



The Benzodiazepine Balancing Act

MANAGING ANXIETY, INSOMNIA, AND
SUBSTANCE USE RISK

TOMEKIA Y. LUCKETT, PHD, APRN, PMHNP-BC

Learning Objectives



- ▶ Explain the pharmacologic profile, indications, and risk factors associated with benzodiazepine prescribing for anxiety and insomnia.
- ▶ Discuss non-benzodiazepine alternatives and integrative strategies for anxiety and sleep management.
- ▶ Demonstrate best practices for screening, monitoring, and tapering patients at risk for benzodiazepine misuse or dependence.

Mechanism of Action

- ▶ Benzodiazepines are positive allosteric modulators of the GABA-A receptor.
- ▶ Increase frequency of chloride channel opening → neuronal hyperpolarization.
- ▶ Clinical effects: anxiolysis, sedation, muscle relaxation, anticonvulsant activity.
- ▶ Rapid symptom relief does not equal long-term disease management.



Common Clinical Indications

- ▶ Acute severe anxiety or panic symptoms
- ▶ Short-term insomnia (when appropriate)
- ▶ Alcohol withdrawal management
- ▶ Status epilepticus and seizure disorders
- ▶ Procedural sedation

Pharmacokinetics: Key Considerations

Onset of action (rapid vs delayed)



Half-life (short, intermediate, long acting)



Lipophilicity and CNS penetration



Active metabolites (e.g., diazepam)



Accumulation risk in older adults and hepatic impairment



Common Agents

- ▶ Alprazolam: rapid onset, higher misuse potential, rebound anxiety.
- ▶ Lorazepam: predictable kinetics, no active metabolites.
- ▶ Diazepam: long half-life, active metabolites, accumulation risk.
- ▶ Clonazepam: longer acting, often used for panic disorder.
- ▶ Temazepam: commonly used for insomnia.

Adverse Effects & Safety Concerns

- ▶ Sedation and psychomotor impairment
- ▶ Falls and fractures (especially older adults)
- ▶ Cognitive impairment and delirium risk
- ▶ Respiratory depression (in high-risk patients)
- ▶ Motor vehicle accident risk
- ▶ Paradoxical agitation (rare)

Tolerance, Dependence, and Addiction

- ▶ Tolerance: diminished response requiring higher doses.
- ▶ Dependence: withdrawal symptoms when medication is reduced or stopped.
- ▶ Addiction: compulsive use despite harm.
- ▶ Dependence can occur even with prescribed, adherent use.

High-Risk Populations

- ▶ Older adults (Beers Criteria: increased risk of falls and cognitive impairment)
- ▶ COPD, obstructive sleep apnea, or respiratory compromise
- ▶ Concurrent opioid therapy or CNS depressants
- ▶ History of substance use disorder
- ▶ Pregnancy (neonatal withdrawal and teratogenic concerns)
- ▶ Severe depression or suicidality

Clinical Red Flags for Misuse

- ▶ Early refill requests or escalating dose demands
- ▶ Multiple prescribers or pharmacies (PDMP concern)
- ▶ Frequent reports of lost/stolen medications
- ▶ Refusal of urine drug screening or PDMP review
- ▶ Concurrent illicit substance use
- ▶ Functional decline despite continued prescribing



Mini Case Discussion

- ▶ 45-year-old female with anxiety and insomnia x 2 months.
- ▶ Requests alprazolam because “it works.”
- ▶ PMH: depression; reports occasional alcohol use.

Why Alternatives Matter

- ▶ Benzodiazepines provide symptom suppression rather than long-term treatment.
- ▶ Long-term use increases tolerance, dependence, and withdrawal risk.
- ▶ Safer evidence-based options exist for anxiety and insomnia.

Pharmacologic Alternatives for Anxiety

- ▶ First-line: SSRIs (sertraline, escitalopram) and SNRIs (venlafaxine, duloxetine).
- ▶ Buspirone (GAD): non-sedating, no dependence.
- ▶ Hydroxyzine: short-term PRN option (sedation, anticholinergic effects).
- ▶ Propranolol: performance anxiety (avoid in asthma/bradycardia).
- ▶ Gabapentin: caution for misuse potential in some populations.

Pharmacologic Alternatives for Insomnia

- ▶ Melatonin (circadian rhythm support)
- ▶ Low-dose doxepin (sleep maintenance)
- ▶ Trazodone (commonly used; monitor orthostasis)
- ▶ Mirtazapine (beneficial if depression and weight loss)
- ▶ Non-benzodiazepine hypnotics (zolpidem): use cautiously

CBT-I: Evidence-Based First-Line Treatment

- ▶ Stimulus control (bed is for sleep only)
- ▶ Sleep restriction therapy
- ▶ Cognitive restructuring
- ▶ Relaxation training
- ▶ Sleep hygiene education
- ▶ Sustained benefit compared to medication-only approaches

Integrative Strategies (Adjunctive)

- ▶ Mindfulness-based stress reduction (MBSR)
- ▶ Progressive muscle relaxation
- ▶ Box breathing (4-4-4-4)
- ▶ Guided imagery and meditation
- ▶ Exercise, sunlight exposure, and structured routines
- ▶ Caffeine/alcohol reduction

Sleep Hygiene Myth Busters

- ▶ 1. Alcohol improves sleep quality.
- ▶ 2. Watching TV in bed is harmless if it relaxes the patient.
- ▶ 3. A consistent wake time is more important than bedtime.
- ▶ 4. Napping improves chronic insomnia.

Patient Education (Sample Script)

- ▶ “Benzodiazepines can help quickly, but they can also train the brain to rely on them.”
- ▶ “My goal is to help you sleep and feel calmer without creating a dependence.”
- ▶ “We will use a plan that treats the root cause and supports long-term stability.”

Activity: Mini Case Discussion

- ▶ 60-year-old male with insomnia.
- ▶ PMH: hypertension and obstructive sleep apnea.
- ▶ Reports drinking 2–3 beers nightly.
- ▶ Requests temazepam.

- ▶ Discussion prompts:
 - What is the safest next step?
 - What alternative plan would you recommend?

Validated Screening Tools



- ▶ GAD-7: generalized anxiety severity
- ▶ PHQ-9: depression severity
- ▶ Insomnia Severity Index (ISI): insomnia assessment
- ▶ AUDIT-C: alcohol use screening
- ▶ DAST-10: drug abuse screening

Monitoring Best Practices

- ▶ Prescription Drug Monitoring Program (PDMP) review
- ▶ Baseline and random urine drug screening
- ▶ Controlled substance agreement
- ▶ Document functional goals (sleep hours, panic frequency, work performance)
- ▶ Follow-up every 2–4 weeks during initiation or taper



PDMP Dilemma

- ▶ Scenario: PDMP shows the patient received alprazolam from another provider last week.

Benzodiazepines + Opioids = High Risk

- ▶ Synergistic respiratory depression
- ▶ Increased overdose mortality
- ▶ FDA boxed warning on combined use
- ▶ Avoid combination whenever possible; if unavoidable, document rationale and monitor closely

When to Avoid Prescribing

- ▶ Active substance use disorder without structured monitoring plan
- ▶ Concurrent opioid therapy (unless rare exception)
- ▶ Unstable COPD or untreated OSA
- ▶ History of overdose or recurrent intoxication
- ▶ Cognitive impairment/dementia
- ▶ Severe suicidality without close monitoring

Withdrawal Symptoms (Can Be Life-Threatening)

- ▶ Rebound anxiety and insomnia
- ▶ Tremors, sweating, tachycardia
- ▶ Irritability and agitation
- ▶ Nausea and GI distress
- ▶ Seizures and delirium (severe withdrawal)
- ▶ Withdrawal risk increases with high-dose or long-term use

Tapering Principles

- ▶ Typical reduction: 10–25% every 1–2 weeks (individualize).
- ▶ Go slower in long-term users or older adults.
- ▶ Consider switching to a longer-acting benzodiazepine (e.g., diazepam) when appropriate.
- ▶ Address underlying anxiety disorder with SSRI/SNRI and psychotherapy.
- ▶ Frequent follow-up improves success.

Example Taper Schedule

- ▶ Patient: clonazepam 1 mg BID
 - ▶ Weeks 1–2: 0.75 mg BID
 - ▶ Weeks 3–4: 0.5 mg BID
 - ▶ Weeks 5–6: 0.25 mg BID
 - ▶ Weeks 7–8: 0.25 mg daily
 - ▶ Week 9+: discontinue
-
- ▶ Support with CBT-I, sleep plan, and anxiety treatment.

Harm Reduction Strategies



- ▶ Motivational interviewing and shared decision-making
- ▶ Education on overdose risk and interactions
- ▶ Naloxone prescribing when opioids are present
- ▶ Avoid alcohol and other sedatives
- ▶ Coordinate care with PCP, psychiatry, pharmacy, and behavioral health

Activity: “Write the Plan”

- ▶ Case: Patient taking alprazolam 1 mg TID for 2 years.
- ▶ In 2 minutes, outline:
 - ▶ • Screening tools you will use
 - ▶ • PDMP/UDS plan
 - ▶ • Taper approach and follow-up schedule
 - ▶ • Alternative pharmacologic and nonpharmacologic treatments

Collaborative Care Model



- ▶ Primary care + psychiatry coordination
- ▶ Behavioral health integration and therapy referrals
- ▶ Pharmacist medication review support
- ▶ Sleep medicine referral for suspected OSA
- ▶ Interdisciplinary care improves safety and adherence

Key Takeaways

- ▶ Benzodiazepines may be appropriate short-term but carry significant risks.
- ▶ Older adults and patients with SUD/OSA/opioids are high risk.
- ▶ Use validated tools and structured monitoring (PDMP, UDS).
- ▶ Treat the underlying disorder: anxiety, insomnia, trauma, depression.
- ▶ Taper slowly and support with evidence-based alternatives.

References

- ▶ American Geriatrics Society. (2023). Updated AGS Beers Criteria® for potentially inappropriate medication use in older adults.
- ▶ FDA. (2020). FDA requiring Boxed Warning updated to improve safe use of benzodiazepine drug class.
- ▶ Baldwin, D. S., et al. (2022). Evidence-based pharmacological treatment of anxiety disorders.
- ▶ Morin, C. M., & Benca, R. (2012). Chronic insomnia. *The Lancet*.
- ▶ SAMHSA. (2020). TIP 63: Medications for opioid use disorder (for co-prescribing considerations).

Questions & Discussion

Contact:
tluckett@wmcarey.edu

