in some way, so the outcome of the therapy must be changed. Again, if the client's defences against therapy and resistance are increased, then the use of benzodiazepines must be detrimental to therapy especially in long-term work. To this extent I believe that long-term benzodiazepine use is incompatible with psychotherapy, unless very reduced goals are accepted.

In short-term work, either the client is difficult to engage in a working alliance, or they realise at some level that they are being offered too little, or they make very slow progress and lose heart and belief in the therapy. The alternative of a tablet is an easy route to exit prematurely from therapy. However I do think that for many long-term users of benzodiazepines, therapy helps to give them the information and support to make a choice about withdrawal with a realistic hope of success.

Implications

Outcome propositions

13. Medication is a neglected area in therapeutic training and supervision.
14. The implications of benzodiazepine prescribing for clients in therapy are largely ignored.

Training and supervision of psychotherapists

If psychotherapists who have had some training and experience in the implications of psychotropic drugs believe their training was inadequate, is there any evidence that training courses now address the issue more thoroughly? Since much learning takes place through supervision particularly for the novice therapist, is there any evidence that supervisors are capable of teaching it?

It is surprising that this subject attracts so little attention in spite of there currently being approximately one million people dependent on benzodiazepines in the United Kingdom, 25% of referrals to counsellors in general practice involving medicated patients (Mellor-Clarke 1999), and large numbers of elderly (Morgan et al 1988) often bereaved people taking benzodiazepines long-term. One half-day out of a three-year training course, if at all, is not exceptional. The training may only cover information about psychotropic drugs and their uses and not how they impact on therapy.

Supervision is not a universally understood concept even within professional psychology, nor all branches of therapy. While it may be understood as a consultative process, which encompasses the person of the therapist as well as the client, in which psychodynamic issues can be challenged and clarified, it can be confused with line- and case-management

with little attention to process. Several therapists reported knowing much more about the subject than their supervisors who were unaware of the need for greater support and encouragement to challenge. This is a very unsatisfactory situation.

There seems to be a collective "unknowing" consisting of denial, avoidance and resistance involving prescribers, patients, therapists, course directors and supervisors. Whatever the stance taken on the issue, the subject itself must have some significance for psychotherapists. Several of the experienced therapists involved in this study confessed from time to time of having to consider these questions for the first time. Some of them also confessed to having thought something about the subject for a long-time, but never having dared voice it before. I believe that part of the problem has been the perception of medicine's dominance, which few have been willing to challenge.

Implications for others

Therapists

Practising psychotherapists have an obligation to make a full assessment of a potential client, including treatments they are receiving from doctors. It is improper to ignore this because medication alerts therapists to medical conditions that might impinge on therapy as well as to possible uses for psychological problems and dependence. The medication must be discussed with the client, to explore the client's understanding and beliefs about their drugs, and the implications for psychotherapy before the client can make an informed choice.

The decision about continuing or withdrawing from medication has implications for what is possible in therapy and the client has a right to be aware of that. It is improper to start

therapy with unrealistic goals, which could have been anticipated. It is also improper to leave the client to find out for themselves how to withdraw from benzodiazepines because the therapist or their organisation does not consider that to be part of their responsibility. During the 1980s clients were frightened into abrupt withdrawal with serious consequences in some cases. At the very least the client should expect a referral to someone who can advise on withdrawal.

In addition to the issue of informed consent, there are two other major issues in most codes of practice for psychotherapists. The psychotherapist has a duty to ensure their competence to practice, recognising their limits, working within them and ameliorating factors, which restrict it (British Psychological Society 1998). It might be acceptable to decline to accept clients who take psychotropic medication on the grounds that one is not competent in that area, (for example a recently qualified or inexperienced psychotherapist might reasonably do that).

However, it could hardly be an acceptable practice for psychotherapists employed in the NHS, not to be competent in this area as it appears from the NHS survey some are not. Competence in dealing with medication issues should also be a standard required of all therapists employed as counsellors in general practice, and for any whose training did not include medication issues, it ought to constitute an area for continuing professional development in order to develop competence. Continuing ignorance could not be an acceptable practice, once a therapist becomes aware of it. A psychotherapist has a duty to seek competent supervision for the clients or work that they do, in spite of managerial ignorance or resistance.

The third major issue that other therapists might address is confidentiality. There is a difference between confidentiality and permitting a client to impose secrecy on the therapist. If there are two people providing treatment to a client concurrently, then they both ought to be aware of it. In practice many therapists do check that the client has informed the doctor about their therapy or informs the doctor themselves. However it may not go much further if the doctor does not realise the implications of concurrent treatment with a therapist. It is widely assumed (Department of Health 2001), that medication can be combined with psychotherapy, which seems to me to be an enormous over-generalisation.

Psychotherapists of every orientation need to address psychodynamic implications, however they construe them, when they are aware of them. Many are aware of the danger of splitting when the client has two therapists for example. Shared care sounds fine in theory but is not so agreeable in practice if there is not realistic collaboration. With benzodiazepines, it is not easy to correct a medical mistake, provide a more appropriate treatment in its place, or imply that psychotherapeutic criteria must take precedence over medical practice for psychological problems, without sometimes risking giving offence.

Clients

Clients have a responsibility in this too, which is to take responsibility for themselves and not to seek to hand it all over to others. They have a duty to inform themselves of the nature of drug treatments they might be offered, the limitations of their use and the dangers of their misuse. One aspect of this which is important is that this responsibility for drug use is given back to the patient while they are still taking their drugs, so that they make the decision and determine the pace of withdrawal. Only then can the patient take

responsibility for drug abstinence and not constantly seek to sabotage themselves and request different drugs. While this may be the ideal, none of this is at all easy to do.

Because benzodiazepines are quickly effective, patients notice immediate sedation, which they might initially welcome. However both the research literature and the participants in this study point out that clients taking benzodiazepines are not aware of their cognitive and affective and behavioural deficits or seriously underestimate them. This may account for patients' willingness to continue with the medication without complaint to the prescriber, who is easily reassured and continues to prescribe.

A further implication for the client is the awareness of what therapy implies. It requires the active participation of the client in the process, a willingness to uncover what was buried and to re-experience thoughts and feelings, which are often uncomfortable or painful, and sufficient time for the process to be completed. Partial treatments are often not an improvement. This may also have implications for the family and friends of the client who have to witness the therapy without being able to engage in it.

Withdrawing from benzodiazepines often involves the client in a regression which goes beyond the period of drug use to unresolved experiences of object relationships in the client's early life. The issue of dependence has to be worked through again, this time in a therapeutic relationship that replaces the substance that was a substitute for it. It is difficult enough to explain or interpret these experiences to clients who are drug-free and virtually impossible while they are still affected by the drug.

Many clients have as their goals for therapy to find contentment or calmness and ways of coping with life. Those are probably the same goals they had when they started taking benzodiazepines but by the time they reach therapy, they may have deteriorated into feeling more anxious or depressed and may have become more dysfunctional not less. The client may attribute that decline to themselves rather than the drug use, as was the case when withdrawal effects were attributed to the underlying "illness" re-emerging during the 1960s and 1970s. The client may have to stop seeing themselves as ill, when illness may have been an important dynamic within the family for being nurtured.

Doctors

The most important implication for doctors both singly and as a profession is the recognition that the responsibility for prescribing is theirs. That means that they ought to recognise that the prescribing of benzodiazepines outside the guidelines is improper, extremely common and that there are no sanctions. The temptation is to make an exception, take the easy way out, go for a short-term solution, be over-enabling and please the patient, avoid confrontation with patients and relatives or carers, and believe that no serious harm is being done.

Individual clinical freedom has to be weighed up against prescribing policies amongst partners in a practice but too often there is no consensus to the detriment of the patient. Unless there is an agreement, each practitioner can undermine another and patients will play one off against another. Doctors need to consult practice counsellors if therapy is being offered both to understand what therapy is and how compatible it is with benzodiazepines.

What seems to be very helpful when doctors are working alongside counsellors and psychotherapists is their understanding that psychotherapy fits into a different paradigm from medicine. The study of psychology in the initial training of doctors and the study of psychotherapy for psychiatrists could make understanding other professionals' work, easier. It might also be helpful if doctors were aware how much they are influenced by pharmaceutical companies. A group of psychiatrists are challenging the Royal College of Psychiatrists over sponsorship of medical conferences for example, and the influence drug firms have over "the way in which psychiatrists frame mental health problems" (Boseley 2001a).

Drug companies' information services, which are in reality marketing departments, repeat inaccurate and flawed research, which undermines doctors' confidence in counselling (Counselling in Primary Care Trust 1999). The manufacturers of benzodiazepines have not been quick to recognise their over-optimistic claims. Drug companies have been found to conceal the findings of clinical trials and to be most reluctant to publish accurate information in their information leaflets. Dr Healy, director of the North Wales department of psychological medicine, who gave evidence in a case against a drug company is quoted as saying "The person taking the drug is left thinking he or she has a problem, rather than that the pill caused them the problem" (Boseley 2001b).

Other implications

There are implications for organisations and institutions that accredit training courses or psychotherapists, such as The British Association for Counselling and Psychotherapy, The United Kingdom Council for Psychotherapy and The British Psychological Society among several accrediting organisations. This study raises questions about what psychotherapists

need to know about psychotropic medication in order to practice competently and that would have implications for training course directors and accrediting bodies.

There are implications for organisations considering quality, and effectiveness and auditing practice within the NHS, not least those commissioning psychotherapeutic services for Primary Care Groups as well as Health Trusts. Many organisations in the voluntary sector which provide services and advocacy to psychologically distressed people and those who provide counselling services to particular groups, especially bereaved or traumatised people need to be aware of the implications of medicated clients. Medication may undermine their worthwhile efforts.

Statutory social services teams often work with people on benzodiazepines and tell me they are frustrated by the lack of progress they make. Either their views are not asked for or are frequently ignored. Nurses in hospital and community psychiatric nursing have been embedded in the medical context and frequently accept prescribing without question. Even when they are aware of mis-prescribing, the hierarchical dynamics of the hospital encourage them to dutifully carry out instructions rather than risk challenging them from a weak power-base.

Other psychotropic drugs

The antidepressant group of drugs is seen as the likely successors to the benzodiazepines. Medical practice has not really changed and the belief in using drugs to remove symptoms remains largely untouched. The pattern of denial that antidepressants have dependence potential is a repetition of the pattern of denial over benzodiazepines, and dependence is seen as the only possible disadvantage. Psychotherapists are aware that while the social

pressures which support psychotropic prescribing are much the same, nevertheless there are differences between antidepressants and benzodiazepines when they are used in conjunction with psychotherapy.

In so far as antidepressants are sedatives, there is the likelihood that like benzodiazepines, they will impair cognitive processes and affect therapy. However, the ones which are psychostimulants such as SSRIs may increase arousal and hence the symptoms of anxiety and insomnia. The potential for adverse psychodynamic effects remains exactly the same whichever drug is prescribed, so at a psychological level there is a risk that therapy is undermined.

There is, however, one scenario when antidepressants can be said to have a beneficial effect when combined with psychotherapy. When a client is severely depressed, antidepressants may assist the client's functioning, by lifting their mood so that therapy can take place. It is important that the client understands this and does not attribute the mood change to psychological improvement, nor believe that drugs can ever treat anything other than the symptoms of depression. However this effect is not guaranteed and antidepressants such as prozac may be effective in only 10% of cases (Boseley 2001a) while there is an increased risk of suicide and 25% risk of becoming disturbingly agitated (Boseley 2001b). It is important that the use of drugs does not induce complacency.

Background to the thesis

There was an earlier version of this thesis that was submitted in July 1999 and was accepted subject to correction after a lengthy viva in December. The examiners wrote separate reports and subsequently disagreed about the corrections. The validating

university sought the views of a third examiner who confirmed the view of one examiner and it was decided that the corrections were to be done again under the guidance of the existing supervisor. This was notified to me in a meeting to which I was summoned in June 2000, when I asked for and received confirmation that the two original examiners would review the corrections.

The resubmission was assessed by one of the original examiners and the third examiner who had not been present at the viva, and rejected in September 2000. I was given one month in which to appeal but had no help to do so from the supervisor or either academic institution. I had privately suggested to my supervisor in June 2000 that the thesis would be rejected, and he was astonished and said he would support an appeal, which he subsequently did. The appeal was granted in December 2000, without a hearing and I was given six months to resubmit the thesis to new examiners. This information is offered as contextual background to what follows.

A personal reflection on the research process.

I started this research study full of hope and enthusiasm and very naïve. I had spent several months writing a proposal and talking about it to various people and I wanted to be accepted onto the programme. So I was all too ready to hand over responsibility to others, follow their advice to the letter and did not ask too much about the "treatment, the limitations or dangers" of what I was about to engage in. Just like a patient who does the same and is too trusting of doctors, I was lulled into a false sense of security. When my proposed supervisor wrote to disclose his past links with benzodiazepines, I was flattered to be asked for my approval and fell for the seduction.

At our first supervision meeting, we agreed a qualitative phenomenological approach and that I would conduct a survey. When I saw my supervisor again in early 1996, he told me I needed 100 pages, 100 subjects and 100 references, and when I looked surprised he said it was just a guideline. I left with my first prescription feeling a little uneasy. Some time later in 1996, I heard rumours of insurrection, treason and dismissal at my study institute and waited to hear what had happened to my "good parents" and whether one had symbolically murdered the other. I didn't know what to do and felt very insecure and dependent on my supervisor as my only secure base. I found myself in the dark.

I had a letter in June 1996 from the Institute full of bland reassurances, which of course did not reassure me, and I never heard from the next programme director before he too had gone without me knowing why. I was cut off emotionally. I did not notice because by this time I was engaging with the people I was interviewing and my attention was on that. I sent my supervisor two transcripts to read and was puzzled by his reply that indicated that he did not think agoraphobia was caused by long-term benzodiazepine use and didn't understand the reference to object relations and "neutralised" mothers.

Where was he coming from? What was this about a trade union of therapists in the USA who want prescribing rights? Are they more okay than those UK ones who appear to be against prescribing? He is talking about what I can't prove, can't assert with confidence, that reliance on hospitals is necessary, that assembling this transcript material into a coherent whole is a going to be a big task. I think a switch had just occurred and my supporter was starting to attack me. I was reminded of how patients feel when they go back to their doctor after their first prescription for benzodiazepines saying they have really worked, to be told they can't have any more.

Gradually the qualitative approach is undermined by references to empirical data and prescribing benzodiazepines is rigorously defended in terms that remind me of the way in which patients' stories used in litigation against the drug companies were undermined. He says there is a lack of "hard evidence" that benzodiazepines have damaging effects from improper use. Then I am told that scientific evidence 20 years ago did not show benzodiazepines were addictive, so perhaps my thesis will take a similar time to be demonstrated.

As the challenges continue, the arguments become more desperate to defend prescribing to patients who demand them and insist they could not live without them. Justifying psychotherapy is " a pious hope of relief" and the views of therapists are not the level of evidence that a medical journal would accept, but the examiners might allow impressionistic studies. I fear it is too late for me to change now as I am nearing submission so I struggle to keep out advice to "dispose of sceptics like me".

The first version of the thesis reflected all the conflict between the two paradigms that had secretly co-existed throughout the research process and writing. I had done qualitative research in the actual way I had carried it out, but had to keep it secret in order not to have it all undermined from a positivist perspective. I wrote the thesis trying to keep true to what I had done as a therapist researcher and yet to keep the medical establishment happy. As bricoleur, I was trying to stitch up the split down the middle. If as some suggest it is possible to combine two different approaches, I realise now it is not wise for novice qualitative researchers to do so.

I submitted the thesis and heard nothing at all for two months, which must be what it is like waiting for a hospital appointment to see the consultant psychiatrist, or a way of preparing people for academic life. The examination left me confused and battered and quite unable to accept their congratulations for having passed. I was told how what I knew to be true wasn't, but that they would write it all down for me to learn later. I numbly wandered around in a daze trying to find the way out down corridors that all led to dead-ends.

There were lots of telephone calls in the next few weeks, telling me I would get the report soon and then maybe not. It was like being bounced up and down on a piece of elastic, so I was wound up for the start when the gun went off. There was a good cop and a bad cop and the adjudicator told me the good cop was nicest but the bad cop was better for me, so I should mix them and take the stronger medicine that had been prescribed. By now the drugs were muddling my thinking so I didn't notice the side effects at all. I was told eventually that the two cops had fallen out in disagreement and the matter had been referred to the hospital board.

It seemed like I was being patient all those months but perhaps I was being passive waiting to see what the board thought. They convened a case conference and I realised with a great shock that I was totally dependent on my supervisor and demanded more of the drugs and told him I couldn't live without them. I did wonder whether I was burning my boats but I couldn't face a case conference without an ally. They were all there, the one who doesn't look you in the eye, the one who is seductively nice and says "I'm sure we really want to get better don't we?" and the chair who is neutral and trying to be fair. They had already met and decided I should be given another chance, but must listen to my

doctors in future and not go on having crazy delusions; that way led to madness. They were going to be gentle with me and keep the cops away until I was feeling better and talking more sense.

I woke up from my addiction in a very remote part of the asylum where no one ever came. The two cops had sent me down; they had got rid of the good cop and replaced her with another bad one. I was allowed one final appeal and had one month to write it. I found the institute had given me a card, years before with the number of a counselling service and I had a telephone so I rang up and talked during the time I was coming off the drugs. The withdrawal symptoms are too awful to relate and that time is unbearably painful to recall. It was the dark night of the soul that St John of The Cross describes.

I met some old friends in the asylum grounds and realised they weren't patients like me but visitors. Three of them told me I needed legal advice before I went to the appeal, so I took their advice. She talked to me about the Consumers' Act and I began to realise I had consumed and swallowed a lot without thinking what I was doing, just popping them in thinking they would help. She also told me about a Human Rights Act and I realised that I had thought you were born with human rights. Apparently not, but in October somebody was going to be giving me some at last.

I got a reprieve and came out of the hospital drug free at last, able to think more clearly again and recall what it had been like before I started on the drugs and how much of my life I had lost in the last two years. I still get angry and depressed and the pain is ironically called heartburn, but I know now it is caused by telephone calls not something organic. I still have to visit the hospital as an outpatient because I haven't yet been

discharged and that makes me worse for a while. However they let me see a therapist who takes a very different view of things and I am beginning to hope that one day my paranoia will be gone and I shall be mad no more.

What I learned about the topic.

The survey alerted me to the fact that many psychotherapy services in the NHS did not see the need to have a policy on benzodiazepines, or any incongruity in their policies if they had one, and that what seemed implausible to me was apparently not to others. I began to consider the possibility that I would not find sufficient people to interview, or that they would have little to tell me about their therapeutic experiences. It led me to expect that I should hear a wide variety of views from psychotherapists, predominantly that they thought benzodiazepines did not effect the psychotherapeutic process.

The literature review was mostly over familiar territory but finding the works on the metaphors used about benzodiazepines and their uses was a startling discovery since it immediately fitted in with a half-examined part of my own experience in working with clients withdrawing from benzodiazepines. It gave me a way of making sense of how drugs as transitional objects fulfil object relations functions for people through their dependence on them and in the language with which the client talks to their therapist.

Of course my own therapeutic work has continued and it has both influenced and been influenced by this study. I have been particularly aware of a growing number of my clients who have experienced early loss of a parent in some way. Some have described problems of the emotional absence of one parent taking drugs, sometimes through the over-use of alcohol, or the inversion of the relationship with one parent and this has been

particularly so with clients whose problems have centred around eating disorders, another addictive behaviour.

However problems in understanding and interpreting difficulties in the transference with some clients led me to consider more deeply the early object relations of clients who have been dependent on benzodiazepines and formed a conflicted, often powerful transference with me. A second realisation was that several of my clients have had mothers who were long-term users of benzodiazepines and have displayed difficulty in forming a consistent attachment with me. This provided ideas for further research.

Perhaps the most significant impact on me was that of analysing the interviews. The process of repeatedly searching the transcripts showed me the importance of doing this manually, because it was only during this analysis of the detail that the real significance of what they were saying emerged. I colour-coded the material once used to prevent it being re-used, and came back to the transcripts afresh each time to select material from within its context.

I accepted and valued each person's contribution as their own experience and was stunned by the wealth of material as the pattern of their ideas and theories emerged. I had set out to explore the views of other therapists and by analysing them find patterns and categories and theories. Contrary to my expectation, they were confirming and clarifying much of my own reflective experience. That seems a wholly appropriate conclusion for reflective practitioners.

After the interviews were completed, I had no continuing contact with the co-researchers and found myself quite isolated in the process of analysis, interpretation and writing. This distancing, an effect of the research process on the researcher, was both necessary and useful, enabling a more objective view of the material in order to constantly challenge the assumptions in it, but was also personally challenging in trying to stay engaged with the process.

Verification of findings

In order to verify these findings with the interviewees, I wrote to 25 whose addresses I still had, (one had emigrated and I could find no method of contact) and eleven agreed to read one chapter of the four. Each participant chose which chapter they wanted to read or if they stated no preference, I chose a chapter to which I knew they had contributed, and ensured that all four chapters were subjected to verification. I asked them to verify that I had accurately reflected what they had said and what they had meant by what they had said, and invited them to make any further comments.

All the therapists who replied confirmed that the findings were an accurate reflection of their views. They made additional comments on therapeutic accessibility being dose-dependent, that many of the propositions could refer to other psychotropic drugs, collaboration with doctors, transitional objects, and parents who take benzodiazepines. One therapist was confusing benzodiazepines with antidepressants.

Learning from my own theoretical perspective

Attachment theory predicts that when someone is faced with distress or threat, they seek out an attachment figure from whom they may obtain relief (Holmes 1993). I believe

therapy works by the provision of a temporary secure base in the person of the therapist, and the establishment of the base depends on the interaction between the help-seeker and the help-giver. A second feature of psychotherapy is the establishing of autobiographical or narrative competence, Winnicott's (1965) extended form of history taking. The third critical element in psychotherapy is affective processing. Benzodiazepines affect attachment, narrative competence and affective processing.

Object relations theory shows how the patient seeking relief may consult a doctor, as an attachment figure or good object, who responds to the need for calming and wisdom identified by Kohut (1977). Rather than calmness and wisdom being internalised by transmuting internalisation from the object, he or she responds with the provision of a transitional object in the form of a drug which is believed to perform and in fact mimics those functions for the patient. However no internalisation takes place and the patient remains dependent for those functions on the substance, which ultimately the therapist must replace.

Not all patients who take benzodiazepines become dependent on them and not all of those who become physiologically dependent become psychologically dependent. Researchers (Hamlin 1988) have estimated that about one third of those prescribed benzodiazepines had no difficulty in stopping them, about one third had a primarily physical dependence on them and could withdraw with information and guidance and one third needed therapy to deal with the psychological dependence.

It seems to be this latter category in which the drug has been performing significant object functions that need a particular form of therapy which can be behaviourally focussed while

being particularly aware of the psychodynamic significance of dependence on benzodiazepines. These are the clients who present in therapy taking benzodiazepines who may resist requests to withdraw because of what the drug now represents for them.

Giving our attention to the metaphors the client uses either about benzodiazepines or their use may alert us to the positive transference to the drug as transitional object. However it may also be important to notice when the transference to the drug turns negative and the positive attachment is transferred to the therapist. I think this is a change that therapists can use to inform them of the deepening of the quality of the therapeutic alliance.

Furthermore, I believe that we can use this knowledge pro-actively to promote such a shift, particularly in the early stage of therapy when decisions about drugs are being made, or for motivational work in addiction services. If the client speaks of the drug as a crutch, comforter, and lifeline for example, we can acknowledge its importance and significance to the client, indicating our understanding and respect. But we also need to not accept that as a long-term solution because a person using a crutch is disabled, a comforter is given up by autonomous adults and our relationships with others are our real lifelines.

Then as therapists we have to take the risk of offering ourselves as substitutes for the drug so that the real object relations deficits can be made good. Metaphors can be used in therapy, as suggested by the therapists in this study as reflections, in stories and fantasy or to access meanings (Table 6.16). They are also a means to promote change, allowing the clients to develop a trust in their therapy rather than that it is also a crutch, dependence or a worse alternative to prescription (Table 6.17).

What I learned about research

The first thing that is obvious is that eventually I began to learn to distinguish between positivist and qualitative research methodologies and to stay within one paradigm. Perhaps this mirrored the whole topic of the research, which is a merging of two paradigms. It has not been an easy or comfortable process. I did learn to trust myself as the human-as-instrument in devising and conducting the interviews, drawing on my experience as a therapist. Then I had to adjust to the role of interpreter of stories and weaver of tales.

The first three interviews showed me that the interview form was too tightly packed because I was following too formal a structure and trying to fit answers into response categories. I re-wrote the form and reverted to recording the answers verbatim when possible, as I had previously done in the semi-structured assessment interviews at the Withdraw Project. I also realised that I needed to allow my therapeutic training to help me find ways of establishing an appropriate relationship with my co-researchers.

I found the interviews enjoyable, interesting and stimulating and each one added to the knowledge and understanding I took into the next, so that it became a cumulative process. I learned from doing them that the bond I formed with participants was the means to elicit ideas from my co-researchers. I was also aware that they found the interview challenging in that it required considerable reflection on their practice with very little warning. I think all the co-researchers said that they had learned something from the process so that my hope that it would be mutually useful was probably realised.

I discovered that theoretical orientations did not seem to figure very largely in this study and that perhaps people pay too much attention to them as dividing us rather than enriching us through variety. Metaphors helped me here since they seemed to transcend differing therapeutic orientations, and provide a representational model and a common terminology. When I presented the findings about metaphors to a client group, they confirmed that they had used these metaphors, and were fascinated at the idea of exploring their own metaphors as part of the process of increasing their self-awareness.

I learned some things about academic institutions and that they are just as keen to attract research students as I was to get accepted. I think that education may now be spelled "business" and that money has become the main objective and sometimes the main lever too. One of my supervisors told me I pay too much respect to authority figures and advised me to publish and be damned. I hope I have learned some necessary scepticism, might publish some of these findings, and will survive damnation.

Evaluation

I now have to go back to the original aims of this research and see whether the goals have been achieved and whether I did what I set out to do. Have I discovered new knowledge or enhanced our knowledge of this field? Have I allowed for complexity, context, and diversity in the discovery and used inductive logic? Does the study have internal consistency between the question and the research methodology? Is it ethical, rigorous, plausible and applicable? Have I been a reflective researcher?

Asking this group of therapists for their views means that in one sense the study has produced new knowledge, since they were not known before. However I think that the

study goes beyond that to produce forty-four propositions that go beyond what was previously known about therapy with clients taking benzodiazepines. Of course there is undoubtedly more that could be known or discovered both from this group or groups like it and from others who belong to groups I did not interview. I have indicated in places that the study has produced new questions for me and others to consider.

I did not try to over-simplify the study by using the survey method to do what it is unsuited to. That method of data collection can never fully anticipate what might be worth exploring or thrown up unexpectedly by the interaction that occurred between the therapists and me. Nor did I attempt to over-generalise the study to cover too wide a topic and I think that the decision to limit it to benzodiazepines only was a good one. Using interviews of people in their work setting and building as diverse a group as possible meant that contextual factors could be noted and explored rather than missed or ignored. I think that having me there, helped the therapists to feel properly understood and encouraged them to disclose quite personal comments on occasions. I have acknowledged the limitations brought about by the obvious yet unintended exclusion of psychiatric therapists.

The methods I used to analyse the data in order to discover the theory that was grounded in the data and inductively derived are consistent with the overall methodological approach. I believe I carried this out carefully and conscientiously, trying to capture the essence of the meanings in my interpretations. Inevitably, and this is desirable, the meanings which emerged are co-constructed by all the participants in the research. I think that although I played a major role, the therapists' clients also contributed in a very

significant way to the findings. Theirs after all were the metaphors and the other half of those shared therapeutic sessions that were the subject of my inquiry.

Internal consistency (Lynch 1996) requires a consistent logic between the philosophical base, the way in which the research is approached, the phrasing of the research questions, the methods used and the conclusions which are drawn. This is the criterion for the assessment of qualitative research and this study has taken these factors into account in its methodology, design, conduct and evaluation. I have also used a variety of sources from which to collect data and cross-checked them as far as possible.

I have tried to adhere to the ethical principles of beneficence, respect and justice. I hope that good will come of these findings and that none have been harmed by my inquiry. I respected the privacy and confidentiality of the participants by exercising care over details in the list of therapists. One decision I made was to exclude the customary acknowledgements. This allowed me to comment on the research process in a personal and reflective way and to be both honest about my views while keeping identities concealed as far as possible. I acknowledge that where I have disagreed with others over much that went wrong, I also acknowledge their good intent.

Critical reflexivity

I have found the process of rewriting some of the thesis under time pressure difficult to engage with, particularly as at times I have also been drawn unwillingly into fighting legal battles with educational institutions. I am still feeling harassed by those battles which means I am still paranoid and mad at times. There are places in the thesis where I have not softened the lead in or out of a chapter with a helpful sentence, where the style

remains formal or distant, and this reflects how prickly I still feel. Perhaps the very idea of "defending a thesis" puts me on the defensive, even if I would not want to be.

I wrote my reflections on the research process as an allegory, a narrative or picture that is to be understood symbolically. I think it shows the parallel process between my own experience of this research and the experiences of the clients who have been described in it. I think that by living this experience I have been able symbolically to live theirs and thereby understand it in a new way.

About my own experience of emancipation, I am less certain. I did manage with help to free myself from the mental slavery of following established positivist methodology and practice and find a more liberating way of doing research even if for a while I was unable to own it. Rewriting some of this thesis has partially enabled me to find my own distinctive voice. However, in addressing Colaizzi's (1978) fourth question about what hidden gains there might be for me in doing this research, I overlooked that where there may be gains, there might also be losses.

I first submitted a thesis in July 1999, which coincided with my year of office as the Chair of the BPS Division of Counselling Psychology, an honour to which I had looked forward with great enthusiasm. I had hoped that it would also be the year in which I might achieve a PhD degree. But events did not happen like that and as the confusion and chaos following the viva unfurled, I began to realise that the process was totally beyond my control.

Those who were slaves had no control over their futures. They could be bought and sold at whim, were subject to arbitrary punishment and could be separated from those they loved. Some took the name of their owners; some had no name just a number. It was both de-humanising and demeaning. Perhaps they could only dream of freedom.

While publicly I was leading the Division, encouraging and affirming others, privately I was suffering what felt like an appalling, demeaning experience. I too was at the mercy of people who can move the goal posts at whim and was left for long periods of time without knowing what was happening. I felt that I was being punished on occasions and when I was ignored, I felt I was not a real person. I experienced a stark contrast between being powerful and being powerless.

Continuing with my therapeutic work has at times been very difficult especially when the client's experience has paralleled my own. I lost a lot of lived experience too but found support in unexpected places. Until I completed this thesis I could not begin the process of grieving that must precede any sense of gain. I have become fearful, have expressed some of my anger in my writing and now the sadness. None but ourselves can free our minds.

We shall not cease from exploration
And the end of all our exploring
Will be to arrive where we started
And know the place for the first time.

T.S. Eliot

CHAPTER 12

CONCLUSION

Summary of key findings

Firstly, of the twenty-two responses to the survey questionnaire only five agencies had either a formal or informal policy about a client's use of benzodiazepines whilst engaged in psychotherapy. Of these five, two left it up to the individual therapist as did several of those who did not claim to have a policy. There appears to be a marked lack of specific policies in NHS psychotherapeutic services in relation to benzodiazepine use while clients are engaged in therapy and possibly a reluctance to develop or even consider one according to their responses.

The rationale for the development of a policy, the therapeutic implications, referral policy, ethical issues, psychodynamic issues, research implications and the importance of communication between all the parties involved, are discussed in detail by me elsewhere (Hammersley 2000). I have also outlined the questions that need to be considered in developing such a policy rather than providing a template for one, since I believe that each service is unique. This is one of the applications of this research investigation.

Secondly, twenty-four of the twenty-six therapists who were interviewed thought that benzodiazepines limit narrative competence, suppress emotional processing and inhibit or prolong the grieving process, which can be mitigated by gradual withdrawal of the drugs within therapy, so that issues of loss can be resolved.

Third, twenty-four of the twenty-six therapists thought that the sedated client is less able to respond within the relationship and requires a different therapeutic strategy that includes consideration of the part played by benzodiazepines.

Fourth, the therapeutic alliance is affected by the psychodynamic role of the drug and complex transferential and counter-transferential issues involving a number of participants have to be identified and addressed.

Fifth, since benzodiazepines increase the client's psychological defences, long-term use is incompatible with psychotherapy.

Sixth, the issue of psychotropic medication, benzodiazepines and antidepressants in particular, is a neglected area in the training, supervision and professional development of psychotherapists.

Learning from the research process

I want to return to the question of whether it is possible or appropriate to combine two differing research paradigms. The interpretive approach by its nature demands a different form of inquiry because it is based on a phenomenological perspective and concerned with understanding human experience from the actor's frame of reference. This demands a change in the mode of inquiry in two ways. Firstly, it denies the existence of a true or correct interpretation against which the results of research can be measured allowing instead for tacit knowledge, contextual variability, grounded theory, the mutual and simultaneous

shaping of entities, including the impact of the researcher on the researched. In this research the essential subjectivity of our views of reality has meant that a consistent interpretive approach has been appropriate.

The second change relates to the different criteria for trustworthiness, so that traditional criteria of internal and external validity, reliability and objectivity are replaced by credibility, transferability, dependability and confirmability (Lincoln & Guba 1985). Naturalistic inquiry demands representing as closely as possible what people feel, know, how they know it and what their understandings are. This requires flexibility on the part of the researcher who must adapt the line of inquiry evaluating, assessing and monitoring the research process along the way. It also means going to the site to collect data in its contextual setting. Lincoln & Guba point out that once you select one of these assumptions the rest more or less automatically follow, and it is therefore not possible to select one and apply it in a different research paradigm. That has been my experience in doing this research.

Although many researchers combine paradigms and this appears possible on the surface, Lincoln & Guba say they are incompatible. However Mertens (1998) states that they later had second thoughts, that the two paradigms have more in common than has been recognised, and that a new paradigm will be developed in the future, by looking at everything as a matter of degree rather than as real or not.

Perhaps combining paradigms is possible by asking a number of subsidiary questions derived from the main research question. I relied on research with experimental designs to answer the subsidiary question about the effects of benzodiazepines on people, yet much of that research relies on subjective experience (although not explicitly) as well as experimental results which have to be interpreted by the researcher and are affected by contextual factors. Combining paradigms may also occur sequentially where hypotheses derived from qualitative inquiry may be tested quantitatively or the other way around, in case studies or by including open-ended questions in quantitative questionnaires (McLeod 2001). I conclude from my experience that the answer to the question about compatibility is not absolutely yes or no but maybe, and that methodological pluralism can have benefits if pursued appropriately. The choice a researcher makes depends largely on the nature of the research question and the philosophical assumptions made about the nature of reality.

Assessment of research quality

Lincoln & Guba (1985) identified five criteria by which qualitative inquiry might be assessed as credibility, transferability, dependability, confirmability and authenticity. Mertens (1998) proposes the same, so I will evaluate this research against these criteria initially.

Credibility

I had a prolonged and substantial engagement with the participants in this inquiry, being open about the aims and purpose of the inquiry, allowing them as long as they wanted to respond in the interview and inviting them to add anything that I had not asked about. There

were opportunities for a debriefing after the interview when participants could comment on the effect the interview had on them. In the analysis, I have dealt with cases/ comments that did not fit with the predominant view and presented material for discussion in workshops and conferences. Although Guba & Lincoln (1989) no longer advocate triangulation, I have done so where possible.

Transferability

I described the individual participants in some detail in chapter 5 and the characteristics of the group of participants in chapter 6, in order to give a picture of the therapists, their setting, context and culture. I was open and transparent about my previous involvement with some of the participants, which has influenced their views as they have influenced mine. I have provided a thick description of their views with multiple examples of their comments. The number of participants is relatively high compared with the twelve or no more than twenty advocated by Lincoln & Guba (1985).

Dependability and Confirmability

Dependability relates to stability over time, and confirmability to the chain of evidence which has been preserved, in the tapes, transcripts, field notes and researcher's journal which are available for audit. This allows for reliance on the data and the evidence that has been kept. I checked with participants that I have presented their views accurately and they confirmed that I have.

Authenticity

This criterion refers to the commitment to fairness, that it is a balanced view, the learning of both the participants as well as the researcher, the sharing of knowledge and the stimulation and enabling of social action. This latter criterion of catalytic authenticity by which the inquiry process leads to action led me to an experience of how this research has stimulated action beyond the participants as well as taking me further in my own thinking. When I presented some of this material to therapists in a workshop, it led to a participant returning to a psychology service to raise the issue of a policy on prescribed drugs and therapy and asking me for suggestions about the rationale and procedure for developing one. This sharing of knowledge and ideas led me to write about the subject for other psychotherapeutic services (Hammersley 2000) and I have had inquiries from someone pursuing the topic further as a result of reading the article.

Elliot et al (1999) specify criteria which relate to both qualitative and quantitative approaches as: explicit scientific context and purpose, appropriate methods, respect for participants, specification of methods, appropriate discussion, clarity of presentation and contribution to knowledge. I believe that I have demonstrated how I addressed these general criteria, which lay a foundation upon which criteria that are specific to qualitative research can be added.

In interpretive inquiry Lincoln (1995) describes emerging criteria for quality as the position or standpoint judgements, the community as arbiter, voice, critical subjectivity, reciprocity, sacredness of texts and sharing the perquisites of privilege. These criteria have something in

common with those of Elliott et al (1999), who outline guidelines that are especially pertinent to qualitative research. These are: (1) owning one's perspective, (2) situating the sample, (3) grounding in examples, (4) providing credibility checks, (5) coherence, (6) accomplishing general versus specific research tasks, and (7) resonating with readers.

Assessing the quality of this inquiry against Elliot et al's second set of criteria that are pertinent to qualitative research, I conclude the following:

1. I specified my personal background, theoretical orientations, professional background, my values and assumptions, so that readers can form their own judgements about the data and my interpretation of it.
2. I describe the research participants, their gender, profession, theoretical orientation, work setting, experience of the subject under inquiry etc, so that readers can judge the range of people and settings within which the findings may be relevant.
3. I described the process of analysing the data and provide examples to illustrate the understandings and propositions reached.
4. I checked the findings with the original participants, with other therapists not interviewed, and used triangulation with quantitative data.
5. I presented my understandings in a way that linked ideas in categories that were logically related and a hierarchical grouping of propositions in outcome propositions that summarised them.
6. I intended to describe a general understanding of the phenomenon rather than a specific example and so I have provided a range of informants and contexts and noted the limitations of not finding interviewees in certain fields.

7. I have presented the material in a way that it might resonate with the reader who can identify aspects of their own therapeutic experience, and presented my own experience in a literary and creative way that relates it to the experiences of clients who are the focus of therapeutic work.

McLeod (2001) discusses these guidelines and whilst acknowledging the value of them says that in the end it all comes down to a matter of trust, particularly in the personal qualities of the researcher, qualities such as integrity, courage, honesty and commitment to the task. If research is carried out with integrity, then there is certainly some value in it and some truth in it. I want this research to be evaluated primarily by this test. Even if research is technically flawless if it lacks personal integrity, it is of limited value. McLeod states that although the guidelines proposed by Elliott et al (1999) make an important contribution they do not really address research quality. It needs to be interesting, useful and evocative in order to become widely accepted in the counselling and psychotherapy community and lead to changes of practice. Ultimately, I hope that readers of this research are sufficiently convinced by it to act on it and test the propositions within their own therapeutic practice.

Implications for practice

In chapter 10 I outlined a number of implications that derived from the inquiry and were suggested to me by the participants during interviews and have already been discussed in chapter 11, so I shall refer to them here briefly.

1. Providers of psychological therapies, both individuals and agencies, should have a policy about the use of benzodiazepines concurrent with therapy.

2. Knowing that a client is taking benzodiazepines whilst engaging in psychotherapy is important to client, therapist and prescriber and for their practice. It may impose an external limitation on the effectiveness of therapy and mean that withdrawal from benzodiazepines should precede therapy.

3. Therapy which has limitations placed upon it which are not acknowledged by reduced therapeutic goals, is wasteful of individual and public time, money and effort.

4. People who are bereaved and those who care for them should be aware of the dangers of prescribing benzodiazepines and how they affect the grieving process, even when used for the limited time the prescribing guidelines permit.

5. Trainers and supervisors of counsellors and psychotherapists have a responsibility to promote a greater awareness of how therapy and benzodiazepines interact and to teach and develop the skills required for working with these clients.

6. The use of other psychotropic medication, especially antidepressants, needs to be scrutinised for its impact on psychotherapy, to determine whether it may be helpful or unhelpful and vice versa.

7. The guidelines for those who commission psychological therapies could be written in a manner that does not make blanket statements about combining psychological and medical approaches without consideration of the available evidence.

8. An implication for me is that other therapists share many, but not necessarily all, of my concerns about the impact of benzodiazepines on the psychotherapeutic process and I shall continue to monitor it in my practice in the light of their concerns.

9. I have a responsibility to my co-researchers to publish these findings where they may be useful to others and promote action.

Suggestions for future research

1. The question of how the therapeutic process is affected by benzodiazepines could be addressed by looking at it from other perspectives, such as the client's.

2. Some groups of long-term benzodiazepine users advocate the use of a research paradigm which does not pathologise them, but which would address the social and political contexts of prescribing.

3. Since research is affected by what the researcher brings to it of themselves, values, and assumptions, it would be interesting were the inquiry into how therapists view process, to be conducted by a non-therapist prescriber.

4. Antidepressants, especially the SSRIs, have largely replaced benzodiazepines in popularity so there is a need for research into how they impact on the therapeutic process with clients who take them.

5. It would be useful to explore effective ways to inform prescribers about psychotherapy processes as well as outcomes and how to influence their prescribing practices through collaboration.

6. It would be useful to develop and trial modules about prescribed medication for inclusion in training courses for counsellors and psychotherapists.

Taking forward any of these suggestions for research would further some of the original purposes for which this research was undertaken, to widen and increase knowledge in this field and contribute to social justice. I stated in the introduction that I wanted to discover whether my experience of psychotherapy with clients taking benzodiazepines was similar to that of other therapists and this research has answered that question for me. I still feel passionately about the mental slavery of those who are dependent on benzodiazepines as well as the mental slavery that persists in the minds of doctors and therapists who accept the use of this medication unquestioningly. I also believe that it need not be so and that each of us can "free our minds". By questioning established attitudes and accepted practices we start the process of emancipation.

APPENDIX 1. BENZODIAZEPINES

Benzodiazepines act on the central nervous system at benzodiazepine receptor sites enhancing the effects of gamma-aminobutyric acid (GABA).

The Committee on Safety of Medicines advice:

1. Benzodiazepines are indicated for the short-term relief (two to four weeks only) of anxiety that is severe, disabling or subjecting the individual to unacceptable distress, occurring alone or in association with insomnia or short-term psychosomatic, organic or psychotic illness.
2. The use of benzodiazepines to treat short-term "mild" anxiety is inappropriate and unsuitable.
3. Benzodiazepines should be used to treat insomnia only when it is severe, disabling or subjecting the individual to extreme distress.

   (*British National Formulary* September 1998)

Benzodiazepines used as hynoptics:		
Nitrazepam	Flunitrazepam	Flurazepam
Loprazolam	Lormetazepam	Temazepam
Benzodiazepines used as anxiolytics:		
Diazepam	Alprazolam	Bromazepam
Chlordiazepoxide	Clobazam	Clorazepate
Lorazepam	Oxazepam	

Dependence and Withdrawal

1. Withdrawal of a benzodiazepine should be gradual at the client's pace and with their informed consent.
2. A withdrawal syndrome may develop particularly if the client has been taking the benzodiazepine for longer than the recommended length of time.
3. The withdrawal syndrome may be delayed in onset for up to three weeks with a longer acting compound or may occur within a few hours with a shorter acting one.
4. Withdrawal symptoms, if they occur, increase in number and severity at first and then subside. No further reduction of the benzodiazepine should be made until the withdrawal symptoms have subsided.
5. Some symptoms may continue for months after stopping benzodiazepines entirely, particularly if withdrawal has been too rapid.

APPENDIX 2. LETTER TO NHS PSYCHOTHERAPY SERVICES

The Clinical Director

Address

Date:

Dear Clinical Director

I am a Chartered Counselling Psychologist investigating the use of benzodiazepines and psychotherapy. Little is known about current clinical practice and whether psychotherapy services operate a policy or not. I am therefore contacting a number of providers to establish briefly what the pattern is.

I believe your service offers psychotherapy or therapeutic counselling to patients and that some of them may also be taking or have taken benzodiazepines for their problems. I would be very grateful if you would be willing to complete the enclosed survey of 4 questions and return it to me in the enclosed stamped-addressed envelope.

Thank you for your help.

Yours sincerely

Chartered Counselling Psychologist

APPENDIX 3. SURVEY QUESTIONNAIRE

Survey of Psychotherapy Services

1. Do you have a policy about patient's or client's use of benzodiazepines or similar drugs, whilst engaged in psychotherapy?

   YES [ ]
   NO [ ]
   DECIDED ELSEWHERE [ ]

2. Could you describe the policy briefly? (or enclose a copy if you prefer)

   CONTINUING BENZODIAZEPINES IS A REQUIREMENT [ ]
   ABSTINENCE FROM BENZODIAZEPINES IS REQUIRED [ ]
   IT IS AT THE DISCRETION OF THE THERAPIST [ ]
   IT IS LEFT UP TO THE CLIENT OR PATIENT [ ]
   BENZODIAZEPINES ARE REDUCED OR WITHDRAWN [ ]
   OTHER .....

3 Could you give the rationale behind your policy or no policy?

   PROFESSIONAL BOUNDARIES [ ]
   PSYCHOTHERAPY MODEL/THEORY [ ]
   PRACTICAL ISSUES [ ]
   COMBINING APPROACHES INCREASES THE BENEFIT [ ]
   THE TWO APPROACHES ARE INCOMPATIBLE [ ]
   IT HAS NOT BEEN CONSIDERED [ ]

4 Please add any other comments you would like to make, or indicate if you would like to be involved further.
   [ ]

Name

Address

APPENDIX 4. NOTICE GIVEN OUT AT CONFERENCES.

BENZODIAZEPINES AND PSYCHOTHERAPY

I am investigating the effects of clients taking benzodiazepine medication whilst engaged in psychotherapy. I am particularly keen to find psychologists, psychotherapists and counsellors who have experience of this, willing to be interviewed about their experiences and views.

If you would like to be involved or know other people who would, I am looking for therapists willing to be interviewed, who fulfil the criteria:

a) trained in a style of therapy which uses the relationship,
b) have experience of working with clients taking benzodiazepines,
c) have worked with a client taking benzodiazepines, who stopped.

Contact:

APPENDIX 5. ADVERTISEMENT PLACED IN JOURNALS.

COUNSELLORS WANTED

As co-researchers, for an investigation into therapy with clients taking benzodiazepines. The criteria are:

a) trained in a style of therapy which uses the relationship,
b) have experience of working with clients taking benzodiazepines,
c) have worked with a client taking benzodiazepines, who stopped.

The commitment is to be willing to give one interview about your experience and views. I hope that it will be a mutually beneficial discussion which may be some reward for taking part.

Contact: Diane Hammersley, 52 Hanbury Road, Droitwich Spa, WR9 8PR
Telephone: 01905-776197 anytime.

APPENDIX 6. THERAPIST INTERVIEW

BENZODIAZEPINES AND PSYCHOTHERAPY

1 **Therapist details**:

Name: Profession:
Place of work: Approach used:
Year of first contact with bzs: Date:

2 **Client details**:
Proportion of clients taking bzs:
Number in case load:

3 **In what ways have you noticed clients being affected by bzs?**
Thinking:
Behaviour:
Emotions:
Dependence:
Relationships:

4 **What beliefs about bzs do clients have?**
What metaphors do they use?
Do you use the metaphors in the therapy?
What beliefs about therapy do they have?

5 **When a client came off bzs, what was that like?**
Who decided?
Was it integrated with the therapy?
Were there any problems?
Were there issues that came up after withdrawal?
After withdrawal, were there issues that no longer came up?
Did withdrawal make any difference to the therapy?

RECORD HERE

6 **Bzs are believed to interfere with grieving. Have you ever noticed that?**
What do you think may be happening?

7. **When the client is taking bzs, is therapy different in any way?**

8 **What supervision input have you had for work with clients on bzs?**
What was helpful?
What was unhelpful?

9 **What is your attitude to working with clients taking bzs?**
Can you explain your reasons for me?

10 **Do you have a theory about the interaction between bzs and therapy?**

11 **What are the wider implications of this?**
For you?
For clients?
For others?

12 **Is there anything that I have not mentioned that you feel is relevant to this subject?**
Would you like to add anything else?

REFERENCES

Angus, W. and Romney, D. (1984) "The effects of diazepam on patient's memory," *Journal of Clinical Psychopharmacology*, 4: 203-6.

Arendt, H. (1958) *The Human Condition,* Chicago, University of Chicago.

Armstrong, P. (1996) "Counselling and Mind-Altering Medications", *Counselling*, 7(3): 233-236.

Arthern, J. and Madill, A. (1999) "How do transitional objects work? The therapist's view," *British Journal of Medical Psychology*, 72: 1-21.

Ashton, H. (1984) "Benzodiazepine withdrawal: an unfinished story," *British Medical Journal*, 288: 1135-1140.

Ashton, H. and Golding, J.F. (1989) "Tranquillisers: prevalence, predictors and possible consequences. Data from a large United Kingdom Survey," *British Journal of Addiction*, 84: 541-546.

Association of Community Health Councils for England and Wales, (1989) Benzodiazepines - A Suitable Case for Treatment, London.

Bakhtin, M. (1986) *Speech Genres and Other Late Essays,* Translated, McGee, V. Austin Tx, University of Texas.

Balint, M. (1964) *The Doctor, His Patient and the Illness*, (2nd Ed) London, Churchill Livingstone.

Balter, M.B., Manheimer, D.I., Mellinger, G.D. and Uhlenhuth, E.H. (1984) "A cross-national comparison of anti-anxiety / sedative drug use," *Current Medical Research and Opinion*, 8(4): 5-20.

Bancroft, J. (1979) "Crisis intervention" in S. Block (Ed) *An introduction to the psychotherapies*, Oxford, OUP

Barkin, L. (1978) "The Concept of the Transitional Object", in S. A. Grolnick and L. Barkin (Eds.), *Between Reality and Fantasy*, New Jersey, Aronson.

Bergin, A.E. and Garfield, S.L. (1994) "Overview, Trends, and Future Issues", in S.L. Garfield and A.E. Bergin (Eds.) *Handbook of Psychotherapy and Behaviour Change*, New York, Wiley.

Bishop, K.I. and Curran, H.V. (1995), "Psychopharmacological analysis of implicit and explicit memory: a study with lorazepam and the benzodiazepine antagonist flumazenil", *Psychopharmacology*, 107: 00-00(no pagination).

Bixler, E.O., Kales, A., Manfredi, R., Vgontzas, A.N., Tyson, K. and Kales, J.D. (1991), "Next-day memory impairment with triazolam use", *The Lancet*, 337: 827-831.

Block, S. (1979) "Supportive psychotherapy", in S. Block (Ed*) An Introduction to the Psychotherapies*, Oxford, OUP

Bond, A.J., Curran, H.V., Bruce, M.S., O'Sullivan, G. and Shine, P. (1995) "Behavioural aggression in panic disorder after 8 weeks' treatment with alprazolam", *Journal of Affective Disorders*, 35: 117-123.

Boseley, S. (2001a) "Psychiatric agenda 'set by drug firms'", *The Guardian Newspaper*, 9 July 2001.

Boseley, S. (2001b) "Suicide fear over antidepressants", *The Guardian Newspaper*, 10 July 2001.

Bowlby, J. (1969) *Attachment*, London, Hogarth Press

Bowlby, J. (1988) *A Secure Base: Clinical Applications of Attachment Theory*, London, Routledge.

Breggin, P. (1991) *Toxic Psychiatry*, New York, St Martin's Press.

British Medical Association and The Royal Pharmaceutical Society (1998) *British National Formulary*, London, The Pharmaceutical Press.

British Psychological Society (1993) Code of Conduct, Leicester, B.P.S.

Busto, U., Sellers, E.M., Naranjo, C.A., Cappell, H.D., Sanchez-Craig, M. and Simpkins, J. (1986), "Patterns of Benzodiazepine Abuse and Dependence", *British Journal of Addiction*, 81: 87-94.

Cashdan, S. (1988) *Object Relations Therapy,* London, WW Norton & Co.

Catalan, J., Gath, D.H., Bond, A., Edmonds, G., Martin, P. and Ennis, J. (1988) "General Practice Patients on Long-term Psychotropic Drugs - A controlled investigation", *British Journal of Psychiatry*, 152: 399-405.

Charmaz, K. (2000) "Grounded Theory: Objectivist and Constructivist Methods" in N. K. Denzin & Y. S. Lincoln (Eds.) *Handbook of Qualitative Research,* Thousand Oaks CA, Sage.

Chouinard, G., Annable, L., Fontaine, R. and Solyom, L. (1982) "Alprazolam in the Treatment of Generalised Anxiety and Panic Disorders: Double-Blind Placebo-Controlled Study", *Psychopharmacology*, 77: 229-233.

Christians, C.G. (2000) "Ethics and Politics in Qualitative Research" in N. K. Denzin & Y. S. Lincoln (Eds.) *Handbook of Qualitative Research,* Thousand Oaks CA, Sage.

Colaizzi, P. F. (1978) "Psychological research as the phenomenologist views it" in R. S. Valle & M. King (Eds.), *Existential-Phenomenological Alternatives for Psychology,* New York, Oxford University Press.

Committee on The Review of Medicines (1980), "Systematic Review of the Benzodiazepines: Guidelines for Data Sheets on Diazepam, Chlordiazepoxide, Medazepam, Chlorazepate", *British Medical Journal*, 280: 910-912.

Committee on Safety of Medicines (1988) "Benzodiazepines, dependence and withdrawal symptoms", *Current Problems*, 21: 1-2.

Cooperstock, R. (1979) "A Review of Women's Psychotropic Drug Use", *Canadian Journal of Psychiatry*, 24: 29-34.

Cormack, M.A. and Sinnott, A. (1983) "Psychological alternatives to long-term benzodiazepine use", *Journal of the Royal College of General Practitioners*, 33: 279-281.

Counselling in Primary Care Trust (1999) *Newsletter*, Counselling in Primary Care Trust.

Curran, H.V. (1986) "Tranquillising memories: a review of the effects of benzodiazepines on human memory", *Biological Psychology*, 23: 179-213.

Curran, H.V. (1991) "Benzodiazepines, memory and mood: a review", *Psychopharmacology*, 105: 1-8.

Curran, H.V., Gardiner, J.M., Java, R.I. and Allen, D. (1993), "Effects of lorazepam upon recollective experience in recognition memory", *Psychopharmacology*, 110: 374-378.

Curran, H.V., Bond, A., O'Sullivan, G., Bruce, M., Marks, I., Lelliot, P., Shine, P. and Lader, M. (1994), "Memory functions, alprazolam and exposure therapy: a controlled longitudinal study of agoraphobia with panic disorder", *Psychological Medicine*, 24: 969-976.

Denzin, N. K. & Lincoln, Y.S. (Eds) (1994) *Handbook of Qualitative Research*, Thousand Oaks CA, Sage.

Denzin, N. K. & Lincoln, Y. S. (2000) "The Discipline and Practice of Qualitative Research", in N. K. Denzin & Y. S. Lincoln (Eds) *Handbook of Qualitative Research,* Thousand Oaks CA, Sage.

Department of Health (2001) *Treatment Choice in Psychological Therapies and Counselling,* London, Department of Health Publications.

Dillon, S.C. (1991) "Personal Construct Therapy with long-term users of Benzodiazepines", Unpublished Dip Clin Psych. Diss. B.P.S.

Dilsaver, S.C. (1989) "Antidepressant withdrawal syndromes: phenomenology and pathophysiology", *Acta Psychiatr. Scand.* 79: 113-117.

Elliot, R., Fischer, C.T. and Rennie, D.L. (1999) "Evolving guidelines for publication of qualitative research studies in psychology and related fields", *British Journal of Clinical Psychology*, 38: 215-229.

File, S.E. and Pellow, S. (1987) "Behavioural pharmacology of minor tranquillisers", *Pharmacological Therapy*, 35: 265-90.

Fine, G. & Sandstrom, K. L. (1988) *Knowing children: Participant observations with minors,* Newbury Park CA, Sage.

Fisher, S. and Greenberg, R. (1989*), The Limits of Biological Treatments for Psychological Distress,* Hillsdale, N.J. Lawrence Erlbaum Associates.

Fletcher, J., Fahey, T. and McWilliam, J. (1995) "Relationship between the provision of counselling and the prescribing of antidepressants, hypnotics and anxiolytics in general practice", *British Journal of General Practice*, 45: 467-9.

Flew, A. (1978) "Transitional Objects and Transitional Phenomena: Comments and Interpretations," in S. A. Grolnick and L. Barkin (Eds), *Between Reality and Fantasy*, New Jersey, Aronson.

Fontana, A. & Frey, J. H. (2000) "The Interview: from Structured Questions to Negotiated Text", in N. K. Denzin & Y. S. Lincoln (Eds) *Handbook of Qualitative Research*, Thousand Oaks CA, Sage.

Frank, J.D. (1979) "What is psychotherapy?" in S. Block (Ed) *An Introduction to the Psychotherapies*, Oxford, OUP

Garfield, S. L. & Bergin, A. E. (1994) "Introduction and Historical Overview", in S.L. Garfield and A.E. Bergin (Eds) *Handbook of Psychotherapy and Behaviour Change*, New York, Wiley.

Ghodse, H. (1995) *Drugs and Addictive Behaviour*, (2nd Ed) Oxford, Blackwell Science.

Glaser, B. G. & Strauss, A. L. (1967) *The Discovery of Grounded Theory*, Chicago Il, Aldine.

Goldhamer, P.M. (1993) "The Challenge of Integration", in M. Schachter (Ed) *Psychotherapy and Medication*, New Jersey, Aronson.

Golombok, S., Moodley, P. and Lader, M. (1988), "Cognitive impairment in long-term benzodiazepine users", *Psychological Medicine*, 18: 365-374.

Green, A (1978) "Potential Space in Psychoanalysis: The Object in the Setting" in S.A.Grolnick and L. Barkin (Eds) *Between Reality and Fantasy*, London, Jason Aronson.

Guba, E. G. & Lincoln, Y. S. (1989) *Fourth generation evaluation*, Newbury Park CA, Sage.

Guba, E. G. & Lincoln, Y. S. (1994) "Competing paradigms in qualitative research", in N. K. Denzin & Y. S. Lincoln (Eds) *Handbook of Qualitative Research,* Thousand Oaks CA, Sage.

Guntrip, H. (1971) *Psychoanalytic Theory, Therapy and the Self*, London, Basic Books.

Gupta, A.S. (1998) "Training in the use of the 'counselling style' interview in qualitative research", *Counselling Psychology Review* 13(3): 13-19.

Gutheil, T.G. (1982) "The psychology of psychopharmacology", *Bulletin of the Menninger Clinic*, 46: 321-330.

Hackman, A. (1993) "Psychological alternatives to taking benzodiazepines", in C. Hallstrom (Ed) *Benzodiazepine Dependence*, Oxford Medical Publications.

Hamlin, M.A. (1988) "Psychological group treatment in the withdrawal of benzodiazepine medication", Unpublished Ph.D. Thesis, University of Birmingham.

Hamlin, M.A. (1993) "Why people take benzodiazepines", in C. Hallstrom (Ed) *Benzodiazepine Dependence*, Oxford Medical Publications.

Hamlin, M. and Hammersley, D. (1989) "Managing benzodiazepine withdrawal", in G. Bennett (Ed) *Treating Drug Abusers*, London, Routledge.

Hammersley, D. (1995) *Counselling People on Prescribed Drugs*, London, Sage.

Hammersley, D.E. (2000) "Developing a policy on drugs and alcohol for a psychotherapeutic service", *Counselling Psychology Review*, 15(3): 18-25.

Hammersley, D. and Beeley, L. (1996) "The Effects of Medication on Counselling", in S.Palmer, S.Dainow and P.Milner (Eds) *Counselling*, London, Sage/B.A.C.

Hausner, R. (1993) "Medication and Transitional Phenomena", in M. Schachter (Ed) *Psychotherapy and Medication*, New Jersey, Aronson.

Hayward, P., Wardle, J. and Higgitt, A. (1989) "Benzodiazepine research: Current findings and practical consequences", *British Journal of Clinical Psychology*, 28: 307-327.

Helman, C.G. (1981) "Tonic, fuel, and food: social and symbolic aspects of the long-term use of psychotropic drugs", *Social Science and Medicine*, 153: 521-33.

Heron, J. (1996) *Co-operative Inquiry: Research into the Human Condition*, London, Sage.

Holden, J.M., Sagovsky, R. and Cox, J.L. (1989) "Counselling in a general practice setting: Controlled study of health visitor intervention in treatment of postnatal depression", *British Medical Journal*, 298: 223-226.

Holmes, J. (1993) John *Bowlby and Attachment Theory*, London, Routledge.

Holstein, J. A. & Gubrium, J. F. (1994) "Phenomenology, ethnomethodology, and interpretive practice", in N. K. Denzin & Y. S. Lincoln (Eds) *Handbook of Qualitative Research*, Thousand Oaks CA, Sage.

Horner, A.J. (1984) *Object Relations and the Developing Ego in Therapy*, London, Jason Aronson.

House, R. (1996) "General Practice Counselling: a plea for ideological engagement", *Counselling* 7(1): 40-44.

Howard, G. S. (1991) "Culture tales: A narrative approach to thinking, cross-cultural psychology, and psychotherapy", *American Psychologist*, 46:187-197.

International Drug Therapy News, (1984) Vol. 19:23-24.

Josselson, R. (1996) *Ethics and Process in the Narrative Study of Lives*, Thousand Oaks CA, Sage.

Kahn, D.A. (1993) "Medication Consultation and Split Treatment During Psychotherapy", in M. Schachter (Ed) *Psychotherapy and Medication*, New Jersey, Jason Aronson.

Karasu, T.B. (1982) "Psychotherapy and pharmacology: Towards an integrative model", *American Journal of Psychiatry*, 138: 1102-1113.

Kaufman, K. (1994) *Psychotherapy of Addictive Persons*, New York, Guilford Press.

Kleinknecht, R.A. and Donaldson, D. (1975) "A Review of the Effects of Diazepam on Cognitive and Psychomotor Performance", *Journal of Nervous Mental Disease*, 161(6): 399-411.

Klerman, G.L., Budman, S., Berwick, D., Wersman, M.M., Damico-White, J., Denby, A. and Feldstin, M. (1987) "Efficacy of a brief psychosocial intervention of symptoms of stress and distress among patients in primary care", *Medical Care*, 25: 1078-1088.

Klerman, G.L., Weissman, M.M., Markowitz, J., Glick, I., Wilner, P.J., Mason, B. and Shear, M.K. (1994) "Medication and Psychotherapy", in Bergin, A.E. and Garfield, S.L. (Eds), *Handbook of Psychotherapy and Behaviour Change*, New York, Wiley.

Kohut, H. (1971) *The Analysis of the Self,* Connecticut, Int.U.P.

Kohut, H. (1977) The *Restoration of the Self*, New York, Int.U.P.

Koumjian, K. (1981) "The Use of Valium as a Form of Social Control", *Social Science and Medicine,* 15(e): 245-249.

Lader, M.H. (1983) "Benzodiazepines, psychological functioning and dementia", in M.R.Trimble (Ed) *Benzodiazepines Divided*, Chichester, Wiley.

Lader, M.H. (1992a) "Abuse Liability of Prescribed Psychotropic Drugs", in J.M. Kane and J.A. Lieberman (Eds.), *Adverse Effects of Psychotropic Drugs*, New York, Guilford Press.

Lader, M.H. (1992b) "Guidelines for the management of patients with generalised anxiety: consensus statement", *Psychiatric Bulletin*, 16: 560-5.

Lambert, M.J. & Hill, C.E. (1994) "Assessing Psychotherapy Outcomes and Processes", in S.L. Garfield and A.E. Bergin (Eds.) *Handbook of Psychotherapy and Behaviour Change*, New York, Wiley.

Lennard, H.L. and Cooperstock, R. (1980) "The social context and functions of tranquilliser prescribing", in R. Mapes (Ed), *Prescribing Practice and Drug Usage*, London, Croom Helm.

Levin, J.D. (1995) "Psychotherapy in Later-Stage Recovery" in A.M. Washton (Ed), *Psychotherapy and Substance Abuse*, New York, Guilford Press.

Levy, M. (1987) "A change in orientation: Therapeutic strategies for the treatment of alcoholism", *Psychotherapy*, 24: 786-793.

Levy, S.T. (1993) "Countertransference Aspects in the Treatment of Schizophrenia", in M. Schachter (Ed), *Psychotherapy and Medication*, New Jersey, Aronson.

Lincoln, Y.S. (1995) "Emerging Criteria for Quality in Qualitative and Interpretive Research", *Qualitative Inquiry*, 1(3): 275-289.

Lincoln, Y. S. & Guba, E. G. (1985) *Naturalistic Inquiry*, Beverley Hills CA, Sage.

Lincoln, Y. S. & Denzin, N. K. (2000) "The Seventh Moment", in N. K. Denzin & Y. S. Lincoln (Eds) *Handbook of Qualitative Research*, Thousand Oaks CA, Sage.

Lindsay, W.R., Gamsu, C.V., McLaughlin, E., Hood, E.E. and Espie, C.A. (1987) "A controlled trial of treatments for generalised anxiety disorder", *British Journal of Clinical Psychology*, 26: 3-15.

Lister, R.G. (1985) "The amnesic action of benzodiazepines in man", *Neuroscience and Biobehavioural Reviews*, 9: 87-94.

Loose, R. (1998) "Sexual and other addictions", *The Psychoanalysis Newsletter*, The Higher Education Network for Research and Information in Psychoanalysis. (THERIP)

Lynch, G. (1996) "What is Truth? A philosophical introduction to counselling research", *Counselling* Vol. 7(2): 144-148.

Mac, D., Kumar, R. and Goodwin, D. (1985) "The effect of lorazepam on memory in a double-blind study", *Journal of Clinical Psychiatry*, 46: 137-8.

Mahrer, A.P. (1998) "Embarrassing Problems for the Field of Psychotherapy", *B.P.S. Psychotherapy Section Newsletter*, 23: 19-29.

Maykut, P. & Morehouse, R. (1994) *Beginning Qualitative Research: A Philosophic and Practical Guide,* London, The Falmer Press.

McDougall, J. (1995) *The Many Faces of Eros: A psychoanalytic Exploration of Human Sexuality,* London, Free Association Books.

McLeod, J. (1994) *Doing Counselling Research*, London, Sage.

McLeod, J. (1996) "Qualitative Research Methods in Counselling Psychology", in R. Woolfe & W. Dryden (Eds) *Handbook of Counselling Psychology,* London, Sage.

McLeod, J. (2001) *Qualitative Research in Counselling and Psychotherapy,* London, Sage.

Medawar, C. (1984) The *Wrong Kind of Medicine?* Consumers' Association / Hodder & Stoughton.

Medawar, C. (1992*), Power and Dependence*, Social Audit.

Mellor-Clark, J. (1999) "National Survey of Counsellors Working in General Practice", *Counselling in Practice*, 3(1): 2.

Mertens, D. M. (1998) *Research Methods in Education and Psychology,* Thousand Oaks CA, Sage.

Miles, M. B. & Huberman, A. M. (1994) *Qualitative Data Analysis (2nd Ed),* Thousand Oaks CA, Sage.

Mischler, E. G. (1986) *Research Interviewing: Context and Narrative,* Cambridge MA, Harvard University Press.

Montague, M. (1988a) "The metaphorical nature of drugs and drug taking", *Journal of Drug Issues,* 26: 417-24.

Montague, M. (1988b) "Philosophies of drug giving and drug taking", *Journal of Drug Issues,* 18: 139-148.

Montague, M. (1991) "The culture of long-term tranquilliser users", in J. Gabe (Ed), *Understanding Tranquilliser Use: The role of the social sciences*, London, Tavistock / Routledge.

Morgan, J.P. (1983) "Cultural and medical attitudes towards benzodiazepines: conflicting metaphors", *Journal of Psychoactive Drugs*, 15: 115-20.

Morgan, K. and Oswald, I. (1982) "Anxiety caused by a short-life hypnotic", *British Medical Journal,* 942: 00

Morgan, K., Dallosso, H., Ebrahim, S., Arie, T. and Fentem, P.H. (1988) "Prevalence, frequency, and duration of hypnotic drug use among the elderly living at home", *British Medical Journal*, 296: 601-602.

Morgan, M. (1996) "Qualitative Research: a package deal?" *The Psychologist*, 9(1): 31-32.

Murphy, S.L. and Khantzian, E.J. (1995) "Addiction as a Self-Medication Disorder: Application of Ego Psychology to the Treatment of Substance Abuse", in A.M. Washton (Ed) *Psychotherapy and Substance Abuse*, New York, Guilford Press.

Nevins, D.B. (1993) "Psychoanalytic Perspectives on Medication for Mental Illness", in M. Schachter (Ed), *Psychotherapy and Medication*, New Jersey, Aronson.

Orlinsky, D.E., Grawe, K. and Parks, B.K. (1994) "Process and outcome in psychotherapy", in A.E. Bergin and S.L. Garfield (Eds.), *Handbook of Psychotherapy and Behaviour Change*, Chichester, Wiley.

Ostow, M. (1993) "On Beginning with Patients who Require Medication", in M. Schachter (Ed) *Psychotherapy and Medication*, New Jersey, Aronson.

Parkes, C.M., Stevenson-Hinde, J. and Marris, P (Eds.) (1991) *Attachment across the Life Cycle*, London, Routledge.

Parry, G. (1996) *NHS Psychotherapy Services in England. Review of Strategic Policy*, NHS Executive.

Patton, M. Q. (1990) *Qualitative Evaluation and Research Methods (2nd Ed),* Beverley Hills CA, Sage.

Petursson, H. and Lader, M.H. (1981) "Withdrawal from long-term benzodiazepine treatment", *British Medical Journal*, 283: 643-645.

Polanyi, M. (1967) *The Tacit Dimension,* Chicago Il, The University of Chicago.

Power, K.G., Jerrom, D.W.A., Simpson, R.J., Mitchell, M.J. and Swanson, V. (1989) "A controlled comparison of cognitive behaviour therapy, diazepam and placebo in the management of generalised anxiety", *Behavioural Psychotherapy*, 17: 1-14.

Power, K.G., Simpson, R.J., Swanson, V., Wallace, L.A., Feistner, A.T.C. and Sharp, D. (1990) "A controlled comparison of cognitive-behaviour therapy, diazepam, and placebo, alone and in combination, for the treatment of generalised anxiety disorder", *Journal of Anxiety Disorders*, 4: 267-292.

Priest, R.G. (1980) "The Benzodiazepines: A Clinical Review", in R.G. Priest (Ed) *Benzodiazepines Today and Tomorrow*, M.T.P.Press.

Priest, R.G., Vize, C., Roberts, A., Roberts, M. and Tylee, A. (1996) "Lay people's attitudes to treatment of depression: results of an opinion poll for the Defeat Depression Campaign just before its launch", *British Medical Journal*, 313: 558-9.

Prochaska, J. O. & DiClemente, C. C. (1984) *The Transtheoretical Approach: Crossing Traditional Boundaries of Therapy,* Homewood Ill, Dow-Jones-Irwin.

Raphael, B. (1977) "Preventative intervention with the recently bereaved", *Archives of General Psychiatry*, 34: 1450-1454.

Rawson, R.A. (1995) "Is Psychotherapy Effective for Substance Abusers?" in A.M. Washton (Ed) *Psychotherapy and Substance Abuse*, New York, Guilford Press.

Reason, P. & Rowan, J. (Eds) (1981) *Human Inquiry: A Sourcebook of New Paradigm Research,* Chichester, Wiley.

Rhodes, L.A. (1984) "This will clear your mind: the use of metaphors for medication in psychiatric settings", *Culture, Medicine and Psychiatry*, 8: 49-70.

Risse, S.C., Whitters, A., Burke, J., Chen, S., Scurfield, R.M. and Raskind, M.A. (1990) "Severe withdrawal symptoms after discontinuation of alprazolam in eight patients with combat-induced PTSD", *Journal of Clinical Psychiatry*, 51: 206-9.

Rosin, U. and Köhler, G.K. (1991) "Psychodynamic aspects of psychopharmacology in functional somatic complaints", *Psychotherapy and Psychosomatics*, 56(3): 129-134.

Roth, A.D. and Fonagy, P. (1996) *What works for whom? A Critical Review of Psychotherapy Research,* New York, Guilford Press.

Rowan, J. (1992) "Response to K. Mair's 'The myth of therapist expertise'", in W. Dryden and C. Feltham (Eds.) *Psychotherapy and its Discontents,* Milton Keynes, O.U.P.

Royal College of Psychiatrists (1987) "Benzodiazepines and dependence: A College statement", *Bulletin of the Royal College of Psychiatrists*, 12: 107-9.

Salzman, C. (1992) "Behavioral Side Effects of Benzodiazepines", in J.M. Kane & J.A. Lieberman (Eds) *Adverse Effects of Psychotropic Drugs*, New York, Guilford Press.

Salzman, C. and Watsky, E. (1993) "Rational prescribing of benzodiazepines", in C. Hallstrom (Ed) *Benzodiazepine Dependence*, Oxford Medical Publications.

Schachter, M. (1993) *Psychotherapy and Medication*, New Jersey, Aronson.

Schopf, J. (1983) "Withdrawal Phenomena after Long-term Administration of Benzodiazepines: A Review of Recent Investigations", *Pharmacopsychiatry*, 16: 1-8.

Seligman, M.E.P. (1995) "The effectiveness of psychotherapy: The Consumer Reports Study" *American Psychologist*, 50:965-974.

Sexton, J. (1996) The Role of Psychotropic Medication and Counselling in a Primary Care Setting, *Personal Communication*.

Sherrard, C. (1997) "Qualitative research", *The Psychologist*, 10(4) 161-162.

Shillito-Clarke, C. (1996) "Ethical Issues in Counselling Psychology", in R. Woolfe & W. Dryden (Eds), *Handbook of Counselling Psychology,* London, Sage.

Sibbald, B., Addington-Hall, J., Brenneman, D. and Freeling, P. (1996) "Investigation of whether on-site general practice counsellors have an impact on psychotropic drug prescribing rates and costs", *British Journal of General Practice*, 65: 63-7.

Smail, D. (1996) "Environmental Cause and Therapeutic Cure: The Impotence of Insight", *B.P.S.Psychotherapy Section Newsletter*, 19: 4-16.

Smiley, A. (1987) "Effects of minor tranquillisers and antidepressants on psychomotor performance", *Journal of Clinical Psychiatry*, 48(12): 22-8.

Stainback, S. & Stainback W. (1988) *Understanding and conducting qualitative research,* Dubuque IA, Kendall/Hunt.

Stern, D. (1985) *The Interpersonal World of the Infant*, New York, Basic Books.

Stevenson, C. and Cooper, N. (1997) "Qualitative and quantitative research", *The Psychologist,* 10(4): 159-160.

Stewart, I. & Joines, V.S. (1987) *TA Today,* Nottingham, Lifespace Publishing.

Stone, W. and Rodenhauser, R. (1991) "Combining group psychotherapy and pharmacotherapy", *International Journal of Group Psychotherapy*, 41(4): 449-464.

Strauss, A. and Corbin, J. (1990) *Basics of Qualitative Research: Grounded Theory Procedure and Techniques,* Newbury Park CA, Sage.

Strauss, A. and Corbin, J. (1994) "Grounded Theory methodology: an overview", in N.K. Denzin and Y.S. Lincoln (Eds.) *Handbook of Qualitative Research,* London, Sage.

Szasz, T.S. (1972) *The Myth of Mental Illness*, London, Granada.

Szasz, T. (1974) *Ceremonial Chemistry: The Ritual Persecution of Drugs, Addicts and Pushers*, New York, Doubleday.

Tesch. R. (1990) *Qualitative research analysis types and software tools,* New York, Falmer.

Toukmanian, S. G. and Rennie, D. L. (Eds.) (1992*) Psychotherapy process research: Paradigmatic and narrative approaches,* Newbury Park, C.A., Sage.

Trotter, C. (1995) "Stages of Recovery and Relapse Prevention for the Chemically Dependent Adult", in M. Hunter (Ed) *Adult Survivors of Sexual Abuse*, Thousand Oaks, Sage.

Tyrer, P. and Murphy, P. (1988) "The Nottingham Study of Neurotic Disorder: comparison of drug and psychological treatments", *Lancet*, 30 July: 235-240.

Tyrer, P., Owen, R. and Dawling, S. (1983) "Gradual Withdrawal of Diazepam after long-term therapy", *Lancet*, June 25: 1402-1406.

Tyrer, P., Rutherford, D. and Huggett, T. (1981) "Benzodiazepine Withdrawal Symptoms and Propanolol", *Lancet*, 1: 520-522.

Warner, J. and King, M. (1997) "Using tranquillising medication after bereavement", *Bereavement Care*, 16(2): 14-15.

Washton, A.M. (1995) Psychotherapy *and Substance Abuse*, New York, Guilford Press.

Wax, R. H. (1991) *Doing Fieldwork: Warning and Advice,* Chicago Il, University of Chicago Press.

Weingartner, H.J., Sirocco, K., Curran, V. and Wolkowitz, O. (1995) "Memory Facilitation Following the Administration of the Benzodiazepine Triazolam", *Experimental and Clinical Psychopharmacology,* 3(3): 298-303.

Winnicott, D. W. (1965) *The Maturational Processes and the Facilitating Environment,* London, Hogarth.

Winnicott, D. W. (1971) *Playing and Reality*, London, Routledge.

Winnicott, D. W. (1986) *Home Is Where We Start From*, London, Penguin Books.

Worden, J.W. (1982) *Grief Counselling and Grief Therapy*, London, Tavistock.

Zisook, S. and De Vaul, R.A. (1977) "Adverse behavioural effects of benzodiazepines", *Journal of Family Practice,* 5: 963-6.