MEDICAL PRACTICE

Contemporary Themes

Pills for Personal Problems

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The purpose of this paper is to call attention to what appears to be the relentless march of the psychotropic drug juggernaut. At a recent symposium, at which the prescribing habits of general practitioners came under scrutiny, Harman stated, "Opinion is growing that in the use of psychotropic drugs we may be evolving a dangerous monster, not by intent but by unplanned increments."¹ How justified this alarm call was is a matter for debate, which must necessarily be based on an examination of available statistics.

Prescriptions and their Cost

In England in 1972 255.9 million family doctor prescriptions were dispensed. Table I shows how these were distributed according to the kinds of diseases for which they were prescribed. Those acting in some manner on the central nervous system (C.N.S.) formed easily the largest proportion, amounting to 27.2% of the total. From this group of drugs a subgroup of "psychoactive" drugs has been extracted; these are all those drugs that are most likely to be prescribed for patients suffering from some kind of psychiatric disorder. These constituted 17.7% of all drugs prescribed—the largest single group when considered separately—the remaining drugs acting on the C.N.S. amounting to only 9.5% of the total.

Table II shows the constitution of the psychoactive drug subgroup. Though appetite suppressants, some of which may not, of course, have been prescribed primarily for psychiatric reasons, were included, these formed only a small proportion of the total.

The total cost of C.N.S. drugs was more than that of any other group (table I), while the cost of the psychoactive drug group exceeded that of all the other drugs acting on the C.N.S. (table II). This was due not only to the larger number of prescriptions in this category

but also to the fact that the average prescription cost of psychoactive drugs is higher than that of other C.N.S.-acting drugs—about 55p compared with 45p. The average prescription costs for drugs in both

TABLE I—Numbers and Costs of E.C. 10 Prescriptions made in England in 1972 according to Disease Category

Drugs	Prescriptions		Cost	
	No. (Millions)	%	£ (Millions)	% of Total Cost
Central nervous system:	69.6	27.2	34.9	26.5
Psychoactive	45.3	17.7	23.8	15.3
Anti-infective	36.0	14.1	23.7	15.2
Respiratory	25.5	10.0	15.1	9.7
Cardiovascular system (+ diuretics)	25.3	9.9	26.2	16.9
Alimentary	19.7	7.7	9.2	5.9
Skin	17.3	6.7	8.7	5.6
Blood	13.9	5.4	5.1	3.3
Ear, nose, throat/eye	10.2	4.0	2.8	1.8
Rheumatic	8.4	3.3	10.0	6.5
Steroids (metabolic)	8.3	3.2	8.2	5.3
Other (miscellaneous)	7.0	2.7	2.2	1.4
Dressings (applied)	6.5	2.5	5.7	3.7
Antiallergic	6.4	2.5	2.2	1.4
Genitourinary	1.8	0.7	1.1	0.7
Total	255.9	100	155.1	100

TABLE II—Numbers and Costs of E.C. 10 Prescriptions for Drugs Acting on Central Nervous System in England in 1972. Percentages are of Total Number of Prescriptions and Total Cost (see table I)

Drugs	No.	Cost (£ Millions)	Subtotal	Cost (£ Millions)
Addictive analgesics	0.6	0.3	24.3 (9.5%)	11.1 (7.2%)
Antipyretic analgesics	16.4	6.1		
Local anaesthetics	2.5	0.5		
Antiemetics	1.4	1.1		
Anticonvulsants	3.4	3.1		
Antiparkinsonian agents				
Cholinergics				
Neuromuscular blockers				
Psychoactive Subgroup				
Hypnotics (barbiturate)	9.8	1.6	45.3 (17.7%)	23.8 (15.3%)
Hypnotics (non-barbiturate)	7.8	3.2		
Tranquillizers	18.1	10.7		
Antidepressants	6.9	6.0		
Stimulants/appetite suppressants	2.8	2.3		

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categories, however, was considerably less than that, for example, for drugs prescribed for rheumatic disorders (£1.69 per prescription) cardiovascular conditions (£1.03). It was the larger number of prescriptions for drugs acting on the C.N.S. that determined their foremost place in the cost league.

Fig. 1 indicates the relative constancy of patterns of prescription during 1968-72. There was a rise during the last year of this quinquennium of just over 3% (10 million) in the number of prescriptions, but all groups of drugs contributed about equally to this rise. The rise in cost of family doctor prescriptions, however, was considerably greater than the increase in their number. The cost rose from just over £100 million in 1968 to over £156 million in 1972—a rise of just over half as much again. The increase in the cost of psychoactive drugs (39%) over the same period, however, was not as steep.

FIG. 1—Numbers and types of general practitioner prescriptions 1968-72.

Within the psychoactive drug group the overall pattern of prescribing seems to be changing, at least in one respect, in a manner that is slightly encouraging. Fig. 2 shows that though the proportion of prescriptions for tranquilizers, non-barbiturate hypnotics, and antidepressants is rising, that for barbiturates is apparently falling, suggesting that current antibarbiturate propaganda is having an effect on the prescribing habits of family doctors. A decline, though a much smaller one, can also be seen in the proportion of prescriptions for stimulants and appetite suppressants.

FIG. 2—Changes in general practitioners' prescribing habits over five years (1968-72). Results are percentages of types of drugs making up psychoactive subgroup.

What are the Drugs Prescribed for?

In view of the fact that barbiturate and non-barbiturate hypnotics accounted for just under 40% of psychoactive drugs, insomnia, or something like it, seems to be the main reason for their prescription. Probably only about 16% of all psychoactive drug takers take the drugs for more specific conditions.² The remainder seem to be taking them for vague conditions, such as "neurosis," "depression," "to calm me down," etc.

Apart, therefore, from a relatively small proportion of prescriptions given for fairly specific and recognizable types of psychiatric disorder there does seem to be evidence that psychotropic drugs are being increasingly prescribed to try and modify personal and interpersonal processes. One of several dangers inherent in this is the promotion of what may be regarded as a positive feedback mechanism; the more the habit of prescribing pills for personal problems grows among doctors, the more likely it is that their patients may come increasingly to demand this kind of solution to their difficulties—a solution that is likely to turn out to be a "non-solution."

It is not only general practitioners who can be taken to task. Are psychiatrists so blameless? Could it be that they have only too clearly demarcated the steps in which the general practitioner, like Good King Wenceslas's page, should tread. Worse still, though general practitioners are possibly more vulnerable to the skilful propaganda put out by the drug companies, are psychiatrists, or other specialists so very much more discerning?

One thing the advent of the "tranquillizing era" has brought about is a very much sharper polarization of psychiatry into what may be called organic as against psychogenic schools of thought. This schism seems to have been growing ever wider since the early 1950s, when chlorpromazine was first introduced. It is, of course, regrettable that treatment should be allowed to modify notions about aetiology, for this is a risky business and best avoided. It may, however, be understandable in psychiatry where so many conflicting views on aetiology still exist, and firm views on causation tend to remain elusive.

While psychoactive drugs have undoubtedly contributed much to the treatment of psychotic disorders, using them to try and relieve neurotic symptoms is in the long term likely to be self-defeating. The question should always be asked, and critically so in the case of a patient who complains of anxiety of neurotic origin, whether there are reasons other than to cope with an acute crisis why an anxiolytic or tranquillizing drug should be prescribed; does the neurotic disorder itself warrant it? There are two principal risks in taking what seems to be such an easy way out. The first, of course, is drug dependence. The second is that anxiety, like pain, is biologically purposive in that it draws attention to a threat. When this threat is not a real but a neurotic one it points to a conflict that needs to be resolved. If the sufferer is given too ready a means to suppress his anxiety his motivation to try and resolve the conflict that underlies it may also be suppressed. In short, to overcome anxiety a patient must be allowed to experience it, albeit in tolerable doses. Merely to suppress anxiety is to run the risk of suppressing the will needed to try and overcome it. Reciprocal inhibition and other behaviour therapy techniques have clearly shown this to be so.

MATERIAL WORRIES

To take the matter even further still, it may be asked: if over-prescribing anxiolytic or tranquillizing drugs is inadvisable in treating those whose anxiety is due to overt neurotic problems, how much more so should this practice be called into question in the management of the seemingly growing number of people who present themselves for medical help because of difficulties which are primarily personal, interpersonal, or environmental in origin? For example, one may cite those who dislike their jobs, fear redundancy, cannot get along with their wives, or who have any of a large variety of other material worries. It is these people who suffer from *dis-ease* rather than disease who seem to be turning to the general practitioner or the psychiatrist in ever-increasing numbers, presumably, in the hope of finding a solution for their difficulties. It is not too hard to guess that because the general practitioner, and perhaps the psychiatrist too, finds himself ill-equipped to deal with these people and their problems, overburdened on some occasions or frankly uninterested in others, that he resorts all too readily to prescribing a tranquillizer. Meanwhile the nation's drug bill continues to mount.

The doctor is not wholly to blame, however, for his patients connive in the process. One has also to consider the expectation of patients

quite apart from the doctor's compliance. Patients are themselves gullible to the claims of advertisers and believe that for every disease there is a specific remedy—usually a drug—if only the doctor knew what it was. Such an attitude is all too often reinforced by newspaper or television advertising.

There are patients who are nearly as sensible as some of their doctors, and some who are even more so. But leaving these on one side we may perhaps agree with Marinker's witty proposition that it is an exceptional barmaid indeed who responds to an order for a double gin with the statement, "Never mind the gin; why don't we sit down and talk about why you feel you need one."³ Thus, the explanation may well be that doctors are evermore being expected to do for their patients what they have not been trained to do. This has implications for medical education about which perhaps medical teachers ought to be losing more sleep than some of them are currently doing.

Harm caused by Over-prescription

How much harm, other than to the economy, does all this over-prescription of psychoactive drugs bring about? If we are honest we must say surprisingly little; surprisingly little, that is, from a physical point of view and in relation to the apparent size of the problem. Indeed, one almost paradoxical aspect of the matter is that though in Britain there has been a 10% yearly increase in the number of apparent suicidal attempts carried out by self-poisoning (for the most part using psychoactive drugs prescribed by doctors) there has been no rise in the actual suicide

rate by this method. The overall suicide rate in Britain has been falling fairly dramatically over the past seven years. It seems, therefore, that doctors, by placing psychoactive drugs in the hands of those who make suicidal attempts, but who for the most part lack a real intention to kill themselves, have provided them with a relatively inefficient means of dicing with death in order to signal their distress. We should not condone over-prescription on this account, however, for improved methods of resuscitation clearly have much to do with it. Furthermore, though over-prescription of tranquillizers may not do all the physical harm to patients that we might expect it to, it undoubtedly harms the quality of medical practice.

There is such a thing as pharmacogenic disease and we are clearly seeing much more of it, particularly, though not wholly, among old people. Indeed, it sometimes seems that over-prescription may lead to an entirely new reason for admission to hospital—that is, to take a patient off all drugs just to find out what really is the matter with him.

References

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Social Medicine

Suicide and "The Befrienders"

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Summary

The short-term effect of "The Befrienders"—an 11-episode weekly series on B.B.C. 1 portraying the Samaritans as a suicide prevention service—on suicide and undetermined deaths was monitored in Edinburgh. No preventive effect was observed though the series was associated with a dramatic rise in new client referrals to the Edinburgh branch of the Samaritans.

Introduction

The telephone Samaritans were established in 1953 by the Rev. Chad Varah as a suicide prevention service, but it remains unresolved whether their major effect is suicide prevention. Bagley¹ found a significant reduction in the suicide rate in 15 towns in which Samaritan branches had been established compared with the rate in matched control towns. Atkinson² con-

cluded in a study of the Samaritans and the elderly that: "it seems that those who are most likely to commit suicide are least likely to know of the Samaritans and marginally less proficient at using telephones." Barraclough and Shea³ found that the suicide rate for Samaritan clients in six county boroughs was 10 times that of the general population and highest in the month after referral; the Samaritan branches studied were attracting the suicidal but these were only a small proportion of all clients, and it was not possible in that study to evaluate the effectiveness of the service.

On the hypothesis that the Samaritans are a major factor in suicide prevention a rise in Samaritan referrals should result in a fall in the number of suicides, other factors being equal. "The Befrienders," an 11-episode weekly series screened at peak viewing times and dramatizing the role of the Samaritans as a suicide prevention service, provided a natural experiment for testing the hypothesis that the Samaritans are a major factor in suicide prevention. In co-operation with the Edinburgh branch of the Samaritans a 140% rise in new client referrals was monitored in 1972 in association with the B.B.C. series, but no preventive effect on parasuicides ("attempted suicides") known to the hospital services in Edinburgh was observed.⁴ The present study was concerned with *completed* suicides.

Method

"The Befrienders" was screened weekly from 19 February 1972 to

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