Social Science & Medicine 339 (2023) 116358

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

From prescribing dilemma to knowledge in practice: The ontological politics of benzodiazepines and Z-drugs

Melissa Ceuterick [a,*], Pauline Van Ngoc [b], Piet Bracke [a], Beatrice Scholtes [b]

[a] Hedera, Department of Sociology, Faculty of Political and Social Sciences, Ghent University, Ghent, Belgium
[b] Research Unit of Primary Care and Health, Department of General Medicine, Faculty of Medicine, University of Liège, Liège, Belgium

ARTICLE INFO

Handling Editor: Medical Sociology Office

Keywords:
Benzodiazepines/BZRA
Positioning theory
Prescribing dilemma
Mindlines
Ontological politics

ABSTRACT

The discrepancy between official guidelines and clinical practice is hardly more pronounced than in the case of benzodiazepines and Z-drugs, also known as benzodiazepine receptor agonists (BZRA). Using social-constructionist positioning theory, we unravel how health care professionals deal with the dilemma of prescribing this medication. Our results reveal a prescribing spectrum that is discursively organised around four different storylines used by professionals. The storylines are organised along three axes that are related to a) prescribers' opinions on prescribing and the negotiation of the related risks, b) the power dynamics between provider and patient in the prescribing process and c) the rhetorical use of arguments. The discerned storylines allow us to explore the emotional and moral side of prescribing and demarcate clinical mindlines -internalised tacit guidelines-that professionals adhere to when they prescribe. By relying on Annemarie Mol's conceptualisation of ontological politics, we explain how these storylines enact multiple versions of this class of medication and justify seemingly contradictory prescribing practices.

1. Introduction

1.1. The double-bind of benzodiazepines

'We find ourselves at times trying to withdraw an individual from a drug we recently prescribed.' This quote could be interpreted as a reflection on the challenges faced by contemporary prescribers of psychotropics. However, it was Freedman (1972: 411) who was among the first to highlight the dilemma of potential iatrogenic effects caused by prescribing psychotropic medications. Interestingly, this observation came not long after the introduction of benzodiazepines, which were initially considered less harmful than the preceding barbiturates. Benzodiazepine receptor agonists -hereafter referred to as BZRA- are a class of psychoactive medications with anxiolytic, sedative, hypnotic, anticonvulsant and muscle-relaxing effects, most often prescribed as sleeping aids and tranquillisers. Already in 1961 Hollister and colleagues reported on withdrawal reactions from chlordiazepoxide or Librium® for people who suddenly withdrew from high dosages (Hollister et al., 1961). Yet few subsequent cases of dependence were reported until the 1980s. And it was not until 1991 that the American Psychiatric Association formally acknowledged the risk of dependence associated with BZRA (Salzman, 1991). Currently, official guidelines generally only recommend short-term prescribing for acute insomnia and severe anxiety as an alternative for non-pharmacological treatment and SSRI's (see Table 1). Although the immediate effect generally produces desirable outcomes for the patient, use that exceeds two to four weeks is not recommended due to adverse effects such as tolerance, physiological and psychological dependence and rebound symptoms following attempts to withdraw, even when used in low and constant doses (Liebrenz et al., 2015; Soyka, 2017; Heberlein et al., 2008). Eventually, long-term effects of habitual BZRA use are subtle and sometimes difficult to differentiate from original symptoms. Overall, BZRA have a high potential for both *abuse* -or nonmedical use without prescription, usually for the pleasant effect it can provoke- and *misuse* or use that does not follow medical instructions or in a way other than prescribed (Al-Worafi, 2020), especially among younger adults (Maust et al., 2019). Thus, once treatment exceeds the recommended duration of two to four weeks, the risk-benefit ratio of prescribing BZRA is contested (Dell'Osso and Lader, 2013; but see also: Baldwin et al., 2013, 2014 for a different standpoint). Nonetheless, long-term habitual use is common worldwide and seems to have increased since the COVID-19 pandemic (Sarangi et al., 2021). In general, prescribing practices thus do not reflect common guidelines

* Corresponding author.
E-mail address: melissa.ceuterick@ugent.be (M. Ceuterick).

https://doi.org/10.1016/j.socscimed.2023.116358
Received 30 May 2023; Received in revised form 17 October 2023; Accepted 24 October 2023
Available online 3 November 2023

Table 1
Overview of guidelines in Belgium.

Organisation	Recommendation *insomnia*	Recommendation *anxiety*
BCFI-CBIP	- 3rd option after non-pharmacological treatments	- 2nd option (after CBT), or in acute situation combined with CBT
	- Medium-acting BZRA	- Long-acting BZRA
	- Maximum one week	- Maximum a few weeks
VAD	- Maximum one week	- Acute anxiety: two to four weeks
Domus Medica	- Last resort - Medium acting BZRA - Lowest possible dose - Maximum one week	
FOD	- Maximum one week	- Only for exceptional acute crises
	- After one week: reduced efficacy, tolerance and possibility of physical and psychological dependence already after two weeks	- After one week: reduced efficacy, tolerance and possibility of physical and psychological dependence already after two weeks.
EBP Practice net	- Not recommended as first option Maximum one week	- Can be used in the initial stages
	- Medium-acting BZRA	- Attempt to discontinue after 4–6 weeks
	- Lowest possible dose	

(Sim et al., 2007). Belgium is no exception to this trend. Internationally, the country stands out as one of the prominent examples of over-consumption and -prescription of BZRA (Gisle et al., 2020). Data from the latest Health Survey indicate that 12% of Belgians currently use at least one BZRA, with an estimated one in three of those users becoming chronic consumers (Christiaens et al., 2018; Van der Heyden et al., 2020). Despite consecutive prevention campaigns, and an amalgam of guidelines (see Table 1) prescription rates have not dropped over the past decade (Coteur et al., 2022). Clearly, BZRA usage is both substantial and persistent in Belgium. A rare study focussing onthe northern part of Belgium, by Anthierens et al. (2007) revealed that Flemish general practitioners (GPs) do not necessarily perceive the addictive nature of BZRA as a major concern with first-time users. However, to the best of our knowledge, in the Belgian setting, no studies have focussed on GPs working in the southern Walloon region nor on other health care providers' perceptions of prescribing.

1.2. The sociology of prescribing

Within health sociology and anthropology, prescribing is seen as a symbolic and social act that is formed by both the meaning attributed to the performance of prescribing and the substance that is being prescribed; not only by the patients but also by the prescriber (Van der Geest et al., 1996). As such prescribing is value-laden as it is embedded in a complex matrix of social and institutional values. According to Whyte et al. (2012: 117) prescribing is 'speaking without words, through medicines' or a way of communicating meaning. This interpretation of prescribing practices stipulates that prescribing is a way to deal with the unavoidable clinical uncertainty around anamnesis, diagnosis and treatment, impeded by the subjectivity of an illness experience that has to be communicated in a strictly limited timeframe. In all its concreteness, a prescription bypasses the abstractness of the unanswered questions of the patient (Van der Geest et al., 1996), which applies particularly to the underlying suffering related to insomnia and anxiety (Pilgrim et al., 2011). Hence, a prescription is also a token of concern for and a legitimation of the patient's suffering (Gabe and Lipshitz-Phillips, 1984). Moreover, a prescription is often expected and even explicitly demanded by patients and acts as a closing ritual of a medical consultation (Schwartz et al., 1989). A prescription therefore objectifies both the patient's request for help and the professional's medical diagnosis. The issuing of a prescription -written or electronic-is thus also seen as one of the most visual symbols of a prescriber's knowledge and experience and an essential act of asserting medical authority (Parish, 1974; Whyte et al., 2002; Stevenson et al., 2002; Britten et al., 2004; Rogers et al., 2007; Weiss, 2021).

BZRA in particular, are situated in an 'emotive and controversial area of prescribing, (…) in which the actions and professional norms (…) have been implicated in creating and maintaining a form of clinical iatrogenesis' (Rogers et al., 2007: 182) in the form of 'iatrogenic addiction' (Musto, 1985) and 'iatrogenic sedative dependence' (Lader, 1998). A cross-national meta-synthesis of eight qualitative studies on BZRA prescribing, showed how prescribing decisions are typically seen as uncomfortable, complex and demanding (Sirdifield et al., 2013), rhetorically illustrated in the use of terms like 'the lesser - or necessary evil' (Anthierens et al., 2007; Haw and Stubbs, 2007). This tension between the risk of iatrogenesis and the short-term advantages, creates the so-called 'prescribing dilemma' of BZRA (Sim et al., 2007).

Following Gabe (1990) we argue that the role of BZRA in clinical practice and the question and decision to prescribe or not, can only be fully understood, if one starts with the range of beliefs, experiences and expectations of prescribers in different settings. We thereby aim to contribute to the sociology of prescribing -the field of study that looks into the different social factors that shape prescribing practices-by a) exploring how prescribers in different settings make sense of their prescribing of BZRA and b) how they negotiate the existing guidelines and the ambivalence surrounding potential iatrogenic effects thereof. In this article, we thus aim to find out how prescribers manage the idealised position of the 'non-prescribing' or 'limited term prescriber', apparent from official guidelines, while navigating the pressures and demands of everyday practice. To understand this, we take on a social-constructionist perspective, as this allows us to understand the underlying mechanisms, meanings and value-laden aspects of prescribing that drive prescribers' practices. More specifically, we use positioning theory as both a theoretical premise and a methodological tool to explore how Belgian prescribers deal with the paradoxes of prescribing potentially harmful medications like BZRA.

1.3. Positioning theory

First developed by social psychologists Davies and Harré (1990) to study microlevel identity work in interactional contexts, positioning theory provides a structure for discourse analysis. This social constructionist theory is based on the premises that firstly, people -including professionals- are socialised in different narrative models and discursive skills that form a cultural canon that is available to them to use as they speak (Slocum-Bradley, 2010), and secondly, that through talk and text, individuals position themselves and others -people or topics- both deliberately and unintentionally, or sometimes even compelled by others as is the case in interviews. In the act of positioning, social roles and their adjacent explicit and implicit rights and duties are assumed or rejected. Discursive positioning thus always occurs in reference to existing professional, ideological and cultural discourses. Furthermore, positioning theorists postulate that positioning is related to the obligation to perform in accordance with certain social expectations regarding a specific social or professional role. For example health care professionals are generally expected to follow official guidelines. When these social expectations are not met, speakers may provide an account to explain the inability to act according to those expectations. Unlike roles however, positions are not fixed, but rather fluid, overlapping and sometimes ephemeral (Baert et al., 2019).

The toolkit of positioning theory contains three core building blocks: i.e. storylines, subject positions and speech acts. The latter simply refer to different forms of speech like interviews, conversations, written text and so forth. Storylines are the available interpretative repertoires that people draw on, resist or renegotiate to make sense of themselves and their actions. Storylines are used to assume a specific subject position, i.e. how the speaker wants to be seen by others, and the perspective from which (s/)he sees the world (Ceuterick and Vandebroek, 2017). A

subject position is thus created when people use language to negotiate positions for themselves (Harré et al., 2009; Davies and Harré, 1990). A position has also been called a cluster of rights and duties, typically recognised in a specific social setting (Green et al., 2020). Speakers can be either positioned by available conceptual repertoires or discourses, or newly created ones, throughout the interaction (Saini, 2022). The concepts of storylines and positions should thus not be seen as fixed templates or rules that should always be followed as if one is ordered to do so, but rather evolve through interaction. However, like books on a shelf in a library, discursive possibilities are not endless, and different storylines capture the range within which things can be said and accomplished in a given setting.

Positioning theory is especially useful to gain a deeper understanding of how health care professionals make sense of the complex issues of BZRA prescribing. The aim of this paper is thus to unravel how prescribers manage the so-called prescribing dilemma. More specifically, drawing on positioning theory, we will answer the following research questions:

- How do prescribers perceive and position the role of BZRA in clinical practice?
- What storylines do they construct to motivate this?
- How do they position both themselves as prescribers and their patients in this process?

2. Methodology

2.1. Data collection

We conducted 15 interviews with professional prescribers working in Belgium (see Table 2). A purposive sample was designed to obtain a broad range of professional prescribers working in different settings (primary, mental health and addiction care). The sample contained a balance of professional experience (ranging from five to 30 years) and gender (eight female and seven male). A topic guide was drafted, reviewed extensively by the project's multidisciplinary follow-up committee and piloted. Interviews were conducted between July and December 2021 by the first (MC) and second author (PVN), respectively in Dutch and French. In addition, one interview in Dutch was conducted by a volunteer at the research group. To ensure interviews were conducted in a uniform way, the team discussed the process iteratively and extensively during the interview phase. Interviews were conducted at the interviewees' workplace (n = 10) or by video conference (n = 5) (due to ongoing sanitary restrictions) and lasted between 32 and 126 min (Av. 74′). All interviews were audio recorded after obtaining full written consent from interviewees and transcribed verbatim in the original language.

2.2. Data analysis

The analysis of the interviews started with a round of open coding of relevant fragments related to prescribing and the role of BZRA in clinical practice in general. Subsequently, the transcripts were coded using the different analytical devices of positioning theory (i.e. storylines and subject positions, as described above). To identify these storylines and positions, interviews were scrutinized in the original language for both content (argumentations) and recurrent linguistic devices and vocabulary such as contrasts, repetitions of words, metaphors, analogies and other remarkable schematic representations and coded accordingly. All researchers validated the intermediate coding results in an iterative process until analytical consensus was reached. In the final stage, the most illustrative excerpts were translated into English.

Table 2
Overview of interviewees.

Professional background	Flanders	Wallonia - Brussels
General practitioners (addiction medicine)	5	2
General practitioners (primary care)	2	2
Psychiatrists	2	2
Total	9	6
	15	

3. Results

3.1. Demarcation lines

In our dataset we identify four different storylines that are used by professionals to discursively deal with the described BZRA prescribing dilemma. These storylines have their own specific argumentation, rhetoric devices and vocabulary (see Fig. 1) organised along three different axes that are related to: a) the viewpoint on prescribing and the negotiation of the related risks (from none at all to restricted to liberal prescribing), b) the power dynamics between provider and patient in the prescribing process (i.e. provider-led or patient-led) and c) the overarching rhetorical use of logos (i.e. rational appeal) or pathos (emotional appeal).

3.2. Storyline 1: 'no prescribing'

We name the first storyline 'no prescribing', since this storyline was used to strongly oppose any prescribing of BZRA, built on a rational argumentation around the risks of prescribing. The bottom-line here is that inducing an addiction, must be avoided at all times, as illustrated in the following quotes.

> *"It's not just the Hippocratic oath in short, but first of all do no harm. This is clearly a problem that can be induced by me. And so, I feel an additional responsibility not to bring it up and therefore to fight it, it's kind of the responsibility of each doctor. (…) What also motivates me is a personal propensity to be anti-addiction."* GP, community health centre

> *"Prevent them from becoming addicted, and if they are, then try to get them off."* GP, ambulant addiction care

This storyline is characterised by metaphors that equate BZRA with hard drugs and underlines that BZRA are not medications, as we see in the following quotes:

> *"After all it is a drug that is prescribed."* GP, private group practice

> *"There is a lot of comorbidity. But that does not mean they should have benzos, right? There is other medication. Some get antidepressants, mood stabilizers. But no benzos. Benzo's are not medicines."* Psychiatrist, residential addiction care

Other recurring vocabulary in this storyline includes the verb 'to refuse', used in the active voice, first person. The verb 'to prescribe' on the other hand is usually used in the third person to distance oneself from the act.

> *"It is being prescribed too much."* Psychiatrist, residential addiction care

Overall, this storyline does not contain any mitigating circumstances that justify the use or prescription of BZRA. Comorbidity, as illustrated above, is not considered an exception to that rule. Furthermore, in this storyline, no clear differentiation is made between dependence and addiction. An argument used to motivate this stance, includes the idea that BZRA act on the same receptors as other addictive substances such as alcohol. This equation, also leads to empathy for the difficulties to quit, as shown in the following quote. Here the interviewee makes use of both a comparison and category (expert patients) entitlement for discursive fact construction, which also indicates the tendency in this storyline to rely on rational argumentations.

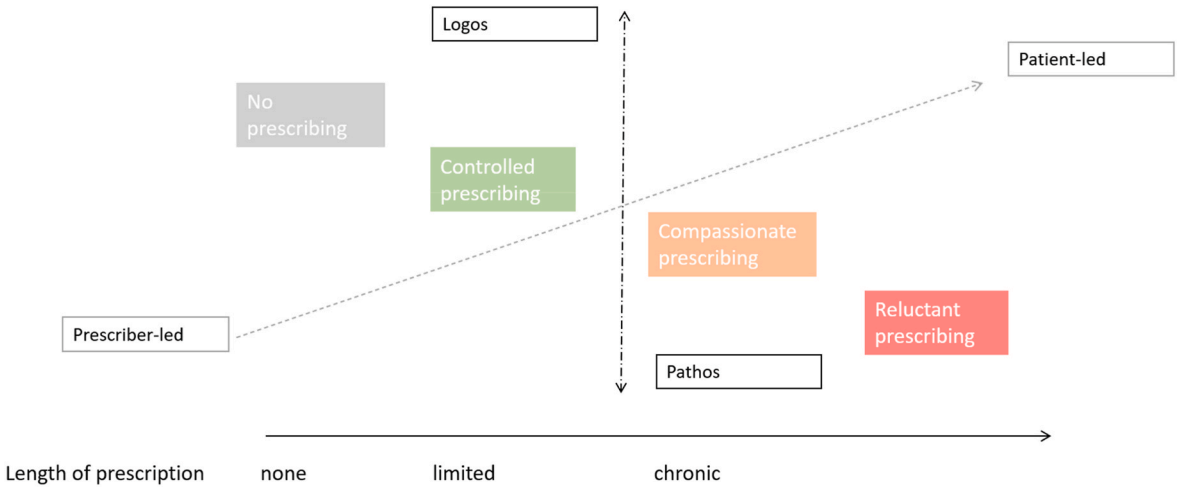

Fig. 1. Overview of different storylines along different demarcations.

"Patients (…) who were on both, say that it is indeed harder to get off pills than [to get off] *alcohol."* Psychiatrist, residential addiction care

As a result, patients who do use BZRA are positioned as being 'addicted' to medication and should be put on a complete tapering schedule (limited in time). Subsequently, when the patient signals that a tapering schedule goes too fast, this is interpreted as negotiation and a sign of addictive behaviour. As such, patients are not framed as equal partners in a process of shared-decision making, if they wish to get a prescription for a BZRA, but rather as passive recipients who must accept the conditions for care:

"They can't choose to take benzos again of course. They can't do that." GP, private practice and residential addiction care

This 'no prescribing' storyline leads to a self-positioning of the speaker as a firm but fair and responsible practitioner who does no harm and helps to withdraw or who protects patients from the perceived harm of BZRA and sometimes from themselves. Despite their firm refusal to prescribe (also illustrated in the literal use of the verb 'to refuse'), non-prescribers self-position as being empathic and protective of their patients, as illustrated below:

"I think I'm quite driven to get rid of them [BZRA]*, in that sense I may be a flag bearer after all, perhaps a little too much; meaning that sometimes I would be a bit too strict (…)* [but] *I am empathetic … I protect them* [patients]*."* GP, ambulant addiction care

This storyline is mostly used by health professionals in addiction care, and to a lesser extent also in primary care. In many addiction care facilities total abstinence is part of the overall treatment goal and a necessary requirement for patients to access continued care. So when professionals use this storyline, they implicitly defend their institution's policy or their own professional position and credibility. This position also leads to distancing from peers who maintain different prescribing policies. By comparing themselves to others, they implicitly defend their own stance, as illustrated in the following quote:

"No one leaves here with benzos. (Interviewer: Is it another story in the other wards?) I don't decide that, do I? (…) There is one doctor per department. And, of course, he has his own therapeutic freedom …" Psychiatrist, residential addiction care

3.3. Storyline 2: 'controlled prescribing'

In the second storyline, prescribing is presented as legitimate, but only under strict conditions, hence the name 'controlled prescribing'. By limiting the instances in which they do tend to prescribe, adherents to this storyline, underline the exceptionality of prescribing. A common argument in this storyline, is that of 'medical indication' or 'selective prescription', that limits the options to prescribe. These exceptions include the following indications: drug substitution (e.g. alcohol), schizophrenia, acute panic attacks or psychosis, anxiety, muscle relaxant and sporadic instrumental use (e.g. for long flights, for switching night shifts). Overall, prescribing -either a first prescription or prolonging a prescription-is framed as a conscious and well-balanced choice. This does not mean that the risks are ignored, yet to the contrary, in this storyline, different discursive devices minimise those risks. An argument that is used to discursively balance the negative effects of BZRA is that of 'controlled and stable use', without dose increase, under (strict) medical supervision. This approach is preferred over an uncontrolled, increasing use, without medical supervision. Hence recurring vocabulary in this storyline relates to that control (see Table 3).

"People who depend on benzos only get prescriptions from a regular doctor and at certain times, so it is clearly stated in the patient file, the next prescription can only be given then (…) If we are in a fixed trajectory, with the pharmacy, there are often agreements, for example, that the patient can go and get a few pills every week." GP, community health centre

"Small doses, frequent controls, under supervision." GP, private practice and residential psychiatric care

In this storyline patients with a long-term prescription, are positioned as 'dependent' on BZRA and showing 'symptoms of tolerance'. Yet this degree of dependence is tolerated and presented as a suitable option as long as patients remain 'on track' and do not indicate that their use has become 'derailed'. However, when signs of addiction appear, then deprescription is advisable. Unlike in the first (no prescription) storyline, a clear distinction is made between dependence and addiction. This differentiation also seems to be maintained to negotiate one's responsibility in causing harm as a prescriber. It is accepted that BZRA can cause dependence, while addiction in the form of misuse or abuse by the patient should be kept under control. Dependence is thus presented as some sort of acceptable collateral damage, to be taken into account when considering offering a prescription.

"People who only take one benzo, perhaps for years, do not actually have an addiction problem in itself. (…) Dependence means if you were to take the drug away, they would have withdrawal symptoms or that they are very anxious to let it go. And an addiction problem is actually that you need it just to be able to function, that you do everything to get it (…) And most importantly, that your behaviour changes and also, your way of

Table 3
Summary of storylines and resulting positions.

Storylines	Core elements	Linguistic features	Subject positions
No prescribing	Emphasis on not prescribing at all Reason for not prescribing: BZRA use equals addiction	Vocabulary: 'drug', 'abstinence', 'zero tolerance', 'anti-addiction', 'to refuse' (active voice) <> 'to prescribe' (passive voice)	Firm non-prescriber Explicit juxtaposition to prescribers in general Passive, vulnerable patient
Controlled prescribing	Emphasis on minimising the risks of prescription (prevent dependence from becoming addiction) Reason for prescribing: (bio) medical, clinical indication	Vocabulary: 'under control', 'controlled', 'not derailing', 'on track', 'rational use', 'acceptable dose', 'exceptional', 'indication' Limitations (of dose, of length of prescription, of who can prescribe, …) 'a few', 'small dose', …	Conscious, responsible prescriber Explicit juxtaposition to 'frequent, liberal prescribers' Empowered, 'compliant' patient, 'responsible user'
Compassionate prescribing	Emphasis on, reducing suffering and maximalisation of patients' quality of life Reason for prescribing: biopsychosocial model	Vocabulary: 'comfort', 'helps', 'quality of life', 'supporting medication', 'maintenance treatment' BZRA are positioned as a 'mist', 'veil', 'shield', 'protection' 'To support the patients with medicines' (active voice) Trade-offs: 'the lesser evil', 'if no complaints', compared to risks of withdrawal, 'no tolerance on anxiety reducing effect', 'not toxic' Refuting rigidity of abstinence	Pragmatic, empathetic prescriber, with a duty to care (i.e. reduce suffering), explicit juxtaposition to prescribers who are 'too strict' 'Deserving patient', suffering patient Patient as equal partner, concordance is crucial
Reluctant prescribing	Emphasis is on reluctance to prescribe and internal struggle and disillusion Reason for prescribing: 'tricked into prescribing' (pathos) by patient who are 'unconsciously addicted'	Vocabulary: 'shopping', 'to supply', 'negotiation', 'trapped', 'tricked', 'having enough', 'to please patients', 'pressure', 'force', 'to have to' (obligation), metaphor 'dealers'	Duped prescriber Forcing patient

feeling emotions and all that changes." Psychiatrist, residential addiction care

"Dependence, yes, dependence where you keep it [consumption] within boundaries, is still different from dependence that keeps on increasing, where you move to abuse or addiction." GP private practice and residential addiction care

"By going along with the benzo story, we have that really addictive behaviour better under control." GP, ambulant addiction care

The resulting self-position of professionals who adhere to this storyline is that of a correct professional and self-aware, agentic prescriber, or a rational prescriber, who limits addiction and tries to stay close to the official guidelines. Empowered by this supervision and guidance, patients are positioned accordingly as 'compliant' or 'responsible users'. Patients are thus assigned a more active position than in the first, 'no prescribing storyline'.

Furthermore, prescribers who adhere to this storyline also distance themselves sometimes explicitly from more liberal prescribers:

"Doctors who are socially incapable and who really need patients … that is what I have already heard from patients." Psychiatrist, private practice and ambulant addiction care

"Performance medicine, eh, if someone is dependent, they keep coming, eh. So that's a win-win situation. That's very harshly said, isn't it? I don't believe all GPs want their patients to be dependent, absolutely not. There is already a huge change in providing quality healthcare or providing evidence-based healthcare. But I still think that it's in there unconsciously, because of the privatisation." GP, community health centre

In Belgium GPs can be financed on a fee for service basis, meaning that a patient pays a fee each time they see the GP, or by capitation fee, whereby the GP receives a lump sum per patient per month directly from the health insurance. The interviewee in the last quote is referring to and criticising unintended outcomes of the former system.

3.4. Storyline 3: 'compassionate prescribing'

In this storyline, BZRA are framed as useful means of 'support' that increase the patient's comfort.

"Then they already have part of the day that they don't have to sit in fear and tension all the time, which also increases their comfort somewhat." Psychiatrist, private practice and ambulant addiction care

"Removes a lot of the burdens from the people." GP, ambulant addiction care

"Maintenance benzos is a full-fledged therapeutic option." GP, ambulant addiction care

In this storyline the focus lies less on limiting a prescription in time. Consequently, this storyline includes statements such as *'I don't believe in abstinence'* or *'abstinence is a waste of time'*. Unlike in the controlled prescribing storyline, the harm potentially caused by long-term prescribing is minimized. Possible negative effects are renegotiated, as illustrated in the following quotes. In the first quote, the comparison of tolerance of the anxiety reducing effects of BZRA to tolerance of the hypnotic effect, implies that anxiety is an indication for a long-term prescription (compared to insomnia) and minimises the risks of prescribing. In the second quote, the dependence forming properties are more explicitly questioned, while also retreating briefly to the controlled prescription storyline.

"Yes, substance-related disorder (…) severe mild or moderate disorder in the use of BZRA in this case (…) but actually [with this definition], we are selling short a group of people who take BZRA chronically on indication (…) There are indeed indications for long-term BZRA use, and those are for example anxiety, because for anxiety it has been proven the least of all that there is a tolerance, to the anxiolytic effect, quite contrary to [tolerance to] the hypnotic effect." GP, ambulant addiction care

"Dependent, I would hardly even dare to use that word. If people can maintain themselves and someone who is recovered in as far that that person can work, has a relationship, a stable household situation, and if he stays on a very light dose, under guidance, I find that already a very,

very nice recovery." GP, private practice and residential addiction and psychiatric care

When acknowledged, the potential harm of prescribing BZRA is presented as a trade-off:

"It can be discussed, but I believe that it is better to have a little dependence than to be completely weaned. For certain personalities." Psychiatrist, ambulant and residential addiction care

"If your really can't get people out, then that harm reduction is better. So, that is sometimes so difficult, such a difficult choice, to choose for the lesser evil. That is what I mean by not always demonising." Psychiatrist, private practices and ambulant addiction care

"Abrupt withdrawal is more dangerous [than prescribing longer than recommended]" GP, private practice and residential addiction and psychiatric care

"*It is a good thing that benzos are not very toxic. They destroy very little in the body. In that sense it's sometimes better for people to take benzos for life than to drink for life.*" GP, ambulant addiction care

Furthermore, divergence from the guidelines is motivated mainly by the fact that patients should be helped. The implicit norm here is that the psychosocial situation of the patient has to be taken into full consideration when prescribing. Reducing the suffering of the patient is put forward as the decisive element when prescribing. The emerging subject position is that of an empathic prescriber who diverges from the guidelines in the best interest of the patient, to 'support' the patient, while the patient is positioned more as an equal partner in striving for concordance.

"How can we improve your comfort? (…) you provide an answer to the client's demand." GP, private practice and residential addiction and psychiatric care

"Yes, sometimes someone has to bypass the guidelines, the information leaflets, to get closer to the patient, right? Eh, although still, you have to be able to justify it, of course (…) this is what we have to do, otherwise we will not get any further with those people." GP, ambulant addiction care

"We're all thinking we should just prescribe less, and we should just sell less. But anyway, I think that is not the solution, I think that people feel the need for a certain anaesthesia, they're looking for that in the products they can find, right? And I think, uh, if we want to do prevention, we have to start much, much earlier with, what stress is everyone exposed to? Doctors prescribe too much, the pharmacy sells too much, and that this need does exist is, in my opinion, not recognised enough. We can all fight against the benzos and then something else will emerge." GP, private practice and residential addiction and psychiatric care

In the latter quote an understanding of the need for a treatment for suffering (the 'need for anaesthesia') is displayed, yet the speaker's responsibility for prescribing is also diverted to underlying societal causes of stress and suffering, thereby implicitly diverting the responsibility for prescribing and in turn presenting it rather as an empathic act.

In this storyline there is also a clear renegotiation of the existing guidelines. In the following quote a prescriber is hinting to the discrepancy between the guidelines and the actual practise of prescribing. Reaching the patient and providing the right care is put forward as the primordial goal of prescribing. Furthermore the speaker also mentions the emotion that accompanies prescribing beyond the guidelines ('feeling bad'). Hence, instead of questioning prescribing practises the speaker is questioning the rigidity of the guidelines.

"How do we explain to psychiatry students the discrepancy between the guidelines that say you cannot prescribe benzos and psychiatric wards that are full of benzos? Because students, want to do well, but they hear a theory that is miles away from practice, how can we understand that and how can we reconcile this? (…) either our theory is incorrect or our policy has not been adapted sufficiently. And what I suspect is that there is a lot of effort done on the policy- but I don't think the theory is entirely correct that we should only prescribe benzos for a week and after that you must start to feel bad as a doctor that you are still doing it … And with that theory we are not going to reach the people and provide the right care, so we have to offer a broader framework … There is no black and white, there is only grey in the world of benzo's." GP, ambulant addiction care

Finally, the legal risk that a prescriber runs by prescribing against the guidelines is also discussed. This storyline is used to juxtapose oneself with colleagues who maintain a more rigid view on prescribing and who might even report others (caricaturised as 'troublemakers who are holier-than-thou' by one interviewee), or as described in the following hypothetical sketch:

"If you are going to punish our colleague for [prescribing BZRA], then we have to stop doing our job." GP, ambulant addiction care

3.5. Storyline 4: 'reluctant prescribing'

We named the last storyline 'reluctant prescribing'. Prescribers who adhere to this storyline, do so to explain how they feel forced by circumstances to prescribe or continue a prescription, although they are in principle opposed. They feel pressured either by the explicit demand of patients themselves, or by circumstances. Although not refunded by the sickness funds in Belgium, BZRA are a less costly and initially efficient solution compared to for example psychotherapy. Hence, prescribers often feel pressured by patients' socio-economic circumstances. Rhetorically, this storyline uses more emotive reasoning (pathos) to evoke empathy in the listener or to express personal emotions. Words like 'negotiation', 'shopping', struggle' are used to describe the process of prescribing, as in the following quote:

"There is this underlying demand, this negotiation almost, where the patient tries to have more or a stronger molecule. These are consultations that are very complicated because we know what would please patients and it's difficult to get by and try to find a common ground and a way to avoid overconsumption of BZRAs in these consultations." GP, private group practice

"There are many [patients] who conceptualize that they can't live without. And if we don't give them to them, there's a power struggle…" Psychiatrist, ambulant addiction care

This storyline depicts how some prescribers struggle with conflicting values. On the one hand, they do not really want to prescribe, yet they feel heavily pressured to do so, often to keep a therapeutic relationship or working alliance with the patient. This internal struggle with the ambiguity and responsibility of prescribing is a recurring idea in this storyline.

"One would say that benzos are a bit more vicious (…) We, doctors, are also responsible for prescribing BZRA. It's very complicated afterwards to go tell a patient that there is abuse and that there is something wrong because we also feel responsible. It is a kind of poker game where somewhere, it is more complicated to broach the subject during a consultation because it is not easy for the patient." GP, private group practice

The ambiguity is even more highlighted in the use of the word 'poker game' to describe the (de)prescribing process and the taboo that lies on openly discussing tapering-off.

In this storyline, subtle discursive strategies to avert responsibility include not just diverting partial responsibility to the patient, but also to predecessors. Full responsibility for prescribing is also subtly diverted by the use of the verb 'to have to'.

"We recuperate the medicinal legacies of the doctors before us. Patients come here with prescriptions for benzos they have for a long time." GP, private group practice

"This is what we have to do, otherwise we do not get any further with those people." GP, ambulant addiction care

"We would rather they [BZRA] weren't there, but they are, so we have to do something with them, right?" GP, ambulant addiction care

A lack of genuine agency on the prescriber's part and an accompanying disillusionment, colour this storyline. This disappointment is illustrated in the following quotes, respectively uttered in a sarcastic, a resigned and an irritated way.

"We are good legal dealers." GP, group practice

"I renew the prescription and that's it." GP, ambulant addiction care

"I'm sick of it!" GP, ambulant addiction care

All this leads to self-positioning as a pressured and internally struggling prescriber who sometimes even feels 'tricked' by patients who in turn are positioned as demanding and dominating the prescribing process, forcing the prescriber into a more passive, accepting position.

3.6. Drawing on different storylines

Within the interviews, prescribers sometimes draw on different storylines. They switch positions in three instances, first when they compare their prescribing practises between two different settings in which they concurrently work. Professionals who work in two or even three different settings, often differentiate between those contexts as to whether or not they strive for zero tolerance or they will prescribe under strict conditions, a stance that is then either motivated with the 'no prescribing' or 'controlled prescribing' storylines, for example when they both have a private practice as GP and work in an addiction care facility with more strict guidelines. Secondly prescribers also shift storylines during an interview when they juxtapose their prescribing practises to the idealised guidelines. For example the 'no prescribing' storyline was sometimes used by interviewees to juxtapose their idealised personal vision of prescribing and their actual, often contradicting prescription practices. Thirdly, interviewees also adhere to different storylines when they describe an evolution over time in their personal opinions and practices as illustrated in the following quote:

"Well, I'm also from the, I, I used to be stricter in the sense that, I used to be so right, I think I was from the first generation where, uh, the benzos were labelled as a great danger in our medicine courses. And you were never allowed to prescribe that and it was outrageous that people prescribed that and so on. So in the beginning I've always refused that so hard and, and, uh, trying to get people off it. But actually over the years I've learned both a bit with er, experience that you have 'people and people'. People who have a potential addiction profile and others who don't." Psychiatrist, residential addiction care

4. Discussion

4.1. Unfolding mindlines

Challenging the gold-standard evidence-based practice movement, Gabbay and le May developed the concept of 'clinical mindlines', to explain how practitioners actually develop and apply clinical knowledge (Wieringa and Greenhalgh, 2015). Mindlines are collectively reinforced, internalised tacit guidelines based on health care practitioners' experience and are experiential knowledge in practice (Gabbay and Le May, 2004) and thus socially constructed. While founded in training, mindlines are continuously reconstructed over time and collectively refined in clinical organisational settings, often through discourse and storytelling (Gabbay and Le May, 2010; 2016). At the root of these mindlines are implicit norms and values which determine the degree of acceptable flexibility around textbook practice and clinical guidelines. Unlike guidelines, mindlines are more flexible and thus better adapted to coping with the sometimes conflicting demands of clinicians' diverging roles. Precisely such tacit norms and values become visible through the identified storylines. Specifically, these storylines reveal varying underlying norms and values regarding prescribing, as well as to how interviewees see their role as a prescriber.

A first norm that informs the mindlines on prescribing BZRA is centred around the prescriber's evaluation of the involved risks. In each storyline, the negotiation of potential negative outcomes of prescribing differs and hence the motivation to prescribe outside the guidelines also differs. In the 'no prescribing' storyline, dependence and addiction are not separated. Hence, any prescription is seen as causing harm, whereas in the 'controlled prescribing' storyline, the potentially inflicted harm is discursively minimized by separating dependence from addiction. In the 'compassionate prescription' storyline, there is even a further subdivision of types of dependence. The 'controlled prescribing' storyline and its premise that if BZRA use is under control, it is not addiction (at the maximum a dependence) is linked to the limitation of additional damage in the harm reduction discourse in addiction care (Roe, 2005).

Secondly, we see a shift in power dynamics that influences the prescribing process across the storylines. While the 'no prescribing' storyline is fully prescriber-led, the 'reluctant prescribing' is presented as patient-led. The other storylines on the other hand are situated towards the middle of that continuum. According to Dowell et al. (2007), the prescription of BZRA is often more patient- than provider led on the prescribing spectrum. The described storylines can indeed be distinguished based on where they can be situated on this prescription continuum, yet also show that this nuance is needed, since who leads the decision is equally dependant on the health care setting and the ideas of the prescriber. A study by Anthierens et al. (2007) showed that GPs often feel overwhelmed by the psychosocial problems of their patients, and therefore offer a prescription as a form of empathy. Likewise, Cook et al. (2007) showed how prescribers construct a prescription as compassionate. Forced by a perceived limitation of other options and pressured by time constraints, they retreat to what has been called 'the lesser evil'. GPs in the study by Anthierens et al. (2007) specifically mentioned patients' demand as an element for starting a prescription. Gabe and Lipshitz-Phillips (1982) showed that the idea of the 'lesser evil' is also expressed by patients and later also debunked the idea of a deliberate creation of BZRA dependence by prescribers (Gabe and Lipshitz-Phillips, 1984). Similar arguments appear in the 'reluctant -' as well as the 'compassionate prescribing' storylines. In the words of Leibovici and Lièvre (2002: 866) 'there is a boundary beyond which medicine has only a small role. When doctors are forced to go beyond that role they do not gain power or control: they suffer'. This is exactly what is portrayed in the latter two storylines: doctors feel directly or indirectly forced by patients and their circumstances to accept to pharmaceuticalise their problem and thus to prescribe. Prescribers have equally been criticised for maintaining a purely medical biological explanatory model and thus for medicalising psychosocial problems with a medical prescription (Calmeyn and Petrovic, 2023). In the 'compassionate prescribing' storyline however, we do not see a lack of understanding of the biopsychosocial reasons for human suffering, it just shows the limitations of prescribers to constructively and sustainably deal with that human suffering within the limitations of their own institutional setting and practises. Depending on the setting in which they work (especially in residential addiction care settings with a strict abstinence policy) prescribers feel they have more freedom to resist this explicit and implicit demand by patients.

Furthermore, earlier work on interpretative repertoires of patients shows how the imaginary of BZRA is constructed around a tacit societal norm on the undesirability of pharmaceuticalising sleeping problems (Ceuterick et al., 2021), reflecting the moral positions (used to deal with conflicting values) of patients as either 'noble non-users', 'deserving and/or compliant patients' or 'rational users', also found in offline settings (Gabe et al., 2016). The positions of a 'responsible user' and 'deserving patient' also result from our storylines (as illustrated in the

last column of Table 3), which reveals that prescribers equally draw on similar moral positionings of patients when making sense of a decision to prescribe. These findings show that the decision to prescribe is more nuanced than merely opting for the 'lesser evil' (Anthierens et al., 2007) and the latter is just one of many arguments that inform decision-making processes of prescribers.

4.2. The ontological politics of BZRA

The shifts in storylines between different settings in which several of our interviewees concurrently work, or over time throughout their careers, do not only illustrate how practice-based guidelines emerge in the daily practice of prescribers. The described storylines also align with what Ferris et al. (1989) have called organisational myths which serve to maintain certain organisational politics (Ferris et al., 1989). For example, in the 'no prescribing' storyline, BZRA are incorporated in the wider organisational policy of total abstinence, which is a prerequisite for certain types of residential addiction care. That this does not necessarily concur with prescribing practices in another division of the same institute, is not seen as something contradictory yet is explained away as 'therapeutic freedom' (see also Britten, 2001). Moreover, what is so puzzling about this specific example is that the exact same class of medication, with its similar chemical structure and effect, changes dramatically depending on the setting in which they are either prescribed or deprescribed. To unravel this apparent contradiction, we retreat to the theory of 'ontological politics'. This conceptualisation by Mol (1999) theorises how different versions of reality - also called 'alternative ontologies' (Dennis et al., 2020) - come into being, not only through social practices, but also through material arrangements or technologies, like pharmaceuticals. The reality of the setting in which BZRA are prescribed or deprescribed, constitutes the multiple ontologies of this class of medication and their prescribing. The sometimes contradictory portrayals of BZRA across the respective storylines, as a drug, a medication to control, a support or even a leverage in the relationship between patient and prescriber, show how the different realities of BZRA 'are neither given, nor fixed' (Pienaar and Dilkes-Frayne, 2017: 145) but shaped within specific prescribing practices and thus diverge from the idealised strictly prescribed BZRA portrayed in the official guidelines. With Lancaster and Rhodes (2020: 1), we agree that thinking ontopolitically 'calls into question the realist presumptions' which in our case underpin the official prescribing guidelines namely that BZRA are one, set and fixed, and also provokes critical thinking about what counts as 'evidence' and the 'evidence-based' paradigm itself. This approach draws attention to the object of BZRA, which, because of their particular materiality and their similar chemical structure, seems finished, static and one. Yet our results show that there are multiple versions of BZRA, embedded within prescribing mindlines and enacted through storylines. With this, we situate our contribution to the sociology of prescribing, in the addition of an ontopolitical lens to the conceptualisation of the shifting meaning of a prescription in itself, which varies, almost metonymically along with the meaning of the prescribed medication.

5. Conclusion

With this article we have shown that outside the realm of prescription guidelines, there exists a world in which prescribing practices and decisions are never as black and white as on paper. Prescribers juggle with priorities that oscillate between the official guidelines, patients' demands and interests, and the duties related to their specific institutional position and policy. The discerned storylines capture these dilemma's in a way previously not shown as nuanced and illustrate different mindlines that prescribers in different sectors in Belgium draw on to base prescribing decisions on. Furthermore, our data show how multiple versions of the same class of medication are performed, or enacted, by and through these storylines.

Finally, the nuances that our data add to the existing literature ask for a more tailored approach when addressing the BZRA problem on the prescribers' side. Future policy initiatives that aim to tackle high prescription rates by targeting prescribers, need to take into account how knowledge-in-practice unfolds, and should be sensitive to the underlying norms and values that inform these mindlines as well to the multiple ontologies of BZRA, thereby also considering possible differences in prescribing depending on the indication (insomnia or anxiety).

Funding

The authors received financial support from BELSPO (DR/91/BENZOCARE) for this study.

Data availability

The data that has been used is confidential.

Acknowledgements

The authors sincerely thank all participants for sharing their inspiring insights and the reviewers for their valuable suggestions. Special thanks go to Annemie Vermassen for her contributions to the project as a volunteer and to the members of the BENZOCARE follow-up committee for their guidance.

References

Al-Worafi, Y.M., 2020. Medication abuse and misuse. In: Drug Safety in Developing Countries. Academic Press, pp. 127–135.
Anthierens, S., Habraken, H., Petrovic, M., Christiaens, T., 2007. The lesser evil? Initiating a benzodiazepine prescription in general practice: a qualitative study on GPs' perspectives. Scand. J. Prim. Health Care 25 (4), 214–219.
Baert, F., Van Langenhove, L., James, M., 2019. Rethinking role theory in foreign policy analysis: introducing positioning theory to international relations. Pap. Soc. Representations 28 (1), 4, 1.
Baldwin, D.S., Aitchison, K., Bateson, A., Curran, H.V., Davies, S., Leonard, B., Wilson, S., 2013. Benzodiazepines: risks and benefits. A reconsideration. J. Psychopharmacol. 27 (11), 967–971.
Baldwin, D.S., Anderson, I.M., Nutt, D.J., Allgulander, C., Bandelow, B., den Boer, J.A., Wittchen, H.U., 2014. Evidence-based pharmacological treatment of anxiety disorders, post-traumatic stress disorder and obsessive-compulsive disorder: a revision of the 2005 guidelines from the British Association for Psychopharmacology. J. Psychopharmacol. 28 (5), 403–439.
Britten, N., 2001. Prescribing and the defence of clinical autonomy. Sociol. Health Illness 23 (4), 478–496.
Britten, N., Stevenson, F., Gafaranga, J., Barry, C., Bradley, C., 2004. The expression of aversion to medicines in general practice consultations. Soc. Sci. Med. 59 (7), 1495–1503.
Calmeyn, M., Petrovic, M., 2023. Opinie: kalmte alleen kan u redden. Artsenkrant 7.
Ceuterick, M., Christiaens, T., Creupelandt, H., Bracke, P., 2021. And they slept happily ever after: online interpretive repertoires on the use of benzodiazepines and z-drugs. Health 27 (5), 847–866.
Ceuterick, M., Vandebroek, I., 2017. Identity in a medicine cabinet: discursive positions of Andean migrants towards their use of herbal remedies in the United Kingdom. Soc. Sci. Med. 177, 43–51.
Christiaens, T., Creupelandt, H., Rogiers, R., Thoen, A., 2018. Slaap- en kalmeermiddelen, hoe kunt u uw patiënten bijstaan op zoek naar andere oplossingen? FOD Volksgezondheid, Veiligheid van de Voedselketen en Leefmilieu. Projectgroep Benzodiazepines.
Cook, J.M., Marshall, R., Masci, C., Coyne, J.C., 2007. Physicians' perspectives on prescribing benzodiazepines for older adults: a qualitative study. J. Gen. Intern. Med. 22, 303–307.
Coteur, K., Mamouris, P., Vaes, B., Van Nuland, M., Matheï, C., Schoenmakers, B., 2022. Evolution of benzodiazepine receptor agonist prescriptions in general practice: a registry-based study. Front. Public Health 10, 1014734, 1014734.
Davies, B., Harré, R., 1990. Positioning: the discursive production of selves. J. Theor. Soc. Behav. 20 (1), 43–63.
Dell'osso, B., Lader, M., 2013. Do benzodiazepines still deserve a major role in the treatment of psychiatric disorders? A critical reappraisal. Eur. Psychiatr. 28 (1), 7–20.
Dennis, F., Rhodes, T., Harris, M., 2020. More-than-harm reduction: engaging with alternative ontologies of 'movement' in UK drug services. Int. J. Drug Pol. 82, 102771.
Dowell, J., Williams, B., Snadden, D., 2007. Patient-centered Prescribing. Taylor & Francis.
Ferris, G.R., Fedor, D.B., Chachere, J.G., Pondy, L.R., 1989. Myths and politics in organizational contexts. Group Organ. Stud. 14 (1), 83–103.

Freedman, A.M., 1972. Drugs and society: an ecological approach. Compr. Psychiatr. 13 (5), 411–420.
Gabbay, J., Le May, A., 2004. Evidence based guidelines or collectively constructed "mindlines?" Ethnographic study of knowledge management in primary care. BMJ 329 (7473), 1013.
Gabbay, J., Le May, A., 2010. Practice-based Evidence for Healthcare: Clinical Mindlines. Routledge.
Gabbay, J., Le May, A., 2016. Mindlines: making sense of evidence in practice. Br. J. Gen. Pract. 66 (649), 402–403.
Gabe, J., 1990. Towards a sociology of tranquillizer prescribing. Br. J. Addict. 85 (1), 41–48.
Gabe, J., Coveney, C.M., Williams, S.J., 2016. Prescriptions and proscriptions: moralising sleep medicines. Sociol. Health Illness 38 (4), 627–644.
Gabe, J., Lipshitz-Phillips, S., 1982. Evil necessity? The meaning of benzodiazepine use for women patients from one general practice. Sociol. Health Illness 4 (2), 201–209.
Gabe, J., Lipshitz-Phillips, S., 1984. Tranquillisers as social control? Socio. Rev. 32 (3), 524–546.
Gisle, L., Drieskens, S., Demarest, S., Van der Heyden, J., 2020. Geestelijke gezondheid: gezondheidsenquête 2018. Brussel, België: Sciensano; Rapportnummer: D/2020/14.440/4.
Green, J.L., Brock, C., Baker, W.D., Harris, P., 2020. Positioning theory and discourse analysis: An explanatory theory and analytic lens. In: Handbook of the Cultural Foundations of Learning. Routledge, pp. 119–140.
Harré, R., Moghaddam, M., Cairnie, T.P., Rothbart, D., Sabat, S.R., 2009. Recent advances in positioning theory. Theor. Psychol. 19 (1), 5–31.
Haw, C., Stubbs, J., 2007. Benzodiazepines—a necessary evil? A survey of prescribing at a specialist UK psychiatric hospital. J. Psychopharmacol. 21 (6), 645–649.
Heberlein, A., Bleich, S., Kornhuber, J., Hillemacher, T., 2008. Benzodiazepine dependence: causalities and treatment options. Fortschr. Neurol. Psychiatr. 77 (1), 7–15.
Hollister, L.E., Motzenbecker, F.P., Degan, R.O., 1961. Withdrawal reactions from chlordiazepoxide ("Librium"). Psychopharmacologia 2, 63–68.
Lader, M., 1998. Iatrogenic sedative dependence and abuse–have doctors learnt caution? Addiction 93 (8), 1133.
Lancaster, K., Rhodes, T., 2020. Towards an ontological politics of drug policy: intervening through policy, evidence and method. Int. J. Drug Pol. 86, 102932.
Leibovici, L., Lièvre, M., 2002. Medicalisation: peering from inside medicine: professionals and lay people should work together to a common purpose. BMJ 324 (7342), 866.
Liebrenz, M., Schneider, M., Buadze, A., Gehring, M.T., Dubé, A., Caflisch, C., 2015. High-dose benzodiazepine dependence: a qualitative study of patients' perceptions on initiation, reasons for use, and obtainment. PLoS One 10 (11), e0142057.
Maust, D.T., Lin, L.A., Blow, F.C., 2019. Benzodiazepine use and misuse among adults in the United States. Psychiatr. Serv. 70 (2), 97–106.
Mol, A., 1999. Ontological politics. A word and some questions. Socio. Rev. 47 (1_Suppl. l), 74–89.
Musto, D.F., 1985. Iatrogenic addiction: the problem, its definition and history. Bull. N. Y. Acad. Med. 61 (8), 694.
Parish, P.A., 1974. Sociology of prescribing. Br. Med. Bull. 30 (3), 214–217.
Pienaar, K., Dilkes-Frayne, E., 2017. Telling different stories, making new realities: the ontological politics of 'addiction' biographies. Int. J. Drug Pol. 44, 145–154.
Pilgrim, D., Rogers, A., Gabe, J., 2011. Social Aspects of Psychotropic Medication. The SAGE Handbook of Mental Health and Illness, pp. 367–388.
Roe, G., 2005. Harm reduction as paradigm: is better than bad good enough? The origins of harm reduction. Crit. Publ. Health 15 (3), 243–250.
Rogers, A., Pilgrim, D., Brennan, S., Sulaiman, I., Watson, G., Chew-Graham, C., 2007. Prescribing benzodiazepines in general practice: a new view of an old problem. Health 11 (2), 181–198.
Saini, R., 2022. Using" Positioning" Theory to analyze a female school teacher's experiences with care-work during COVID-19 in India: towards Decolonizing Feminist Research. Curr. Issues Comp. Educ. 24 (1).
Salzman, C., 1991. The APA Task Force report on benzodiazepine dependence, toxicity, and abuse. Am. J. Psychiatr. 148 (2), 151–152.
Sarangi, A., McMahon, T., Gude, J., 2021. Benzodiazepine misuse: an epidemic within a pandemic. Cureus 13 (6).
Schwartz, R.K., Soumerai, S.B., Avorn, J., 1989. Physician motivations for nonscientific drug prescribing. Soc. Sci. Med. 28 (6), 577–582.
Sim, M.G., Khong, E., Wain, T.D., 2007. The prescribing dilemma of benzodiazepines. Aust. Fam. Physician 36 (11).
Sirdifield, C., Anthierens, S., Creupelandt, H., Chipchase, S.Y., Christiaens, T., Siriwardena, A.N., 2013. General practitioners' experiences and perceptions of benzodiazepine prescribing: systematic review and meta-synthesis. BMC Fam. Pract. 14, 1–13.
Slocum-Bradley, N., 2010. The positioning diamond: a trans-disciplinary framework for discourse analysis. J. Theor. Soc. Behav. 40 (1), 79–107.
Soyka, M., 2017. Treatment of benzodiazepine dependence. N. Engl. J. Med. 376 (12), 1147–1157.
Stevenson, F., Britten, N., Barry, C.A., Bradley, C.P., Barber, N., 2002. Perceptions of legitimacy: the influence on medicine taking and prescribing. Health 6 (1), 85–104.
Van der Geest, S., Whyte, S.R., Hardon, A., 1996. The anthropology of pharmaceuticals: a biographical approach. Annu. Rev. Anthropol. 25 (1), 153–178.
Van der Heyden, J., Berete, F., Drieskens, S., 2020. Gezondheidsenquête 2018: gebruik van geneesmiddelen. Brussel, België: Sciensano; D/2020/14.440/17.
Weiss, M.C., 2021. The rise of non-medical prescribing and medical dominance. Res. Soc. Adm. Pharm. 17 (3), 632–637.
Whyte, S.R., Van der Geest, S., Hardon, A., 2002. Social Lives of Medicines. Cambridge University Press.
Wieringa, S., Greenhalgh, T., 2015. 10 years of mindlines: a systematic review and commentary. Implement. Sci. 10, 1–11.