Benzodiazepine: A Much Abused Drug

Benzodiazepines (BZDs) are psychoactive drugs described as having qualities that can help to reduce anxiety and seizures, relax the muscles, and induce sleep. Benzodiazepines effect the neurons that trigger stress and anxiety reactions and are prescribed to treat a range of psychological and neurological disorders (e.g., insomonia, Generalized anxiety disorder (GAD), seizures, alcohol withdrawal, panic attacks, anxious depression).

This class of drugs includes: Alprazolam, or Xanax, Chlordiazepoxide, or Librium, Clorazepate, or Tranxene, Diazepam, or Valium, Estazolam, Flurazepam, or Dalmane, Oxazepam, Temazepam, or Restoril, Triazolam, or Apo-Triazo, Halcion, Hypam, and Trilam.

Given the opioid epidemic, it is not surprising that the abuse and the problematic dependency of so many people on this class of widely prescribed medications has not been well-publicized.

Warnings About Use

While the short-term use of benzodiazepines generally is discussed as safe and effective, long-term use is not. Concerns have been raised not only about dependence, but a range of other adverse effects. For example, the recognized side effects of benzodiazepine usage may include: drowsiness, confusion, dizziness, trembling, impaired coordination, vision problems, grogginess, feelings of depression, and headaches. It is possible to overdose on benzodiazepines, and mixing them with alcohol or other substances can be fatal.

Dependency can begin after using the drugs for as little as one month, even on a prescribed dosage. Therefore, recommended use is 2-4 weeks. (However, reports indicate that some providers prescribe BZD's for months or even years.) Total BZDs use increased from 1999 to 2014 "largely driven by increases in long-term use" (Guina & Merrill, 2018).

Benzodiazepines withdrawal symptoms include trouble sleeping, feelings of depression, and sweating.

Increased Use and Abuse are Associated with Increased Concern about Mental Health Problems

Johnston and colleagues (2006) warn that increased awareness of mental health problems has proven to be a double-edged sword. That is, it has led to more prescription treatment for those with serious disorders but has also increased the rates of misuse and abuse of medications. This abuse is particularly rampant at colleges (seen as an increasing trend as students use prescription drugs for their "stress-relieving and euphoria-producing properties" (Johnston et. al, 2006).

Watkins (2016) reports that, among a sample of undergraduates differentiated by motives for using (i.e., instrumental, recreational, or mixed motive users), social learning risk factors (e.g., differential association and differential reinforcement) as well as the use of other drugs, exerted the greatest impact on likelihood of PDM between the motivational typologies.

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*The material in this document reflects work done by Alexandra Watts as part of her involvement with the national Center for MH in Schools & Student/Learning Supports at UCLA.

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Benzodiazepines as a Response to Young Peoples' Anxiety

Based on diagnostic interview data from National Comorbidity Survey Adolescent Supplement (NCS-A) reported in 2005, an estimated 31.9% of adolescents had any anxiety disorder (i.e., panic disorder, generalized anxiety disorder, agoraphobia, specific phobia, social anxiety disorder [social phobia], post-traumatic stress disorder, obsessive-compulsive disorder, and separation anxiety disorder). An estimated 8.3% had severe impairment using DSM-IV criteria. Thus, the majority of diagnosed anxiety disorders are considered mild and probably border on nonpathological emotional/stress fluctuations (Kessler, Chiu, Demler, Merikangas, & Walters, (2005).

Mild conditions always raise concerns about overpathologizing and misdiagnosing common problems and misprescribing responses to the problem. With specific reference to benzodiazepines, the widespread ads in the media tend to convey the perception that these drugs can and should be used to combat common stress related anxiety, and this plays into their over- prescription, misuse, and abuse.

Anxiety disorders have high comorbidity with other problems (e.g., depression). Given this, it is not surprising that BZDs are widely prescribed and that prescription drug misuse (PDM) is commonplace – with the highest rates reported among college students and young adults (Rigg & Ford, 2014; Watkins, 2016).

In general, evaluating pathological disorders in a time when youngsters are experiencing tumultuous changes and hormonal fluctuation is difficult. Normal mood changes and adolescent mercurialism and a variety of biasing factors also play a role in misdiagnosis.

The Problem of the Marketplace

Student problems have become a commodity. Thus, the term *commodification* has been applied to this aspect of enhancing the commercial value of young people. Large amounts of money and resources are tied specifically to dealing with the problems of children and adolescents. Many folks have an economic interest in emphasizing that young people are troubled and troubling and in need of "care."

Long ago, Nicholas Hobbs stressed that

> *Society defines what is exceptional or deviant, and appropriate treatments are designed quite as much to protect society as they are to help the child .... To take care of them' can and should be read with two meanings: to give children help and to exclude them from the community.*

Today, it is necessary to add a commercial agenda to that of protecting and helping.

The commercial agenda is focused on creating a large market for products and services aimed at caring for young people. And, unfortunately, more money is to be made by treating problems than preventing them and/or from promoting healthy development – especially when the money is from public funds.

Schools Can Avoid Contributing to the Problem

For various reasons, society tends to overpathologize behavior. Schools play a role in this. Overpathologizing of commonplace learning, behavior, and emotional problems too often leads to diagnoses of LD, ADHD, and anxiety disorders and inappropriate interventions (e.g.,.students who are seen as having high levels of anxiety often are prescribed medication such as benzodiazepines).

Schools must counter practices that lead to misdiagnosis and inappropriate prescriptions, and they must address problems such as substance abuse by improving how they promote healthy development, prevent problems, and provide supports that address barriers to learning and teaching. To do so, they must move away from mainly thinking in terms if special programs and services. Such interventions alone are insufficient. More services to treat problems, such as substance abuse, certainly are needed. But so are programs for prevention and early-after-problem onset that can reduce the number of students in need of special interventions.

Unfortunately, there is considerable pressure on schools to identify specific types of problems and develop discrete programs for each. This has led to ad hoc and piecemeal approaches that have produced a marginalized, fragmented, and quite limited set of prevention efforts and student/learning supports. Initiatives to make things better have focused on coordinating existing activity, calling for more hiring of student support staff, and looking to community services for help with students' problems.

Approaching student problems as discrete, separate phenomenon ignores the reality that such problems tend to be multifaceted. It is widely recognized that the same etiological biological, genetic, social, psychological, and environmental factors can produce a variety of problem behaviors and that several of these can co-occur, often exacerbating each other (e.g., substance abuse, delinquency, violence, comorbidity of mental disorders). Such a reciprocal determinist perspective of development ensures awareness of the degree to which substance use and other risky behaviors reflect the experimentation and risk taking that is so much a part of the developmental processes of moving toward individuation and independence. Characteristic behaviors during these facets of development include skepticism about the warnings and advice given by adults, as well as reactions against rules and authority. (The very fact that using the substances is illegal and forbidden often adds to the allure.)

Rather than treating each concern as a discrete problem, schools need to embed their efforts to deal with all barriers to learning and teaching into a unified, comprehensive, and equitable system for preventing problems and providing student/learning supports.

For more on school improvement practices designed to engage students and develop a unified, comprehensive, and equitable system for preventing problems and providing student/learning support, see the following (free) resources from the Center at UCLA:

>*Addressing barriers to learning: In the classroom and schoolwide*
http://smhp.psych.ucla.edu/improving_school_improvement.html
>*Improving school improvement*
http://smhp.psych.ucla.edu/improving_school_improvement.html

Countering Student and Staff Over-pathologization and Misdiagnoses

To help develop appropriate perspectives about what is and isn't a disorder and curb tendencies to over-prescribe medication, schools can promote open discussion about how much deviation from the norm there must be before a condition should be viewed as pathological.

- As part of mental health education, schools can share general information (including fact sheets)
- Staff concerns and referrals for assistance with specific students can be used as opportunities to personalized education about what is and is not pathological and what should be done in each instance.

Perhaps one of the hardest things to counter is use of the need for funds and other resources as justification for a "pathological" interpretation of student actions and performance. Nevertheless, schools must consider how to resist the pull of special funding that overemphasizes pathology and leads to misdiagnoses (e.g., of LD, ADHD, anxiety disorders, depression).

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For more resources, see the Center's online clearinghouse Quick Finds at
http://smhp.psych.ucla.edu/quicksearch.htm