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Can One Avoid The Dependence To The Benzodiazepines?

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ABSTRACT:

CAN ONE AVOID THE DEPENDENCE TO THE BENZODIAZEPINES?

Benzodiazepines are widely used derivatives due to their efficiency and weak toxicity. However, there is a myth of clinical dependence to the prescription and the faulty attitudes of the pharmaceutical companies towards making benzodiazepines to be prescribed more which was later found not to be necessary. When a benzodiazepine is to be prescribed, question must be asked if the patient has predisposing factors for dependence. Since not all the benzodiazepines prescribed patients develop dependency, patients' possible dependency profile must be considered. For example, attention must be paid to avoid prescription to the patients with Antisocial Personality Disorder. Since patients with Social Anxiety Disorder (previously known as social phobia) do no benefit from benzodiazepine treatment since core problems wont to be targeted, the antidepressant treatment will be more beneficial. Thus it's important to be cautious when prescribing to this group of patients who generally have a history of drug abuse. Therefore, it is important to discuss with the patient to make the time limit of the treatment certain.

In conclusion, when the efficiency of the benzodiazepines are re-evaluated and demonstrated, the personality traits should, strongly, be taken into consideration in the risk-benefit assessment.

Key words: benzodiazepines, dependency, substance abuse.

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ÖZET:

BENZODİAZEPİNLERE BAĞIMLILIK ÖNLENEBİLİR Mİ?

Benzodiazepinler yüksek etkinlikleri ve zayıf toksik özellikleri nedeni ile sıkça kullanılan türevlerdir. Bununla birlikte, bunların reçetelendirilmesinde klinik bağımlılık yaptıkları ve bazı ilaç firmalarının geçmişte toplumu bu ilaçları gereksiz yere kullanırmaya özendirme ve bunun daha sonra gereksiz olduğunun anlaşılması gibi yanlış tutumlarından dolayı genel bir çekingenlik vardır. Bir hastaya benzodiazepin reçete edileceği zaman hastanın bağımlılığa yatkın özelliklerinin olup olmadığına bakılmalıdır. Benzodiazepin yazılan hastaların tümü bağımlılık geliştirmeyeceğinden dolayı hastanın bağımlılık geliştirebilme profili iyi belirlenmelidir. Örneğin, Antisozyal Kişilik Bozukluğu potansiyeli olan hastalara benzodiazepin yazılmamasına dikkat edilmelidir. Yine Sosyal Anksiyete Bozukluğu (eski adıyla sosyal fobi) tanısı konan hastalarda antidepressan tedavisi daha yararlı olacağından ve benzodiazepin tedavisi temel sorunlarını hedef almaya çağından ve ilaç kötüye kullanımı bu grupta da sık görüldüğünden bu hastalara benzodiazepinler dikkatle yazılmalıdır. Bu nedenle, benzodiazepin tedavisinin zaman sürecini belirlemek için hasta ile ayrıntılı görüşmede fayda vardır.

Sonuç olarak, benzodiazepinlerin etkinliğini yeniden gözden geçirip sergilerken risk-yarar yargısında kişilik özellikleri önemle dikkate alınmalıdır.

Anahtar sözcükler: benzodiazepinler, bağımlılık, madde kötüye kullanma.

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Benzodiazepines are derivatives extensively used as anxiolytics and hypnotics by reason of their efficiency and weak toxicity (1). However, in a lot of countries alarm bells are ringing concerning risks of dependence. Indeed, the use of these medicines has been generalized after 30 years utilisation period. Thus, in USA 1,6% adults consume benzodiazepines in contrast to 3,1% in Britain and 5% in France (2). Various arguments have been developed to explain their continuous use (3):

- the resurgence of the anxiety after withdrawal,
- the unpleasant withdrawal effects,
- the fear to withdrawal,

- the non-precision of the length of the treatment by the physician,
- the sociological phenomenon.

A myth especially developed is the development of clinical dependence to the prescription and that pain due to the benzodiazepine is the fault of the pharmaceutical companies' laboratories.

A question; are there predisposing factors in the patients for dependence? Indeed, if one considers that not all patients prescribed benzodiazepines are dependent, even though the treatment is short length, the candidates' possible dependent profile must be considered. Unfortunately, there doesn't

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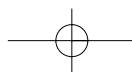
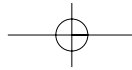


Table 1. Withdrawal scale (8)

1) Physical tiredness	
None	0
Tiredness but without need to lie down	1
Requiring to lie down from time to time	2
To lie down all day long	3
2) Sleep disruption	
Normal sleep without hypnotics	0
Normal sleep with hypnotics	1
8 to 6 hrs sleep with hypnotics	2
Less than 3 hrs of sleep with hypnotics	3
3) Migraines	
None	0
Occasional without need of analgesics	1
Constants but moderate, or occasional severe, salicylate efficient	2
Constants and severe, inefficient salicyléses	3
4) Dizziness	
None	0
Blackouts, occasional and light	1
Constant blackouts but light or occasional severe blackouts	2
Constant severe blackouts. Requiring to lie down	3
5) Orthostatic symptoms	
None	0
Blackout feeling when stand-up abruptly	1
Requiring to stand up slowly to avoid the blackout feeling	2
Unconsciousness	3
6) Palpitations	
None	0
Light palpitations	1
Palpitations occasionally disturbing	2
Constant disturbing palpitations	3
7) Tremors	
None	0
Light tremor, movements not affected	1
Obvious tremor, small movement disruptions,	2
Severe tremor	3
8) Sweating	
Normal	0
Increased slightly	1
Increased in an obvious manner	2
Profuse	3
9) Dry mouth	
None	0
Light, but not subjectively unsettled	1
Obvious, but not severe or painful	2
Severe, rendering eating painful	3
10) Constipation	
None	0
Light constipation without need of laxatives	1
Obvious constipation, requiring laxatives,	2
No bowel movements in spite of laxatives	3
11) Micturition problems	
None	0
Light	1
Difficulties in emptying bladder. Treatment required	2
Urinary retention	3



exist a convenient method to know whether this type of problem develops. The answer cannot be given at the time of the reduction of dosage or at the stop of the treatment when withdrawal symptoms appear (table 1).

One third of patient population seen by the British psychiatrists were reported to suffer from withdrawal symptoms, however these only included those who consulted psychiatrist rather than a general practitioner. Also, one third of the population at risk must be identified knowing that the definitive answer is unavailable, until after treatment begins. Firstly, attention must be given to avoid prescribing benzodiazepines to potential antisocial personality disorder cases i.e., characterised by an unstable mood and manifesting impulsive reactions. In these cases, the benzodiazepines are likely to exaggerate their natural disinhibition.

Other subjects, proven to be dependent, correspond to the description of the DSM III R of "shy" persecutors. A large proportion of these patients suggesting chronic anxiety suffer from personality disorders along with mood disorders. Long-term benzodiazepine treatment does not affect the underlying problems. Perhaps it is more appropriate to utilise antidepressant in this case? However, it is possible that these personalities are also perceptible to antidepressant dependency (4).

To avoid risk of dependence it would be necessary to choose ones' patients suffering anxiety and lacking mood disorders and hysteria. However, it is better to discuss with the patients the treatment duration, to arrange a specific time-limit, in conjunction with true evaluations of anxiety and dependence levels, especially not to augment the dosage after beginning the course.

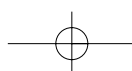
Another solution that does not depend on neither the physician, nor the subject, would be to avoid the strong marketing used by the pharmaceutical business to protect profitability, resulting in the increase of prescriptions. Physicians feel "trapped" and develop a guilt at withdrawing prescriptions

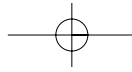
especially at the failure of the relationship they have with patients as well as the laboratory manufacturers. Conversation in the remedy to anxiety and the shade of the confessional seems to be less suspicious to the dialogue. To re-evaluate so much finance that morally affects the medical act, to teach to the physician whom it is to the centre of the social dialogue and to give back to him forces himself "alone", this remedy is more expensive to begin with in comparison with the benzodiazepines but may be more profitable in the long term. All societies have their illnesses and ours is not sicker than the previous, it meets the normal difficulties bound to the complexity of tasks. We enter into a civilisation excluding the "infirmity" for lacking the intellectual quotient in comparison to the previous civilisation who excluded those with psychotic problems.

Curiously benzodiazepines consumption is higher than average in towns whose population are less 5000 inhabitants and cities of 100000 or more inhabitants. Can social life be easier to organise between these two extremes?

In conclusion

It must be noted that if dependence exists, the risk of dependence to benzodiazepines is weak in relation to their large distribution (5) and there is little chance of overdose. The most serious side effects are the risk of daytime sedation, loss of memory and de-socialisation of the aged (6). It would be useful to re-evaluate the efficacy of the benzodiazepine treatment of chronic anxiety in order to show that it does not interfere with the psychic workings of the person while diminishing the symptoms. Efficacy may be influencing dependence, as this seems more notable in neurotic patients (7). The potential for difficulty with discontinuation related to personality traits should be one of the factors weighted in the risk - benefit assessment for making the planning of benzodiazepine treatment for patients with anxious symptomatology.





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