

Benzodiazepine Abuse and Dependence: Misconceptions and Facts

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Benzodiazepines can be prescribed for a number of medical conditions. Many physicians are reluctant to prescribe benzodiazepines out of fear of producing dependence in patients and incurring the disapproval of their peers. Studies of psychotropic drug use and abuse demonstrate that individuals using benzodiazepines for treatment of a medical illness rarely demonstrate tolerance to the therapeutic action of the medication or escalate the dose. Eighty percent of benzodiazepines are prescribed for 6 months or less, and elderly women are the most common long-term users of low-dose benzodiazepines. In contrast, recreational use of benzodiazepines is associated with polysubstance abuse, lack of medical supervision, rapid tolerance to the euphoric or sedating side effect, and escalation of dose. Most recreational users of benzodiazepines are young men. Documentation of indication for use, collection of drug-abuse history, close monitoring, and drug holidays can improve the management of this class of medication. J FAM PRACT 1990; 31:393-400.

Benzodiazepines, as a class of psychotherapeutic medications, have enjoyed widespread use since their US introduction in the early 1960s. These medications are used to treat some of the most prevalent emotional and physical disorders seen in medical practice, which include anxiety, insomnia, seizure disorders, muscle spasms, and alcohol withdrawal. Benzodiazepines are also used as preanesthetics. The World Health Organization (WHO) has identified benzodiazepines as "essential drugs" that should be available in all countries for medical use.¹

Because of their safety and efficacy, the benzodiazepines have largely replaced their anxiolytic predecessors. The oldest and most widely used drug for anxiety was alcohol. Its protean adverse effects, however, encouraged the search for better treatments. In the late 19th century, chloral hydrate and paraldehyde, with characteristics similar to alcohol, were introduced into medical practice as sedatives. Bromide salts and barbiturates were added to the pharmacopoeia in the early 20th century. By the 1950s most of these drugs had fallen out of favor. The

barbiturates and meprobamate, introduced in 1955, remained as dominant anxiolytic drugs. Physicians, however, were concerned with the propensity of barbiturates to induce tolerance, physical dependence, drug interactions, and potential for a lethal withdrawal syndrome. Accordingly, chlordiazepoxide was synthesized and marketed in the United States in 1961. Since that time, a total of 12 different benzodiazepines have been marketed in the United States for several Food and Drug Administration-approved indications (Table 1). Whereas the drugs vary in rate of absorption, duration of action, relative potency, and metabolism, little evidence exists to support real differences in therapeutic action at equipotent doses.²

Despite the success of benzodiazepines as anxiolytics, many physicians have been reluctant to prescribe this class of medication because of concern for the potential misuse and abuse of these agents by their patients.

This concern had its origin with the negative media scrutiny and public perception of the overuse of diazepam in the late 1960s and early 1970s—as portrayed in books and film.³ The unfortunate consequence of this overemphasis on the potential abuse of the benzodiazepines may be impairment in the delivery of effective treatment for legitimate medical illnesses.

In this article three case examples will illustrate the common misconceptions regarding the use and abuse of benzodiazepines. The actual abuse risk of these medica-

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TABLE 1. FOOD AND DRUG ADMINISTRATION APPROVED BENZODIAZEPINES

| Indication | Drug |
|------------------------------------|--|
| Insomnia | Flurazepam Temazepam Triazolam |
| Epilepsy | Clonazepam Clorazepate Diazepam |
| Alcohol withdrawal | Chlordiazepoxide Chlorazepate Diazepam Oxazepam |
| Anxiety associated with depression | Alprazolam Oxazepam |
| Muscle spasm | Diazepam |
| Anxiety | Alprazolam Chlordiazepoxide Chlorazepate Diazepam Halazepam Lorazepam Oxazepam Prazepam |
| Preoperative medication | Midazolam Chlordiazepoxide |

tions will be contrasted with other abused psychoactive drugs. Guidelines for the safe use of benzodiazepines by the primary care physician will be discussed.

BENZODIAZEPINE USE IN THE UNITED STATES AND EUROPE

The ideal anxiolytic drug is as yet unavailable to medicine. The properties of an ideal antianxiolytic agent include effective relief of anxiety symptoms without significant side effects such as sedation, freedom from tolerance to the anxiety-relieving properties, oral administration, rapid onset of action and moderate elimination that does not require multiple daily dosing that could jeopardize compliance, no active metabolites, no drug interactions, and no potential for abuse or dependence.

When introduced, the benzodiazepines were touted as being effective, nonhabit-forming, and nonlethal in overdose when compared with barbiturates. The benzodiazepines appeared to be nearly ideal anxiolytic drugs. As a result, prescriptions escalated, reaching a peak in 1975, when approximately 100 million prescriptions were writ-

ten in the United States. Benzodiazepine use in the late 1980s is about 25% below the peak rates of the mid-1970s.⁴ Diazepam dominated the early market in both the United States and Europe, but was supplanted by lorazepam in Europe and alprazolam in the United States by the mid-1980s. The rates of benzodiazepine use among adults have been similar in Western industrialized countries. Approximately 12% to 18% of the adult population of the United States, Belgium, Great Britain, and West Germany have been exposed to benzodiazepines.⁵ The significant drop in benzodiazepine prescriptions after 1975 and the slight rebound in the mid-1980s may be the result of numerous factors. Physicians frequently misdiagnosed major depression and treated the insomnia component of depression with a benzodiazepine rather than the depression with an antidepressant.⁶ Emergence of better diagnostic criteria, as reflected in the *Diagnostic and Statistical Manual of Mental Disorders*, 3rd edition (DSM-III)⁷ and DSM-III Revised,⁸ better epidemiologic surveys of mental illness,^{9,10} the recognition of benzodiazepine dependence, and the discovery of antidepressant efficacy in some anxiety disorders may have contributed to changes in the benzodiazepine prescription rate.

Physician concerns regarding benzodiazepine use fall broadly into two areas. The first area is the potential for dependence on benzodiazepines prescribed for medical use. The issues involved in physical dependence include identifying appropriate candidates for medication, duration of treatment, dose requirements, escalation of dose, and possibility of adverse peer reaction. The second area of concern is nonmedical (recreational) use and abuse of benzodiazepines. The issues involved in this area include the legal and illegal procurement of drugs, deception by patients, and unethical behavior of physicians dispensing the medications inappropriately.

Medical use of benzodiazepines differs significantly from nonmedical use. Medical use is characterized by supervised management of the benzodiazepine in the treatment of a recognized medical condition. The goal of treatment is to restore normal function at home, work, or school. A patient using a benzodiazepine for this purpose does not want to get high or to escape from reality but rather to function at a normal level, free of anxiety or other disabling mental conditions. In contrast, nonmedical (recreational) use of benzodiazepines is characterized by a lack of medical supervision and a desire to alter one's mental state. The goal is not to achieve a normal level of functioning, but to get high. Typically, the mood-altering effects of benzodiazepines are rapidly tolerated, and escalation of dose is common.

A problem that handicaps the discussion of substance abuse is lack of a uniform vocabulary employed by clinicians and researchers. Abuse, dependence, and addiction may be defined narrowly or broadly. Dependence, for

example, may embrace physical or psychological components. Abuse is a value-laden term that may mean culturally unsanctioned drug use or inappropriate, but sanctioned, drug use. For example, a patient chronically using a low-dose benzodiazepine for sleep may be abusing the substance by one definition. If the patient is receiving the medication by prescription (ie, sanctioned use), however, then the issue may actually be malprescription rather than abuse, and the onus of responsibility shifts in part from the patient to the physician. Clear terminology is essential in understanding the risk of benzodiazepine dependence and misuse.

Dupont¹¹ has defined several of the key terms as follows: *Abuse*: self-administration of any drug in a culturally disapproved manner that causes adverse consequences. *Addiction*: A behavior pattern of drug abuse characterized by a overwhelming involvement with the use of a drug, the securing of its supply, and a high tendency to relapse after discontinuation. *Dependence*: This condition may be either physical or psychological. Physical dependence refers to a state of neuroadaptation produced by repeated administration of a drug, necessitating continued administration to prevent a recurrence of the withdrawal or abstinence syndrome. Psychological dependence refers to the state of drug craving and compulsive drug seeking that is not based on the experience of withdrawal. Psychological dependence can occur with any substance in which a patient has significant psychological investment. *Tolerance*: Tolerance is developed when increasingly larger doses of the drug must be administered to obtain the effects observed with its original use. *Withdrawal*: This condition represents the psychological and physical reactions caused by abrupt cessation of a dependence-producing drug.

These definitions and physician concerns regarding benzodiazepines will be explored further in the following case examples.

ILLUSTRATIVE CASES

Case 1

A 34-year-old self-employed man with no prior history of substance abuse, psychiatric problems, or past medical problems presented to his primary care physician with a 6-month history of unexpected, brief episodes of shortness of breath, palpitations, trembling, choking, and nausea that had occurred several times each week. Medical evaluation revealed no pathology, and a diagnosis of panic disorder was made. The patient was treated with alprazolam 0.25 mg twice a day, and he experienced complete cessation of symptoms. The patient remained on the alprazolam for 8 months without escalating his dose, and he

experienced no side effects. When he returned for follow-up, he was seen by a second physician covering for his own vacationing physician. The second physician refused to renew the benzodiazepine, and advised the patient to enroll in a stress-reduction program. One week later, the panic symptoms returned, and the patient called the covering physician. The patient was told that the symptoms represented proof of benzodiazepine addiction and withdrawal, and that the symptoms should improve within a week. Two weeks after the discontinuation of the medication, the symptoms remained and the patient contacted his own physician, who had returned from vacation. His physician also refused to restart the benzodiazepine and referred the patient to a psychiatrist for "benzodiazepine misuse and drug-seeking behavior."

The psychiatrist discussed medication-treatment options for panic disorder—tricyclic antidepressants and benzodiazepines. After reviewing side effects and risks, the patient elected to continue with the benzodiazepine. The patient also agreed to periodic discontinuation of the medication to minimize the risk of physical dependence and to assess the continued presence of the panic disorder. Every 6 months the medication was tapered over 4 weeks, and the patient remained off the alprazolam for 4 weeks. When panic symptoms returned, the patient was restarted on the medication. After 2 years of treatment, he had no further complaints of panic symptoms, and the medication was discontinued.

This case illustrates many of the concerns regarding the medical use of benzodiazepines. The patient was correctly determined to have panic disorder. Anxiety disorders represent the most common clinical syndromes for which benzodiazepines are prescribed. The National Institute of Mental Health epidemiologic study of the United States identified that 8.3% of the US population experienced an anxiety disorder.⁹ Yet only 23% of these individuals actually received treatment. Anxiety disorders were found to be more common than substance abuse (6.4%) or mood disorders (6.0%) in the study.

The DSM-III-R identifies six anxiety disorders: panic disorder, generalized anxiety disorder, post-traumatic stress disorder, obsessive-compulsive disorder, simple phobia, and social phobia. Primary care physicians will most frequently encounter and treat panic disorder and generalized anxiety disorder in their practices. Symptoms of generalized anxiety and panic disorder are listed in Table 2.

Problems arose in the management of this patient's clinical syndrome when the substitute physician failed to recognize the chronic nature of the psychiatric disorder and the potential need for treatment to extend beyond a few months. This error was further compounded by the physician's conclusion that the reemergence of anxiety symptoms represented benzodiazepine withdrawal.

TABLE 2. DSM-III-R CRITERIA FOR PANIC DISORDER AND GENERALIZED ANXIETY DISORDER

| Panic Disorder | Generalized Anxiety |
|--|--|
| Unexpected, brief intense attacks Four attacks in 4 wk or anticipatory anxiety after one or more attacks No organic cause Four of the following symptoms during attack: Dyspnea Dizziness or faintness Palpitations Trembling Sweating Choking Nausea Depersonalizations Numbness Flushes or chills Chest pain Fear of dying Fear of going crazy or doing something uncontrolled | Duration 6 mo or longer Excessive or unrealistic worry No other mental disorder No organic cause Six of the following 18 symptoms: Trembling, twitching Muscle tension Restlessness Fatigability Dyspnea Palpitations Sweating Dry mouth Dizziness Gastrointestinal complaints Flushes or chills Frequent urination Trouble swallowing Feeling keyed up Exaggerated startle Difficulty concentrating Insomnia Irritability |

The periodic discontinuation of the medicine (drug holiday) employed by the psychiatrist was very different from the abrupt discontinuation the patient experienced initially when he was seen by the substitute physician. The psychiatrist explained the rationale for the drug holiday at the beginning of treatment, and the patient could anticipate it without excessive apprehension. Not warning a patient about the need for periodic reassessment, abrupt discontinuation, and pejorative statements about possible "addiction" heighten apprehension and are countertherapeutic. During the drug-abstinence period, supportive psychotherapies should be employed to minimize patient discomfort. In a therapeutic drug holiday, the patient is as invested in the outcome as is the physician. Patient and physician are perceived as working together.

Both tricyclic antidepressants and benzodiazepines are effective in alleviating symptoms of panic disorder. Because a significant overlap of symptoms occur between the anxiety disorders and depression,¹² a tricyclic antidepressant should be considered first. The tricyclic antidepressants have numerous side effects, including dry mouth, blurred vision, constipation, orthostatic hypotension, tachycardia, sedation, and weight gain, which must be considered in selecting an agent. Likewise, the monoamine oxidase inhibitors may be excellent choices for depression or panic disorder, but orthostatic hypotension, diet restriction, and potential for hypertensive crisis limit their clinical utility. Ultimately, medication selection must be based on specific diagnosis, target symptoms, medication side effects, and patient lifestyle and preferences.

Three benzodiazepine discontinuation syndromes exist: symptom recurrence, rebound, and benzodiazepine withdrawal. Symptom recurrence refers to the reemergence of the primary anxiety symptoms for which the benzodiazepine was originally prescribed. Since anxiety disorders may be long lived, a brief treatment with benzodiazepine may not fully eradicate the disorder, and symptoms may reemerge once the benzodiazepine has been discontinued. Rebound refers to the exaggerated expression of the original anxiety condition experienced by some patients immediately after the discontinuation of effective treatment. This rebound phenomenon may produce symptoms that are more severe than the original complaints and may suggest to the physician that the patient is exaggerating in an attempt to seek drugs or represent benzodiazepine withdrawal. Benzodiazepine withdrawal symptoms may begin as soon as 7 to 10 days following cessation of the benzodiazepine, and withdrawal symptoms may include anxiety, insomnia, agitation, tremor, perceptual changes, hallucinations, delusions, seizures, or gastrointestinal upset.¹³ Many withdrawal symptoms are similar to the original symptoms for which the benzodiazepine was prescribed.

Intermediate-acting, high-potency benzodiazepines, such as alprazolam, lorazepam, or clonazepam, may produce more pronounced rebound phenomena and mild-to-moderate withdrawal symptoms if not tapered and discontinued over a prolonged period, perhaps as long as 8 weeks.¹⁴ The practice of employing a slow and gradual

taper will help to minimize drug-associated discontinuation syndromes.

In this patient's case, there is little evidence to support a diagnosis of benzodiazepine addiction. He had no prior history of substance abuse and was supervised by a physician. He took the medication to function normally. Escalation of dose was absent, as were complaints of tolerance to the antianxiety action of the agent.

Physical dependence to benzodiazepines can occur iatrogenically. In general, benzodiazepine dependence emerges at doses of 40 mg of diazepam or equivalent per day in conjunction with prolonged duration of treatment.¹⁵ The following case will illustrate a very common phenomenon in clinical practice.

Case 2

A 66-year-old retired white woman with a long history of "nerves and insomnia" was treated for 20 years with 5 mg of diazepam twice a day. She had no chemical dependency history, nor had she seen a psychiatrist for an evaluation. When her general practitioner retired, she was referred to another primary care physician, who was reluctant to continue her benzodiazepine treatment. He began a gradual taper program of 2 mg/mo. The patient, however, almost immediately complained of increased insomnia, nausea, shaking, dysphoria, and anxiety. The diazepam was restored to 5 mg twice a day, and the patient's complaints subsided. After three subsequent attempts to taper the medication, the physician was frustrated and referred the patient to a psychiatrist for a second opinion and advice on managing the benzodiazepine. After a careful history, the patient was felt to have met criteria for generalized anxiety disorder and benzodiazepine dependence. Before beginning a taper of the benzodiazepine, the patient was started on buspirone for her generalized anxiety disorder. After 2 weeks, a diazepam taper of 1 mg/mo was initiated. After 10 months the diazepam was discontinued, but she complained of residual insomnia. She was given L-tryptophan, 500 mg at bedtime. She then had no further complaints of anxiety or insomnia.

This patient fit the most common profile of long-term medical users of benzodiazepines—white women aged over 50 years.¹⁶ Long-term medical users represent a small percentage of the total number of benzodiazepine users. The 1979 national survey of psychotherapeutic drug use demonstrated that 11% of individuals aged 18 years or older used a benzodiazepine for medical purposes in 1979. Only 1.6% of the total sample used a benzodiazepine for 12 months or longer. This 1.6% accounted for 14.8% of all individuals using benzodiazepines for medical purposes. An additional 0.6% of benzodiazepine users took them from 4 to 12 months. Thus,

80% of benzodiazepine users used the medications for less than 4 months.¹⁷ Most benzodiazepine use is appropriately short-term.

While physical dependence is seen in individuals who take benzodiazepines chronically, tolerance to the antianxiety effects does not appear to be a significant concern.¹⁸ Individuals in long-term medical treatment for anxiety or to control seizure disorders rarely escalate their dose over time.¹⁹

Three quarters of the individuals who develop physical dependence on benzodiazepines do not experience a clinically significant benzodiazepine discontinuation syndrome. Of the one quarter of long-term benzodiazepine users who have clinically significant problems, approximately one third of that number have significant difficulty to the point where they experience clinical distress that is severe or prolonged and may require additional psychotherapeutic intervention.¹³

Overall, the data suggest that for individuals who receive benzodiazepines for a medical illness, duration of treatment is generally brief, tolerance is not experienced, escalation of dose is rare, and only a small percentage of individuals who take the medications for long periods experience significant benzodiazepine withdrawal symptoms. Patients may become benzodiazepine dependent but do not become benzodiazepine addicts.

A distinctly different profile emerges of benzodiazepine abusers. The following case will illustrate characteristics of the benzodiazepine abuser.

Case 3

A 27-year-old single man presented to a primary care physician with complaints of anxiety and a request for continuation of lorazepam he had received from another physician in a distant city. The patient stated that he had been treated for approximately 1 year with a dose of 5 mg/d. The patient's history of anxiety was vague and was characterized as feeling restless, unable to sleep, and "nervous." The physician was reluctant to dispense the benzodiazepine. She was concerned, however, that the patient might experience a withdrawal syndrome or possible seizure and agreed to continue the medication for 2 weeks while she obtained records from the previous physician. Three days after the patient was seen, he called the clinic and talked to a different physician. He requested another renewal of his benzodiazepine claiming that his original prescription had been stolen. The physician refused to renew the prescription and recommended the patient talk to his physician the following day. The physician made no note in the patient's chart that the patient had called to request additional medication. Two days later the patient called again and this time spoke to a third physician. He claimed that his lorazepam had been stolen,

and he was requesting only a few days' supply until he could come back and see his physician. The third physician, unaware that the patient had spoken to a second physician, agreed to renew the prescription until he could see his primary physician. When the patient's old records arrived, they revealed the patient had a past history of cocaine and alcohol abuse. He had fled that city after receiving a recommendation for chemical dependency treatment. When the patient returned to the clinic and was confronted about the medications and abuse of street drugs, he consented to a chemical dependency assessment. He failed to follow up with the chemical dependency assessment and never returned to the medical clinic.

Multiple Substance Abuse

The 1985 national household survey revealed that about 6.5 million Americans aged 12 years or older used a tranquilizer nonmedically in 1985.²⁰ The group of non-medical tranquilizer users was 61% male and 89% white, and 75% were aged 34 years or younger. Fifty-five percent of the group reporting nonmedical use of the benzodiazepines used the drugs 10 or fewer times. Thirty-two percent reported using them 11 to 99 times, and 13% reported use more than 100 times in their lifetime. Individuals who reported using a tranquilizer nonmedically also reported significant lifetime rates of use of other drugs. Ninety-five percent reported alcohol abuse, 72% marijuana abuse, 63% tobacco use, 49% cocaine abuse, and 2% heroin abuse. Benzodiazepine abusers were therefore multiple-substance abusers of which benzodiazepines were but one drug. While most medical users of benzodiazepines take low doses of benzodiazepines, abusers take doses in ranges of, or equivalent to, 80 to 200 mg of diazepam per day.¹⁵ Tolerance to the euphoric effect and dose escalation are common in substance abusers. A recent study also suggests that individuals with chronic pain may be at risk for misuse of benzodiazepines.²¹

The 1985 national household survey identified the relative rates of abuse of many psychoactive drugs. Cigarettes and alcohol were the most widely used drugs in the United States.²⁰ Fifty-nine percent of the respondents reported consumption of alcohol in the past month. Cigarettes were used by 31.5%. Illicit drug use (marijuana, cocaine, hallucinogens, and heroin) was reported by 13% of the respondents. In contrast, tranquilizers (primarily benzodiazepines) were used by only 1.1% of the surveyed population in the past month. These data suggest benzodiazepine abuse is relatively uncommon in comparison with other abused substances. If an individual abuses a benzodiazepine, it is unlikely to be a drug of choice, and more likely the individual is abusing many different psychoactive substances.

This observation has also been borne out by experimental studies comparing benzodiazepine preference to placebo. Normal or anxious individuals show no preference to benzodiazepines over placebos. Substance abusers, on the other hand, demonstrate marked preference of benzodiazepines to placebos.²²⁻²⁴

PHYSICIAN LIABILITY CONCERNS

Many physicians are reluctant to prescribe benzodiazepines out of a fear of producing dependency in their patients and potential negative scrutiny by their peers or medical examining boards.

Most physician do prescribe benzodiazepines appropriately and safely. Physicians who inappropriately prescribe benzodiazepines (or any controlled substances) fall into four groups: (1) dated physicians—those physicians who have failed to keep abreast of current developments in medicine and dispense controlled substances for inappropriate reasons; (2) deceived physicians—those physicians who are given false histories by patients and who dispense the medication in the belief that they are treating a legitimate medical disorder; (3) impaired physicians—physicians who themselves are impaired by a substance use problem or psychiatric condition that reduces their ability to make rational and well-informed medical decisions; (4) criminal physicians—physicians who dispense controlled substances for profit. These individuals clearly violate ethics of medicine as well as laws of the United States.

Despite good intentions, physicians may still make mistakes in prescribing controlled substances. The Minnesota State Board of Medical Examiners recently published a review of malprescribing practices by physicians in Minnesota.²⁵ The board identified acetaminophen with codeine as the most frequently malprescribed medicine in Minnesota. Diazepam was cited as the second most frequent malprescribed medication. The malprescribing practices included (1) administering a drug for too long a period, (2) prescribing a drug to an addicted or dependent patient, (3) prescribing a medication for inappropriate indication, (4) dosing a medication higher than recommended, (5) failing to monitor the medication once dispensed, (6) prescribing a medication without a proper history or physical in the chart, (7) prescribing a medication for self-addiction, (8) issuing a prescription for a controlled substance without knowing the patient, (9) prescribing controlled substances for a family member for that family member's addiction, (10) prescribing amphetamines for weight loss, (11) producing addiction in patients because of the prescription, and (12) prescribing controlled substances with other drugs producing undesirable drug interactions.

TABLE 3. PRACTICES TO MINIMIZE MEDICOLEGAL PROBLEMS ASSOCIATED WITH PRESCRIBING BENZODIAZEPINES

| |
|---|
| Identify and document specific diagnosis |
| Use alternative medication if available and if side effects are tolerable |
| Assess for risks of benzodiazepine abuse |
| Discuss and document benzodiazepine risk with patient |
| Document why benzodiazepine is the appropriate treatment |
| Use benzodiazepines for approved indication |
| Use benzodiazepines at approved doses |
| Specify target symptoms and response |
| Medicate for limited time (4–6 mo) |
| Employ drug holidays |
| Keep pill counts; document telephone contacts |

What can physicians do to minimize the risks associated with prescribing benzodiazepines for their patients? Table 3 lists practices to reduce benzodiazepine problems. It is important to identify and document the specific diagnoses of individuals and to tailor treatment to that specific condition. As previously mentioned, many patients with major depression present with symptoms of generalized anxiety or panic, and a trial of a tricyclic or monamine oxidase inhibitor antidepressant should be considered in the clinical management of anxiety symptoms. Buspirone, a nonbenzodiazepine antianxiety medication, is useful in the treatment of generalized anxiety but has no utility in the management of panic disorder or major depression. Adjunctive therapies such as relaxation therapy, meditation, biofeedback, group therapy, or individual therapy should also be an integral component in the comprehensive management of these disorders.

Since benzodiazepine abuse is most common in multiple-substance abusers, an appropriate chemical history and collateral data from family members and medical records are important to corroborate the patient's report. Documentation of all aspects of care is important. Benzodiazepine risks and benefits should be discussed with the patient and documented. The rationale for the use of the benzodiazepine as appropriate treatment should be documented at the outset of treatment. Benzodiazepines should be used for approved indications and at appropriate doses. Rapid escalation of the dose or the patient's complaint of no benefit should increase the physician's concern that the diagnosis may be in error or that the patient is abusing the medication. Target symptoms and responses to treatment of those target symptoms should be documented during regularly scheduled visits. Drug holidays, a scheduled time of medication discontinuation, should be employed at least every 6 months, and the patient should be informed at the outset of treatment the rationale for the drug holiday to minimize discomfort and apprehension. The benzodiazepines should be tapered

slowly over 6 to 8 weeks to minimize rebound or withdrawal symptoms. Once the medication has been discontinued, an observation period of 2 to 4 weeks is necessary to document emergence of anxiety symptoms. If they return, reinstatement of treatment is necessary, and appropriate documentation should accompany the resumption of medication. The anxiety disorders can be chronic in nature, and the treatment may be protracted.

SUMMARY

The benzodiazepines have received a great deal of negative coverage by the communication media, and misinformation exists about their abuse potential, both of which have created apprehension on the part of physicians dispensing them for legitimate medical purposes. As the data in this paper demonstrate, the prevalence of benzodiazepine abuse is low in the general population and highest among individuals who have a history of multisubstance abuse. Physicians can reduce their concerns about dispensing these medications by becoming more familiar with the common symptoms of anxiety disorders, understanding the potential benzodiazepine discontinuance syndromes, and collecting a thorough history. Documentation of the need for benzodiazepines and close follow-up should be stressed. By following the proposed guidelines, physicians should adequately protect their professional integrity, avoid accusations of malpractice, minimize the development of dependence in their patients, and provide the care and treatment that their patients need.

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