

The APA Task Force Report on Benzodiazepine Dependence, Toxicity, and Abuse

In 1987 the American Psychiatric Association, recognizing the need for guidelines for prescribing benzodiazepines, established a task force to gather and report on the available information regarding these widely prescribed drugs. The report has recently been published by APA (1) and is strongly recommended to all psychiatrists. The report represents a group consensus; agreement was not unanimous on all points. The work of the task force was supported entirely by APA funding.

Although many adults may take an occasional benzodiazepine, two-thirds of therapeutic use is for 60 days or less. Small but substantial numbers of adults have been taking benzodiazepines daily (or nightly) for 1 year or more. Over a period of many years, these adults represent 1.65% of the population, and they fall into four distinct groups. The first group comprises older, medically ill patients who are taking other medications. Benzodiazepines are usually prescribed for these patients by a nonpsychiatrist. The second group comprises psychiatric patients with panic or agoraphobic disorders. In the first and second groups, benzodiazepines are seldom abused, doses are not escalated, and patients as well as their physicians attest to the therapeutic necessity for the medication. The third group comprises psychiatric and general medical patients with recurrent dysphoria. Because of the vagueness and chronicity of symptoms in this group, the indications for long-term use are less certain than those for the first two groups. Occasional patients may escalate their doses, and abuse of higher doses in combination with alcohol or other abused substances may occur. The fourth group is composed of patients with chronic sleep disorder. Although research data do not consistently support the long-term hypnotic efficacy of benzodiazepines when taken for more than 30 consecutive nights, some patients claim that they cannot sleep without a benzodiazepine at bedtime. To what extent regular nightly benzodiazepines are preventing rebound insomnia or actually are treating a chronic sleep disturbance is not known.

Therapeutic use of benzodiazepines can be associated with potential hazards to the patient. True physical dependence can arise from chronic therapeutic use, defined by the appearance of a constellation of discontinuance symptoms following abrupt withdrawal. These symptoms can be divided into three categories: rebound, recurrence, and withdrawal. Rebound symptoms, the first to appear after drug termination, are the mirror image of the effects of the drug (worse anxiety, insomnia, and restlessness) and may be severe enough to cause the patient to return to the drug. For some short-half-life benzodiazepines, rebound symptoms may appear between doses, so that patients become dependent and are aware when the next dose will be needed. Other discontinuance symptoms, usually appearing after rebound, may be identical to the symptoms for which the drug was originally prescribed and confuse both the patient and the clinician. It is often difficult to determine whether these symptoms represent a recurrence of the original reasons for the benzodiazepine prescription, a manifestation of drug discontinuance, or both. Withdrawal symptoms that were not present when the drug was initially prescribed make up the third

category of discontinuance symptoms. Seizures and psychosis are infrequent but are the most serious of the withdrawal symptoms. They occur after high doses, long duration of treatment, and abrupt discontinuation, and the risk of seizures may be higher when another drug that lowers the seizure threshold is also being used. Other disconcerting withdrawal symptoms include tinnitus, depression, and a sensation of seasickness. Although all discontinuance symptoms occur primarily after abrupt drug termination, they may also appear after gradual tapering, especially in patients who have been taking higher than usual doses or have been taking therapeutic doses for extended periods of time.

The types of discontinuance symptoms are the same for both long- and short-half-life benzodiazepines. Clinical experience suggests, however, that short-half-life benzodiazepines, especially those which also have high potency, produce a more severe discontinuance syndrome that appears earlier than with long-half-life drugs. The severity of these discontinuance symptoms is reduced when doses are very slowly tapered. Clinical experience also suggests that high-potency, short-half-life benzodiazepines are more likely than other benzodiazepines to induce a state of therapeutic dose dependence, although there are no research data to confirm these observations.

In young and middle-aged adults, benzodiazepine toxicity is usually mild unless the drug is mixed with other sedative hypnotics or alcohol. Sedation, unsteadiness, and impaired psychomotor speed and accuracy are well-known benzodiazepine effects. Driving skills are not usually impaired by regular therapeutic doses of benzodiazepines but may be substantially compromised when a benzodiazepine is mixed with alcohol or when it is taken by a benzodiazepine-naïve person. Clinicians should regularly warn their patients about the risks of driving while taking benzodiazepines, and the mixing of alcohol or other sedative hypnotics must be forbidden if the patient is to drive.

Among the elderly, the toxicity of benzodiazepines takes on an additional dimension. Subtle but measurable cognitive impairment may be associated with both acute and chronic therapeutic doses of benzodiazepines. Unsteadiness and an increased predisposition to falling are not uncommon, so that extra caution must be exercised when benzodiazepines are prescribed.

In summary, benzodiazepines are important therapeutic drugs when carefully prescribed for appropriate patients. At standard therapeutic doses, short-term treatment is usually without substantial toxicity or development of dependence. At high doses or for prolonged periods of use, toxicity and dependence may increase in frequency and severity. Benzodiazepines are not drugs of abuse, although benzodiazepine abuse is common among people who are actively abusing alcohol, opiates, cocaine, or sedative hypnotics. Clinical evidence suggests that abuse is also more likely among patients with a history of alcoholism. It is important for clinicians to feel comfortable prescribing benzodiazepines for appropriate patients, but the potential for toxicity and dependence must be considered before prescribing. Patients who may receive benzodiazepines for long periods or at high doses should be also informed of these risks.

REFERENCE

1. Benzodiazepine Dependence, Toxicity, and Abuse: A Task Force Report of the American Psychiatric Association. Washington, DC, APA, 1990

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