Benzodiazepines are NOT Appropriate for Long Term Anxiety Treatment

Current use of benzodiazepines in anxiety disorders
Cloos, Jean-Marc; Ferreira, Valérie
Current Opinion in Psychiatry
Issue: Volume 22(1), January 2009, p 90–95

The following are excerpts from the above article. All of the information is supported by valid references:

The American Psychiatric Association (APA, 1998) guideline for the treatment of panic disorder and the National Institute for Health and Clinical Excellence (NICE, 2004, amended 2007) guideline on the management of anxiety actually recommend selective serotonin reuptake inhibitors (SSRIs) as the best choice for the treatment of these anxiety disorders, alongside cognitive–behavioural therapy (CBT) and self-help based on CBT principles.

According to the NICE guidelines, benzodiazepines (BZDs) are associated with a less good outcome in the long term and should not be prescribed for the treatment of individuals with anxiety disorders, and they should not usually be used beyond 2–4 weeks.

The APA guideline points out that, with BZDs, consideration must be given to the fact that all of them will produce physical dependency in most patients and that this may make it difficult to discontinue treatment.

Even though BZDs mainly have a favourable side effect profile, patients may experience sedation, fatigue, ataxia, slurred speech, memory impairment and weakness.

If BZDs are used, even when anti-anxiety medication or CBT has probably started to work, the patient may still believe that the BZD is the effective agent and then have difficulty discontinuing it.

BZDs may relieve anxiety to such an extent that the patient loses motivation to follow all the steps of CBT.

Even after relatively brief periods of BZD treatment – often only a few weeks – some patients experience withdrawal reactions upon discontinuation and may believe that they are experiencing an anxiety relapse; thus, they have great difficulty in discontinuing the use of the BZD.

For all these reasons, BZDs are currently recommended only in the initial stages of the treatment of anxiety disorders, until more definitive treatment is likely to work.

In order to prevent addiction, the clinician should avoid unnecessarily high doses of BZDs, ask the patient to take these medications only when needed, and favour psychotherapy or antidepressants or both.

Clinicians should not prescribe BZDs to patients with a history of substance abuse, owing to a higher prevalence of BZD abuse and a greater euphoric response to BZDs in these patients, and be careful when prescribing them in the elderly.

SSRIs are a first-line treatment in these disorders, alongside serotonin–norepinephrine reuptake inhibitors (SNRIs). The study points out that BZDs are also effective treatments, especially because of the advantage of a rapid onset of action, but that their use is limited by their potential for abuse and lack of antidepressant properties.

Clinicians should remain careful when prescribing BZDs to potentially suicidal patients. It has been suggested that ... BZDs have disinhibitory effects in approximately 5% of the patients.

There are studies that did not find any convincing evidence of the short-term effectiveness of BZDs in GAD.

Equally interesting was a research report assessing the effects of diazepam and chlordiazepoxide in mice exposed to a three-dimensional maze, which showed that administration of these BZDs did not reduce anxiety in the animals, but produced sedation only when given in a higher dosage; thus, demonstrating for the first time that it is likely that the primary effect of BZDs is not anxiolytic.

Long-term prescription may have some important secondary effects such as driving problems and falls.

The sole use of BZDs in anxiety disorders, without having tried the alternatives, is to be avoided and BZDs are contraindicated for patients with a history of substance use disorder.