**In the shadow of the benzodiazepines**


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**Response**

# In the shadow of the benzodiazepines

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We are grateful for the lucid commentaries on our critique. It was difficult to argue with any of the points made but in the final analysis, while there is a certain amount of overlap among the various respondents, they appear to be offering aspects of a multifaceted picture rather than a model of the whole, which leads us back to our original position that a new synthesis is needed. In this, we agree fully with Haddad and Anderson. We disagree with them and Baldessarini and colleagues when it comes to the question of emphasis, namely that the problems of discontinuation can be readily managed. Clearly, slow tapers and specific approaches may help many individuals avoid difficulties. In the case of neuroleptics, however, for some individuals at least, it may be effectively impossible to stop treatment no matter how slow the taper and the experience may be pure hell.

But there is an entire dimension to the issues that the respondents seem to have missed. The all but exclusive focus of the commentaries was on the discontinuation period, leaving largely unaddressed the issues raised by the emergence of syndromes such as tardive dyskinesia in the course of treatment. We suspect that there are many other such syndromes of which the most pernicious may be tardive dysthymia. A long-lasting dysthymic syndrome certainly can occur on neuroleptic discontinuation. We neither know the frequency with which this happens, nor whether similar to tardive dyskinesia it may emerge in the course of treatment. Why don't we know?

What is the research community doing about phenomena like 'poop-out' on selective serotonin reuptake inhibitors (SSRIs)? This is tardive in onset, probably dysthymic, occurring in a group of drugs that may also produce long-lasting treatment emergent dyskinesias. The phenomenon has been extensively reported in Internet forums but something prevents the academic community from getting to grips with it. Serious neuroleptic discontinuation syndromes were extensively reported in the 1960s but then vanished from view, so that no textbook or review article makes any mention of them for 30 years. Why?

These facts suggest that something about our theoretical preconceptions is inhibiting our ability to see things in front of our noses. It may be the belief there is something wrong with the 5-HT system in depression or the dopamine system in psychoses blocks our ability to see that the SSRIs or neuroleptics might act more like stressors on brain systems rather than replacement therapies like insulin. Or it may be that linking physical dependence to abuse liability and both to addiction makes us unable to recognize problems caused by agents which, despite occasional cases of escalating doses, are simply not 'addictive'. Or it may be that a 'heroic' (occasionally cowboy) ethic affects Western therapeutic practices leading to periodic crises in which a group of drugs such as the benzodiazepines, which do not cause significant problems in Japan for instance, end up all but proscribed in the West.

Ashton and colleagues note that there are important issues concerning what addicts do with drugs. It would seem that there are also important issues concerning what medical researchers, pharmaceutical companies and regulators do with information. If it is a truism that most drugs, even ones without clear effects on the central nervous system (CNS), can cause tolerance-related phenomena and dependence, why haven't we collected specific data on the nature of the problems caused by each of the drugs we use in psychopharmacology? Why did discontinuation syndromes with the SSRIs come as such a surprise? Similar scotomas in the case of the benzodiazepines resulted in the opprobrium traditionally heaped on addicts being redirected to medical practitioners, who had left themselves open to castigation. We deal with a vulnerable group of patients, where treatment emergent problems are likely to mirror the index conditions. This is a challenge requiring innovative and sensitive science to generate medicine-based evidence. We have effectively done nothing to improve our data collection on these issues since the benzodiazepine crisis.

This is unfortunate. Negatively, it is unfortunate because we leave ourselves open to a replay of the benzodiazepine story with the consequent loss of useful drugs. But there is another reason why the situation is unfortunate for anyone who is hopeful for the future. While we agree fully with Tyrer that there are constitutional and personality components to the problem, and withdrawal phobia is certainly a real phenomenon, to focus too much on this aspect of the problem risks perpetuating a nihilistic view that sees all drugs as the same. This is simply wrong. All drugs do not cause clinically significant treatment-induced problems. CNS drugs do not all cause similar problems. There are strong indications within the group of SSRIs and the group of neuroleptics that not all compounds cause similar problems. But without the data that establish the nature and frequency of the problems and differential effects between drugs, we cannot begin to pinpoint what mechanisms confer protective benefits or which patients are most at risk.