



Benzodiazepine Myths and Truths

At the same time that I was asked to review Dr. Lorraine Sharon Roth's article "PTSD and Benzodiazepines: A Myth Agreed Upon" published on page 12 of this issue of *Federal Practitioner*, an article with a similar title ("Benzodiazepines and Addiction: Myths and Realities"), but with somewhat different conclusions, appeared in *Psychiatric Times*.¹ The differing perceptions of "myth" in the twentieth century may help explain how the same term could be applied in 2 concurrent expert reviews—of the evidence-base that undergirds clinical guidelines regarding the use of benzodiazepines for anxiety disorders—and allow the authors to arrive at relatively divergent interpretations. According to the *Dictionary of the History of Ideas*, the meaning of the word myth is ambiguous, as "Today the word is employed in both the older sense of 'fiction' or 'illusion' and in the sense of 'sacred tradition, primordial revelation, and exemplary model.'"²

The lack of agreement evident in these 2 recent articles challenges the authors' contention that there is consensus (a myth agreed upon) in the views of opinion leaders in psychopharmacology regarding the effectiveness and appropriateness of benzodiazepines when utilized in anxiety disorders, particularly post-traumatic stress disorder (PTSD). As I have argued elsewhere,³ there is perhaps no psychoactive drug in the contemporary cache of medications that arouses such controversy and disagreement. The authors argue in both articles that benzodiazepines are not advocated as widely in treatment guidelines as the drugs' merits warrant. Yet, studies show that in clinical

practice the drugs continue to be first-line treatments for chronic anxiety disorders like PTSD, contrary to current recommendations.⁴

In her article, Dr. Roth presents an incisive analysis of the actual data underlying recommendations regarding the use of benzodiazepines in PTSD presented in national and international guidelines. She has done primary care and mental health practitioners a great service in pointing out the datedness, design biases, and methodologic flaws in many of the most frequently cited articles that support a lack of benefit and propensity for harm when benzodiazepines are prescribed for PTSD. This analysis reinforces that evidence-based medicine is only as reliable and useful as the evidence on which it is based.

The truth disclosed by this analysis of myths in the sense of fiction or illusion, is that benzodiazepines are safe and effective medications for the treatment of PTSD-associated insomnia and anxiety in carefully selected patients. This is why practitioners continue to prescribe benzodiazepines for PTSD and other anxiety disorders contrary to what guidelines recommend. The use of these medications has become a tradition with real-world reinforcement from patients who tend to be more satisfied with the rapid relief they obtain from benzodiazepines than with recommended first-line medications like selective serotonin reuptake inhibitors (SSRIs). As every primary care and mental health practitioner knows, tapering patients off benzodiazepines when they are no longer working, when they cause adverse effects, or when concerns for abuse have developed, results in both physi-

ologic perturbations in the patient and interpersonal conflict in the therapeutic alliance. The truth in the sense of revelation that Cloos and other experts emphasize is the addictive potential of this class of drugs especially in patients with active and historical substance use disorders.⁴ Dr. Roth does acknowledge these risks, but may not give them the same weight in the risk/benefit balance of decision-making as other experts.

Whatever side of the benzodiazepine PTSD controversy clinicians favor, the division of perspective highlights the historic lack of communication and collaboration between the substance use disorder and PTSD communities and the need for integrated care for these 2 prevalent and disabling co-occurring disorders.⁵ On one hand, practitioners trained in anxiety disorders and focused upon the care of patients with PTSD often see benzodiazepines as an unfairly maligned class of drugs, allowing even patients with dual diagnoses to participate in trauma therapy. On the other hand, practitioners whose background is in preventing and treating addiction often have had clinical experience confirming that benzodiazepines can be dangerous exemplars of the self-medication hypothesis that is actually detrimental to recovery from both disorders. For instance, sleep and anxiety are well-known triggers for relapse and yet benzodiazepines can lead to resumption of drinking or the development of sedative abuse or dependence; so what is the practitioner, who is faced with this dilemma and wishing to act ethically, to do?

By uncovering the deficiencies in some of the most-often-quoted articles cited in key recommendations

discouraging the use of benzodiazepines for PTSD, Dr. Roth has taken an important first step in responding to such clinical situations. Study of even the imperfect medical literature on benzodiazepines⁶ and consultation with clinical experts can help practitioners to identify risk factors for prescribing benzodiazepines (such as current alcohol dependence and cognitive impairment), as well as target PTSD symptoms for which the medications are more likely to be effective (such as insomnia, anxiety, and hyperarousal). Identifying those members of the benzodiazepine class with more addictive profiles, for example diazepam,⁷ and administering scheduled, rather than when needed, medications may maximize the benefit and minimize the risk.

Those who are cautious about using benzodiazepines in the treatment of PTSD would robustly second Dr. Roth's call that more research needs to be conducted into the role of benzodiazepines in PTSD and other anxiety disorders. This is especially true as we face an ever-growing cohort of active duty soldiers and veterans presenting to primary care providers with newly diagnosed PTSD and

often concomitantly with a substance use disorder.⁸ Unfortunately, because benzodiazepines are relatively inexpensive and now generic, there is little pharmaceutical industry incentive to conduct such studies. The funding and initiative will need to come from the DoD/VA, who have demonstrated interest in studying any medications old or new that could successfully treat PTSD. Proponents and opponents also would agree that other pharmaceutical options available for PTSD, such as the growing prescription of atypical antipsychotics and even the ubiquitous SSRIs, also come with serious adverse effects, further underscoring the urgency of expanding the PTSD pharmacopeia. ●

Author disclosures

The author reports no actual or potential conflicts of interest with regard to this editorial.

Disclaimer

The opinions expressed herein are those of the author and do not necessarily reflect those of Federal Practitioner, Quadrant HealthCom Inc., the U.S. Government, or any of its agencies. This article may discuss unlabeled or

investigational use of certain drugs. Please review complete prescribing information for specific drugs or drug combinations—including indications, contraindications, warnings, and adverse effects—before administering pharmacologic therapy to patients.

REFERENCES

1. Cloos J-M. Benzodiazepines and addiction: Myths and realities (Part 1). *Psychiatr Times*. 2010;XXVII(7):26-29.
2. Eliade M. Myth in the Nineteenth and Twentieth Centuries. In: Wiener PP, ed. *Dictionary of the History of Ideas*. Vol III. New York, NY: Charles Scribner's Sons; 1973:307.
3. Geppert C. The religion of benzodiazepines. *Psychiatr Times*. 2007;24(4).
4. Cloos JM, Ferreira V. Current use of benzodiazepines in anxiety disorders. *Curr Opin Psychiatry*. 2009;22(1):90-95.
5. Norman SB, Tate SR, Wilkins KC, Cummins K, Brown SA. Posttraumatic stress disorder's role in integrated substance dependence and depression treatment outcomes. *J Subst Abuse Treat*. 2010;38(4):346-355.
6. Fang SY, Chen CY, Chang IS, Wu EC, Chang CM, Lin KM. Predictors of the incidence and discontinuation of long-term use of benzodiazepines: A population-based study. *Drug Alcohol Depend*. 2009;104(1-2):140-146.
7. Pradel V, Delga C, Rouby F, Micallef J, Lapeyre-Mestre M. Assessment of abuse potential of benzodiazepines from a prescription database using 'doctor shopping' as an indicator. *CNS Drugs*. 2010;24(7):611-620.
8. McDevitt-Murphy ME, Williams JL, Bracken KL, Fields JA, Monahan CJ, Murphy JG. PTSD symptoms, hazardous drinking, and health functioning among U.S. OEF and OIF veterans presenting to primary care. *J Trauma Stress*. 2010;23(1):108-111.