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A Self-Help Handout for Benzodiazepine Discontinuation Using Cognitive Behavioral Therapy

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Although prescription rates may be declining, benzodiazepines (BZs) are still very commonly prescribed for the treatment of anxiety disorders. Because many anxiety patients require assistance in successfully discontinuing BZs, cognitive behavioral therapy (CBT) approaches have been specifically developed to target this issue, and an evidence base now exists to support their use in this manner. In this paper, we first provide the rationale for why BZ discontinuation is desirable. We then present a self-help handout that we have used productively in our cognitive-behavioral practice to assist patients in deciding whether they are ready to attempt discontinuation of their BZs, and to prepare them with strategies for successful discontinuation. The clinical use of this handout is discussed and suggestions offered for integrating it effectively into CBT for anxiety.

ALTHOUGH prescription rates may be declining in view of alternative, less problematic pharmacotherapies, benzodiazepines (BZs) are still commonly used for the treatment of anxiety disorders (Boixet, Batlle, & Bolibar, 1996; Bruce et al., 2003). For example, recent population level data from Statistics Canada suggest that nearly 20% of individuals with a current anxiety disorder are taking BZs (Beck et al., 2005). Moreover, 50% of patients presenting for anxiety disorders treatment are already on BZs, with many unable to discontinue (Romach, Busto, Somer, Kaplan, & Sellers, 1995). Despite known difficulties with the use of BZs, they continue to be sanctioned by general physicians (Boixet et al., 1996; Mant, Mattick, de Burgh, Donnelly, & Hall, 1995) and psychiatrists (Balter, Ban, & Uhlenhuth, 1993; Uhlenhuth, Balter, Ban, & Yang, 1995) for long-term use in clinical anxiety management.

Despite the continued widespread use of BZs for treatment of anxiety, research suggests several reasons for patients to consider discontinuation. BZ use has been associated with cognitive problems, dampens benefit from exposure-based treatments for anxiety disorders, and can be addictive (Michelini, Cassano, Frarre, & Perugi, 1996; Westra, Stewart, & Conrad, 2002). Other reasons for BZ discontinuation include limited long-term efficacy in anxiety management and patient preference for nonpharmacological treatments for anxiety (Banken & Wilson, 1992; Otto, Pollack, & Sabatino, 1996).

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Given that there is a withdrawal syndrome associated with BZ discontinuation (which can be serious), and most chronic BZ users have had one or more unsuccessful discontinuation efforts (Romach et al., 1995), patients require assistance in successfully discontinuing these medications (Otto, Hong, & Safren, 2002). The intent of this paper is to offer a patient self-help handout that can be used to facilitate successful BZ discontinuation (see Appendix A). The impetus to create the handout was based on observation in clinical practice of frequent and reoccurring concerns expressed by clients in the context of BZ discontinuation. As well, there was a need to integrate management of these common concerns with basic psychoeducation from research on BZ discontinuation (e.g., common withdrawal symptoms, appropriate taper schedule). To contextualize BZ discontinuation, we offer a brief elaboration of the reasons for considering such a course of action, particularly in the context of clients presenting for cognitive behavioral therapy (CBT).

Reasons for Considering Discontinuation

Addiction

BZ discontinuation has received increased attention as a result of high rates of unsuccessful discontinuation attempts and the severity of discontinuation-related symptoms among anxiety disorder patients (Otto et al., 2002). For instance, rebound panic attacks are common in discontinuation of BZs in panic disorder (Fyer et al., 1987) and the withdrawal symptoms of BZs mimic somatic symptoms of anxiety (e.g., shakiness, agitation, tension; Roy-Byrne & Hommer, 1988). In fact, anxiety symptoms experienced with BZ discontinuation are reported to be

equally or more severe than those experienced prior to BZ treatment (Noyes, Garvey, Cook, & Suelzer, 1991; Rickels, Schweizer, Case, & Greenblatt, 1990). Among chronic BZ users, the reported incidence of withdrawal symptoms on discontinuation is estimated at between 40% and 100% (Rickels et al., 1990).

In this regard, Otto, Pollack, Meltzer-Brody, and Rosenbaum (1992) have developed a conceptual model for BZ discontinuation in anxiety. They have proposed that, despite the effectiveness of BZs in providing a partial or full blockade of panic attacks, a fear of the physical sensations associated with panic still persists (Otto & Reilly-Harrington, 1999). In fact, in a naturalistic study of BZ users with anxiety disorders, Stewart, Westra, Thompson, and Conrad (2000) reported greater selective attention to physical threat cues compared to those not using BZs, supporting the continued vigilance to bodily threat sensations in BZ users. These fears may be increased upon an attempt to discontinue BZs since withdrawal symptoms mimic the anxiety for which BZ use was initiated. Moreover, Stewart et al. (2000) also found an association between selective attention to threat and as-needed or p.r.n. use of BZs, suggesting that this type of use in particular may be problematic for individuals with anxiety.

Otto and colleagues (Otto et al., 2002; Otto et al., 1992) have proposed that an effective treatment for BZ discontinuation must (a) decrease conditioned fears of somatic sensations and the tendency to catastrophically misinterpret these sensations; (b) provide patients with coping skills for managing the severity of anxiety sensations; and (c) provide patients with skills for minimizing withdrawal symptoms. Several discontinuation studies provide support for the model and suggest that brief CBT can be used as an aid to BZ discontinuation (Hegel, Ravaris, & Ahles, 1994; see also Otto & Reilly-Harrington, 1999, for a review). Thus, although simultaneous BZ use may interfere with the efficacy of CBT in treating anxiety disorders (see review by Westra and Stewart, 1998), ironically, the one place where CBT may be particularly beneficial for anxiety patients taking BZs is in helping patients discontinue their use of BZs. For example, Bruce, Spiegel, and Hegel (1999) have demonstrated that upon CBT-assisted discontinuation of alprazolam, panic disorder patients maintained treatment effects and were abstinent from further medication use at 2- to 5-year follow-up. Moreover, a reduction in Anxiety Sensitivity Index score was a significant predictor of BZ discontinuation success.

Similarly, it has been suggested that CBT interventions are likely to be effective in assisting antidepressant discontinuation (Schmidt et al., 2002). Selective serotonin reuptake inhibitors (SSRIs) are often recommended as a pharmacological treatment for anxiety disorders (American Psychiatric Association, 1998; Coplan, Pine, Papp, & Gorman, 1996). However, upon tapering or discontinuation of SSRIs, patients report increased anxiety symptoms (Coupland, Bell, & Potokar, 1996; Rickels, Schweizer, Weiss & Zavodnick, 1993). At least one study (Whittal, Otto, & Hong, 2001) found support for the effectiveness of CBT in assisting patients to discontinue SSRI treatment for panic disorder and agoraphobia (PDA).

Interference With CBT

CBT is recommended as a first-line treatment for anxiety (Evans, Bradwejn, & Dunn, 2000; National Institute for Clinical Excellence, 2004). Curran (1991) suggests that progress in CBT might be hindered by simultaneous BZ use due to CBT's emphasis on episodic learning, which is weakened with BZ use. Controlled investigations of anxiety disorder treatment outcome comparing CBT with and without concomitant BZ use suggest a superiority of CBT alone and a general failure of these treatments to operate in a complementary fashion in the treatment of anxiety (Marks et al., 1993; also see Otto, Smits, & Reese, 2005, for review).

Several cognitive factors associated with BZ use (e.g., reduced self-efficacy, heightened selective attention to threat cues) have been suggested as potential explanations for such treatment noncomplementarity (for a review see Westra & Stewart, 1998). For example, memory impairments might be one mechanism involved in poorer CBT performance observed in individuals with anxiety disorders concurrently utilizing BZs. CBT places heavy emphasis on learning and integration of new experiences. It is possible that new information acquired in session or between sessions (e.g., during exposure exercises) might be less well-remembered by individuals taking BZs compared to nonmedicated individuals. This might lead to poorer integration of new information for challenging catastrophic beliefs. Consistent with this hypothesis, Westra & colleagues (2004) have demonstrated that BZ-medicated patients with panic disorder, in comparison with their unmedicated counterparts, show poorer recall of psychoeducational material presented in the clinical setting during CBT (Westra et al., 2004).

In addition, as-needed use of BZs might be particularly detrimental to positive CBT outcomes compared with regularly scheduled use. BZs are often used on an as-needed or p.r.n. basis among anxiety patients (Romach et al., 1991) and are frequently prescribed for use on an as-needed basis by prescribers (Westra and Stewart, 2002). Among the most common reasons stated for p.r.n. use is facilitation of exposure to feared situations, reduction of general anxiety, and inhibiting impending panic attacks. Despite the intuitive appeal of such uses to produce anxiety reduction, the treatment benefits of such practices are generally not supported by empirical data, which find increased anxiety with p.r.n. use (for a review, see Rachman,