TREATMENT OF DISEASE WITHOUT THE USE OF DRUGS. V PHASING OUT OF BENZODIAZEPINE AND AMITRIPTYLINE MEDICATION WITH THOUGHT CONTROL

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SYNOPSIS

Four subjects voluntered to phase out their benzodiazepine and amitriptyline medication by learning to increase their palmar skin resistance (GSR) with a method of thought control. This method involved a form of daily mental exercise which produced an accompanying increase in palmar GSR and a decrease in arousal level. Following two weeks of daily exercise subjects began to phase out their drugs and by the eighth week were free of their medication. In the three months of follow-up subjects practised the daily exercise at their own discretion and the symptoms which required drug medication did not return.

Five other subjects each suffering from one of the following diseases: hypertension, hyperthyroidism, parkinsonism and gastritis (and were prescribed diazepam in addition to the drugs used to control the symptoms of their diseases) also participated in the same program. All the five subjects were able to phase out their diazepam by the end of the sixth week. There was no aggravation of their diseases during the three months of weekly observation and the three months of follow-up.

INTRODUCTION

We recently showed that the palmar skin resistance (GSR) could be voluntarily increased by a (learning) process of thought control. This increase in GSR was accompanied by a clam and restful experience suggestive of an attainment of low arousal (Sim, 1980a) Psychosomatic diseases like migraine and asthma which could be precipitated by an increase in arousal level had also been shown to be effectively controlled by the constant practice of thought control and various breathing exercises (Sim, 1980b; Ratnam and Sim, 1980). In this article we report a deliberate attempt to wean individuals of their benzodiazepine and amitriptyline medication by training them to increase their palmar GSR (with the method of thought control) and two breathing exercises.

MATERIALS AND METHODS

Subjects

Subjects were volunteers and were grouped into two categories. Group I consisted of those who were on benzodiazepine and or amitriptyline medication. Group II consisted of those who suffered

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from one of the following diseases: hypertension, hyperthyroidism, parkinsonism and gastritis and were prescribed diazepam in addition to the other drugs used to control the symptoms of their diseases. Subjects' personal particulars, history of current illness and current drug medication are summarised in Table 1.

Procedure

On the first visit palmar skin resistance (GSR) of each subject was measured for the control and during the first attempt at body visualisation as described previously (Sim, 1980a). It was unexpectedly found that both the GSR values (i.e. the control measurement and the value obtained for the first attempt at body visualisation) were exceptionally high for all the subjects, with three having values exceeding the 1 mega ohm range of the Grass Polygraph amplifier. These high values were later found to be due to the effect of the benzodiazepines and amitriptyline the subjects were taking (see Discussion).

A six month program similar to that used for the self-treatment of asthma (Ratnam and Sim, 1980) were employed. Subjects' daily practice for the first two weeks consisted of two 15 minutes sessions of body visualisation and one session of 15 minutes diaphragmatic breathing. Third week practice consisted of daily two 20 minutes sessions of void visualisation and two 15 minutes sessions of diaphragmatic breathing. Fourth and subsequent weeks (up to 3 months) practice consisted of daily two 30 minutes sessions of void visualisation, 15 minutes of diaphragmatic breathing and 15 minutes of the second breathing (complete breathing) exercise. Besides the daily breathing exercise subjects were encouraged to breath diaphragmatically whenever they were conscious of their breathing. Subjects were instructed in the recording of their exercise routine, the conditions and symptoms of their diseases and the medicines taken. They came weekly for the first three months to have their GSR recorded during the performance of the body and void visualisation (the blood pressure of the two hypertensive subjects were also taken) and were taught the various exercises at these appointments.

Table 1. Summary of subjects' personal particulars, current illness and drug medication

SUBJECTS*	SEX	AGE	DURATION OF ILLNESS	CURRENT DRUG MEDICATION**
A	M	30	2 years	2 mg diazepam t.i.d. 25 mg amitriptyline t.i.d.
B	M	36	1½ years	0.5 mg lorazepam t.i.d. 1 mg lorazepam o.n.
C	M	35	1 year	0.5 mg lorazepam t.i.d. 25 mg amitriptyline b.d.
D	F	32	1 year	1 mg trifluoperazine b.d. 2 mg diazepam o.n.
E	M	26	3 years	2 mg diazepam t.i.d. 15 mg guanethidine o.m. 500 mg chlorothiazide o.m.
F	F	32	2½ years	2 mg diazepam b.d. 250 methyldopa b.d.
G	F	28	2 years	2 mg diazepam b.d. 5 mg carbimazole t.i.d.
H	M	37	2 years	5 mg diazepam b.d. 200 mg L-dopa + 500 mg benserazide b.d. 100 mg amatadine b.d.
I	M	41	1½ years	2 mg diazepam b.d. 15 mg propantheline t.i.d. 400 mg magnesium-aluminium hydroxide gell t.i.d.

*Group I consisted of subjects A, B, C, D; and group II of subjects E, F, G, H, I.

**For the last six months (or longer) prior to participation in our program.

Subjects, after completing two weeks of daily exercises, phased out one dose of their benzodiazepines i.e. t.i.d. regimens were reduced to b.d. and b.d. to a mid-day dose. A similar reduction were made after the third week and another one after the fourth week. A week after the ceasation of the day time benzodiazepine medication subjects on o.n. medication took half the dose of the drug for one week before phasing out the medication. Amitriptyline medication of subjects A and C were similarly phase out following the ceasation of benzodiazepine medication. In the second three months of follow-up subjects came fortnightly for the first month and monthly for the remaining two months. During the follow-up period subjects practised the daily exercises at their own discretion.

RESULTS

The nine subjects had exceptionally high GSR readings measured during the control recordings and their first attempts at body visualisation. Subjects A, C and H who took 10 mg or more per day of benzodiazepines and or amitriptyline had GSR values that exceeded the 1 mega ohm range of the Grass Polygraph amplifier. The other subjects had GSR values ranging from 600 to 800 K ohm. Similar magnitude of GSR values were obtained during the performance of body visualisation at the second and third weekly appointments. However, following the first and second benzodiazepine reductions GSR readings taken during the performance of the void visualisation were respectively lower than the preceeding values. With further dossage reduction different GSR values were obtained for different subjects as they continued with the daily practice of the program. In the first three months of the program the overall GSR value of each subject showed a downward trend during the period of drug withdrawal followed by a rise after the subjects had ceased their drug medication (see Figure 1).

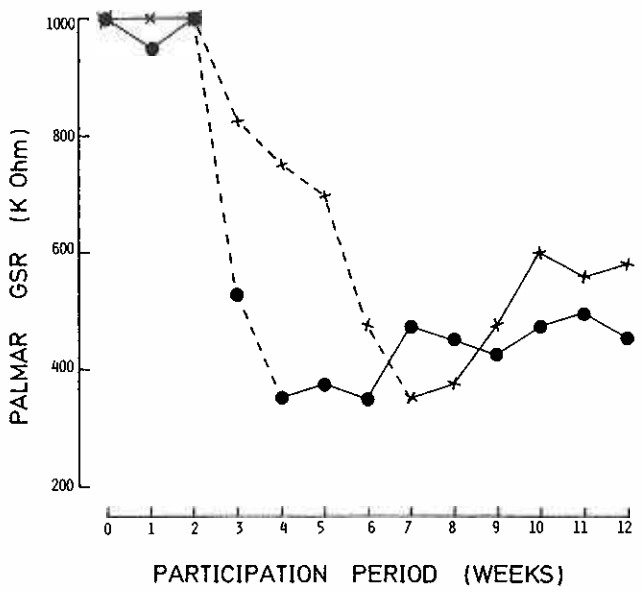

Figure 1. A plot of palmar GSR (measured during the performance of body cum void visualisation) of subjects A (x ——— x) and B (o ——— o) against the 12 weekly appointments. The periods of drug withdrawal of both subjects are represented by the dashed lines.

Subjects of group I experienced mild withdrawal symptoms e.g. jaw twitching, anxiety, tension headache and difficulty in getting to sleep during the weeks when they were phasing out their medication. Subjects overcame the withdrawal symptoms by performing the void visualisation and breathing exercises and did not resort to increasing their drug dossage. Group II subjects did not experienced any noticable withdrawal symptoms or an aggravation of their diseases during the weeks when diazepam were gradually withdrawn. By the tenth week of participation all subjects were free of their benzodiazepine and or amitriptyline medication and were able to produce an increase of 500 K ohm or more of palmar GSR during the performance of void visualisation. During the follow-up period none of the group I subjects reported any reoccurance of their symptoms. Group II subjects enjoyed complete remission of the symptoms of their diseases during the six months of the program.

DISCUSSION

Our results show that benzodiazepines and or amitriptyline could affect an individual ability to increase his or her palmar GSR. Subjects were able to increase their palmar GSR with ease when they were on benzodiazepine and or amitriptyline medication. Lower increases in palmar GSR were observed as subjects phased out their medication. The former observation was probably due to the tranquilising action of the drugs subjects were taking, namely a lowering of arousal and anxiety. Tranquilisers of the phenothiazine class had also been been known to affect palmar GSR in a similar way. Garras (1958) in his study on adaptation to stress found his tranquilised patients had higher basal GSR values than the non-drugged subjects and a significant increase in palmar GSR of the same patients during the relaxation period but no similar increase was observed in the non-drugged subjects. These findings lend support to our earlier suggestion that increases in palmar GSR of individuals are accompanied by a lowering of their arousal (Sim, 1980a) and to the rationale of learning to increase one's palmar GSR in the control of migraine and asthma (Sim, 1980b; Ratnam and Sim, 1980). From the overall results we suggest that patients taking benzodiazepines and or amitriptyline either as a primary or an auxillary medication could wean themselves off the drugs by learning to increase their palmar GSR using the method of void visualisation.

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