

The benzodiazepine dilemma

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As clinicians, we are faced with a conflict when deciding whether or not to prescribe a benzodiazepine. If we prescribe one of these agents, we might be putting our patients at risk for dependence and abuse. However, if we do not prescribe them, we risk providing inadequate treatment, especially for patients with panic disorder.

Benzodiazepine dependence and abuse can take many forms. Dependence can be psychological as well as physiologic. While many patients will adhere to their prescribing regimen, some may sell their benzodiazepines, falsely claim that they have “panic attacks,” or take a fatal overdose of an opioid and benzodiazepine combination.

Here I discuss the pros and cons of restricting benzodiazepines use to low doses and/or combination therapy with antidepressants.

Weighing the benefits of restricted prescribing

Some double-blind studies referenced in the American Psychiatric Association (APA) 2010 Practice Guideline for the Treatment of Patients with Panic Disorder¹ suggest that benzodiazepine duration of treatment and dosages should be severely restricted. These studies found that:

- Although the combination of a selective serotonin reuptake inhibitor (SSRI) and a benzodiazepine initially decreased the number of panic attacks more quickly than SSRI monotherapy, the 2 treatments are equally effective after 4 or 5 weeks.^{2,3}
- For the treatment of panic disorder, a low dosage of a benzodiazepine (clonazepam 1 mg/d or alprazolam 2 mg/d) was

as effective as a higher dosage (clonazepam 2 mg/d or alprazolam 6 mg/d).^{4,5}

However, these studies could be misleading. They all excluded patients with a comorbid condition, such as bipolar disorder or depression, that was more severe than their panic disorder. Severe comorbidity is associated with more severe panic symptoms,^{6,7} which might require an SSRI/benzodiazepine combination or a higher benzodiazepine dosage.

The APA Practice Guideline suggests the following possible options:

- benzodiazepine augmentation if there is a partial response to an SSRI
- substitution with a different SSRI or a serotonin-norepinephrine reuptake inhibitor (SNRI) if there is no response to an SSRI
- benzodiazepine augmentation or substitution if there is still no therapeutic response.

The APA Practice Guideline also states that although the highest “usual therapeutic dose” for panic disorder is clonazepam 2 mg/d or alprazolam 4 mg/d, “higher doses are sometimes used for patients who do not respond to the usual therapeutic dose.”¹

Presumably, an SSRI/benzodiazepine combination should be considered if an



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SSRI alleviates major depressive disorder but does not alleviate a comorbid panic disorder. However, the APA Practice Guideline does not include studies that investigated this clinical scenario.

Monitor carefully for dependency/abuse

Restricting benzodiazepine use to low doses over a short period of time may decrease the risk of dependence and abuse. However, this practice may also limit or prevent effective treatment for adherent patients with panic disorder who do not adequately respond to SSRI or SNRI monotherapy.

Therefore, clinicians need to carefully differentiate between patients who are adherent to their prescribed dosages and those who may be at risk for benzodiazepine dependence and abuse. Consider using prescription drug monitoring programs and drug screens to help detect patients who “doctor shop” for benzodiazepines,

or who could be abusing opioids, alcohol, marijuana, or other substances while taking a benzodiazepine.

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Use drug screens and monitoring programs to detect patients who ‘doctor shop’ for benzodiazepines