Benzodiazepines and Anxiety: Myths, Management Strategies and Alternate Medications

Christina Girgis, M.D.
Associate Professor of Psychiatry, Loyola University Medical Center
Medical Director, CL Psychiatry Service, Edward Hines Jr. VA Hospital
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Disclosure & Disclaimer

• I have no disclosures that are relevant to the content being presented today

• The views, opinions, and content expressed in this presentation do not necessarily reflect the views, opinions, or policies of the Center for the Veterans Health Administration
By the end of this presentation, audience members will be able to:

• Discuss anxiety and other disorders treated with benzodiazepines (BZDs)
• Differentiate appropriate vs. problem use of BZDs
• Describe safe and successful discontinuation strategies for BZDs
• Select and implement alternative treatment options based on underlying diagnosis

• We will also go over case examples for discussion as a group
Psychiatrist describes Medical Council views on benzodiazepines as 'utterly alarmist'
A leading psychiatrist has described as “utterly alarmist” and “frightening for doctors and patients” Medical Council advice that raises concerns about over-prescribing of benzodiazepines.

Ted Dinan, who recently retired as Professor of Psychiatry at University College Cork (UCC) said the view from the Council was that taking benzodiazepines “is a bit like taking opiates and that is simply not true”.

"Patients could be led to believe you might as well be taking crack cocaine,” Prof Dinan said.

“I believe they went seriously over the top in their threats, particularly in relation to GPs who do have a role to play in managing psychiatric illness.”

Prof Dinan was commenting on a recent Medical Council statement warning doctors to reduce over-prescribing of benzodiazepines, Z-drugs and pregabalin - or face potential investigation. The drugs are used to treat anxiety and insomnia.

The Council also warned that long term use of these drugs could lead to dependency.
"CAAAAAAAAAALM DOWWWWWWN !!"
"TAAAAAAAAAKE A XANAX !!!!"
Definitions

• What is anxiety?
• Use disorder
• Misuse
• Abuse
• Dependence
• Addiction
History

• 1955: Chemist Leo Sternbach discovers chlordiazepoxide
• 1960: Marketed as Librium
• 1963: Diazepam created (Valium)
• 1960s: Medical professionals enthusiastic
• 1970s: Most-prescribed
• 1980s: Concerns for abuse/dependence

Consult Pharm 2013
History

- 1955: Chemist Leo Sternbach discovers chlordiazepoxide
- 1960: Marketed as Librium
- 1963: Diazepam created (Valium)
- 1960s: Medical professionals enthusiastic
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Consult Pharm 2013

2000s:
You can't set her free.
But you can help her feel less anxious.

You know this woman.
She's anxious, tense, irritable. She's felt this way for months.
Best by the seemingly insurmountable problems of raising a young family, and con-
fronted by the home maid of the time, her symptoms reflect a sense of inadequacy and
isolation. Your reassurance and guidance may have helped some, but not enough.

Sarax (oxazepam) cannot change her environment, of course. But it can help
relieve anxiety, tension, agitation and irritability, thus strengthening her ability to
cope with day-to-day problems. Eventually—as she regains confidence and com-
potence—your counsel may be all the support she needs.

Indicated in anxiety, tension, agitation, irritability, and anxiety associated
with depression.
May be used in a broad range of patients, generally with considerable
dosage flexibility.

Contraindications: History of previous hypersensitivity to oxazepam. Sarax is not indi-
cated in pregnancy.

Precautions: Hypersensitive reactions are rare, but use with caution where complications could
appear. Patients should be advised to avoid alcoholism and other drug usage while taking the med-
cation. The patient should be informed that he should not engage in hazardous activities or drive
while taking the medication if he is aware that he is sensitive to alcohol.

Adverse Reactions: The following reactions may be seen, but they are infrequent, and are
likely to be dose-related. The reactions that are most frequent are nausea, diarrhea, dry mouth,
tachycardia, dizziness, and drowsiness. Other reactions include headache, lightheadedness,
irritability, and nervousness. No significant changes in laboratory values or vital signs have
been observed.

Dosage: The usual adult dosage is 5 to 10 mg. four times a day. The dosage may be increased
to a maximum of 20 mg. four times a day, but a careful watch should be kept on the patient's
response to treatment.

Availability: Capsules of 50, 150 and 30 mg. oxazepam.

To help you relieve anxiety and tension

Sarax (oxazepam)

Wyeth Laboratories
"Things are different today"
I hear ev'ry mother say
Cooking fresh food for a husband's just a drag
So she buys an instant cake and she burns her frozen steak
And goes running for the shelter of a mother's little helper
And two help her on her way, get her through her busy day
Doctor please, some more of these
Outside the door, she took four more
What a drag it is getting old

-Cultural Commentary

-The Rolling Stones 1966
Do These Medications Still Make Money?

- Xanax
  - Accounted for $276M of sales for alprazolam (48.5M total rx in 2013)
  - 2017: $223M
  - 2018: $225M
  - 2018: “Legacy Established Product”
FDA Warnings: 2016

Federal Agency’s Highest Warning

- FDA added “black box” warning to labels for opioids and benzodiazepines regarding risks associated with concomitant use

  “Concomitant use of the drugs may result in profound sedation, respiratory depression, coma, and death
  - Reserve concomitant prescribing of these drugs for use in patients for whom treatment options are inadequate.
  - Limit dosages and durations to the minimum required.
  - Follow patients for signs and symptoms of respiratory depression and sedation.”
FDA Warning: 2019

PHARMACEUTICAL NEWS

NEW BOXED WARNING TO Z-DRUGS REGARDING SLEEPWALKING AND SLEEP DRIVING

These incidents can occur after the first dose of these sleep medicines or after a longer period of treatment.

Eszopiclone, Zaleplon, Zolpidem
Anxiety Disorders

- Specific Phobia
- Separation Anxiety Disorder
- Social Anxiety Disorder
- Panic Disorder (not Panic or Anxiety Attacks)
- Agoraphobia
- Generalized Anxiety Disorder

*Excludes: Obsessive Compulsive Disorder and Post Traumatic Stress Disorder*
Audience Question:

Q: What are the psychiatric indications for long-term daily benzodiazepine use?
Audience Question:

Q: What are the psychiatric indications for long-term daily benzodiazepine use?
A: Virtually nothing
Long-term Indications for BZDs

• Should be rare
• Treatment resistant psychiatric conditions
• Severe chronic psychiatric conditions
Audience Question:

Q: What reasons are you prescribing BZDs long-term?
Why Do We Prescribe?

• A study of family practice physicians found that:
  • they were overwhelmed by the psychosocial problems of their patients
  • prescriptions were driven by wanting to help the patient

• Other factors included:
  • limited availability of psychological services
  • personal use of benzodiazepines for stress relief
  • perception of benzodiazepines as benign
  • time constraint for counseling by the physician

BMC Fam Pract 2013
Short-term Indications for BZDs

- Severe or complicated alcohol or BZD withdrawal
- First-line for acute catatonia
  - Greatly reduce morbidity
- Used in inpatient settings for acute agitation associated with manic and psychotic states
- Various forms of anesthesia
- Terminal illness (J Palliat Med 2016)
Short-term Indications for BZDs

• Anxiety? (Yes)
• Depression? (Yes)
  • J Affect Disord 2019
  • Cochrane Database Syst Rev. 2019
• Trauma? (No)
• Grief? (Maybe) (No)
BZD Use High, Disorder Rate Low

- 46.3% Relax or relieve tension
- 22.4% Help with emotions
- 11.8% Get high/hooked
- 10.5% Help with sleep
- 5.7% Increase/decrease effects of other drugs
- 1.8% Other reason
- 1.5% Experiment

National Institute of Drug Abuse, 2018
So.....What’s the Problem Exactly?

• 2015: 29.7 million people (11.2% of the population) used benzodiazepine tranquilizers (SAMHSA 2016)
  • Of that group, 17.6 million (6.6% of the population) used alprazolam-containing products

• 6-year review in England/Wales indicates that BZDs ranked 6th for severe harm or death in med-related incidents (Br J Clin Pharm 2012)

• Between 2010 and 2014, 2 of the top 10 drugs implicated in overdoses were diazepam and alprazolam (National Center for Health Statistics 2016)
  • 95% of related deaths included other drugs
  • 30% of fatal opioid overdoses in the US involve BZDs

• BZD use associated with more ED visits, psychiatric comorbidities, substance use and suicidal ideation (BMJ 2017)
National Drug Overdose Deaths
Number Among all Ages, 1999-2017

- Synthetic Narcotics other than Methadone (mainly fentanyl): 28,466
- Prescription Opioids: 17,029
- Heroin: 15,482
- Cocaine: 13,942
- Benzodiazepines: 11,537
- Psychostimulants with Abuse Potential (Including Methamphetamine): 10,333
- Antidepressants: 5,269

CDC, 2018
Who is Prescribing BZDs?

- Visit rate doubled from 3.8% to 7.4% of visits from 2003 to 2015
- 52% of visits for BZD were to primary care physicians
- Rate stable with psychiatrists (29.6% to 30.2%) over time
- Rate increased for all other physicians including primary care (3.6% to 7.5%)
- Slight increase in visits for anxiety and depression
- No change for insomnia
- Co-prescribing rate of BZD+opioids quadrupled (0.5% to 2%)
- Co-prescribing rate of BZD+other sedative doubled (0.7% to 1.5%)
Ongoing Assessment for Other Substance Use

• Sleep problems are frequent in moderate/heavy drinkers, use BZDs and z-drugs for sleep and morning withdrawal sx
• Unprescribed BZDs are taken to treat opioid withdrawal, and are used to augment euphorigenic effect of opioids
• Can be taken with a number of other agents to induce intoxication delirium
• Urine drug screen
Controlled Substances Agreement

Controlled substance medications (i.e. narcotics, tranquilizers, barbiturates, stimulants and hormones) are very useful, but have a high potential for misuse and are, therefore, closely controlled by local, state, and federal governments. As a patient of _____ Clinic, I agree to the following:

1. I am responsible for the controlled substance medications prescribed to me. If my prescriptions is misplaced, stolen, or if “I run out early,” I understand that this medication will not be replaced regardless of the circumstances.

2. Refills of controlled substance medications will be made only during regular office hours Monday through Friday, in person, once a month, and preferably during a scheduled office visit.

3. I may be asked to complete routine urine testing.

4. I understand that if I violate any of the above conditions, my prescriptions for controlled medications may be terminated immediately. If the violation involves obtaining these medications from another individual, or the concomitant use of non-prescription illicit (illegal) drugs, I may also be reported to other physicians, pharmacies, medical facilities, and the appropriate authorities.

5. I understand that I am given medications to assist in reaching treatment goals. I agree to help myself by following better health habits, exercise, weight control, and avoidance of the use of tobacco and alcohol. I must also comply with the treatment plan as prescribed by my physician.

6. I understand that if I violate this controlled substance contract due to non-compliance of medical directions, such as, failure in taking medications as prescribed, utilizing other illicit drugs, or abuse of controlled medications, I may be subject to dismissal from this facility.

I have been fully informed regarding psychological dependence (addiction) of controlled substance medications. I know that some individuals may develop a tolerance to the medications, necessitating a dose increase to achieve desired effect, and doing so increase the risk of becoming physically dependent on the medication. This may occur if I am on the medication for several weeks. Therefore, when I need to stop taking the medication, I must do slowly and under medical supervision, or I may have withdrawal symptoms. By signing below, I understand and accept the above treatment agreement.

Patient Signature: _____________________________________________Date:___________________

Cleveland Clinic J Med 2016
Red Flags/Concern for Misuse

• In your office: observable signs
• Cognitive exam on everyone (BOMC, mMSE)
• Focus is only on medications and never the symptoms
• Dishonesty (frequent loss, theft and early refill requests)
• Fast need for dose escalation
• Ineffective despite high dose
• Refusal for consent for collateral information from family collaboration of care with other physicians
• Active substance use disorder to something else
• Diversion concerns: requests for high number of pills, negative UDS
But BZDs Can’t Kill You...

- Yes they can. 5% of the deaths involving BZD, there are no other substances involved. Untreated withdrawal can also lead to death.
- Drug overdose deaths involving benzodiazepines rose from 1,135 in 1999 to 11,537 in 2017.
- MVAs, falls, impaired psychomotor performance, cognitive impairment including confusion, depression, sleep automatism.
- Benzodiazepines, cocaine, or methamphetamine were present in 63% of opioid deaths, which increased from 2017 to 2018.

*Am J Public Health 2016*
Tips for BZD Prescribing: Interpersonal Dimension

1. Avoid emotional prescribing based on how stressful the situation is or on patient characteristics
2. Have a well thought-out general approach to prescribing and stick to it
3. Be aware of how prescribing a controlled substance can affect your decision-making and the relationship with the patient
4. Maintain a conservative prescribing bias in general and especially in the case of suspected substance use disorder
5. Educate: risk/benefits, rationale for prescribing or not prescribing BZD; informed consent, addiction risk and prevention
6. Consult with colleagues. Solicit feedback. In group practices, controlled substance prescribing can be the basis of a QI initiative
Best Practices for Treatment of Anxiety

- First-line: *therapy*, SSRIs plus therapy, or TCAs and behavior therapy

- The basic position on benzodiazepines has been unaltered:
  - limited use for the first month until the SSRI starts to work is preferred unless there is insufficient response, and in that case benzodiazepines are added at the level of various therapies as maintenance treatment for insufficient response.

- “Indefinite” use of BZD only if other treatments insufficient (exception, not the rule)

*Principles and Practice of Psychopharmacology, 2011*
Types of Therapy

- Cognitive Behavior Therapy (CBT)
- Exposure and Response Prevention Therapy (type of CBT)
  - Prolonged Exposure (PTSD)
- Relaxation Training
- Supportive Therapy
- Placebo Effect of Therapy
  - Dodo Bird Effect? (Front Psych 2019)
<table>
<thead>
<tr>
<th>Who Can I Refer to for Psychotherapy?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Background</td>
</tr>
<tr>
<td>Affect</td>
</tr>
<tr>
<td>Trouble</td>
</tr>
<tr>
<td>Handling</td>
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<td>Empathy</td>
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*The Fifteen Minute Hour: Therapeutic Talk in Primary Care*

Fourth Edition

Marian R Stuart PhD and Joseph A Lieberman III MD, MPH

Foreword by Robert E Rakel MD
What to Do

- Do not simply stop prescribing: physical dependence present event if patient is not abusing medication
  - Ideally would avoid withdrawal
- Prescription monitoring site
- Extended taper
- Reassess for correct dx
- Alternative tx

<table>
<thead>
<tr>
<th>Anxiety</th>
<th>-Cognitive behavior therapy, -SSRIs, TCAs and buspirone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insomnia</td>
<td>-Proper sleep hygiene</td>
</tr>
<tr>
<td></td>
<td>-Cognitive behavior therapy</td>
</tr>
<tr>
<td></td>
<td>-TCAs (amitriptyline, doxepin), mirtazapine, trazodone,</td>
</tr>
<tr>
<td></td>
<td>melatonin, doxylamine, hydroxyzine</td>
</tr>
</tbody>
</table>
Hidden Diagnoses

- Substance use disorders
- Mood/depressive disorders
- Post traumatic stress disorder
- Attention deficit hyperactivity d/o
- Borderline personality disorder
- Obsessive compulsive disorder
- Adjustment disorder
- Complicated grief
Approach to Taper

• You can do it!
• Who to taper?  > 1 month BZD use → Dependence → Taper
• How to tell the patient?
• Patient: how can you help them?
  • Provide anticipatory guidance
  • Reinforce behavioral strategies
  • Individualized plan
Taper Considerations: Medications

- **Medication**: should you change medication to longer-acting?
- **Technique**: decrease frequency (TID to BID) or dosage?
- **Duration**: over what time period should you taper?
- **Withdrawal sx**: what can you do?
  - Gabapentin, carbamazepine, imipramine, divalproex, trazodone
- **Pregnancy**: maintain or taper off?

*J Clin Psych 2019*
<table>
<thead>
<tr>
<th>Benzodiazepines</th>
<th>Half-life (hrs)</th>
<th>Approximately Equivalent Oral dosages (mg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alprazolam (Xanax, Xanox, Tafil)</td>
<td>6-12</td>
<td>0.5</td>
</tr>
<tr>
<td>Bromazepam (Lexotan, Lexomil)</td>
<td>10-20</td>
<td>5-6</td>
</tr>
<tr>
<td>Chloridiazepoxide (Librium)</td>
<td>5-30 [36-200]</td>
<td>25</td>
</tr>
<tr>
<td>Clobazam (Frisium)</td>
<td>12-60</td>
<td>20</td>
</tr>
<tr>
<td>Clonazepam (Klonopin, Rivotril)</td>
<td>18-50</td>
<td>0.5</td>
</tr>
<tr>
<td>Clorazepate (Tranxene)</td>
<td>[36-200]</td>
<td>15</td>
</tr>
<tr>
<td>Diazepam (Valium)</td>
<td>20-100 [36-200]</td>
<td>10</td>
</tr>
<tr>
<td>Estazolam (ProSom, Nuctalon)</td>
<td>10-24</td>
<td>1-2</td>
</tr>
<tr>
<td>Flunitrazepam (Rohypnol)</td>
<td>18-26 [36-200]</td>
<td>1</td>
</tr>
<tr>
<td>Flurazepam (Dalmarn)</td>
<td>[40-250]</td>
<td>15-30</td>
</tr>
<tr>
<td>Halazepam (Passiamp)</td>
<td>[30-100]</td>
<td>20</td>
</tr>
<tr>
<td>Ketazolam (Anxion)</td>
<td>30-100 [36-200]</td>
<td>15-30</td>
</tr>
<tr>
<td>Loprazolam (Dormoncot)</td>
<td>6-12</td>
<td>1-2</td>
</tr>
<tr>
<td>Lorazepam (Ativan, Tenesta, Tavor)</td>
<td>10-20</td>
<td>1</td>
</tr>
<tr>
<td>Lormetazepam (Noctamid)</td>
<td>10-12</td>
<td>1-2</td>
</tr>
<tr>
<td>Medazepam (Nobrium)</td>
<td>36-200</td>
<td>10</td>
</tr>
<tr>
<td>Nitrazepam (Mogadon)</td>
<td>15-38</td>
<td>10</td>
</tr>
<tr>
<td>Nordazepam (Nordaz, Calmday)</td>
<td>36-200</td>
<td>10</td>
</tr>
<tr>
<td>Oxazepam (Serax, Serendil, Serex, Seresta)</td>
<td>4-15</td>
<td>20</td>
</tr>
<tr>
<td>Prazeepam (Centrax, Lysanxia)</td>
<td>[36-200]</td>
<td>10-20</td>
</tr>
<tr>
<td>Quazepam (Doral)</td>
<td>25-100</td>
<td>20</td>
</tr>
<tr>
<td>Temazepam (Rastoril, Normison, Euthynos)</td>
<td>8-22</td>
<td>20</td>
</tr>
<tr>
<td>Trizolam (Halcion)</td>
<td>2</td>
<td>0.5</td>
</tr>
</tbody>
</table>

**Non-benzodiazepines with similar effects**

| Zaleplon (Sonata)                  | 2              | 20                                       |
| Zolpidem (Ambien, Stilnoct, Stilnox) | 2         | 20                                       |
| Zopiclone (Zimovane, Imovane)      | 5-6            | 15                                       |
| Eszopiclone (Lunesta)              | 6 (9 in elderly)| 3                                       |
Managing BZD Withdrawal Symptoms

• Three classes of medications:
  • Non-BZD GABAergic agents (i.e. propofol)
  • Anticonvulsant agents (i.e. carbamazepine, valproic acid, *gabapentin*, pregabalin, tiagabine, and vigabatrin)
  • Alpha-2 adrenergic agonists (i.e. guanfacine, clonidine)

• Will this strategy reduce anxiety? *Possibly but not guaranteed.*
Will it mitigate BZD withdrawal symptoms? *Yes.*
Anxiety Medication Alternatives

• Anxiolytic Medications
  • Hydroxyzine: antihistamine, bid, tid, sedating
  • Diphenydramine: antihistamine, sedating
  • Cyproheptadine: antihistamine, sedating, used for nausea
  • Buspirone: up to tid with meals, short half-life
  • Guanfacine, clonidine: sedating
  • Gabapentin: now scheduled
  • Propranolol: up to tid
  • Trazodone: also for sleep, dry mouth, orthostasis
  • Nefazodone: panic disorder, liver toxicity less than initially thought
  • NAC: n-acetylcysteine: anxiety, OCD
  • L-theanine: derived from green tea

• SSRIs: sertraline, escitalopram, citalopram, fluvoxamine, paroxetine
• SNRIs: venlafaxine, desvenlafaxine, duloxetine
• DNRIs: bupropion

Optimize Dosing!
Insomnia Medication Alternatives

• Target aggressively

• Insomnia Medications
  • Melatonin: better for circadian rhythm shift, may need to take early in the day for best effect
  • Magnesium: alone or combined with melatonin
  • Mirtazapine: weight gain concern
  • Clonidine: hypotension
  • Trazodone: orthostatic hypotension, dry mouth, daytime grogginess
  • Hydroxyzine: daytime use for anxiety with higher dose at night
  • Diphenhydramine: minimize use in elderly
  • Cyproheptadine: minimize/avoid use in elderly, helpful for nausea
  • Doxepin, amitryptyline: minimize use in elderly, low doses can be effective
General Self-Care

• Avoid caffeine!
• Support groups
• Mindfulness, meditation, yoga
• Daily exercise (yes daily)
• Sleep hygiene
Information helps!

You May Be at Risk
You are taking one of the following sedative-hypnotic medications:

- Alprazolam (Xanax®)
- Bromazepam (Lectopam®)
- Chlorazepate
- Chloridiazepoxide-aminopyrine
- Clidinium-chlordiazepoxide
- Clozebazam
- Clonazepam (Rivotril®, Klonopin®)

- Diazepam (Valium®)
- Estazolam
- Flurazepam
- Loprazolam
- Lorazepam (Ativan®)
- Lormetazepam
- Nitrazipam
- Oxazepam (Serax®, Quazepam)
- Temazepam (Restoril®)
- Triazolam (Halcion®)
- Eszopiclone (Lunesta®)
- Zaleplon (Sonata®)
- Zolpidem (Ambien®, Intermezzo®, Edluar®, Sublinorm®, Zolpimist®)
- Zopiclone (Imovane®, Rovane®)

Centre du Recherche, Montreal CA 2014
Case Discussions
Case #1: Psychiatrist frustrated with inheriting patients being prescribed high doses of alprazolam
Case #1: Approach/Thoughts

- Reserve judgment
- Yes, boundaries may have been crossed
- Supervision always helpful
- Taper, but also:
  - Manage withdrawal
  - Reassess diagnosis
  - Consider all types of treatments
Case #2: Management of discontinuation syndrome when tapering, use equivalent doses of BZDs?
Case #2: Approach

- Referring to a “discontinuation syndrome”
- Taper down slowly (Ashton Manual)
- There will be rebound insomnia
- Characterize the insomnia
- Manage with:
  - Reassessing diagnosis
  - Sleep hygiene
  - CBT/Meditation/Exercise
  - Other sleep aids based on individual
- Withdrawal medications: gabapentin, divalproex, carbamazepine, etc.
Case #3: Frustration with BZD seeking patients. Patient with EtOH use seeking BZD only.
Case #3: Approach

- Check your countertransference
- Patient is discounting “everything else”
- Informed consent discussion with patient, including explanations of why no BZDs
- Reassess underlying diagnoses, including length of sobriety
- Can AUD treatment be optimized?
- Previous medication trials
- Therapy
- Consider how cooperative/motivated patient is
Case #4: Working mom with multiple dx including AUD, lots of medications on board, requesting BZD, okay to give?
Case #4: Approach

- “Working mom,” I don’t think she is drug-seeking, are BZDs a definite no? Countertransference may be there
- Reassess diagnosis! (GAD, panic, MDD, EtoH)
- Reassess treatment! (Vraylar, Topamax (migraines), Pamelor, trazodone, Vistaril, no therapy
- Pushing for Ativan, h/o gabapentin
Case #5: Combo of temazepam and diazepam, h/o neuro surgery. Need to taper off due to risky behaviors including active alcohol and cannabis use.
Case #5: Approach

• Emergently and rapidly taper
• Doses not high but chronic and possible underlying seizure risk
• Would likely not switch to anything different (these are not so short-acting, also would not trust patient to take as prescribed)
• Recommend inpatient withdrawal management, if available
• If not, or if patient refuses: stop diazepam altogether, start benzo-sparing protocol with gabapentin
• Have patient return in 3-4 days, stop temazepam, assess utility of gabapentin, and return again in one week
Case #6: Healthy pt in 20s would like to switch from diazepam to alprazolam, psychiatrist wants to do this and taper off after switch.
Case #6: Approach

• Concern for diversion or misuse
• Assess for diagnosis, reasons for change—generally would not switch from longer acting to shorter acting
• Alprazolam less safe, assoc. with more overdoses than all other BZDs
• Diazepam (esp. in healthy pt) could easily transition to gabapentin protocol then taper off
Case #7: Young athlete in a competitive and strenuous sport, with performance anxiety, can be started on propranolol or alprazolam?
Case #7: Approach

• Look for other underlying issues (including substance use, caffeine use, performance enhancement drugs)
• Screen for eating disorders
• Concern about age/effects from alprazolam (including on performance in competition)
• Many alternatives treatments available
• Propranolol: better for less strenuous sports (archery, golf)
Resources

BZD Management

• Example taper schedules: https://www.va.gov/painmanagement/docs/OSI_6_Toolkit_Taper_Benzodiazepines_Clinicians.pdf
• Ashton Manual: https://www.benzo.org.uk/FAQ1.1.htm
• Safety information for patients: http://www.criugm.qc.ca/fichier/pdf/BENZOeng.pdf?fbclid=IwAR2-RcqnjcXQaeC72HxVvR5QiBHNA9U_eFLFdMz6kJbOAF5GnSqNdbrOL0
• CDC sleep hygiene: https://www.cdc.gov/sleep/about_sleep/sleep_hygiene.html

Therapy Information

• Free Online CBT Workbooks from Centre for Clinical Interventions: https://www.cci.health.wa.gov.au/?fbclid=IwAR2VOSZ5q8sCL9z2LUYG34inH-0DnsQ_eHPUitnxepBv4eqHR5ppBFV4gN4
• DIY therapy: Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy, 2005, by Steven C. Hayes
• The Fifteen Minute Hour: Therapeutic Talk in Primary Care, Fourth Edition 2008, by Marian Stuart and Joseph Lieberman
• Insight Timer smartphone app for meditations of different lengths


References

Questions?

• Find Psychiatry Network at facebook.com/groups/psychnetwork
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