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The damnation of benzodiazepines

SIR: Like Kräupl Taylor (*Journal*, May 1989, **154**, 697–704) we have been concerned by misinformation about the benzodiazepines. We believe that the term 'dependence' should be discouraged, as for many people 'dependence' means 'addiction' and benzodiazepine dependence means being 'enslaved' to the drug rather than the unpleasant, but rarely serious, withdrawal syndrome experienced by 30% or less of users.

The benzodiazepines are the latest of many anti-anxiety drugs to produce dependence (Olivieri *et al*, 1986). Morphine, bromides, barbiturates, meprobamate, glutethimide, and methaqualone were considerably more dangerous. It seems that any anti-anxiety drug may be associated with an abstinence syndrome. It is not clear whether newer agents like buspirone, with more widespread use, will lack an abstinence syndrome.

Benzodiazepine withdrawal from conventional doses should be a minor problem. Marks (1985) summarised 871 cases of benzodiazepine withdrawal reported in the medical literature from 1961 to 1984. The 871 cases reported in those 24 years are reduced to 19 by eliminating polydrug users, epileptic patients, those taking more than 30 mg/day of diazepam (or the equivalent dose for other benzodiazepines), and those patients who used benzodiazepines continuously for more than one year.

Abstinence syndromes after therapeutic doses of benzodiazepines were not reported until 1973, 12 years after their introduction (Covi *et al*, 1973). Millions of people had taken these drugs before a single case of an abstinence syndrome after conventional dose withdrawal was reported. Does this mean that for 12 years physicians callously ignored patients who had difficult withdrawal, or is it that withdrawal severity is linked to changed community attitudes? In the 1970s, 14 of 21 lay articles on tranquillisers were critical (Smith, 1988) and Manheimer *et al* (1973) found that 40% of those surveyed agreed that "taking tranquillisers is a sign of weakness". Around 1973, in the USA at least, use of any benzodiazepine was considered to be a misuse. Misuse is defined as the medical or lay use of a drug for a disease state *not considered appropriate by the majority* (our italics) (Marks, 1985). Publicising a few cases of an abstinence syndrome with conventional doses has led the lay and medical public to believe that withdrawal symptoms are common and severe. Patients now fear taking these drugs, feel guilty while taking them, and are scared of stopping.

Benzodiazepine withdrawal in the 1980s is erroneously perceived as a greater problem than barbiturate withdrawal in the 1950s, because of the greater publicity and heightened public interest in health issues. The abstinence syndrome is real to the people experiencing 'withdrawal', but we would suggest that in the 1960s similar people withdrew with bearable discomfort because they did not expect intolerable withdrawal. Today, a 'climate of fear' may be exacerbating 'withdrawal' for many people.

We hope Dr Kräupl Taylor's article will instigate community re-education to reverse the misinformation that frightens the significant minority who require benzodiazepines as part of the management of their disabling anxiety.

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References

COVI, L., LIPMAN, R. S., PATTISON, J. H., *et al* (1973) Length of treatment with anxiolytic sedatives and response to their sudden withdrawal. *Acta Psychiatrica Scandinavica*, **49**, 51–64.

MANHEIMER, D. I., DAVIDSON, S. T., BALTER, M. B., *et al* (1973) Popular attitudes and beliefs about tranquillisers. *American Journal of Psychiatry*, **130**, 1246–1253.

MARKS, J. (1985) *The Benzodiazepines. Use, Overuse, Misuse, Abuse* (2nd edn). Lancaster: MTP Press.

OLIVIERI, S., CANTOPHER, T. & EDWARDS, J. G. (1986). Two hundred years of dependence on antianxiety drugs. *Human Psychopharmacology*, **1**, 117–123.

SMITH, M. C. (1988) Small comfort: the introduction of minor tranquillisers to the public and the medical profession. *Journal of Psychoactive Drugs*, **20**, 409–418.

Is diazepam an antidepressant?

SIR: Like many other trainee psychiatrists, no doubt, we read the paper by Tiller *et al* (*Journal*, October 1989, **155**, 483–489) with much interest. The title, 'Is diazepam an antidepressant?', intrigued us. However, a careful reading of the article showed that the study was not originally intended to investigate the antidepressant activity of diazepam, but that of the antidepressant moclobemide. Diazepam was chosen as a placebo. Against predictions, the authors found that there was a significantly better improvement in the Hamilton Rating Scale for Depression (HRSD) scores in the diazepam group compared with the moclobemide group after one and four weeks of treatment. As a result, they concluded that diazepam was a better antidepressant than moclobemide in atypical depression.

There are two points here. Firstly, atypical depression is not a descriptive diagnostic concept in DSM–III and in ICD–9. The HRSD contains items rating not only for depression but for anxiety as well. The authors rightly pointed out that the patients might in fact be suffering from an anxiety state instead of depression. The rapid improvement in the HRSD scores (within one week) in the diazepam group is certainly more suggestive of an anxiety state responding to the anxiolytic properties of the benzodiazepine.

Secondly, and more importantly, we think that what this article really describes is a failed drug trial of moclobemide. The title seems to be an afterthought, given that the main focus was on moclobemide rather than diazepam. We wonder about the ethics of suggesting the use of diazepam as an antidepressant founded on these unclear results. Certainly trainees should not decide to start prescribing diazepam in depression on the basis of this curious study.

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SIR: I read the paper by Tiller *et al* (*Journal*, October 1989, **155**, 483–489) with a sense of *déjà vu*. Alprazolam, a 1,4-benzodiazepine like diazepam, was originally credited with antidepressant properties, but the methodology of most such studies is suspect (O'Shea, 1989). Later studies failed to support a primary role for alprazolam in the treatment of depression.

The major flaws in most such research are as follows. Firstly, the benzodiazepines often improve 'depression scores' faster than true antidepressants in the first weeks of a study, but the antidepressant then produces a longer-lasting and superior effect (O'Shea, 1989).

Secondly, the Hamilton Rating Scale for Depression (Hamilton, 1960) is not a diagnostic instrument. The effect mentioned above is due to anxiolysis, because up to 8 of the 21 items in this instrument measure anxiety (O'Shea, 1989).

Thirdly, the definitions of depression have been flawed. Studies which used neurovegetative signs (Goldberg *et al*, 1986) or reduced REM latencies (Rush *et al*, 1985) failed to demonstrate an antidepressant use for alprazolam.

For these reasons, as well as the potential for dependence, it may be premature to use diazepam as a replacement for antidepressants.

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References

GOLDBERG, S. C., ETTIGI, P., SCHULZ, A., *et al* (1986) Alprazolam versus imipramine in out-patients with neurovegetative signs. *Journal of Affective Disorders*, **11**, 139–145.

HAMILTON, M. (1960) A rating scale for depression. *Journal of Neurology, Neurosurgery and Psychiatry*, **23**, 56–62.

O'SHEA, B. (1989) Alprazolam: just another benzodiazepine? *Irish Journal of Psychological Medicine*, **6**, 89–94.

RUSH, A. J., ERMAN, M. K., SCHLESSER, M. A., *et al* (1985) Alprazolam *vs* amitriptyline in depressions with reduced REM latencies.