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Mother's little helper? Contrasting accounts of benzodiazepine and methadone use among drug-dependent parents in the UK

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Abstract

Aims: To explore the ways in which opioid-dependent parents accounted for their use of opioids and benzodiazepines during and after pregnancy. *Methods*: Longitudinal qualitative interviews [$n = 45$] with 19 opioid-dependent adults recruited in Scotland, UK, were held during the antenatal and post-natal period. Interviews focused on parenting and parenting support within the context of problem drug use and were analysed using a narrative informed, thematic analysis. *Findings*: The majority of participants described using benzodiazepines in addition to opioids. Almost all indicated a desire to stop or reduce opioid use, whereas cessation or reduction of benzodiazepines was rarely prioritised. In stark contrast to opioid dependence, benzodiazepine dependence was portrayed as unproblematic, therapeutic and acceptable in the context of family life. Whereas opioid dependence was framed as stigmatising, benzodiazepine use and dependence was normalised. An exception was benzodiazepine use by men which was occasionally associated with aggression and domestic abuse. *Conclusions*: Drug-dependent parents attach different meanings to opioid and benzodiazepine use and dependence in the context of parenthood. Divergent meanings, and stigma, may impact on stated commitment to stability or recovery from dependent drug-use. Attention should be paid to the way in which policy and practice regarding OST and benzodiazepines reflects this divergence.

Keywords

Benzodiazepine, opioid dependence, pregnancy, parenting, substance-related disorders

History

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Introduction

Parental drug misuse and its effects on children and families are policy priorities in the UK and elsewhere (Flavin & Paltrow, 2010; HM Government, 2010). Polydrug use is the norm among drug users in the UK, and benzodiazepine use is common (Bird & Robertson, 2011; Department of Health (England), 2007; Hay, Gannon, Casey, & McKeganey, 2009; Jones, Mogali, & Comer, 2012). Increased risks and harm, and a range of adverse effects are associated with long-term benzodiazepine use (Lader, 2011, 2014; O'Brien, 2005). However, existing research on drug use and parenting has tended to focus on opioids, opioid substitution therapy (OST), or crack cocaine (Radcliffe, 2009, 2011; Rhodes et al., 2010), and in the case of pregnancy, also alcohol, nicotine, marijuana and amphetamines (Behnke & Smith, 2013). In this paper, we examine accounts provided by polydrug-dependent parents about their use of, and dependence on, benzodiazepines as compared to OST.

Benzodiazepine use is highly prevalent among drug users worldwide (Jones et al., 2012). Opioid-dependent and OST patients use benzodiazepines to prolong and enhance the effects of opiates (Jaffe et al., 2004), and increased rates of dependence are associated with co-occurring psychosocial problems (Jones et al., 2012). Weizman, Gelkopf, Melamed, Adelson, and Bleich (2003) estimated a lifetime prevalence of benzodiazepine dependence in the opiate-dependent population (in or out of treatment) ranging from 61–94%. Benzodiazepines were originally marketed in the 1960s for the relief of anxiety, stress and insomnia (WHO, 1996) and remain one of the most widely used psychoactive drugs (Lader, 2011). Their use within the general population is common, particularly among females (O'Brien, 2005). The gendered cultural meanings of diazepam (Valium®), a well-known benzodiazepine, was cemented in the 1966 Rolling Stones' song ''Mother's little helper''.

Benzodiazepines are recommended for the short-term treatment of anxiety and insomnia (Baldwin et al., 2013). Tolerance and withdrawal effects can develop after only a few weeks of treatment (Lader, 2011). Adverse effects include sedation, impaired cognitive and psychomotor functioning, and increased likelihood of accidents and injuries (Lader, 2011; O'Brien, 2005). Withdrawal effects vary in severity and duration, and include anxiety, insomnia, depression, impaired memory, muscle spasms and tension, and rarely, seizures and

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psychosis (Lader, 2011). Combined benzodiazepine and opioid use is associated with increased sedation, decreased psychomotor performance (Lintzeris, Mitchell, Bond, Nestor, & Strang, 2007; Lintzeris & Nielsen, 2010), poorer psychosocial adjustment and general health, heightened risk-taking behaviour, and increased risk of overdose (Bird & Robertson, 2011). However, evidence is limited (Jones et al., 2012), and few studies have focused on the combined effects of opioid and benzodiazepine dependence on pregnancy or parenting (ACMD, 2003), despite evidence to suggest that both drugs are problematic in these contexts.

Whilst there is evidence that parental opioid use can compromise parenting capacity and pregnancy outcomes (ACMD, 2003), the health and wellbeing of children and families can also be negatively affected by social and structural factors such as poverty, poor housing, unemployment, parental stress, domestic violence and criminal justice involvement (Hepburn, 2004; Klee, Jackson, & Lewis, 2002). However research indicates that despite this complexity, there is a tendency among service users and service providers to focus on drug use alone (Banwell & Bammer, 2006; Chandler et al., 2013), and in most cases the primary drug of misuse (Winklbaur et al., 2008). While this focus may relate to concerns regarding the effects of specific drugs *per se* on parenting capacity and the immediate safety of children, it could also result in a limited view of drug dependence that neglects to consider polydrug use and the impact of socio-economic and structural inequalities.

While the use of opioids and OST is stigmatising, especially in the context of pregnancy and parenthood (Holland, Forrester, Williams, & Copello, 2013), use of benzodiazepines in the context of mothering has historically been characterised in a less problematic (though not entirely positive) manner (Metzl, 2003). We found no published literature which compared benzodiazepine and opioid dependence, from the perspective of parents, or expectant parents. Therefore the aim of our study was to address this gap in the evidence and to undertake a comparative thematic analysis of the ways in which parents accounted for their use of opioids, OST and benzodiazepines during and after pregnancy.

Methods

Study design and setting

This was a longitudinal, qualitative study involving 19 opioid-dependent service users over the course of approximately one year in order to examine changes over time in participants' experiences with healthcare services, drug use and parenting. Accounts were not treated as ''the truth'', but rather as a resource through which to explore how parenting and drug use are understood, negotiated and mutually constructed (Bury, 2001; Rhodes, Bernays, & Houmoller, 2010). The study was carried out in Scotland in an area with a mixed socio-economic profile, containing areas of significant deprivation. OST services for drug-dependent patients are delivered via primary care and specialist community-based substance misuse services. There are local guidelines both for the management of substance misuse in pregnancy (Whittaker, 2003), and parental substance use (ELBEG, 2013). Notably, a large number of patients in the area are prescribed benzodiazepines in addition to OST.

Recruitment, sample and data collection

Participants, recruited via healthcare practitioners, were interviewed at around 28–32 weeks gestation; 2–3 months postnatal; and 6–9 months postnatal. Inclusion criteria were opioid-dependence, being an expectant or recent parent, and >18 years. The sample included five fathers and fourteen mothers, aged 23–39. All were unemployed and white, reflecting the population of opioid-dependent adults in the study area. Five participants were first-time parents, fourteen other participants had between one and three children, aged 2–19. All were receiving OST at the first interview, primarily methadone, with a minority prescribed buprenorphine or dihydrocodeine. Eleven reported heroin use in the 12 months prior to the first interview and thirteen reported benzodiazepine use during the study period.[1] In five cases, diazepam was prescribed long-term alongside OST. This reflects the pattern of poly-drug use and prescribing practices in this geographical setting (Bird & Robertson, 2011). In total, 45 interviews were held with nineteen participants. Semi-structured interviews, lasting between 45–120 minutes, addressed participants' social background, drug use, experiences with parenting, and involvement with services.

Analysis

Interviews were recorded, transcribed, anonymised and allocated pseudonyms. NVivo 9 software was used to carry out content coding. This was supplemented by close reading of transcripts and thematic coding by authors AC and AW (Ritchie, Spencer, & O'Connor, 2003). The present paper is based on analysis of two content codes: benzodiazepine use and methadone practice. These codes contained all interview talk about either benzodiazepines or OST. Accounts were compared and contrasted and analytic themes were generated and agreed by the research team.

Ethics

The research was approved by the local NHS research ethics committee. Participants gave informed consent and were provided with a £20 voucher for each interview completed.

Findings

Benzodiazepine and opioid use for ''normality'' and ''normal'' life.

A common theme across parents' accounts of all drug use was that their substance use helped to support their attempts to engage in ''normal'' daily life, providing a better context in which to undertake parenting. Positive meanings were sometimes ascribed to OST which was portrayed as enabling parents to manage their opioid-dependence in a legal, safer and relatively more socially acceptable manner (Chandler

[1] ''In the study period'' refers both to reported drug use at interview, and the 12 months prior to the first interview.

et al., 2013). This was particularly the case for parents who had only recently ceased use of illicit opioids:

> [T]he only way to have a normal life [. . .] and keep a normal life to normality, to being able to live again is a methadone prescription. (Alison, 3 months postnatal)

However, parents' accounts more often emphasised the barriers and problems OST posed. Particularly in the post-natal period, the structures around OST prescribing (e.g. dispensing requirements) were highlighted as having a negative impact on parents' attempts to engage in a ''normal'' life or recovery-orientated activities such as training and employment:

> I'm no wanting to stay on daily supervised, especially to try and go back to work, to go back to college. (Laura, 9 months postnatal)

This was particularly the case for those participants who were required to have their use of OST ''supervised'' – where methadone was consumed in the pharmacy under the surveillance of the dispensing pharmacist (and any onlookers). Such practices were framed as especially problematic for parents:

> Sometimes when I see ones in the chemist wi' their weans [children] and I think they shouldn't be bringing their wean oot . . . they're standing waiting for their meth and I try and sit in a seat away fae them. (Melanie, antenatal)
> . . . when you're being on supervised and that, because at the chemist I'm at, they've no got a bit that's blocked off, so you're standing at [. . . the locality] swallowing your methadone in the middle of the shop flair. So you get folk looking at you [. . .] whether I've got [daughter] wi' me or no, so it's just, ''There's the junkie, look at her''. (Caitlin, 9 months postnatal)

Both Melanie and Caitlin's accounts highlight the role of stigma in shaping the experiences of parents in OST programmes. In contrast, accounts of benzodiazepine use and dependence tended to be framed more positively, and crucially without reference to stigma. Most participants described using benzodiazepines in constructive ways: treating anxiety states, mood enhancers, providing practical and emotional support for parenting, enabling them to engage in daily routines and household tasks, and ultimately providing a context in which ''normal'' parenting could occur. Carol, for instance, argued that her use of illicit diazepam was controlled, and helped her manage household chores.

> Yes, like that song, ''Mother's Little Helper'', that's what I like to think of it as, just sort of gets me going, puts me in a good mood. (Carol, 6 months postnatal)

Similar justifications for illicit use were given by two fathers in the study. Here, Paul's account refers to his (unsuccessful) attempts to acquire a prescription for benzodiazepines:

> I said to him [General Practitioner] I'm not taking them to get out of my face [intoxicated]. I said I just take the two at night to help me get to sleep. (Paul, antenatal)

Participant's explanations for their continued use of benzodiazepines often centred on the supposed functional benefits of the drug in helping parent's cope with day-to-day life. In contrast, accounts about OST were more likely to be framed around emphasising reduction and abstinence, narratives which were largely absent when it came to benzodiazepines. This is most evident in the accounts of parents who were dependent on both benzodiazepines and OST. In Nicola's final interview she reported that she was committed to reducing her methadone, contrasting starkly with her account of her benzodiazepine prescription:

> I'm fed up being stuck on something, where I wake up with my daughter, feeling like crap, and the first thing I dae is have to swallow medicine and have a cup of tea, to feel normal [. . .] Aye, I'm not ready for [reducing] diazepam. That's like mother's little helper [. . .] they help me, to want to get up in time to do stuff and everything. (Nicola, 10 months postnatal)

Divergent orientations towards methadone and benzodiazepine reduction were also discussed with Tricia. In earlier interviews, Tricia had rejected the idea of reducing any of her prescriptions, however, like Nicola, at 10 months postnatal she reported reducing her methadone, but not her benzodiazepine dosage:

> I feel like I'm still a junkie because I need this green liquid [methadone] every day, it's crap, but I mean I dinnae feel like that with my Valium [. . .] Aye I need to stay there [on the same dose of benzodiazepine] the now, I dinnae ken [don't know] I would get all nervous. I do need my Valium and if they said to me they were going to start cutting me I would panic [. . .] but they're not, they're just happy at me being stable just now. (Tricia, 10 months postnatal)

Rhetoric about stability, abstinence and dependence, therefore, were employed by participants differently according to the particular substance they were discussing.

Accounts of substance use during pregnancy were – for women especially – more similar. In the majority of cases, women indicated that they wanted to reduce their dosage of both OST *and* benzodiazepine. Each of these substances were framed as problematic during pregnancy, largely centring on potential harm to the unborn baby.

> I've forgotten the other one, stop smoking, come off that, like the Valium, and the methadone [. . .] and I said it would be a bit much for me doing all of that [. . .] but it's no too much for me coming down from the methadone and the Valium [. . .]. Because it's going to be helping the baby and me. (Iona, antenatal)

Women stressed a keen awareness that use of a range of substances might have negative effects on their babies. Those women dependent on multiple substances (the majority) described a careful balance of trying to stabilise or reduce one or more prescriptions, whilst avoiding relapse to illicit drug use.

Therapeutic qualities of benzodiazepine and opioid use

A clear contrast between parents' accounts of opioid and benzodiazepine use and dependence was that the latter were often framed as a legitimate method of managing anxiety, negative emotions and past trauma. As such, while women described reducing their benzodiazepine use during pregnancy, as with Nicola's account here, once the pregnancy ended, the need to reduce (based on perceived potential harm to the baby) also ceased.

> I've been on them maist of my life, and that's to stop paranoia, it's to stop me going ootside, and feel like everybody's looking at me, and agitated, anxiety, everything, so they know I'll no' be coming off them. I've already cut doon to ten milligrams, when I was pregnant, and nae mair, that's it. I'll sort the meth [OST], and then see aboot that [diazepam] in the later future. (Nicola, 10 months post-natal)

While Nicola reported recommencing her reduction of OST at 10 months postnatal, she maintained that she would not be doing the same with her benzodiazepine prescription.

Carrie described regular use of illicit benzodiazepines to manage anxiety states, and support her parenting. As with Tricia and Nicola above, she justified her use of benzodiazepines, and need for a prescription of benzodiazepines, on therapeutic grounds, whilst simultaneously affirming a desire to reduce her methadone prescription:

> I've been taking valium, but like the drug worker says, instead of getting it fae the streets, 'cos you don't know what's in it, she's going to give me a prescription [. . .] So I'm not sitting all thingy [pulls agitated face] around the kids and stuff. Just to calm me doon a bit, 'cos I'm a bit, still a bit, like anxious I think that's the word. But I'm down to 19ml [methadone] noo, so I've been coming doon a ml a week. (Carrie, 4 months postnatal)

When participants described benzodiazepine use as therapeutic, their accounts framed this as reasonable, responsible and more importantly, acceptable. Carrie emphasises that she was seeking, and expected to be given, a prescription for benzodiazepine, indicating that her dependence was validated by healthcare staff. Another participant, Michael, maintained that the illicit benzodiazepines he bought were obtained from a reputable source and were trustworthy in terms of pharmaceutical content. These narratives supported participants' arguments that their benzodiazepine use, whether illicit or prescribed, was ''controlled'' and unproblematic. Thus, participants constructed benzodiazepine use and dependence as a ''legitimate'' means to help them regulate problem emotional states which might otherwise interfere with their ability to live a ''normal'' life and effectively parent their children.

Benzodiazepines: mothers little helper; father's ruin?

Benzodiazepine use and dependence for women was frequently normalised: women described using prescribed and illicit benzodiazepines to manage anxiety, perform household chores or regulate sleep patterns. In contrast, while men in the study described using benzodiazepines for similar reasons, their accounts indicated that this was seen as problematic. One participant framed this as explicitly related to gender:

> I've got all these people, telling me what's right, and what's wrong, and I take Valium now and again, so, therefore, I'm not a good parent. How many bloody mothers oot there, do you ken that take Valium? Does that stop them from being good parents [. . .]? Where's their just cause [. . .]? Where's the argument, like, because I chose to be on Valium when I was young, he must be f***ed up. To me, I would like to think I'm reasonably intelligent. But, fae their angle, I'm no', they must think I'm a total madman, which I'm no'. (Stuart, 8 months postnatal)

Stuart alludes to the existence of gendered stereotypes about benzodiazepine dependence suggesting that use among women and mothers is accepted, but that among men and fathers is seen as dangerous or evidence of severe personality dysfunction. While the other men in the study did not make this gendered link explicit, the four male participants who reported illicit use of benzodiazepines provided similar accounts in other ways. All asserted the therapeutic benefits of benzodiazepines, described unsuccessful attempts to acquire prescriptions and subsequently affirmed a desire – or need – to cease their illicit use of benzodiazepines. While it is impossible to say based on this limited sample, these accounts allude to the existence of gendered patterns of prescribing, with healthcare practitioners seeming more ready to legitimise women's use of, and dependence on, benzodiazepines.

Benzodiazepine use among men was also portrayed as problematic by three women in the study who described illicit use of benzodiazepines by their partners. One participant suggested that her partner's benzodiazepine use was associated with aggression and domestic abuse, while the others clearly indicated that benzodiazepine use for their partners was more concerning than their use of other substances, particularly when combined with alcohol. This parallels findings of another study with young offenders (Forsyth, Khan, & Mckinlay, 2011).

> What I'm doing, I'm just pottering about the house quite happy, tidying up, sorting things out, and they [benzodiazepines] make me feel happy, and I go to the shops and chat away to people, and it gives me a bit more confidence, but with him they make him angry, like I don't know, it's weird. (Carol, 9 months postnatal)

In contrast, while women occasionally noted adverse effects of benzodiazepine use, this was generally focused on pregnancy and risks to the unborn baby. The potential harms associated with benzodiazepine use, including the potential for cognitive impairment and acute withdrawal symptoms, appeared little understood or acknowledged in most participant accounts. This contrasted starkly with accounts of the negative effects of opioid dependence.

Discussion

This longitudinal qualitative study explored accounts of poly-drug use within the context of pregnancy and parenting, highlighting differential understandings and practices surrounding benzodiazepine and opioid use. Our findings illuminate a number of issues with implications for theory, policy, prevention and education.

The accounts in our study resonate with others (Klee, 1998; Radcliffe, 2011) in demonstrating the morally difficult nature of being a ''drug-using parent'', and the extent to which stigma can play an important role in the day-to-day lives of parents. Our findings suggest that while drug use, in general, is seen as incompatible with parenting, there are clear indications that some drugs, and types of ''addiction'', are more ''acceptable'' than others. Crucially, our analysis indicates important differences in the way opioid and benzodiazepine use are understood and narrated within the context of parenthood.

Unlike benzodiazepine use, participants in this study often described OST in negative terms – even when they acknowledged that OST was helpful in treating opioid dependence. This dominant negative discourse on OST by drug users themselves, has been described elsewhere (Harris & McElrath, 2012; Lloyd, 2013; Radcliffe & Stevens, 2008), and highlights the unique stigma attached to OST for the treatment of opioid dependence (Keane, 2013). In contrast, benzodiazepine use was consistently portrayed as more socially acceptable. Participants described using benzodiazepines in constructive ways – to enhance social and emotional functioning and engagement in ''normal life'' – appealing to a ''self-medicating hypothesis'' of addiction to explain and justify continued use (Jones, et al., 2012). These meanings served to legitimise benzodiazepine dependence, contrasting sharply with participants' alignment of OST with ''addict'' or ''junkie'' identities, as documented elsewhere (Keane, 2013; Radcliffe & Stevens, 2008).

In the context of parenthood, this was portrayed as particularly important. Accounts of drug treatment engagement and desire for abstinence, reduction or ''stability'', differed significantly according to the type of substance being described. Parents were more likely to describe a desire to reduce opioid rather than benzodiazepine use, and there was evidence that illicit benzodiazepine use was considered less harmful than opioid use. This is noteworthy, because alongside this complacency were occasional notes of concern, particularly in relation to benzodiazepine use by men, and its link with increased aggression and domestic abuse (reported by some women participants). Accounts from this study provide a tentative indication of the way gender may shape understandings of benzodiazepine use. The long-term use of benzodiazepines by mothers was framed as being therapeutic and unproblematic. In contrast, while men reported using benzodiazepine for similar reasons, their accounts indicated that practitioners did not legitimise this and prescriptions were denied.

These findings sit uneasily with the dominant ''recovery'' agenda in UK drug policy (Valentine & Treloar, 2013; Wardle, 2012), where abstinence from all drug use is assumed to be both desirable and necessary for ''social reintegration''. It may be that in practice ''recovery'' refers to particular categories of drugs, with the hierarchy of acceptability identified among service users in this study being apparently mirrored in prescribing practices and approaches taken to treating addiction by clinicians (Anthierens, Habraken, Petrovic, & Christiaens, 2007). Thus, while opioid-dependent individuals may express a desire to reduce their opioid prescriptions, this is not necessarily reflected in their orientation towards other drug use, particularly benzodiazepines. As such, the claim that opioid-dependent individuals would prefer abstinence-based treatment approaches may result from the unique stigma attached to opioids and may not apply to all drug use, or all drugs of dependence (Lloyd, 2013; McKeganey, Morris, Neale, & Robertson, 2004; Neale, Nettleton, & Pickering, 2011).

Our findings suggest a need for further preventative measures and targeted education to address benzodiazepine use and dependence within the context of pregnancy and parenting, especially in populations of parents engaged in OST programmes where ''stability'' on opioids may detract from issues associated with benzodiazepine use and dependence. Reviews of benzodiazepine prescribing (Sirdifield et al., 2013), identify a variety of reasons for inconsistent practice, and conclude that improved education and training, provision of non-pharmacological interventions, and enhanced communication with patients is required. Our findings support these recommendations, especially the need for enhanced education and training of both clinicians and patients, and extra provision of non-pharmacological interventions to promote the psychological and social functioning of parents on OST.

Limitations

This was an in-depth, qualitative exploration of the accounts of nineteen drug-dependent parents on OST in a specific geographical area. As such, our findings and conclusions should be read as indicative and suggestive rather than definitive. Further qualitative exploration in different geographical areas and populations is needed, as it is likely that local or cultural contexts may shape the types of narratives expressed in respect of the range of substances consumed. Our findings may have limited applicability to opioid dependent parents who are not engaged in OST programmes. However, the contrasting accounts depicted here underline the importance of qualitative research in illuminating understandings about the meanings that drugs of addiction have for those who use them (Neale, Allen, & Coombes, 2005).

Conclusion

Although long-term benzodiazepine use and dependence among opioid-dependent populations has been a topic of concern for some decades (WHO, 1996) and is associated with increased risks and harm (Lader, 2011, 2014), research regarding the impact on pregnancy, parenting and family life has been limited (ACMD, 2003). Our findings suggest that parents frame benzodiazepine use and dependence as largely unproblematic, less stigmatising and more legitimate than OST. We suggest these divergent accounts can be understood as drawing on differing cultural meanings attached to OST and benzodiazepine use, which are reflected in policy

and practice. As such, prevention, education and policy initiatives should pay greater attention to the kind of narratives and strategies that are employed in addressing benzodiazepine use and dependence within opioid dependent populations, especially in respect of the parenting and child welfare agenda.

Declaration of interest

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of this article.

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