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Quality of life and attitudes towards psychotropics and dependency: consumers vs. non-consumers aged 50 and over

M. Baumann SocD PhD, F. Bonnetain MSc Epidemiology, S. Briançon MD PhD and F. Alla MD PhD

School of Public Health, Faculty of Medicine, University of Nancy, France

SUMMARY

Aim: **To assess the relationships between socio-demographic factors, quality of life and attitudes towards psychotropic drugs and dependency and to compare those relationships in continuous consumers (CC), occasional consumers (OC) and non-consumers (NC) of those drugs.**

Methods: **Quality of life (SF36) and attitudes (14 statements) were measured in 601 subjects (45–60 years old) from the SUVIMAX cohort (SUpplémentation en VItamines et en sels Minéraux AntioXydants). Data were obtained on 334 NC, 142 CC, 125 OC from the inclusion questionnaire and the monthly consumption report notebooks kept by subjects between 1994 and 1998. Dichotomous and polychotomous logistic regressions were used for the analysis.**

Results: **The lower the quality of life score the more frequent was consumption. NC tended to be men, with high quality of life scores. They entertained negative attitudes towards psychotropics and dependency. OC tended to be women reporting a chronic pathology, with fairly high social status. They had intermediate quality of life and denied dependency. CC tended to be men with no professional activity and low quality of life scores in particular for mental health and perceived health. They had positive attitudes towards psychotropics and accept dependency.**

Discussion: **Assessment of patients' quality of life and understanding of their attitudes towards psychotropics can provide essential information for those in charge of health promotion programmes and may help in identifying new intervention strategies. Preventive education and follow-up of therapy may be better suited to the needs of patients.**

Keywords: **attitudes, continuous consumers, dependency, occasional consumers, psychotropic drugs, quality of life**

INTRODUCTION

In the USA and Europe, the increase in use of psychotropic medication (1, 2) has been shown to be related to medical factors in women, to socio-professional factors in men with professional dissatisfaction and a high level of education being predictive of higher consumption (3), to psycho-affective factors (social isolation, ability to cope), to environmental factors (mother being a consumer), and to social factors (life events) (4). The international literature however suggests no investigation of the relationship between quality of life and consumption of psychotropic medication, although such a link is plausible.

In all cultures, there are popular beliefs relating to health and illness. Depending on whether they are founded on experience of consumption, on beliefs in the effects of the drugs concerned, and on knowledge of mental pathologies, these attitudes may predispose to consumption (5). As medication has several meanings rooted in popular beliefs, it becomes an integral part of the social image that patients have of themselves. With little information on the composition and the pharmaceutical action of the drugs prescribed, the Western consumer views it as a sort of magic potion dispensed by a 'witch-doctor' with social and legal legitimacy. Popular culture with regard to medicines and drugs not only concerns beliefs which serve to interpret the drug,

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Correspondence: Michèle Baumann, School of Public Health EA 3444, Faculty of Medicine, 9, avenue de la Forêt de Haye B.P. 184, 54505 Vandoeuvre-les-Nancy Cedex, France. Tel.: +33 3 83 68 35 10; fax: +33 3 83 68 35 19; e-mail: baumann@sante-pub.u-nancy.fr

but also the drugs themselves in their material form and the consumer behaviour associated with them. This complexity explains variability among groups of psychotropic drug consumers (6).

Knowing about these beliefs is useful for understanding the cultural basis of behaviour, in which attitudes are relatively stable dispositions. Thus in the general population knowing about therapies is accompanied by a negative attitude towards psychotropics, which are associated with representations of doping (7). Recognition of the calming and relaxing effects of psychotropic medication leads to users being viewed as weak individuals. Willpower is preferred for solving problems (8). Recourse to psychotropics is often linked to mental disorders resulting from lack of moral strength and willpower. Conversely, drug consumption for anxiety and depression is viewed by family and professionals as being legitimate (9).

Women have more reserved attitudes than men, and older people have more negative attitudes. The higher the social status, the less mistrustful are attitudes towards these drugs. Hostility with regard to psychotropics goes hand in hand with an attitude that attributes value to 'natural' products, alternative medicines, and recourse to psychotropics for social problems. The main arguments against pharmacotherapy are its side-effects, its undesirable effects, and possible dependency (10) with some individuals becoming regularly dependent, and others succeeding in maintaining intermittent use. Thus there is not one but several consumer behaviours. Duration and regularity of consumption is of more concern that the act of consumption itself.

A study conducted on psychotropic consumers in the SUVIMAX cohort[1] made it possible to characterize those with a 'continuous trajectory' when reviewed monthly over a period of 5 years, and those with an 'occasional trajectory'. This idea of a trajectory over time was found useful for assessing dependency and defining consumer profiles (11). The aim of this study was to assess the relationships between socio-demographic factors, quality of life and attitudes towards psychotropic drugs and dependency and to compare those relationships in continuous consumers (CC), occasional consumers (OC) and non-consumers (NC) of those drugs.

[1]SUVIMAX (SUpplémentation en VItamines et sels Minéraux AntioXydants) is a controlled randomized primary prevention trial using nutritional doses of a combination of antioxidant minerals and vitamins in cardiovasular disease and cancer.

MATERIALS AND METHODS

This is an observational study carried out by follow-up of a cohort of healthy adults.

Population

Two samples were obtained from the SUVIMAX cohort participants, which consisted of 5740 healthy individuals aged from 45 to 60, of whom 340 psychotropic were drug users and 5400 were not (12). The first sample consisted of 267 of the 340 psychotropic drug users who agreed to participate. Among them were 142 defined as having a 'continuous' trajectory (CC = consumption every month for 5 years) and 125 as having an 'occasional' trajectory (OC = the remainder) (11). The second sample consisted of 335 of 500 NC randomly selected from the no users, who agreed to participate NC group.

Measures and data collection

Data were derived from the SUVIMAX inclusion questionnaire (1994) and from a self-completed assessment sent by post, which included a quality of life scale and a set of questions about attitudes with respect to psychotropic drugs and dependency (1998).

The inclusion questionnaire. The inclusion questionnaire provided socio-demographic and medical data: gender, professional status (three categories: executive, non-executive, no professional activity), socio-cultural status on the basis of educational level [two groups: up to the *baccalauréat* (level 12 years) and beyond], matrimonial status (two categories: living alone, living with a partner); history of medical problems or surgery, chronic pathology (yes/no).

Quality of life scale. The scale used was the MOS 36 Short Form Health Survey (SF36) in its French-language version (13, 14). This scale explores eight dimensions of quality of life: physical functioning (10 items), role physical (10 items), role emotional (three items), social functioning (two items), bodily pain (two items), mental health (five items) vitality

(four items), and general health (five items). Scores vary from 0 (worst quality of life) to 100 (optimum quality of life).

Attitudes towards psychotropic drugs and dependency. These were explored (15) by 12 statements with four response choices: complete agreement (1), moderate agreement (2), moderate disagreement (4), complete disagreement (5). Non-responses and multiple responses were classified as 'neither agree nor disagree' (3). Four factors, identified by factor analysis, represented favourable and unfavourable attitudes to psychotropic drugs, and to dependency. From the sum of responses, four scores were constituted. After weighting they range from 0 (least agreement) to 100 (maximum agreement). For each score, its internal coherence was measured by calculating Cronbach's alpha coefficient (CAC):

Score 1: positive attitudes towards pyschotropic drugs (four statements) (CAC = 0·73);

Score 2: explicit dependency attitudes (three statements) (CAC = 0·71);

Score 3: negative attitudes towards psychotropic drugs (three statements) (CAC = 0·51);

Score 4: implicit dependency attitudes (two statements) (CAC = 0·03).

Analysis

The socio-demographic and medical variables, the eight dimensions of the SF36, and the four attitude scores were described in the CC, OC and NC groups by way of frequencies (%) and mean values (±SD). They were compared between CCs and OCs, and then for the three groups respectively by logistic and polychotomous regressions. In both cases, a univariate analysis was performed, followed by a multivariate analysis (ascending stepwise). For each analysis odds ratios (OR) with 95% confidence interval were calculated. The calculations were performed on BMDP® software (Statistical Solutions, Cork, Ireland).

RESULTS

Socio-demographic and medical characteristics of the samples (Table 1)

The average age of all the study subjects sampled was about 56 (53 in 1994 and 58 in 1998). A majority of subject in all three groups, NC, CC and OC, were living with a partner, had high educational status and belonged to upper or intermediate social categories. Less than half had a chronic pathology. The psychotropic drugs most often consumed were anxiolytics, antidepressants, hypnotics and neuroleptics.

Continuous vs. occasional consumers (Table 2)

Among the socio-demographic and medical variables, being male, having no professional activity and use of hypnotics and anxiolytics were independently associated with continuous consumption. For quality of life, only mental health was independently associated with consumption, the better the level of mental health, the less likely the subject was to be a CC (−17% for an increase of 10 points in the quality of life score). Three of the four attitudes showed an independent relationship with the type of consumption: CCs tended to subscribe to attitude scores 1, 2, 4.

CCs vs. OCs and NCs (Tables 3 and 4)

Among the initial characteristics, gender, chronic pathology and the socio-professional category were independently linked to behaviours. Consumers were more often women (in particular OCs), more often declared chronic pathologies, and were more often in higher socio-professional categories (significant for CCs) than NCs. The lower the score for mental health and general (perceived) health (SF36), the more likely was the subject to be a consumer, whether occasional or continuous. Attitude scores 1 and 3 were independently associated with continuous use (CCs have a higher score 1 and a lower score 3 than NCs). Attitude score 1 was positively associated with occasional use, and scores 2, 3 and 4 were negatively associated with occasional use.

DISCUSSION

The poorer the quality of life, the more frequent is consumption. As these are altered by experience, quality of life and attitudes towards these medications and dependency may explain the behaviours of the groups under study. NCs tended to be male with good quality of life, and they more frequently admitted having negative attitudes

Table 1. Mean values of SF36 dimensions, and four attitudes towards psychotropic drugs. Distribution of socio-demographic and medical characteristics of psychotropic drug non-consumers, continuous consumers and occasional consumers

	Non-consumers (n = 334)	Continuous consumers (n = 142)	Occasional consumers 0 (n = 125)
	Percentage		
Gender			
Male	55·4	44·4	28·0
Female	44·6	55·6	72·0
Marital status			
Married/family	83·5	83·1	78·4
Single/divorced/widowed	16·5	16·9	21·6
Education level			
Elementary school	38·3	43·0	39·2
Secondary school/University	61·7	57·0	60·8
Socio-professional categories			
Managerial staff/intermediate professions	54·5	49·3	61·6
Employed/workers	23·1	20·4	17·6
Non-active subjects	22·4	30·3	20·8
Chronic disease			
Yes	27·2	40·8	40·0
Neuroleptic consumption			
Yes	–	3·5	4·8
Anxiolytic consumption			
Yes	–	61·3	41·6
Hypnotic consumption			
Yes	–	25·4	12·0
Antidepressant consumption			
Yes	–	33·8	38·4
	Mean (SD)		
Age (years)	52·9 (4·3)	53·9 (4·6)	53·1 (4·5)
SF36 dimensions[a]			
Physical functioning	91·4 (11·2)	85·4 (17·5)	87·9 (13·2)
Role limitation cause by physical problem	87·5 (25·7)	72·5 (35·5)	79·9 (29·0)
Role limitation cause by emotional problem	86·1 (27·1)	64·2 (39·2)	73·6 (36·7)
Social functioning	83·6 (18·8)	65·9 (24·4)	71·4 (21·6)
Bodily pain	69·2 (20·7)	59·3 (20·7)	62·4 (18·5)
Mental health	70·9 (16·4)	53·1 (19·8)	58·9 (18·3)
Vitality	63·1 (15·9)	49·8 (18·9)	53·0 (16·8)
General health	74·5 (14·9)	61·7 (19·1)	66·8 (17·1)
Attitudes[b]			
Score1: positive towards psychotropic drugs	50·5 (20·0)	70·7 (19·1)	63·5 (17·7)
Score2: explicit dependency	77·7 (24·9)	73·2 (28·9)	61·3 (28·2)
Score3: negative towards psychotropic drugs	72·1 (21·0)	57·4 (27·1)	66·5 (23·8)
Score4: implicit dependency	60·5 (17·6)	68·6 (18·1)	60·9 (17·9)

[a]100 = best quality of life/0 = poorest quality of life.
[b]0 = less in agreement/100 = more in agreement.

Table 2. Odds ratio and adjusted odds ratio for continuous consumers relative to occasional consumers

	Univariate logistic regression		Multivariate logistic regression		
	N	Odds ratio [CI 95%]	*N*	Odds ratio [CI 95%]	Step *n*
SF36[a]			261		
Physical functioning	266	0·90 [0·77–1·05]			
Role limitation cause by physical problem	265	0·93 [0·86–1·00]			
Role limitation cause by emotional problem	266	0·93 [0·89–0·99]*			
Social functioning	265	0·90 [0·81–1·00]			
Bodily pain	266	0·93 [0·82–1·05]			
Mental health	266	0·85 [0·75–0·97]*		0·83 [0·71–0·97]*	8
Vitality	266	0·92 [0·81–1·06]			
General health	266	0·87 [0·74–0·98]*			
Attitudes[a]					
Score 1: positives towards psychotropic drugs	264	1·22 [1·07–1·40]**		1·36 [1·15–1·60]***	2
Score 2: explicit dependence	264	1·16 [1·06–1·26]***		1·20 [1·08–1·34]***	1
Score 3: negatives towards psychotropic drugs	264	0·88 [0·79–0·96]**			
Score 4: implicit dependence	264	1·28 [1·10–1·48]***		1·28 [1·08–1·53]**	4
Age (years)					
46–52	130	1	128		
53–62	137	1·21 [0·74–1·96]	133		
Gender					
Male	98	1	98	1	
female	169	0·49 [0·29–0·82]**	163	0·37 [0·20–0·69]**	3
Marital status					
Married/family	216	1	212		
Single/divorced/widowed	51	0·74 [0·40–1·36]	49		
Education level					
Elementary school	110	1	107		
Secondary school/University	157	0·86 [0·52–1·40]	154		
Socio-professional categories					
Managerial staff/intermediate professions	147	1	145	1	
Employed/workers	51	1·45 [0·76–2·76]	50	1·99 [0·91–4·34]	
Non-active subjects	69	1·82 [1·01–3·27]	66	2·63 [1·29–5·37] *	7
Chronic disease					
No	159	1	154		
Yes	108	1·04 [0·63–1·69]	107		
Neuroleptic consumption					
No	256	1	250		
Yes	11	0·72 [0·21–2·45]	11		
Anxiolytic consumption					
No	128	1	123	1	
Yes	139	2·22 [1·36–3·63]**	138	2·52 [1·39–4·57]**	5

Table 2. Continued

	Univariate logistic regression		Multivariate logistic regression		
	N	Odds ratio [CI 95%]	*N*	Odds ratio [CI 95%]	Step *n*
Hypnotic consumption					
No	216	1	210	1	
Yes	51	2·49 [1·28–4·83]**	51	3·00 [1·37–6·57]**	6
Antidepressant consumption					
No	171	1	167		
Yes	96	0·82 [0·49–1·35]	94		

Univariate logistic regression for 142 continuous consumers according to 125 occasional consumers. ***$P < 0{\cdot}001$; **$P < 0{\cdot}01$; *$P < 0{\cdot}05$. Degree of significance for maximum likelihood X2.

Multivariate logistic regression for 139 continuous consumers according to 122 occasional consumers. Step-by-step procedure. ***$P < 0{\cdot}001$; **$P < 0{\cdot}01$; *$P < 0{\cdot}05$. Degree of significance for maximum likelihood X2 at the last step/goodness of fit = 0·07/Hosmer-Lemeshow = 0·1.

[a]Odds ratio for an increase of 10 points.

towards psychotropics and dependency. OCs were more likely to be female, with fairly high social status, reporting a chronic pathology, having intermediate quality of life and denying dependency on this type of medication. CCs tended to be males with no professional activity, poor quality of life scores, in particular in the mental and perceived health dimensions, and they entertained positive attitudes towards psychotropics and accepted dependency.

In a linear and one-directional conception of the biomedical model, recourse to psychotropic medication has been viewed as a consequence of mental disorders. While recognizing the contributions of classical factors, the present study, with its sociocultural approach, is closer to providing an explanatory model that is both multifactorial and interactionist. Men and women undergoing biological, sociological and psychological influences do not experience adverse events in a passive manner. The study subjects adopted behavioural strategies in which quality of life and attitudes towards psychotropics and dependency predisposed NCs to non-consumption, played a part in consumption for OCs, and reinforced CCs in the maintenance of their consumption of the psychotropic drugs.

Non-consumers

Non-consumers had the best quality of life. They had negative attitudes towards psychotropics and dependency. They recognized the iatrogenic risk of dependency inherent in this type of medication. These results are in line with those published (7, 8). This interaction of psychological with social factors certainly curbed recourse to psychotropic medication in this group of subjects.

Occasional consumers

Occasional consumers tended to be women reporting a chronic pathology; probably related to problems associated with the menopause and arthritis, among others. Thus their quality of life was intermediate and lower than for the NC group. OCs optimized their quest for well-being by limiting their consumption to a socially acceptable level. They adopted an attitude of denial with respect to dependency, whether explicit (e.g. they do not agree that these medications lead to dependency) or implicit (e.g. they do not subscribe to the idea that they would like to do without this medication). These attitudes contrast with those found in the NC and CC groups, and were less positive than for the CC group. Another study on the same OC group (16) showed that these subjects were more frequently in tune with the statements: 'when you feel better, you tend to stop taking the medication'; 'when this medication is taken for too long a period it is less efficient'; 'taking this medication means you are ill'; 'this type of medication has undesirable or unpleasant effects'.

Table 3. Univariate nominal polychotomous logistic regression for continuous and occasional psychotropic drugs consumers relative to non-consumers

	N	Odds ratio for continuous consumers [CI 95%]	Odds ratio for occasional consumers [CI 95%]	*P*
SF36[a]				
Physical functioning	598	0·74 [0·64–0·85]	0·82 [0·70–0·95]	***
Role limitation cause by physical problem	593	0·85 [0·80–0·90]	0·91 [0·85–0·97]	***
Role limitation cause by emotional problem	596	0·83 [0·78–0·88]	0·89 [0·84–0·95]	***
Social functioning	596	0·69 [0·63–0·76]	0·76 [0·69–0·84]	***
Bodily pain	595	0·79 [0·71–0·87]	0·85 [0·76–0·94]	***
Mental health	596	0·59 [0·52–0·66]	0·68 [0·60–0·77]	***
Vitality	597	0·65 [0·58–0·73]	0·70 [0·62–0·80]	***
General health	600	0·64 [0·57–0·73]	0·75 [0·66–0·85]	***
Attitudes[a]				
Score 1: positives towards psychotropic drugs	566	1·90 [1·60–2·10]	1·50 [1·30–1·70]	***
Score 2: explicit dependence	566	0·86 [0·79–0·94]	0·74 [0·68–0·81]	***
Score 3: negatives towards psychotropic drugs	566	0·71 [0·64–0·78]	0·82 [0·75–0·91]	***
Score 4: implicit dependence	566	1·20 [1·10–1·40]	0·92 [0·81–1·10]	***
Age (years)				
46–52	300	1	1	
53–62	301	1·20 [0·81–1·80]	0·99 [0·65–1·50]	
Gender:				
Male	283	1	1	
Female	318	1·60 [1·00–2·30]	3·20 [2·00–5·00]	***
Marital status:				
Married/family	495	1	1	
Single/divorced/widowed	106	1·03 [0·62–1·75]	1·38 [0·83–2·32]	
Education level				
Elementary school	238	1	1	
Secondary school/ University	363	0·83 [0·55–1·20]	0·96 [0·63–1·50]	
Socio-professional categories				
Managerial staff/ intermediate professions	329	1	1	
Employed/workers	128	0·98 [0·59–1·60]	0·68 [0·39–1·20]	
Non-active subjects	144	1·50 [0·94–2·40]	0·82 [0·49–1·40]	
Chronic disease				
No	402	1	1	
Yes	199	1·80 [1·20–2·80]	1·80 [1·20–2·70]	**

Univariate nominal polychotomous logistic regression for 142 continuous and 125 occasional consumers according to 334 non-consumers.

***$P < 0{\cdot}001$; **$P < 0{\cdot}01$; *$P < 0{\cdot}05$. Degree of significance for global maximum likelihood X2 test according to non-consumers, and continuous and occasional consumers.

[a]Odds ratio for an increase of 10 points.

Table 4. Multivariate nominal polychotomous logistic regression for continuous and occasional psychotropic drugs consumers relative to non-consumption

	N	Adjusted odds ratio for continuous consumers [CI 95%]	Adjusted odds ratio for occasional consumers [CI 95%]	*P*	Step *n*
SF36[a]	552				
Physical functioning					
Role limitation cause by physical problem					
Role limitation cause by emotional problem					
Social functioning					
Bodily pain					
Mental health		0·54 [0·46–0·65]	0·67 [0·57–0·80]	***	2
Vitality.					
General health		0·78 [0·65–0·94]	0·82 [0·68–0·98]	*	6
Attitudes[a]					
Score 1: positives towards psychotropic drugs		1·90 [1·70–2·30]	1·40 [1·20–1·60]	***	1
Score 2: explicit dependence		1·00 [0·89–1·10]	0·80 [0·72–0·89]	***	4
Score 3: negative towards psychotropic drugs		0·73 [0·65–0·83]	0·85 [0·76–0·97]	***	3
Score 4: implicit dependence		1·10 [0·97–1·30]	0·90 [0·76–1·00]	**	8
Age (years)					
46–52	274				
53–62	278				
Gender					
Male	262	1	1		
female	290	1·10 [0·65–2·00]	3·6 [2·00–6·20]	***	5
Marital status					
Married/family	455				
Single/divorced/widowed	97				
Education level					
Elementary school	220				
Secondary school/University	332				
Socio-professional categories					
Managerial staff/ intermediate professions	301	1	1		
Employed/workers	117	0·67 [0·34–1·30]	0·36 [0·18–0·72]		
Non-active subjects	134	1·40 [0·73–2·80]	0·58 [0·30–1·10]	**	7
Chronic disease					
No	363	1	1		
Yes	189	1·80 [1·00–3·2]	1·90 [1·10–3·30]	*	9

Multivariate nominal polychotomous logistic regression for 139 continuous and 122 occasional consumers according to 291 non-consumers. Step-by-step procedure.

***$P < 0{\cdot}001$; **$P < 0{\cdot}01$; *$P < 0{\cdot}05$. Degree of significance at the final step for maximum likelihood X2 test according to non-consumers, and continuous and occasional consumers.

[a] Odds ratio for an increase of 10 points.

Goodness of fit = 1.

Thus whenever there is deterioration in psychological health, these attitudes lead the OC group to use psychotropic drugs, but to cease consumption as soon as well-being was re-established so as to protect against side-effects. This occasional use, demonstrates a will to preserve autonomy while resorting to medication. The denial of dependency or addiction enabled the OC group to believe they could control consumption.

A British study (6) on the role of socio-cultural determinants in psychotropic consumption among 60-year-old consumers of at least 6-month standing highlighted three categories of consumer attitudes: fuel, tonic and food. These observations are close to those of the present study, with the OCs having characteristics close to those of the 'tonic' group (34%). This label covers users who considered that this type of medication was a sort of tonic leaving them to have full control over their medical consumption (doses, frequency, etc.). They saw the action of psychotropics as being on them rather than on people around them, thus boosting their independence and autonomy with respect to the opinions of others. They were liable to consider that psychotropics had a psychological effect, and to doubt the pharmacological effects of the medication. For them, psychotropics are designed above all to stimulate and act as a tonic when a person is temporarily depressed, anxious or tense.

Continuous consumers

Continuous consumers had the poorest quality of life of the three study groups. This interaction between poor quality of life and positive attitudes appears to sustain use of psychotropic drugs over long periods. The same CC group, in the study quoted earlier, more frequently subscribed to the statements 'when you have problems, you tend to resort to psychotropics'; 'it would be nice to do without this sort of medication'; 'you can't do without this medication'; 'you become dependent on this type of medication'; 'I have a good opinion of this sort of medication' (16). It would thus appear that their behaviour was built around a feeling of resignation and acceptance of dependency, and a generally fairly favourable attitude towards psychotropics, which provide an answer to a deficit in well-being, or to needs arising from physical and/or psychological dependency.

More than a third of the CC group had taken psychotropics daily, in particular hypnotics and anxiolytics. Only 30 stated they were able to do without the drugs (11). The chronic nature of consumption of psychotropics is therefore not a specifically female phenomenon as has been suggested in the literature (4). In the present study, men were observed to be consumers less frequently, but when they did consume, it was more likely to be on a continuous basis. The study observations on CCs are close to those in the 'fuel' group (44%) and the 'food' group identified in the British study (6). The 'fuel' group included consumers who view medication as a form of fuel; they had limited control over their consumption and considered that the effects of the medication were due to habit and probably of a psychological nature. But psychotropics occupied a very important place in their lives because they felt that the medication enabled harmonious relationships with others, acting as a fuel that made it possible to 'run' or function as expected by people around them. For this group, the medication was not viewed as essential, but as very valuable assistance. The 'food' group was formed by consumers who viewed medication as a form of food. These were subjects who had the least control over their consumption, and showed strong psychological dependency. They considered that the medication acted on others as much as it did on them. It was taken at precise, fixed intervals, in strict compliance. Little by little the medication became a sort of food symbol, essential to life.

This last point makes it easier to understand the complexity of the issues discussed on the use of this type of medication as an instrument facilitating social relationships and conformity with the norm. The social requirement is part of the possible explanations for recourse to psychotropic drugs for the purpose of maintaining or achieving acceptable quality of life (17).

The main limitations of this work relate to the way in which the samples were selected. As the subjects were drawn from the SUVIMAX cohort, they were, 'health-conscious', and thus not representative of the general French population. Their socio-demographic characteristics are relatively homogeneous with respect to age, socio-professional category, family situation, and educational level. This homogeneity may have led to a lack of power in the analysis of the factors selected.

PERSPECTIVES

Assessment of quality of life and evaluation of attitudes towards psychotropics and dependency provide valuable data for exploring determinants of use of psychotropic medication. The present study suggests the following:

- For health system users: all programmes designed to promote optimum use of medication prescribed, in particular those aimed at reducing over-consumption, should be based on results derived from studies on the influence of popular beliefs on consumption behaviours.
- For patients: all therapeutic education should emphasize the side-effects of psychotropic medication and compliance with medical recommendations. Responding to patients' expectations improves the practitioner–patient relationship, and improves patient satisfaction with care received. These in turn lead to better observance of medical recommendations, and reduce the number of medical consultations (18).
- For practitioners: medical training programmes should provide an analysis of popular beliefs, and explore behavioural variations associated with quality of life. Assessment of quality of life and understanding of attitudes towards psychotropics can provide important insights for those in charge of health promotion programmes so that intervention strategies can be improved and new ones developed. Preventive education and follow-up of therapy may be better suited to the needs of patients.

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