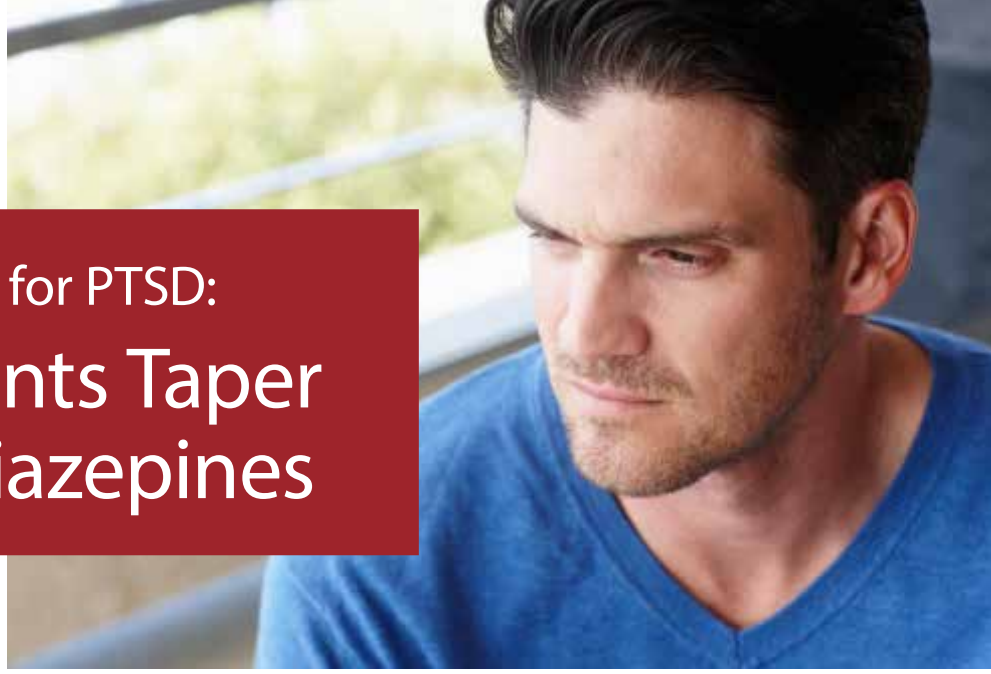
Effective Treatments for PTSD:

Helping Patients Taper from Benzodiazepines



Quick Facts

- Taper anyone taking benzodiazepines for 2 weeks or longer
- Withdrawal symptoms may occur after only 2-4 weeks of treatment
- Risks of recurrence or rebound symptoms may occur as early as a few days to 1 week
- Concurrent use of other sedatives may alter withdrawals

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)

National Center for PTSD
POSTTRAUMATIC STRESS DISORDER

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 anticonvulsant 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.

Adjunctive Options

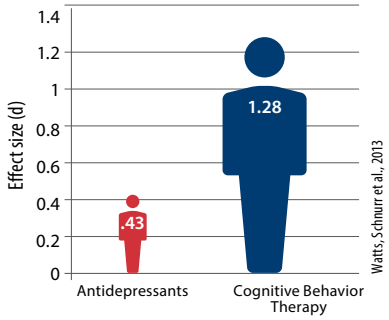
Adjunctive options explored to support the last phase of taper:

- 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



Effects of Treatment on PTSD Severity

Benzodiazepine Equivalent Doses and Suggested Taper

	Approximate Dosage Equivalents	Elimination Half-life
Chlordiazepoxide	25 mg	>100hr
Diazepam	10 mg	>100hr
Clonazepam	1 mg	20-50 hr
Lorazpam	2 mg	10-20 hr
Alprazolam	1 mg	12-15 hr
Temazepam	30 mg	10-20 hr

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		Example: Alprazolam 2 mg bid Convert to 40 mg diazepam daily
Week 1		35 mg/day
Week 2	Total dose decrease by 25%	30 mg/day (25%)
Week 3		25 mg/day
Week 4	Total dose decrease by 50%	20 mg/day (50%)
Week 5-8	Hold dose	Continue at 20 mg/day for 1 month
Week 9-10	Current dose reduction of 25% every two weeks	15 mg/day
Week 11-12		10 mg/day
Week 13-14		5 mg/day
Week 15		discontinue

Perry PJ et al. Psychotropic Drug Handbook Philadelphia PA.2007

Lader M et al. CNS Drugs 2009 ; 23:19-31.

Copyright ©2013 by the National Center for PTSD | ptsd.va.gov

National Center for PTSD
POSTTRAUMATIC STRESS DISORDER