Effective Treatments for PTSD: Helping Patients Taper from Benzodiazepines

Benzodiazepines Overview

Continuing to renew benzodiazepine (BZ) prescriptions to certain subgroups of your patients with PTSD may be a high risk practice. These medications may no longer be of benefit to your patients and carry significant risks associated with chronic use. Due to the lack of evidence for their effectiveness in the treatment of PTSD, it is worthwhile for you to implement strategies for assessing patients who are taking them to determine if a taper is appropriate. It is also important to consider alternate treatment options and to minimize new benzodiazepine prescriptions whenever possible in the veteran PTSD population.

This brochure offers you valuable resources to help you taper your patients from benzodiazepines and information on alternatives.

Despite the involved challenges, strategies to taper existing benzodiazepines prescriptions are effective.

Before You Begin:

- A team-based approach will be most effective in efforts to taper a patient from benzodiazepines
- Build a stable relationship with your patient
- Evaluate and treat any co-occurring conditions
- Obtain complete drug and alcohol history and random drug screen
- Review recent medical notes (ER visits) and coordinate care with other providers
- If available, query prescription drug monitoring database

Priorities: Tapering Existing Prescriptions

- Anyone on multiple BZDs or BZDs combined with prescribed amphetamines, and/or opiates
- Anyone with an active (or history of) substance abuse or dependence
- Anyone with a cognitive disorder or history of TBI
- Older veterans (risk of injury, cognitive effects)
- Younger veterans (better outcomes long term with SSRIs and evidence-based psychotherapies)
Taper Recommendations

Supratherapeutic Doses

- Consider admission due to greater medical risks
- Consider switching to long half-life drug
  (diazepam or clonazepam)
- Reduce dose initially by 25-30%
- Then reduce dose by approximately 5-10% daily to weekly
- Consider anticonvulants for high dose withdrawal

Therapeutic Doses – Bedtime Dosing (Qhs)

- Reduce by approximately 25% weekly
- Anticipate and educate regarding rebound insomnia
  which can occur as early as one day
- Provide reassurance and sleep hygiene information
- Initiate alternate treatment options: CBT-I, non-BZD agents

Therapeutic Doses – Daytime Dosing (generally QD to QID)

- Anticipate and provide education regarding rebound
  anxiety and recurrence of initial anxiety symptoms
- Plan additional psychological support during taper
- Last phase of withdrawal is likely to be difficult
- Points of dosing schedule changes (e.g. TID to BID)
  can be psychologically challenging
- Encourage veteran to actively participate in developing
  withdrawal schedule when possible

Initial dose taper typically between 10-25%
- Observe for signs of withdrawal
- Anticipate early withdrawal for BZDs with a short half-life
- Individualize subsequent reductions based on
  initial response

Generally, further reductions of 10-25% every 1-2 weeks
are well tolerated pharmacologically.
- May need to slow taper and/or offer additional
  psychological support as veterans learn new ways of
  coping with their anxiety

Additional Strategies for Complex Cases

- Can be helpful to be flexible with schedule
- Prolonged taper >6 months may worsen long-term outcome
- Consider stabilizing on 50% dose for several months
  before proceeding with taper
- Consider switching to a long-acting BZD (particularly
  helpful with long-term use, Supratherapeutic doses,
  or short half-life BZDs)
- Establish a team to support veteran (PCP, CaseManager,
  Therapists, Group Facilitators, Pharmacists, Residential
  Treatment, etc)

Concurrent Opioids

- Co-prescribing of benzodiazepines and opiates can lead to
  pain related behavioral management problems and put
  your patients at higher risk for fatal and non fatal overdose.
- Often prescriptions for these medications are given by
  different prescribers; work with your patients and their
  other care providers to determine best treatment options.
- Consider tapering one or both. Patients with increased
  anxiety may have a more difficult time with a
  benzodiazepine taper. Patients whose PTSD and pain are
  related due to their trauma may have a more difficult time
  with an opioid taper.
- Generally any decrease in these medications is a move in the
  right direction. Let the patient guide you where to start.

Adjuvant Options

Adjuvant options explored to support the last phase of taper:
- Mirtazapine (positive case studies), carbamazepine, show
  mixed results
- Propranolol, Progesterone, Ondansetron, TCAs, Valproate,
  Trazodone, Buspirone showed no difference
- Consider duloxetine or amitriptyline for pain

Concurrent CBT

- CBT-I concurrent with taper improved outcomes
- In patients with panic disorder those who received 10
  sessions of group CBT during slow taper had 76% success
  versus 25% with slow taper alone
- CBT concurrent with slow alprazolam taper showed no
  difference in success of taper, however, at 6-month follow
  up, 50% of non-CBT group and none of CBT group had
  resumed BZDs
- Benzodiazepines are thought to hinder the benefits of
  psychotherapy. Cognitive-behavioral therapy (CBT) is
  where your patient will get the biggest benefit

Effect Size Chart

<table>
<thead>
<tr>
<th>Effect Size (d)</th>
<th>Antidepressants</th>
<th>Cognitive Behavior Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0.2</td>
<td>0.4</td>
</tr>
<tr>
<td>0.4</td>
<td>0.6</td>
<td>0.8</td>
</tr>
<tr>
<td>0.6</td>
<td>1</td>
<td>1.2</td>
</tr>
<tr>
<td>1</td>
<td>1.4</td>
<td>1.8</td>
</tr>
</tbody>
</table>

With, Schnurr et al., 2011


Benzodiazepine Equivalent Doses and Suggested Taper

<table>
<thead>
<tr>
<th>Benzodiazepine Equivalent Doses</th>
<th>Elimination Half-life</th>
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<tbody>
<tr>
<td>Chloridiazepoxide 25 mg</td>
<td>&gt;100 hr</td>
</tr>
<tr>
<td>Diazepam 10 mg</td>
<td>&gt;100 hr</td>
</tr>
<tr>
<td>Clonazepam 1 mg</td>
<td>20-50 hr</td>
</tr>
<tr>
<td>Lorazepam 2 mg</td>
<td>10-20 hr</td>
</tr>
<tr>
<td>Alprazolam 1 mg</td>
<td>12-15 hr</td>
</tr>
<tr>
<td>Temazepam 30 mg</td>
<td>10-20 hr</td>
</tr>
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Benzodiazepine Taper:

- Switch to a longer acting benzodiazepine
- Reduce dose by 50% the first 2-4 weeks then maintain on that
dose for 1-2 months then reduce dose by 25% every two weeks

Milestone Suggestions

<table>
<thead>
<tr>
<th>Week 1</th>
<th>35 mg/day</th>
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<tbody>
<tr>
<td>Week 2</td>
<td>Total dose decrease by 25%</td>
</tr>
<tr>
<td>30 mg/day (25%)</td>
<td></td>
</tr>
<tr>
<td>Week 3</td>
<td>25 mg/day</td>
</tr>
<tr>
<td>Week 4</td>
<td>Total dose decrease by 50%</td>
</tr>
<tr>
<td>20 mg/day (50%)</td>
<td></td>
</tr>
<tr>
<td>Week 5-8</td>
<td>Hold dose</td>
</tr>
<tr>
<td>Continue at 20 mg/day for 1 month</td>
<td></td>
</tr>
<tr>
<td>Week 9-10</td>
<td>Current dose reduction of 25% every two weeks</td>
</tr>
<tr>
<td>15 mg/day</td>
<td></td>
</tr>
<tr>
<td>Week 11-12</td>
<td>10 mg/day</td>
</tr>
<tr>
<td>Week 13-14</td>
<td>5 mg/day</td>
</tr>
<tr>
<td>Week 15</td>
<td>discontinue</td>
</tr>
</tbody>
</table>

Example: Alprazolam 2 mg bid
Convert to 40 mg diazepam daily