

# Benzodiazepine therapy

## A global approach to the problems Part 3

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### Summary

*In this 3-part article, the author gives his observations of the good usage but also of the abuse of benzodiazepines as he experienced it in private family practice. He describes the prescribing habits of the doctor, the personality profile of the patient, the effects of the drug and the interrelationship between these. The paradox between the expected effect of benzodiazepine and the actual results, is well illustrated. In Part I, he shows that a thorough working knowledge of various pharmacokinetic and clinical parameters of the benzodiazepine derivatives is essential for efficient benzodiazepine therapy.*

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*In part II, he focuses on the prescribing doctor and his problems in deciding to commit his patient to the benzodiazepine alternative. In Part III, he describes the different types of patients, how they become part of the vicious cycle of this therapy and concludes with a few positive suggestions.*

I have chosen to classify the consumer profile of benzodiazepine usage into 3 groups, depending on the reason for which the drug is used. The practical reason for this classification is that the groups act as predictors for potential abuse.

### GROUP I

Those using a benzodiazepine derivative for a well-defined medical or surgical condition e.g.

- Epileptic convulsions
- Orthopaedic muscular spasm

Here, the benzodiazepine derivatives are used for their other properties, e.g. anticonvulsant properties, muscle-relaxant properties. Usage very rarely causes the problems as outlined in the "vicious cycle of benzodiazepine usage", since the mental attitude of the patient towards his medication is essentially of a non-neurotic nature. In addition usage is usually short term. If, however, the patient has a concomitant anxiety-related condition, which seems to "cure" itself while taking the benzodiazepine for the other somatic condition, and he has the insight and intelligence to relate cause and effect, the vicious cycle may be entered into, by the adoption of the psychological machinations of the cycle as described.

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### GROUP II

Those using benzodiazepines "short-term" (by intention) to minimise the painful impact of a well-defined specific traumatic experience eg

- Death of a loved one
- Divorce
- Business and financial crises

***Acceptance of the situation in its harsh reality is a prerequisite for the resolution of the conflict; and peace.***

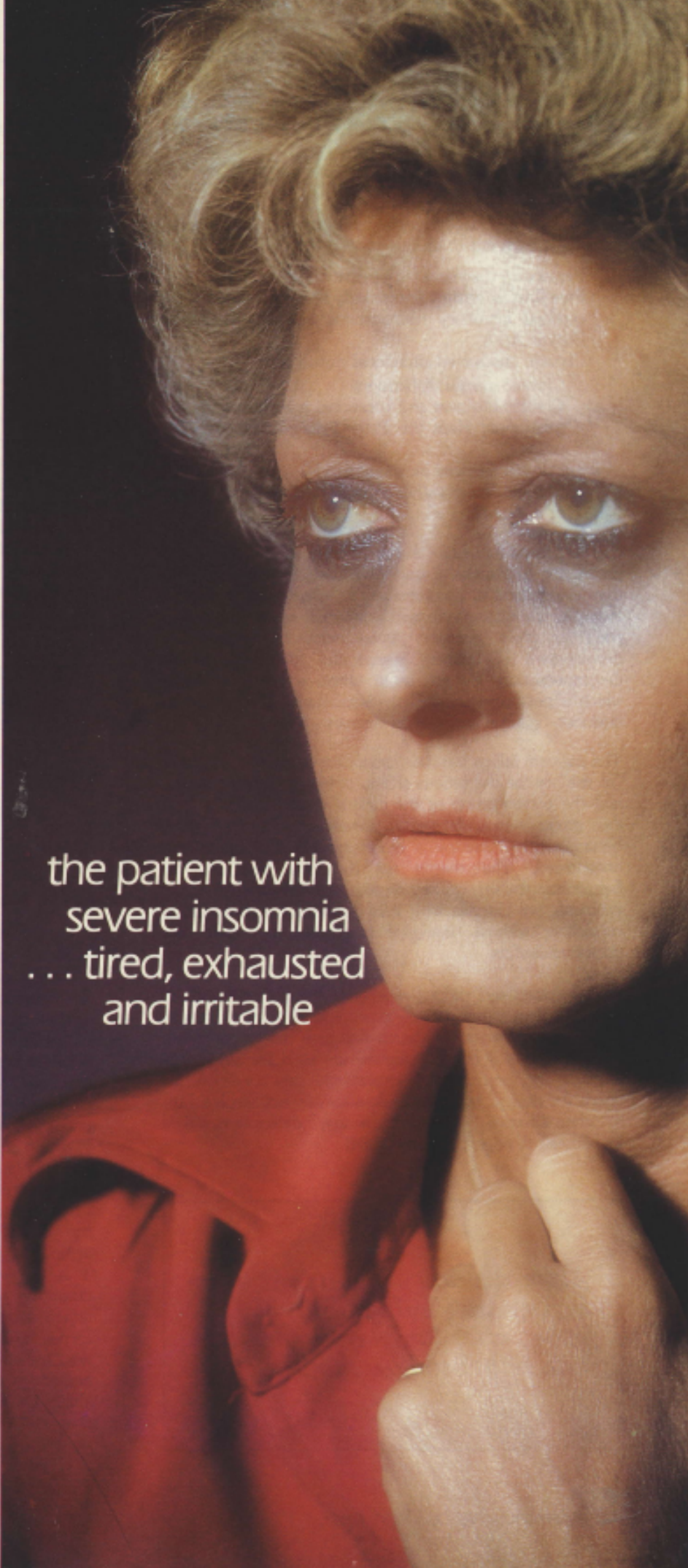
The protagonists for using a temporary anxiolytic crutch in these situations, reason that it is during such periods of crisis that one is often called upon to make far-reaching, critical decisions. One therefore needs a cool, calm head to reach the correct decisions on problems which inevitably flow from these situations, without also having to contend with the additional burdens of anxiety, insomnia and physical fatigue.

The antagonists to this view reason that any unpleasant event or situation, if it is to be effectively resolved, needs to be confronted, and one's psychorationalisation process set into motion. The various stages of initial shock, disbelief and denial are followed, in turn, by anger, bargaining, depression and finally acceptance of the situation, with resolution of the conflict.

***Dulling of the emotional impact by an artificially induced anxiolytic protective shield, will delay the patient's progress in coping with the crisis.***

Failure to resolve these situations will enable the problems to assume chronic characteristics, while the patient continues to use an anxiolytic in order to cope with them.

He then is classified as a Group III patient.



the patient with  
severe insomnia  
... tired, exhausted  
and irritable

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Group II patients are more at risk to enter the vicious cycle of benzodiazepine usage than those in Group I, but are less at risk than Group III.

### GROUP III

Those using a benzodiazepine derivative, potentially long-term for the treatment of:

- Personality disorders (eg passive dependant)
- Free-floating anxiety (intrinsically abnormal levels of the cerebral inhibitory neurotransmitter, Gamma Amino Butyric Acid)
- Chronic unresolved situational disturbance
  - i) Chronic marital disharmony
  - ii) Chronic business and vocational maladjustment and frustration. Here the Peter Principle<sup>2</sup> is often the cause.
  - iii) Chronic financial inadequacy.
  - iv) Chronic illness within one's immediate family circle, or in oneself.

It is important to realise that a problem in any one of the preceding four areas, if unresolved, will inevitably lead to the development of problems in the other three areas. For example, an unresolved marriage crisis often leads to a crisis in one's business arena, with the consequent development of financial stress and ultimately, health decompensation. By the same token, a health problem which is not accepted and psychosocialised, may lead to business, financial and marital stresses.

The patients falling into this group are those who are most "at risk" to the deleterious effects of benzodiazepine usage, and the promulgation of the vicious cycle. Ironically, it is the group which is most prevalent, and for which benzodiazepine therapy is most universally accepted and encouraged. The reason for the bad prognosis for benzodiazepine therapy in this group is that, by definition, the problems are chronic, with little potential for spontaneous resolution without intensive psychotherapy and psychosocialisation.

Having considered various aspects of the characteristics of the drug, doctor and patient, let us consider a few areas in which the paradox of benzodiazepine usage becomes evident; ie that if benzodiazepines are used for any length of time for psychological indications, the condition for which the drug is being used, does usually not resolve, but, in the absence of psychotherapy, deteriorates (see Hypothesis ii, page 169, June 1984).

***Animal studies show that there is a greater vulnerability to stress after long term consumption of benzodiazepine.***

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A similar phenomenon in man is suggested.

Even after the immediate withdrawal phenomena has passed, patients are more vulnerable to the stresses of life, possibly because their coping mechanisms have become atrophied during the long period of drug therapy<sup>7</sup>.

- i) Using a hypnotic for sleep disturbance in the long-term maintenance mould often results in tolerance, incremental dosage regime, tachyphylaxis, increasingly disturbed sleep patterns, including frequent nocturnal awakenings and anxiety attacks, and the development of new anxiety symptoms during the day. R.E.M. sleep is often diminished, and the patient is "always tired". While short-term hypnotics are extremely effective during a crisis, it is the psychological dependence on the hypnotic, gradually acquired, which insidiously alters the act of sleep into a conditional response to ingestion of the hypnotic, which then becomes a pre-requisite without which sleep cannot occur. Ultimately, although one is totally dependant on the hypnotic to fall asleep, the quality and length of one's sleep is usually worse than that operative before the beginning of benzodiazepine use.

***Using a hypnotic for sleep disturbance insidiously alters the act of sleep into a conditional response to ingestion of the hypnotic.***

- ii) It is only a suspicion at present, but one based on recurrent observation of many of my patients, that agoraphobic symptomatology<sup>11</sup> with widely spread phobic situational reactivity, often develops in Group III patients who begin to take benzodiazepines p.r.n. (when necessary) in response to hitherto well defined and cultivated anxiety-provoking situations. There often seems to be a rapid decompensation of the patient's emotional stability coinciding with the initiation of benzodiazepine usage. Often, a fully-blown agoraphobia develops, with the recognition and formation of a host of new situational phobias, all of which are temporarily controlled, when they occur, by ingestion of a benzodiazepine. Thus, while the patient actually is generally much worse since taking the drug, it is the only thing which brings relief short-term, during an acute anxiety attack. The patient begins to attach superhuman properties to his miracle pill. He carries them on his person with obsessive determination, transferring onto them his hope for surviving the hazards of his phobia-filled day. His confidence in his ability to meet a certain situation economically in his own strength becomes eroded with insecurity. He rapidly becomes an emotional cripple.

***While the patient actually is worse since taking the drug it is the only thing which brings relief short term, during an acute anxiety attack.***

This situation seems to develop rapidly in the susceptible personality prototype (Group III patients). These patients should not be encouraged to use benzodiazepines on a p.r.n. basis, because it is by experiencing the magical effect that benzodiazepines have on the palliation of their primary phobia that they become so emotionally and psychologically dependant on them that they cannot conceive of any situation being managed without the ingestion of one of their "happy pills". Again, it seems that the paradox is demonstrated; that the patient's clinical condition deteriorates once benzodiazepines are used.

- iii) It is characteristic to see an anxious patient, with serum levels of benzodiazepines far in excess of the recommended dosage due to chronic usage, tolerance and dependance, sitting in your surgery, shaking with a fine tremor. This, again, is a paradoxical situation — the very symptom complex that one is trying to cure seems to be grossly exaggerated in the patient who is on megadosages of these drugs. Many may like to think that the apparent regression is merely the course of the natural history of the symptomatology, but my impression is that the symptomatology seems to accelerate much faster once benzodiazepine therapy is introduced, particularly if the patient is in Group III.

***The very symptom complex that one is trying to cure seems to be exaggerated in the patient who is on megadosages of these drugs.***

the patient with  
severe insomnia  
... enjoying a good  
night's rest!  
undisturbed, a deep  
and restful sleep

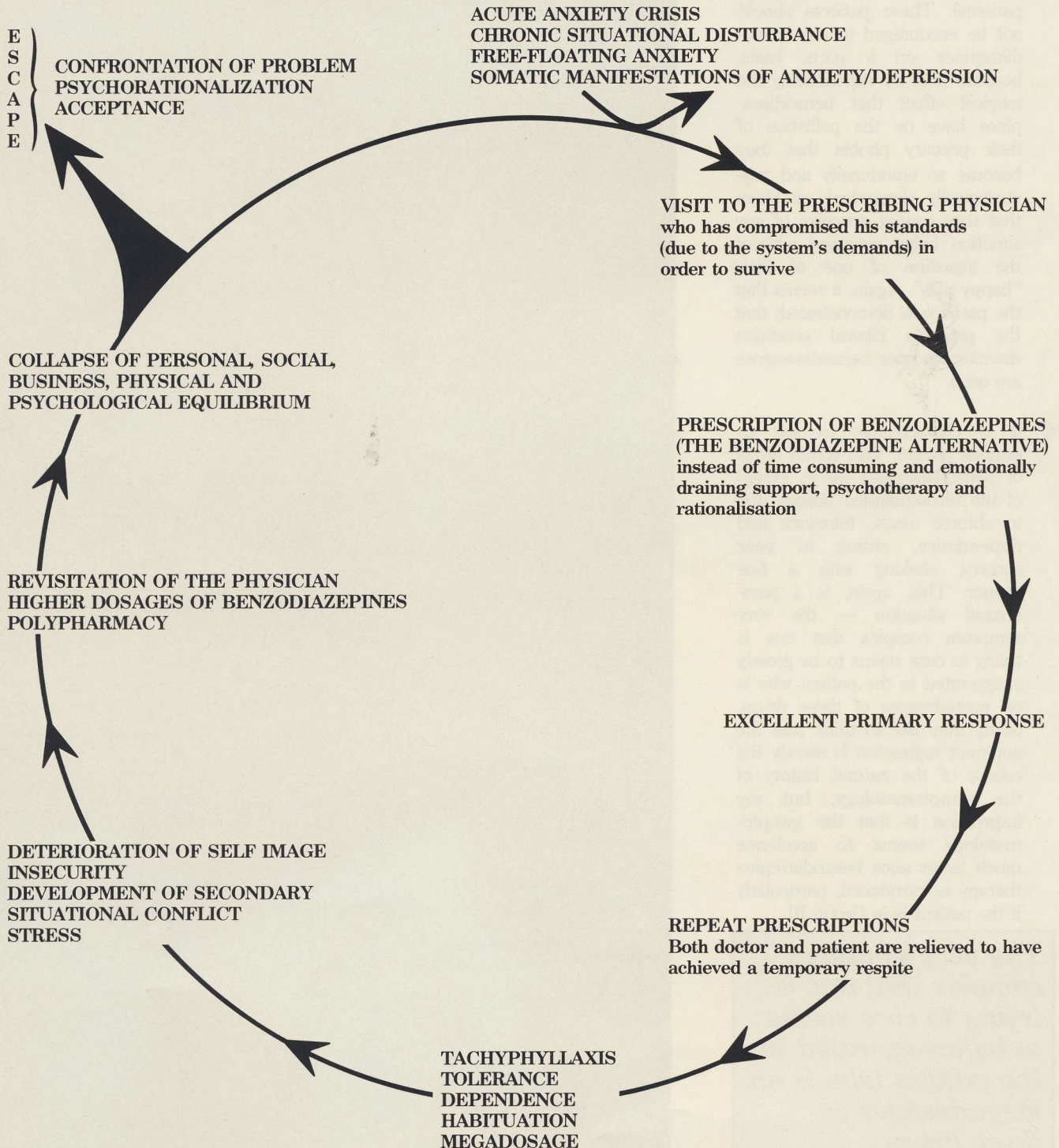


In many somatic manifestations of psychological imbalance due to the internalisation of stress, the underlying disorder is often a reactionary or endogenous depression. The anxiety which is manifested is merely a symptom of the depression. As such, the therapy should be directed primarily against the depression. To use a central nervous system depressant such as a benzodiazepine in a primary depressive disease will obviously compound the problem, and may explain, to a certain extent, the paradox which is observed in these cases. It is up to the prescribing physician to make the correct diagnosis.

## THE VICIOUS CYCLE OF BENZODIAZEPINE USAGE:

It should now be easy to understand the dynamics involved in the formulation of this cycle. We have considered the characteristics of the three interacting parameters, namely, the drug, the doctor and the patient. It is the dynamic inter-reaction between these three variables which gives us, in certain cases, the correct set of circumstances which would encourage the progression of events as depicted in the cycle. The succeeding events are predictable and ordered if one understands the preceding discussion.

### THE VICIOUS CYCLE OF BENZODIAZEPINE USAGE



## Benzodiazepine therapy

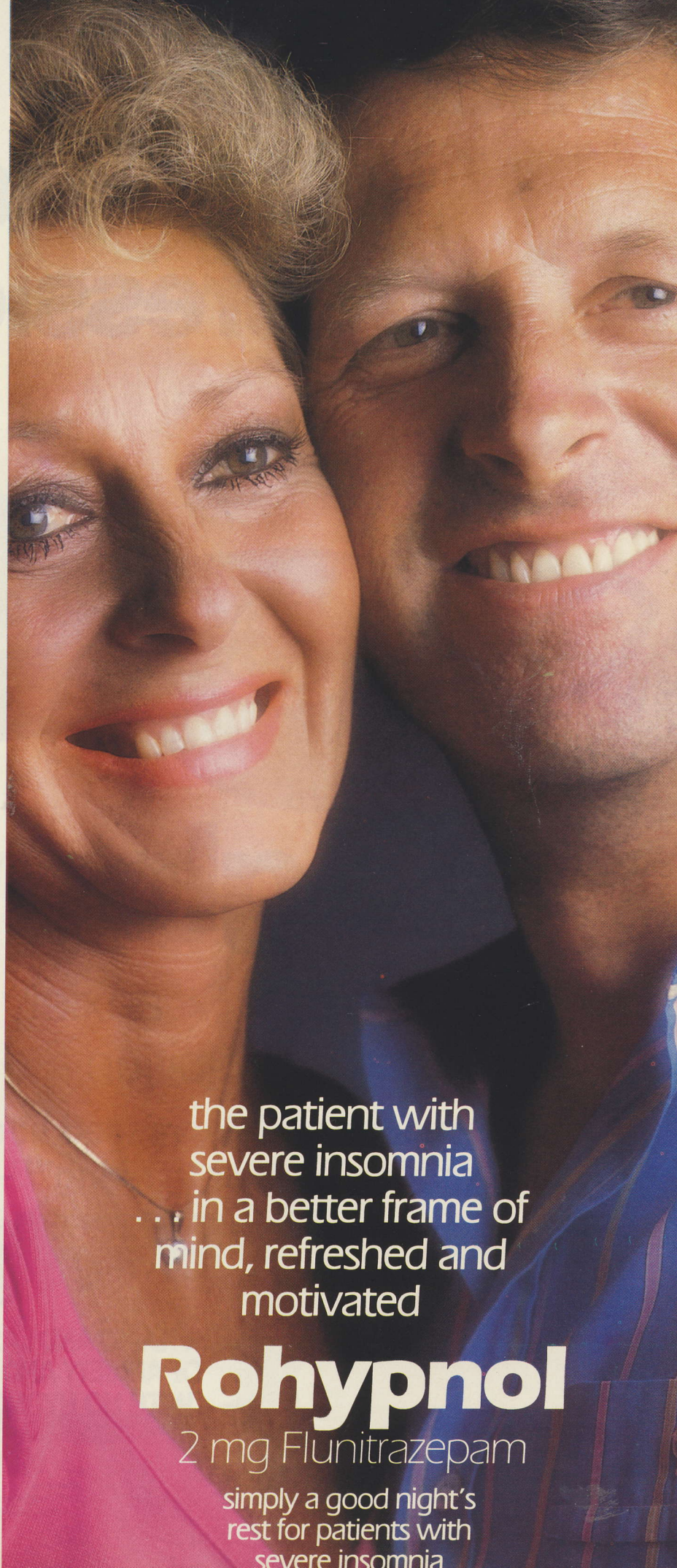
### CONCLUSION

To provide a solution to this multi-factorial problem would be presumptuous. However, there are five aspects arising from this discussion which would undoubtedly result in a more effective outcome for the emotionally compromised patient:

1. Encourage a greater emphasis to be placed on the study of psychological and emotional problems in the medical curriculum. This will equip the graduating doctor with a more acute awareness of the problems which he is likely to encounter in medical practice.
2. Change the remuneration system of the medical practitioners in South Africa — ie link remuneration to a suitable unit of time, and not the number of patients that are seen. This will allow the practitioner to spend more time with his patients and will encourage involvement on a psychotherapeutic basis without compromising his income.
3. Change the status of the benzodiazepines to that of a Schedule 7 drug, thereby increasing control and making it less freely available. Recent correspondence in the *Lancet* has highlighted the tremendous political pressure which the drug companies have exercised in successfully preventing the scheduling of certain benzodiazepines recently on a World Health Organisation recommendation<sup>11</sup>.
4. Educate and inform the general public as to the dangers and consequences of casual usage of the drug.
5. Drug companies to fund a withdrawal centre, to enable those who are already committed to tranquilizer usage, to be weaned and cured. This will enable the drug companies to "put something back", and establish their bona fides.

### REFERENCES:

2. Tyre P, Owen R, Dawling S. Gradual withdrawal of Diazepam after long-term therapy. *Lancet* 1983; 1: 1402-1406.
5. Peter LJ, Hull R. *The Peter Principle*. London: Pan Books, 1970.
11. Weeks C. *Simple effective treatment of agoraphobia*. New York; Hawthorn Books, 1976.



the patient with  
severe insomnia  
... in a better frame of  
mind, refreshed and  
motivated

**Rohypnol**  
2 mg Flunitrazepam

simply a good night's  
rest for patients with  
severe insomnia