Psychological distress and adaptational problems associated with benzodiazepine withdrawal and outcome: A replication

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Abstract

The aim of this study was to replicate and extend the findings of O’Connor, Bélanger, Marchand, Dupuis, Elie, and Boyer [Addict. Behav. 24 (1999) 537], which had established a psychosocial profile associated with psychological distress in benzodiazepine (BZD) use. Forty-one participants with anxiety or insomnia, receiving maintenance therapy of BZD for at least 8 weeks, participated in a 20-week, tapered discontinuation protocol with physician counselling. Drug type and use was monitored throughout. Questionnaire measures of anxiety, behavioural inhibition, neuroticism, withdrawal complaints, social support, psychological distress, self-efficacy in coping without BZD, quality of life, positive and negative life events, were completed at baseline, postdiscontinuation, and at 3-month follow-up.

Measures of baseline psychological distress and anxiety inhibition were consistently associated with both discontinuation and the emergence of withdrawal complaints. Successful withdrawal was characterized by low baseline neuroticism, low behavioural inhibition, higher number of positive events, and higher level of social support satisfaction. Higher dosage (in diazepam equivalent dose) was associated with both poorer outcome and the emergence of withdrawal symptoms. Self-efficacy in coping was negatively associated with relapse but not with outcome. Psychosocial factors play a role at different stages of the BZD withdrawal process and could be targeted in treatment.

Keywords: Psychosocial factors; Benzodiazepine outcome; Withdrawal symptoms

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1. Introduction

Research in the benzodiazepine (BZD) field points to the influence of psychological factors on withdrawal difficulties and relapse (Bélanger, Dupuis, O’Connor, & Marchand, 1999; Murphy & Tyrer, 1991; O’Connor et al., 1999; Rickels, Case, Schweizer, Garcia-Espana, & Fridman, 1990; Rickels, Case, Schweizer, Swenson, & Fridman, 1986; Schweizer, Rickels, Case, & Greenblatt, 1990, Schweizer, Rickels, DeMartinis, Case, & Garcia-Espana, 1998; Tyrer, Owen, & Dawling, 1983). Psychological differences might explain why some patients do and others do not experience difficulties stopping BZDs, but empirical support on the influence of psychological factors is still scarce. A previous study (O’Connor et al., 1999) examined psychological distress and adaptational problems associated with the discontinuation of BZD. A profile of those likely to experience psychological distress emerged from a multiple regression and correspondence analysis (CA), which indicated that participants with higher neuroticism, higher negative life events, lower quality of life, lower education level, and younger age group clustered together, with a higher reported level of distress.

This previous study (O’Connor et al., 1999) used a cross-sectional design, with measures taken at one point in time, calculated to capture the maximum effect of withdrawal, 2–14 days after cessation. The present study aimed to replicate and extend these previous findings by administering the same psychosocial measures to a group of patients before, during, and after BZD withdrawal. We hypothesized that the same profile of psychosocial measures that had previously characterized psychological distress would, also, in the current study be associated with poorer outcome and greater severity of withdrawal symptoms.

2. Method

Forty-one participants receiving maintenance BZD therapy for at least 8 weeks, who wished to discontinue BZD use, entered the trial. The patients were all recruited either through clinician referrals or adverts in local media. After a telephone screening, patients were referred for ADIS-IV evaluation, administered by collaborating psychiatrists. The patients had to meet the following criteria: (1) be aged between 18 and 65 years old; (2) be using BZDs as an anxiolytic or hypnotic drug regularly for at least 8 weeks; (3) meet a current diagnosis of panic disorder, generalized anxiety disorder, social phobia, or any complaint of unspecified anxiety disorder or insomnia, present for at least 3 months; (4) wish to discontinue BZD use. Patients were excluded if they met the following criteria: (1) any serious medical condition; (2) any other Axis I disorder; (3) adaptational disorder, with anxious or depressed mood; (4) any history of drug or alcohol abuse or dependence other than BZDs; (5) use of any other psychotropic medication; (6) had received any form of intensive psychotherapy in the last 3 months.

The interrater reliability of diagnosis was evaluated on the audio-recorded interviews by another psychiatrist, and, for all participants, there was 100% interrater agreement for principal diagnosis.
2.1. Withdrawal procedure and taper schedule

All collaborating psychiatrists were themselves responsible for supervising the withdrawal of their patients. Clinicians offered standard counselling and support to their withdrawal patients but refrained from any structured therapy. The patients were seen weekly for the first month and then every other or third week for the rest of the discontinuation period. There is no standard withdrawal taper schedule. It is clearly recommended that BZD discontinuation is tapered gradually to minimize withdrawal symptoms (Ashton, 1986; Committee on Safety of Medicine, 1988; Tyrer, Murphy, & Riley, 1990). The time necessary for discontinuation varies according to type and dosage of BZD, but invariably takes the form of a negatively accelerating exponential curve. Bisserbe, Boulenger, and Boyer (1992) suggest cutting medication by 25% per week over a 4-week period, initially, and then spacing out the reduction in dosage for a total discontinuation period of 12 weeks. Lader (1994a, 1994b recommends a minimum period of at least 8 weeks and notes that patients may commonly need more time. In the current study, clinicians were encouraged to use a standard taper schedule, which consisted of cutting the dosage by 25% slices weekly for the first 75% of total dosage and reducing the remaining dosage by approximately 1/8 or 1/10 until a complete stop. Patients were withdrawn between 12 and 21 weeks, with a mean time of 15 weeks. Beyond 21 weeks, the patients were considered as nonsucceeders, and all tapering efforts were stopped. Patients then discussed with their clinicians the return to optimal dosage.

2.2. Evaluation procedure

The patients were evaluated at three different times. Baseline evaluation was performed between 2 weeks and 1 month before starting the tapering schedule (T0). Patients who succeeded in their withdrawal were then evaluated again between 4 to 10 days after full cessation (T1). This period was chosen to coincide with the maximal chemical readaptation of the BZD receptor sites, which is the period during which withdrawal symptoms are most likely to appear. Patients who were not capable of ceasing their medication completely were seen between 4 and 7 days after deciding with their clinician that the tapering would be stopped (T1'). Patients who succeeded were seen for follow-up after 3 months (T2: still drug-free). Three months was considered a reasonable time to estimate continued abstinence because relapse mostly occurs within 3 months following cessation. If patients relapsed (returned to drug use) before the 3-month period, they were then seen as soon as possible after resuming BZD intake (T2': relapse).

2.3. Assessments

The research evaluations consisted of a battery of questionnaires, which aimed at collecting three types of information: (1) sociodemographic information: age, sex, education level, and marital status; (2) pharmacological variables: length of BZD use (in terms of years), dosage (in diazepam equivalents of 5 mg = 1 unit), and type of drug (long-acting vs. short-acting) were recorded. A urine sample was collected at each visit to test for correct BZD-use status. The
presence or absence of a BZD or its metabolites in the urine was determined using EMIT essay packages. This procedure determines the concentration of the BZD present in the urine. If positive, a further test was carried out to determine the type of BZD used; and (3) psychosocial variables: level of anxiety was measured using the state-trait anxiety inventory (STAI; Spielberger, Gorsuch, & Lushene, 1983). The Widlocher-Pull Inventory (WP2; Widlocher & Pull, 1988) measured the degree of behavioural inhibition associated with an anxious state. Neuroticism, a personality trait found in previous studies (e.g., O’Connor et al., 1999) to be related to BZD withdrawal difficulties, was measured using the Eysenck Personality Questionnaire (EPQ; Eysenck & Eysenck, 1975). Withdrawal complaints were measured with the benzodiazepine withdrawal symptom questionnaire (BWSQ; Tyrer et al., 1990). Social support was measured using the short form of the social support questionnaire (SSQ) of Sarason, Shearin, Pierce, and Sarason’s (1987). Life experience survey (LES; Sarason, Johnson, & Siegel, 1978) measured the subjects’ experiences, both positive and negative, and sources of stress in over 57 areas of life. Overall psychological distress was assessed using the IDPES-29 (Index de Détresse Psychologique de l’Enquête Santé-Québec) employed by the Quebec Government in its studies of the state of psychological health in the Canadian Province of Quebec, and norms are available (Préville, Potvin, & Boyer, 1995). This measure consists of 29 items measuring four aspects of psychological distress (depression, anxiety, irritability, and

Table 1
Baseline sociodemographic and pharmacological variables and taper outcome

<table>
<thead>
<tr>
<th></th>
<th>Failure</th>
<th>Mean ± S.D.</th>
<th>Success</th>
<th>Mean ± S.D.</th>
<th>$P$ value*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$n$</td>
<td></td>
<td>$n$</td>
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<td><strong>Sociodemographic variables</strong></td>
<td></td>
<td></td>
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<tr>
<td>Age (years)</td>
<td>21</td>
<td>46.7 ± 9.8</td>
<td>12</td>
<td>50.9 ± 10.1</td>
<td>.246</td>
</tr>
<tr>
<td>Education level (years)</td>
<td>19</td>
<td>13.5 ± 3.9</td>
<td>11</td>
<td>13.3 ± 4.0</td>
<td>.894</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>21</td>
<td>13 (61.9)</td>
<td>12</td>
<td>8 (66.7)</td>
<td>1.000*</td>
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<tr>
<td>Male</td>
<td></td>
<td>8 (38.1)</td>
<td></td>
<td>4 (33.3)</td>
<td></td>
</tr>
<tr>
<td>Diagnosis ($n$ %)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insomnia</td>
<td>21</td>
<td>4 (19.0)</td>
<td>12</td>
<td>4 (33.3)</td>
<td>.204</td>
</tr>
<tr>
<td>Panic disorder</td>
<td></td>
<td>12 (57.1)</td>
<td>3 (25.0)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generalized anxiety disorder and others</td>
<td>5 (23.8)</td>
<td>5 (41.7)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Pharmacological variables</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Length of BZD use (years)</td>
<td>21</td>
<td>10.2 ± 9.1</td>
<td>12</td>
<td>14.0 ± 10.9</td>
<td>.294</td>
</tr>
<tr>
<td>Dosage (in diazepam eq. mg)</td>
<td>21</td>
<td>18.0 ± 14.7</td>
<td>12</td>
<td>7.6 ± 6.0</td>
<td>.026</td>
</tr>
<tr>
<td>Type of drug ($n$ %)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Long acting</td>
<td>21</td>
<td>11 (52.4)</td>
<td>5 (41.7)</td>
<td></td>
<td>.554</td>
</tr>
<tr>
<td>Short acting</td>
<td>10 (47.6)</td>
<td>7 (58.3)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Withdrawal complaints ($n$ %)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Two and less</td>
<td>21</td>
<td>11 (52.4)</td>
<td>9 (75.0)</td>
<td></td>
<td>.278*</td>
</tr>
<tr>
<td>Three and more</td>
<td>10 (47.6)</td>
<td>3 (25.0)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Based on unpaired Student $t$ test or on a Pearson’s Chi-square Test (Fisher exact test was used when specified by *).
cognitive problems). Self-efficacy in coping with personalized difficult situations or events without BZD and self-efficacy in discontinuing BZD completely (or at T1 in maintaining discontinuation) were derived from a standard instrument for measuring self-efficacy (Condiotte & Lichtenstein, 1981). Systematic Inventory of the Quality of Life [Inventaire Systémique de Qualité de Vie (ISQV); Duquette, Dupuis, & Perrault, 1994] is an interview-like questionnaire measuring the quality of life based on the subject’s capacity to reach personal goals in seven life domains (family, work, leisure, interpersonal, health, housework, and cognitive functioning). The visually rated instrument measures the personal goal that the patients hope to attain as an acceptable ideal in life, their actual state at the present time, the gap between actual and desired goals, the conflict between priorities in the life domains, and, finally, the impact that the problem of anxiety/insomnia has upon their quality of life.

2.4. End-point variables

There were two end-point measures: taper outcome and withdrawal complaints. Both were analysed as dichotomous variables: success versus failure for taper outcome; three or more complaints versus two and less for withdrawal complaints. Patients unable to withdraw from the drug within 21 weeks were considered as nonsucceeders, even if they were still willing to try to cut down at that time. Withdrawal complaint was defined as either the apparition of a new symptom or the worsening from moderate to severe of a preexisting one.

3. Analysis

Univariate analyses were performed to assess the impact of the sociodemographic, pharmacological, and psychological variables on the end-point measures. Differences between the success and failure groups and between the two and less and the three and more BWSQ withdrawal complaint groups were assessed through proportion comparisons using chi-square test, or Fisher’s Exact Test when needed, one-way analysis of variance, or comparisons of means using unpaired Student t tests, adjusted for inequality of variance when needed. SAS software release 6.12 was used to perform all the statistical analysis. Correlation matrices were computed using Pearson’s product-moment coefficient (r).

4. Results

Analysis was conducted on 41 participants, of whom 8 abandoned. Unfortunately, follow-up data were, by definition, not available on those who abandoned, hence, further quantitative analysis was completed on 33 participants in each group. Those who abandoned were less likely to be married (14.3% vs. 66.7%; \(P < .04\)). There was a nonsignificant (\(P < .06\)) tendency for those who abandoned to be taking more short- than long-acting BZD. Among the 8 who abandoned, 7 were taking short-acting medication. Those who abandoned scored significantly higher (\(P < .05\)) on EPQ extraversion [\(\bar{y}(6) = 14.17 (2.93)\)] than those who
completed \( [\bar{x}(32) = 11.42 (3.16)] \). There were no other significant differences in demographic or clinical characteristics between the abandon and completed groups. Table 1 shows the baseline sociodemographic, pharmacological, and psychological measures.

### 4.1. Comparison of succeeders and nonsucceeders at T1 on T0 measures (Table 1)

At the end of the tapering period (T1), 12 had discontinued and, at the 3-month follow-up (T2), 3 of the 12 had relapsed. Those who did not succeed in discontinuing at T1 had higher baseline WP2 performance inhibition due to anxiety than succeeders \( [\bar{x}(12) = 0.67 (0.48); P < .007] \) more STAI state anxiety \( [\bar{x}(12) = 44.78 (11.86) vs. \bar{x}(12) = 37.54 (6.82); P < .05] \), and more IDESQ-29 distress \( [\bar{x}(12) = 36.51 (19.11) vs. \bar{x}(12) = 24.11 (13.62); P < .05] \). The major difference at baseline between those who succeeded and those who did not was in dosage; greater initial dosage was associated with unsuccessful withdrawal \( [\bar{x}(12) = 17.99 (14.7) vs. \bar{x}(12) = 7.57 (6.03); P < .02] \). Neither long- nor short-acting medication, nor the chronicity of dependence, had an effect on success or failure. Table 2 shows the generic type of medication at baseline and according to outcome status. However, the chi-square analysis of type of medication by success or failure was not significant \( [\chi^2(3df) = 2.69, \text{n.s.}] \).

### 4.2. Comparison of patients with high and low withdrawal complaints (T1; Table 3)

Fig. 1 shows the trend in self-reported withdrawal symptom (BWSQ total score) over successive time periods for succeeders (12) and non-succeeders (21). At T0 and T1, there is no significant difference \( [F(1,30) < 1, \text{n.s.}] \). At T2, however, there is a significant difference in reported symptoms between those who succeeded and those who relapsed \( [t(8) = 2.84, \text{P} < .05] \). However, the small numbers limit the robustness of this finding. In the sample, 13 reported three or more new or worse BWSQ withdrawal symptoms, 20 reported two or less. Higher baseline performance inhibition on the WP2 was associated with a greater number of reported BWSQ withdrawal symptoms \( [\bar{x}(20) = 1.41 (0.54) vs. \bar{x}(13) = 0.86 (0.64); P < .02] \), STAI state anxiety \( [\bar{x}(20) = 47.96 (9.82) vs. \bar{x}(13) = 38.38 (9.86); P < .01] \), and STAI trait

Table 2

Mean dosage and duration of each medication at baseline plus outcome status at T1

<table>
<thead>
<tr>
<th>Type of medication</th>
<th>N</th>
<th>Mean dosage (mg)</th>
<th>Mean duration (yrs)</th>
<th>Success</th>
<th>Failure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clonazepam</td>
<td>13</td>
<td>1.33</td>
<td>9.44</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>Lorazepam</td>
<td>14</td>
<td>1.95</td>
<td>11.29</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Alprazolam</td>
<td>8</td>
<td>1.11</td>
<td>8.00</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Diazepam</td>
<td>2</td>
<td>9.50</td>
<td>12.50</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Bromazepam</td>
<td>2</td>
<td>2.50</td>
<td>27.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flurazepam</td>
<td>1</td>
<td>15.00</td>
<td>20.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oxazepam</td>
<td>1</td>
<td>15.00</td>
<td>14.00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
anxiety ($\bar{x}(20) = 44.74$ (8.30) vs. $\bar{x}(13) = 51.55$ (10.78); $P < .05$]. Self-efficacy, either in discontinuing BZD or in coping without BZD, did not seem to be directly related to the number of reported BWSQ withdrawal symptoms. There was a nonsignificant tendency for a greater percentage of those with panic disorder compared with the other diagnostic groups to report three or more BWSQ withdrawal complaints ($P < .08$; panic disorder = 69.2%, generalized anxiety disorder = 15.4%, insomnia = 15.4%). The panic-disorder group reported higher IDESQ-29 levels of distress [$\bar{x}(15) = 37.98$ (25.94)] than the generalized anxiety disorder [$\bar{x}(10) = 17.35$ (11.55)] and the insomnia groups did [$\bar{x}(8) = 22.5$ (12.57); $P < .04$]. However, long- or short-acting medication type did interact highly significantly with the number of BWSQ withdrawal complaints ($P < .0008$). Seventy-six percent of those reporting 3 or more complaints were on long acting, and 70% of those reporting 2 or less withdrawal symptoms were on short acting. But those reporting three or more BWSQ withdrawal complaints were also more likely to be taking a higher dosage [$\bar{x}(20) = 21.14$ (16.97) vs. $\bar{x}(13) = 9.69$ (7.48); $P < .04$] (Table 3).

4.3. Correlation matrix of measures at baseline (T0)

The duration and dosage of medication were uncorrelated [$r(41) = -.16$, n.s.], and although the duration of medication showed a mild positive correlation with age [$r(41) = .32$, $P < .04$], the pharmacological measures showed no significant correlation with any other questionnaire measure. However, the WP2 was negatively correlated with a number of measures, such as self-efficacy in coping without BZD [$r(36) = -.39$, $P < .02$] and self-efficacy with discontinuation of BZD [$r(36) = -.55$, $P < .0005$], and with SSQ social support satisfaction [$r(39) = -.42$, $P < .007$]. The WP2 was also positively correlated with EPQ neuroticism [$r(37) = .54$, $P < .0006$] and IDESQ-29 psychological distress [$r(40) = .66$, $P < .0001$]. IDESQ-29 distress correlated highly with ISQV quality of life-gap measure between current and ideal quality [$r(32) = .65$, $P < .0001$], WP2 [$r(33) = .72$, $P < .0001$], STAI trait anxiety [$r(33) = .76$, $P < .0001$], STAI state anxiety [$r(33) = .57$, $P < .0005$], self-efficacy of coping without BZD [$r(29) = -.53$, $P < .002$], LES negative life events [$r(33) = .60$, $P < .001$].
Self-efficacy ratings in discontinuing BZD correlated negatively with the WP2 \[ r(32) = .55, P < .0005 \], STAI trait anxiety \[ r(32) = .45, P < .005 \], EPQ neuroticism \[ r(28) = .57, P < .001 \], and the IDESQ-29 distress \[ r(32) = .49, P < .002 \]. Self-efficacy in coping without BZD correlated significantly only with the WP2 \[ r(36) = .39, P < .02 \] and with self-efficacy in discontinuing BZD \[ r(34) = .53, P < .001 \].

### 4.4. Baseline correlates (T0) of psychological distress at point of discontinuation (T1)

Distress, as measured by the IDESQ-29 at the point of discontinuation (T1), was correlated with the baseline measures of ISQV state of quality of life \[ r(31) = -.48, P < .006 \]: the gap between state and ideal ISQV quality of life \[ r(31) = .59, P < .0004 \], the WP2 \[ r(32) = .35, P < .04 \], STAI state anxiety \[ r(32) = .52, P < .002 \], STAI trait anxiety \[ r(32) = .37, P < .03 \], negative LES life events \[ r(32) = .42, P < .02 \], and IDESQ-29 distress at baseline \[ r(32) = .60, P < .0003 \].

### 4.5. Baseline associations (T0) with outcome at three-month follow-up (T2, T2’)

Higher self-efficacy in coping without BZD at baseline was not associated with the success at outcome post discontinuation (T1, T2), but lower self-efficacy was associated with relapse at follow-up T2’ [median: success (8) = 59.0 vs. failure (18) = 43.0 vs. relapse (3) = 8.5; \( P < .03 \).]
Higher dosage (diazepam equivalent) at baseline was also significantly associated with relapse at T2' [median: success (9) = 5.0 vs. failure (21) = 10.0 vs. relapse (3) = 10.0; P < .03]. None of the other measures were associated with relapse at T2', but higher WP2 [median: success (9) = 0.8 vs. failure (21) = 1.5; P < .04] and IDESQ-29 at baseline [median: success (9) = 22.9 vs. failure (21) = 33.3; P < .05] continued to be associated with abstinence at T2.

4.6. Evolution of self-efficacy measures over T0, 1, 2

There was a significant interaction effect of time period and success on both the overall level of self-efficacy in successfully discontinuing BZD or maintaining discontinuation \[ F(1,27) = 6.95; P < .01 \] and self-efficacy in coping with specific difficulties without BZD \[ F(1,27) = 6.52; P < .02 \]. Fig. 2 shows the level of self-efficacy in coping with specific difficulties without BZD at the three time points for succeeders and nonsucceeders. There was a significant change in the group who successfully quit between T0 \[ \bar{x}(11) = 51.5 \ (26.0) \] and T1 \[ \bar{x}(11) = 70.4 \ (22.8); P < .01 \]; a change over time was not found in the unsuccessful group. Self-efficacy in successfully discontinuing or maintaining the discontinuation of BZD also increased in the succeeders \[ \bar{x}(12) = 61.6 \ (31.4) \] at T0 to \[ \bar{x}(12) = 76.7 \ (28.9); P < .04 \] but decreased in the nonsucceeders \[ \bar{x}(20) = 56.0 \ (27.9) \] at T1 to \[ \bar{x}(18) = 39.4 \ (37.5); P < .04 \] at T1.

Correspondence analysis (CA) is a descriptive technique that groups participants and measures into the same two-dimensional space according to communalities, in presence or absence of associations. It can be considered as a kind of nonparametric factor analysis. CA revealed that two dimensions accounted for 39.6% of the total inertia (CA equivalent of variance). Successful withdrawal was characterized by participants with the following profile: low EPQ neuroticism, low WP2 score, low number of LES negative life events, high number of LES positive events, high SSQ social support satisfaction. Conversely, failure was associated with high level of IDESQ-29 distress, high EPQ neuroticism, high number of LES negative, and low LES positive events.

![Fig. 2. The evolution of ratings of overall level of self-efficacy (0–100) in coping with personalized difficulties without BZD over the three time periods (T0, T1 or T1', T2 or T2') separately for succeeders and non-succeeders.](image-url)
5. Discussion

The results replicated the relationship previously reported between psychosocial factors and psychological distress during discontinuation (O’Connor et al., 1999). The profiles of baseline measures characterizing the high levels of psychological distress in the first study were similarly associated with the psychological distress in the current study, that is, low quality of life, low social support, high neuroticism, and high behavioural inhibition. Furthermore, low levels of psychological distress and low behavioural inhibition were the psychosocial measures most strongly associated with successful discontinuation.

Higher levels of baseline psychological distress and behavioural inhibition were consistently associated with unsuccessful outcome, number of withdrawal complaints, and relapse. These latter measures were more strongly associated with end points than diagnostic group and anxiety measures, and suggest that psychological measures of what people feel able to do or not do, experienced prior to discontinuation, may be better indicators of outcome than the measures of state anxiety. However, level of self-efficacy in discontinuation and coping without BZD proved not to be significantly correlated with success or failure at T1 but was associated with relapse at T2’. Self-efficacy evolved differentially during the period of tapered withdrawal, according to success, and this suggests that it is important clinically to pay attention to process variables during discontinuation. Self-efficacy may increase subsequent to perceived success in discontinuing, and this change would explain both its significant negative association with relapse at T2’ and why baseline self-efficacy itself was not a correlate of the initial outcome at T1. Successful taper at T1 was not accompanied by a decrease in reported withdrawal symptoms, and psychological distress was not correlated at baseline with withdrawal complaints. The lack of association between withdrawal symptoms, psychological distress, and taper outcome is emphasized by the presence of those who succeed in discontinuing despite complaining of withdrawal symptoms and vice versa. These subgroups deserve further study.

An advantage of this longitudinal design is that it permitted assessing the impact of psychosocial factors according to stage of the tapering process. Factors, such as level and type of diagnostic severity and anxiety inhibition, quality of life, and social support satisfaction, seem important determinants of psychological distress and the likelihood of withdrawal problems. Initial dosage and degree of behavioural inhibition seem to be predictors of successful outcome. Conversely, self-efficacy becomes important during the tapering period to help relapse prevention postdiscontinuation. Further research might examine the impact of modifying psychosocial variables on taper outcome and withdrawal complaints.

References


