

Résumés de recherche

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Première ordonnance de benzodiazépine

Étude qualitative de l'opinion des patients

Sibyl Anthierens MA Hilde Habraken MA Mirko Petrovic MD PhD Myriam Deveugele MA PhD
Jan De Maeseneer MD PhD Thierry Christiaens MD PhD

RÉSUMÉ

OBJECTIF Examiner les points de vue et les attentes des patients concernant leur première ordonnance de benzodiazépines (BZD).

CONCEPTION Étude qualitative à l'aide d'entrevues semi-structurées.

CONTEXTE Les patients ont été recrutés dans des pratiques générales des régions de Ghent et de Bruxelles en Belgique et on les a interviewés à leur domicile.

PARTICIPANTS Quelque 15 patients recrutés dans des pratiques familiales qui venaient de recevoir leur prescription de BZD pour la première fois.

MÉTHODOLOGIE On a enregistré les entrevues sur bande audio et elles ont été retranscrites intégralement. On a analysé les données en fonction de thèmes à l'aide d'une méthodologie phénoménologique.

PRINCIPALES CONSTATATIONS Les patients avaient demandé «quelque chose» à leur médecin parce qu'ils pensaient être en détresse sérieuse et avaient besoin d'aide. Ils semblaient percevoir un conflit entre la nécessité de prendre un médicament et les connotations négatives entourant l'utilisation des BZD. Les patients utilisaient 2 stratégies pour justifier leur consommation de BZD: maximiser leurs problèmes et minimiser leur usage. Les patients en savaient très peu au sujet de ce médicament et n'ont pas posé de questions à ce sujet. Leurs attentes concernant un usage continu étaient vagues, même s'ils semblaient être conscients des risques de dépendance psychologique et de mécanismes de conditionnement. Les patients n'ont pas demandé de leur propre initiative des solutions de rechange non pharmacologiques, mais lorsqu'on les leur présentait, leurs attitudes à propos des autres options étaient généralement positives.

CONCLUSION Les utilisateurs de BZD pour la première fois demandent de l'aide en raison de leur détresse, mais ils laissent à leur médecin de famille la responsabilité de régler leurs problèmes. Même lorsque les utilisateurs à court terme étaient conscients du concept de dépendance psychologique, ils ne ressentaient pas le besoin d'obtenir plus de renseignements. Les médecins devraient établir des stratégies de communication pour persuader leurs patients qu'ils prennent leur problème au sérieux, même si la consultation ne se conclut pas toujours par une ordonnance. Il importe que les médecins expliquent clairement les risques et les avantages de commencer un traitement aux BZD et établissent des limites dès le début.

POINTS DE REPÈRE DU RÉDACTEUR

- Peu après la mise en marché des benzodiazépines (BZD), on a signalé de nombreux effets indésirables: «lendemain de veille», troubles de la mémoire, tolérance émotionnelle affaiblie, dépendance et risque accru de chute et d'accidents de la route. Malgré tout, dans de nombreux pays, l'utilisation des BZD n'a pas diminué.
- Pour bien comprendre comment réduire le nombre d'ordonnances de BZD et prévenir l'utilisation à long terme, il importe d'étudier les attitudes et les croyances des patients concernant l'amorce d'un traitement aux BZD.
- Les patients utilisent 2 stratégies pour justifier leur consommation de BZD: maximiser leurs problèmes et minimiser leur utilisation des BZD. Les patients laissent au médecin la responsabilité de prescrire des BZD parce qu'ils croient que leur situation échappe à leur contrôle et qu'ils préfèrent transférer la responsabilité à leur médecin.

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Le texte intégral est accessible en anglais à www.cfp.ca/cfp.
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Research Abstracts

Print short, Web long

First benzodiazepine prescriptions

Qualitative study of patients' perspectives

Sibyl Anthierens MA Hilde Habraken MA Mirko Petrovic MD PhD Myriam Deveugele MA PhD
Jan De Maeseneer MD PhD Thierry Christiaens MD PhD

ABSTRACT

OBJECTIVE To explore patients' views and expectations regarding their first prescription for benzodiazepines (BZDs).

DESIGN Qualitative study using semistructured interviews.

SETTING Patients were recruited from general practices in the regions of Ghent and Brussels in Belgium and were interviewed at home.

PARTICIPANTS Fifteen family practice patients who had received prescriptions for BZDs for the first time.

METHOD Interviews were audiotaped and transcribed verbatim. Data were analyzed by themes using a phenomenologic approach.

MAIN FINDINGS Patients had asked their physicians for "something" because they thought they were in serious distress and needed help. They seemed to feel a conflict between the need for medication and the negative connotations surrounding BZD use. Patients used 2 strategies to justify consumption of BZDs: maximizing their problems and minimizing use. Patients knew very little about the medication and did not ask about it. Their expectations regarding continued use were vague, even though they seemed to be aware of the risk of psychological dependency and conditioning mechanisms. Patients did not actively ask for nonpharmacologic alternatives, but when they were offered them, their attitudes toward them were generally positive.

CONCLUSION First-time BZD users ask for help with distress, but place the responsibility for solving their problems on their family physicians. Even when short-term users were aware of the concept of psychological dependency, they did not feel the need for more information. Physicians should develop communication strategies to persuade their patients that they take the patients' problems seriously even though consultations do not always end with prescriptions. It is important that doctors clearly explain the risks and benefits of starting BZD treatment and set limits from the start. This will help doctors manage first-time BZD users more effectively and will help patients avoid chronic use.

EDITOR'S KEY POINTS

- Soon after benzodiazepines (BZDs) were introduced, numerous adverse effects were reported: "hangovers," memory impairment, emotional blunting, tolerance, dependency, and increased risk of falling and of having motor vehicle accidents. Despite this, in many countries, BZD use has not decreased.
- To fully understand how to reduce the number of prescriptions for BZDs and to prevent long-term use, it is important to explore patients' attitudes and beliefs concerning initiation of BZD treatment.
- Patients use 2 strategies to justify BZD use: maximizing their problems and minimizing their use of BZDs. Patients place the responsibility of prescribing BZDs on their doctors because they think the situation is beyond their control and possibly because they prefer to transfer responsibility to their doctors.

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Soon after benzodiazepines (BZDs) were introduced in the 1960s as a safer alternative to older hypnotics and sedatives, numerous adverse effects were reported, including "hangovers," memory impairment, emotional blunting, tolerance, dependency, and increased risk of falling and of being involved in motor vehicle accidents.^{1,2} Despite this, BZD use has not decreased during the last few decades. A cross-national study in the 1980s showed that Belgium was one of the countries with the highest use of anti-anxiety and sedative drugs.³ Since then, use of BZDs has further increased.^{4,5}

In international family practice guidelines, attention is drawn not only to the problem of chronic use of BZDs, but also to the first prescription as a trigger of long-term use.⁶⁻⁸ Advice on initial prescriptions is based on expert opinion because there is little published research on new users (in contrast, there are numerous publications on BZD use in family practice, and chronic use in particular). A search of MEDLINE and PsychLit yielded only 7 publications on initial prescription of BZDs. Their focus was primarily on sociodemographic and health characteristics and, to a lesser degree, on attitudes and beliefs.

A few studies have focused on sociodemographic and health characteristics as possible predictors of chronic use of BZDs.⁹⁻¹¹ Two studies found that elderly people had a higher tendency toward long-term use than younger people did.^{10,11} On the other hand, Fourrier found that age and sex were not independent predictors of chronic use.⁹ The conflicting results of these studies are not surprising, as the studies did not take into account variations in attitude, which can play an important role in explaining chronic use of BZDs.

One study found that first-time users' perceptions of the physician's usual practice with regard to BZD prescribing was an important predictor of their intention to continue to take the drugs.¹² Another study found that continued use was often attributed to difficulties associated with stopping.¹³

Considering the lack of literature on patients' attitudes toward BZDs and on examination of first-time use

Ms Anthierens is a researcher in the Department of General Practice and Primary Health Care at Ghent University in Belgium. **Ms Habraken** is a researcher at Project Farmaka in Ghent. **Dr Petrovic** teaches in the Department of Geriatrics at Ghent University Hospital and Heymans Institute for Pharmacology and Pharmacotherapy and at Ghent University. **Dr Deveugle** teaches in the Department of General Practice and Primary Health Care at Ghent University. **Dr De Maeseneer** teaches in the Department of General Practice and Primary Health Care at Ghent University. **Dr Christiaens** teaches in the Department of General Practice and Primary Health Care and the Heymans Institute for Pharmacology and Pharmacotherapy at Ghent University.

as a potential determinant of long-term use, this paper is an attempt to fill the gap. In order to understand fully how to reduce the number of prescriptions for BZDs and to prevent long-term use, it is important to explore patients' attitudes and beliefs around initiation of BZD treatment. Our study looked at whether the perceptions of first-time users could lead to chronic use of BZDs, and as a result, have implications for the physicians prescribing them. Our findings might serve to inform interventions that help doctors when they are deciding whether to initiate BZD treatment or to start with alternative treatment.

METHODS

Our study aimed to search for the meanings of experiences.¹⁴ The approach required could be found in phenomenology. The view in this study design is that the phenomenon being studied means nothing without the interpretation that patients put on their experiences.

Sample

All 180 family physicians from a list of physician-trainers from the regions of Ghent and Brussels in Belgium were invited by letter to participate in the study and were then contacted by telephone to follow up. To protect patient confidentiality, the physicians were asked to invite 1 or 2 patients for whom they had recently initiated BZD prescriptions to participate in the study. Inclusion criteria for patients were age 18 or older, having a first prescription for BZDs, not being treated for psychiatric disease, not taking neuroleptics, and being capable of being interviewed. The interviewers contacted 22 patients from 17 physicians. All agreed to participate.

To allow generalization of themes, respondents had to be representative of a range of populations. Accordingly, patients were recruited from both sexes, various age groups, and various education levels. Our interview sample included more women than men because, according to health statistics, considerably more women than men receive prescriptions for BZDs.¹⁵

All but 1 patient agreed to be interviewed, but during the interviews it was found that 6 respondents did not meet the inclusion criteria, either because they had been psychiatric patients or because they had taken BZDs before. Therefore, 15 interviews were conducted with 2 male and 13 female patients (age range 18 to 76 years). The patients who took BZDs daily took them for between 3 days and 4 months. The other patients took their BZDs intermittently.

Data collection

The study was approved by the ethics committees of the Ghent University Hospital and the Université Catholique de Louvain Hospital. Written informed consent was

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obtained from all respondents. Respondents were interviewed at home. Interviews followed a semistructured schedule of open-ended questions exploring experiences, opinions, attitudes, and feelings in order to obtain a comprehensive picture of perceptions. Interviews were terminated when the interviewer had clarified with participants that there were no further issues to be addressed.

All interviews, which lasted between 35 and 60 minutes, were recorded with patients' permission and transcribed verbatim. Notes were taken concurrently.

Data analysis

Data were analyzed using the principles of thematic analysis and incorporating the data-driven inductive approach as the study sought to promote understanding of individual perceptions rather than prove a pre-conceived theory.¹⁶⁻¹⁹ First, 2 researchers immersed themselves in the data by independently reading transcripts and field notes to identify principal elements. Coding was done using the constant comparative method, moving back and forth between interview material and analysis and uncovering similarities and differences in data from various interviews.

This procedure generated categories and subcategories; emerging themes became the categories for analysis. Triangulation was used by including a third coder for the final analysis in order to improve the consistency and reliability of analyses.^{16,20,21} Regular review and discussion among those coding evolving themes contributed to data synthesis and interpretation. Final analysis involved examining all the data collectively, thus permitting relationships between and among central themes to emerge. Several techniques to promote the credibility and applicability of findings were used, including audiotaping, verbatim transcription, and use of field notes.^{20,22} Saturation was reached after the first 10 interviews. The basic elements of the main themes were present as early as the sixth interview.

FINDINGS

First BZD prescription

Respondents were distressed and needed help. They perceived the situation as beyond their control and had a helpless "fix me" attitude. They said they were not able to handle the situation and that their problems were too serious to be allowed to continue. Medication was perceived as the only solution, and, in fact, it brought great relief: "I took the medication as it was my last resort. I also think it was the only solution for me at that particular moment."

Explicit demand for prescriptions

Respondents seemed to have asked for "something" to help them, but not explicitly for tranquilizers: "Yes, I

asked for the medication myself, because I know our family physician. He doesn't easily give medication...." A few patients asked explicitly for BZDs and felt particularly strongly about this: "I asked him for a sleeping pill because it had gone too far. I went to see him, and I said, 'Doctor, you have to give me a sleeping pill.' I think he is a good doctor but he doesn't prescribe that easily."

Conflict and ambiguity

There seemed to be conflict between the negative connotations surrounding use of BZDs and patients' actual need for such medication. Respondents expressed negative feelings toward taking medication and seemed opposed to it: "It is a good medicine, but me, I am not a 'pill consumer.'" Patients suggested they wanted to stop taking BZDs to avoid becoming dependent. On the other hand, they were afraid of slipping back into their insomnia or distress. Thus, they were "against" the medication, but at the same time, concerned about the consequences of discontinuing it because they thought the treatment had improved the situation.

Strategies to justify usage

Patients used 2 strategies to justify their use of BZDs. The first was to maximize their problems and to convince themselves that there was no other solution. By labeling the complaint as "really bad," by saying that they had reached the limit of their suffering, by describing it as "vital to take medication," or by viewing prescriptions written in these circumstances as confirming the necessity of drug treatment, they justified taking BZDs. One said, "I could bear it no longer." Another said, "I couldn't handle it any other way at that moment. I could have seen it coming but at that moment there was no other way...."

The second strategy was to underestimate their BZD use. Respondents said they used only small doses, they consumed less medication than prescribed, and they took it only when necessary. One said, "They really are small pills." Another added, "It is really a 'light' medicine. I think that is why I can't sleep through the night because it is so small."

Information on BZDs

Patients said they knew very little about their medication: "I don't know anything about this medication except that it will calm me down." At the same time, patients also expressed no need for information: "I don't want more information. For me the most important thing is that it helps me."

Patients said that the relationship with their physicians was based on trust, thereby explaining why they did not need more information. They said they presumed the doctor would always act in their best interests: "I think it is like when you go to a caterer, we don't ask him how he has made the food. It has to correspond

to our choice. It is the same here. I have confidence in my doctor and in what he prescribes me." On the other hand, the conflict between the need for medication and the negative connotations attached to taking BZDs might explain the absence of a stated need for information. If patients had received more information on their medications, they might have had to give more thought to taking the prescription: "I don't want more information. I am not a hypochondriac, but I know if I read or hear something negative or about side effects I will have to start thinking whether I should continue with it. And I still need it."

Dependency

Even in this sample of first users, psychological dependency seemed to come up very quickly. Several characteristics typical of people who have become dependent on therapeutic doses of BZDs were noted: patients became anxious if their next prescriptions were not readily available; they carried their tablets around with them; and they took an extra dose before an anticipated stressful event. One said, "I need to have it with me, not to take it, but just in case I might need it." Another said, "But I surely won't have enough tablets left, I told him. I already calculated that I will have enough pills to last until April 3rd. So that means I have 23 left, therefore I have to take halves. Then I will certainly return to the family physician."

A conditioning mechanism related to the fear of returning to a state of distress or insomnia if they stopped taking the medication was observed: "I think he knows that if it wasn't necessary I wouldn't take it. But if I don't take it, I am awake for more than an hour and I think I really shouldn't be stopping this medication."

Nonpharmacologic alternatives

Respondents indicated that their doctor-patient relationships were based on trust and confidence. A good conversation with their family physicians helped patients a lot and was viewed as something very positive. The advantage of talking with their family physicians was that they knew the patients' histories and family situations:

I like the fact that once in a while I can talk to my family physician. After all, he maintains confidentiality and you can't tell everything to your family. He also knows my family history. You already have a connection, and if you go to someone else you have to start all over again.

Patients themselves made no explicit demands for nonpharmacologic approaches to their problems. Because of good doctor-patient relationships, patients were more willing to accept what their family physicians suggested. They were, however, reluctant to take

the initiative of going to see a therapist because of the stigma surrounding it: "The family physician suggested that I should go and see a psychologist. But initially you think 'I have always been healthy,' so you don't think 'OK, yes I am going to go'...."

Once introduced to it through their doctors, they became actively involved in changing their behaviour and experienced the change as something very positive.

The doctor suggested that I should go and see a psychologist. I think it is very important to stimulate patients to go, to give them enough information and tell them that it can really help and work. People are really afraid of it and have big questions about it but in fact, it is not all that bad.

DISCUSSION

We found that patients had ambiguous feelings about taking BZDs. They expressed a high level of distress and a need for help when they consulted their family physicians, but they also expressed an aversion to medication. They justified taking BZDs by maximizing their problems and underestimating their consumption. An aversion to medication seemed to be clear in this study, but expressing such an aversion could be a socially approved way of talking about medicines that has little to do with what people really think about their medications.²³

Patients placed the responsibility for prescribing on their doctors, because they thought the situation was beyond their control. Patients assumed that prescriptions were necessary because they were written by their family physicians whom they trusted. This was how they justified their use of BZDs. It is important for physicians to be aware of this process and to guide patients toward more realistic expectations of their treatment options. These findings are similar to those found in other studies on physician prescribing. For example, a qualitative study of patients with unexplained medical symptoms²⁴ found that when they apparently sought to engage their physicians by conveying the reality of their suffering, the physicians responded with investigations, prescribing medications based on symptoms, or referral.

A doctor's perception of what a patient wants has a strong influence on prescribing,²⁵ but doctors' assessments of patients' expectations are often based on an intriguing variety of cues.²⁶ Therefore, it is of utmost importance to clarify patients' exact expectations. Doctors' incorrect perceptions of patients' expectations or unvoiced agendas might result in unnecessary prescriptions.²⁷

A study by Britten et al²⁷ showed that prescriptions written in these circumstances often served to confirm

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to patients the necessity of drug treatment. This finding was also confirmed in our study.

According to patients, little or no information was given to them. This is in agreement with other findings in the literature. In consultations about psychosocial problems, family physicians gave less information than they did in other consultations,²⁸ and patients generally did not ask questions.²⁹ A possible explanation for the fact that physicians do not give information on alternative treatments is because they know little about these options. Cormack's study on factors linked to prescribing BZDs found that physicians would like to obtain more expertise in psychology.³⁰

The literature warns that dependency can develop within a few weeks or months of regular or repeated use of BZDs.³¹ Duration of treatment is an important factor in exposing patients to the risk of dependency. In our study, we found that psychological dependency could arise very quickly, and physicians needed to be aware of it. A transition from focus on symptoms to focus on therapy (use of medication) seems to occur. The mechanisms that patients use to justify taking BZDs are also important for doctors to take into account when they want to talk about stopping the medication. Patients might think doctors fail to appreciate the severity of their problems if they "take away" their BZDs.

Limitations

We could not recruit patients without consulting their family physicians because of doctor-patient confidentiality. Physicians might have selected patients whom they perceived as amenable to participation in the study, so the results might not adequately reflect the views of a full range of patients. We need to be cautious about making generalizations. Also, it is not clear from the interviews whether prescriptions were issued during patients' first consultations for insomnia, anxiety, or stress.

We did not look at the reasons for medical visits when analyzing our data; our main focus was patients' views on initiation of BZD use. It would be interesting for future research to see whether patients with different complaints (insomnia, anxiety, and stress) behave differently. It is also possible that physicians might have tried to avoid prescribing BZDs during previous consultations and only done so as a last resort or because of patients' persistence at this visit. Determining this was not an objective of the study. Future research should look at the history leading up to the first prescription.

Conclusion

First-time BZD users asked for help with their distress, but placed the responsibility for the solution on their family physicians. Physicians should develop communication strategies to persuade patients that they take their problems seriously even though consultations do not always end with prescriptions. Patients justify BZD use

by maximizing their problems. Even if concern about psychological dependency is detectable in short-term users, these users do not ask for information or feel the need for more information.

It is important that family physicians clearly explain the risks and benefits of initiating BZD treatment and set clear limits from the start. These elements will help them manage first-time BZD users more effectively and will assist in avoiding chronic use.

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Contributors

Ms Anthierens and Ms Habraken contributed to concept and design of the study, analysis and interpretation of data, and preparing the article for submission. **Dr Petrovic** and **Dr De Maeseneer** contributed to concept and design of the study and critically revised the article for submission. **Dr Deveugele** contributed to analysis and interpretation of data and critically revised the article for submission. **Dr Christiaens** contributed to concept and design of the study, acquiring funding for the study, and interpretation of data, and critically revised the article for submission.

Competing interests

None declared

Correspondence to: Sibyl Anthierens, Department of General Practice and Primary Health Care, Ghent University, UZ, 1K3, De Pintelaan 185, 9000 Ghent, Belgium; telephone 1 0032/9.240.54.98; e-mail sibyl.anthierens@ugent.be

References

1. Chouinard G. Issues in the clinical use of benzodiazepines: potency, withdrawal, and rebound. *J Clin Psychiatry* 2004;65(Suppl 5):7-12.
2. Holbrook AM. Treating insomnia. *BMJ* 2004;329(7476):1198-9.
3. Balter MB, Manheimer DL, Mellinger GD, Uhlenhuth EH. A cross-national comparison of anti-anxiety/sedative drug use. *Curr Med Res Opin* 1984;8(Suppl 4):5-20.
4. IMS Health. *Verkoops-en voorschrijfgegevens—verkregen op verzoek [Sales and prescription data—retrieved on request]*. Brussels, Belg: IMS Health; 2003. Available from: <http://www.imshealth.com>. Accessed 2007 March 13.
5. De Donder E. *Psychoactieve medicatie: cijfers in perspectief 1990-2002 [Psychoactive medication: numbers in perspective 1990-2002]*. Garant, Antwerpen: Apeldoorn; 2004.
6. Declercq T, Rogiers R, Habraken H, Michels J, Mariman A, De Meyere M. *Insomnia in de eerste lijn. WVVH-aanbeveling voor goede medische praktijkvoering. [Insomnia in general practice. Scientific Association of Flemish Family Physicians guideline for good medical practice]*. Berchem, Belg: WVVH Berchem; 2004. Submitted for publication.
7. Knuistingh Neven A, Lucassen PLB, Bonsema K, Teunissen H, Verduijn MM, Bouma M. NHG standaard slapeloosheid en slaapmiddelen [NHG guideline on insomnia and sleeping pills]. *Huisarts Wet* 2005;48:402-15.
8. National Health Service. *Prodigy guidance. Insomnia*. London, Engl: National Health Service; 2004. Available from: www.cks.library.nhs.uk/insomnia. Accessed 2007 May 10.
9. Fourrier A. Benzodiazepine use in an elderly community-dwelling population. Characteristics of users and factors associated with subsequent use. *Eur J Clin Pharmacol* 2001;57(5):419-25.

10. Holm M. One year follow-up of users of benzodiazepines in general practice. *Dan Med Bull* 1990;37(2):188-91.
11. Mant A, Duncan-Jones P, Saltman D, Bridges-Webb C, Kehoe L, Lansbury G, et al. Development of long-term use of psychotropic drugs by general practice patients. *BMJ* 1988;296(6617):251-4.
12. Van Hulten R, Bakker AB, Lodder AC, Teeuw KB, Bakker A, Leufkens HG. The impact of attitudes and beliefs on length of benzodiazepine use: a study among inexperienced and experienced benzodiazepine users. *Soc Sci Med* 2003;56(6):1345-54.
13. Barter G, Cormack M. The long-term use of benzodiazepines: patients' views, accounts and experiences. *Fam Pract* 1996;13(6):491-7.
14. Beck GT. Phenomenology: its use in nursing research. *Int J Nurs Stud* 1994;31(6):499-510.
15. De Donder E. *Alcohol, illegale drugs, medicatie en gokken. Recent ontwikkelingen in Vlaanderen 2003-2004 [Alcohol, illegal drugs, medication and gambling. Recent developments in Flanders 2003-2004]*. Brussels, Belg: Vereniging voor Alcohol en andere Drugproblemen; 2004. Available from: <http://www.vad.be>. Accessed 2007 March 13.
16. Pope C, Ziebland S, Mays N. Qualitative research in health care: analysing qualitative data. *BMJ* 2000;320(7227):114-6.
17. Thorne S. Data analysis in qualitative research. *Evidence Based Nurs* 2000;3:68-70.
18. Burnard P. A method of analysing interview transcripts in qualitative research. *Nurse Educ Today* 1991;11(6):461-6.
19. Fereday J, Muir-Cochrane E. Demonstrating rigor using thematic analysis: a hybrid approach of inductive and deductive coding and theme development. *Int J Qual Methods* 2006;5(1):1-11.
20. Patton MQ. Enhancing the quality and credibility of qualitative analysis. *Health Serv Res* 1999;34(5 Pt 2):1189-208.
21. Janesick VJ. The dance of qualitative research design: metaphor, methodology and meaning. In: Denzin N, Lincoln YS, editors. *Handbook of qualitative research*. London, Engl: Sage Publications; 1994.
22. Seale C. *The quality of qualitative research*. London, Engl: Sage Publications; 1999.
23. Britten N, Stevenson F, Gafaranga J, Barry C, Bradley C. The expression of aversion to medicines in general practice consultations. *Soc Sci Med* 2004;59(7):1495-503.
24. Ring A, Dowrick C, Humphris G, Salmon P. Do patients with unexplained physical symptoms pressurise family physicians for somatic treatment? A qualitative study. *BMJ* 2004;328(7447):1057. Epub 2004 March 31.
25. Britten N, Ukomunne O. The influence of patients' hopes of receiving a prescription on doctors' perceptions and the decision to prescribe: a questionnaire survey. *BMJ* 1997;315(7121):1506-10.
26. Bradley CP. Factors which influence the decision whether or not to prescribe: the dilemma facing general practitioners. *Br J Gen Pract* 1992;42:454-8.
27. Britten N, Stevenson FA, Barry CA, Barber N, Bradley C. Misunderstandings in prescribing decisions in general practice: qualitative study. *BMJ* 2000;320(7233):484-8.
28. Devuugelaer M, Derese A, De Bacquer D, van den Brink-Muinen A, Bensing J, De Maeseneer J. Is the communicative behaviour of GPs during the consultation related to the diagnosis? A cross-sectional study in six European Countries. *Patient Educ Couns* 2004;54(3):283-9.
29. Devuugelaer M, Derese A, De Maeseneer J. Is GP-patient communication related to their perceptions of illness severity, coping and social support? *Soc Sci Med* 2002;55(7):1245-53.
30. Cormack MA. Factors linked to the prescribing of benzodiazepines by general practice principals and trainees. *Fam Pract* 1992;9(4):466-71.
31. Ashton CH. *Benzodiazepines: how they work and how to withdraw*. Newcastle, Engl: University of Newcastle; 2002. Available from: www.benzo.org.uk/manual/contents.htm. Accessed 2004 November 11.

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