

# TO MEDICATE OR NOT TO MEDICATE?



# OPTIONS



**STAY THE COURSE**

**COME OFF BEFORE CBT-I**

**COME OFF DURING CBT-I**

# **RATIONALE**



**MEDICATION IS WORKING**

**PATIENT IS TOLERANT BUT UNWILLING**

**PATIENT IS TOLERANT BUT INAPPROPRIATE**

# **MEDICATION IS WORKING-DOCTOR CONCERN**



**TALK TO THE DOCTOR-ALLAY CONCERNS**

**PATIENT CAN CONSIDER ALTERNATE DOCTOR**

# MEDICATION IS WORKING- PATIENT CONCERN



**ALLAY PATIENT CONCERNS**

**CBT-I OUTCOME INDEPENDENT OF MED DURATION**

**CBT-I OUTCOME INDEPENDENT OF TOLERANCE**

# PATIENT IS TOLERANT BUT UNWILLING

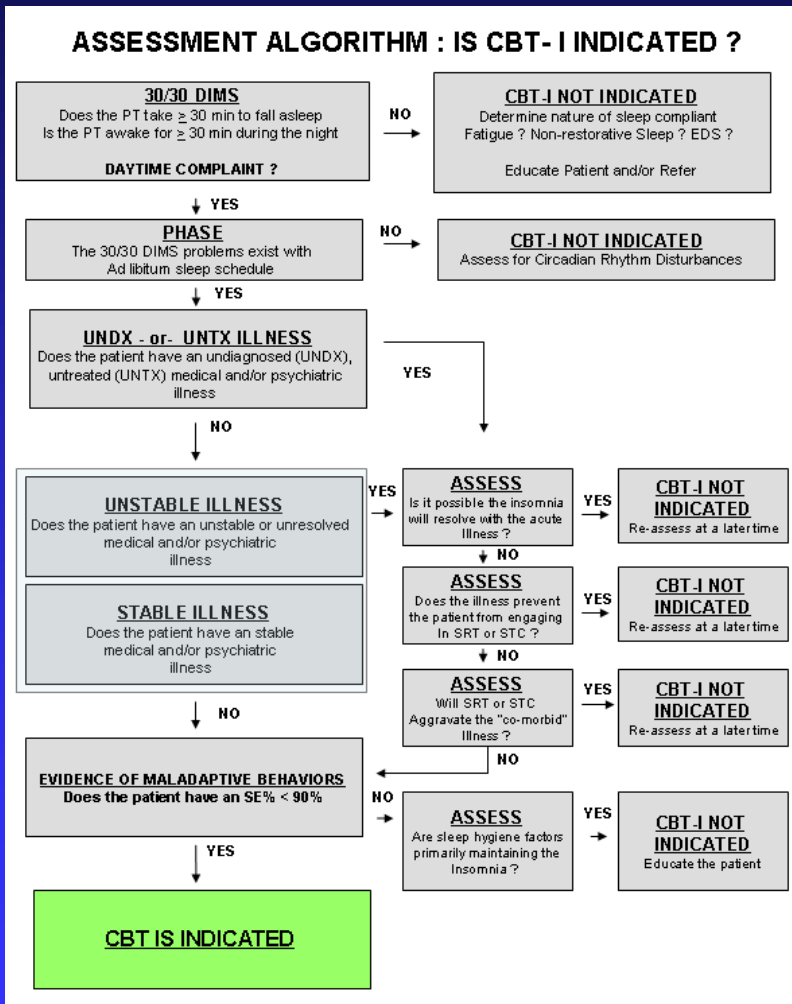


**CONSIDER CBT-I**

**CAUTION FOR FALLS**

**POSSIBLE INTERFERENCE**

# CBT-I IS CONTRAINDICATED



**BIPOLAR DISORDER  
SEIZURE DISORDER  
PARASOMNIAS  
SEVERE PAIN**

# OPTIONS



**STAY THE COURSE**

**COME OFF BEFORE CBT-I**

**COME OFF DURING CBT-I**



# **RATIONALE**



**CLEAN SLEEP BASELINE**

**REDUCE WITHDRAWAL INTERFERENCE**

# CLEAN SLEEP BASELINE

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

COMPLETE IMMEDIATELY BEFORE BED CONCERNING HOW YOU FELT TODAY:

	MON	TUES	WED	THUR	FRI	SAT	SUN		MEAN
TYPICAL DAY? (YES/NO) *									
FATIGUE (NONE 0-1-2-3-4-5 A LOT)									
STRESS (NONE 0-1-2-3-4-5 A LOT)									
ALERT (NOT VERY 0-1-2-3-4-5 VERY)									
CONCENTRATION (GOOD 0-1-2-3-4-5 BAD)									
MOOD (BAD 0-1-2-3-4-5 GOOD)									
TIME SPENT EXERCISING (MIN.)									
TIME SPENT OUTSIDE TODAY (MIN.)									
NUMBER OF ALCOHOLIC BEVERAGES									
PRESCRIPTIONS TODAY (YES/NO)									
OTC MEDS TODAY (YES/NO)									
PAIN TODAY (NONE 0-1-2-3-4-5 A LOT)									
HEALTH (FELT FINE 0-1-2-3-4-5 BAD)									
MENSTRUATE TODAY (YES/NO)									
MENSTRUAL PAIN (NONE 0-1-2-3-4-5 BAD)									

\* PLEASE INDICATE ON THE BACK OF THIS SHEET WHY ANY GIVEN DAY WAS NOT TYPICAL AND/OR WHAT MEDICATIONS YOU TOOK ON ANY GIVEN DAY.

COMPLETE IMMEDIATELY ON AWAKENING

	MON	TUES	WED	THURS	FRI	SAT	SUN		MEAN
TIME TO BED (CLOCK TIME)									
TIME OUT OF BED (CLOCK TIME)									
TIME TO BED (DEV FRM 11)									
TIME OUT OF BED (DEV FRM 7)									
(SL) TIME TO FALL ASLEEP									
(NUMA) NUMBER TIMES AWAKENED									
(WASO) WAKE AFTER SLEEP ONSET									
(TTOB) TOTAL AMOUNT TIME OUT OF BED									
(TST) TOTAL SLEEP TIME (MIN.)									
SLEEP QUALITY (GOOD 0-1-2-3-4-5 POOR)									
FATIGUE (NONE 0-1-2-3-4-5 A LOT)									

SE AND TIB TO BE AUTOCALCULATE

# REDUCE WITHDRAWAL INTERFERENCE



EACH REDUCTION COULD RESULT IN REBOUND

# DISCONTINUATION BEFORE CBT-I



**MAKE IT A PATIENT CHOICE**



# OPTIONS



**STAY THE COURSE**

**COME OFF BEFORE CBT-I**

**COME OFF DURING CBT-I**

# **RATIONALE**



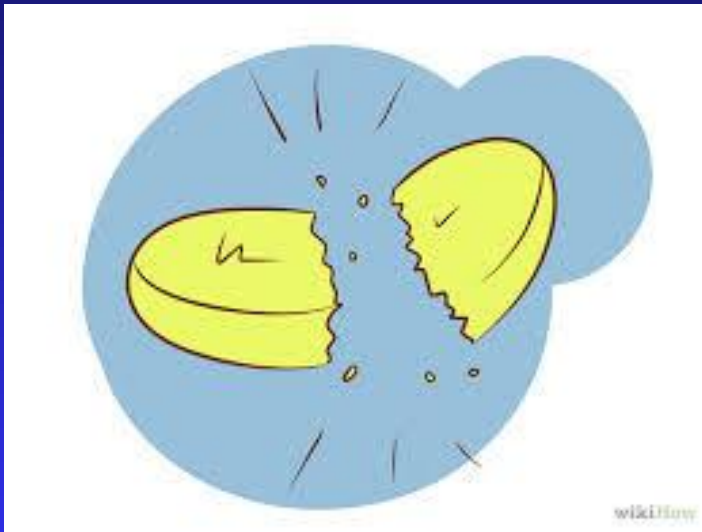
**MEDICATION DOSE TOO HIGH**

**PT./PCP HIGHLY ANXIOUS/UNWILLING**

# MED TAPER DURING CBT-I

**CONSULT PRESCRIBING PHYSICIAN**

**ASSESS FOR INSOMNIA**

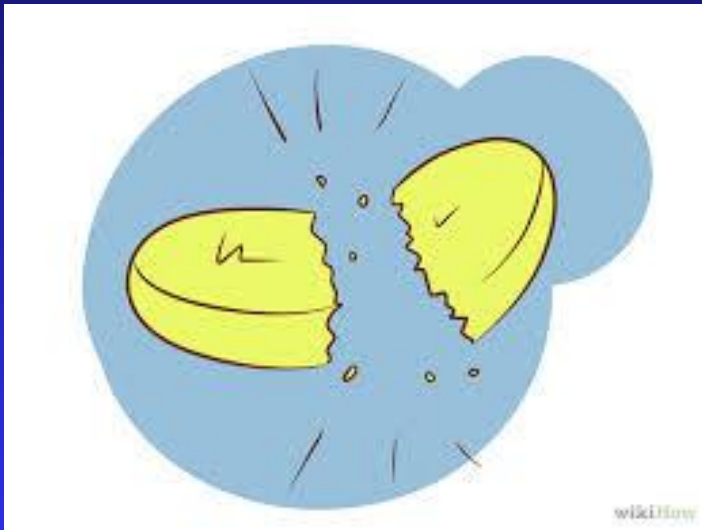




# WHAT IF THE MEDICATION IS WORKING?



# MED TAPER DURING CBT-I



**CONSULT PRESCRIBING PHYSICIAN**

**ASSESS FOR INSOMNIA**

**PROCEED WITH STANDARD CBT-I**

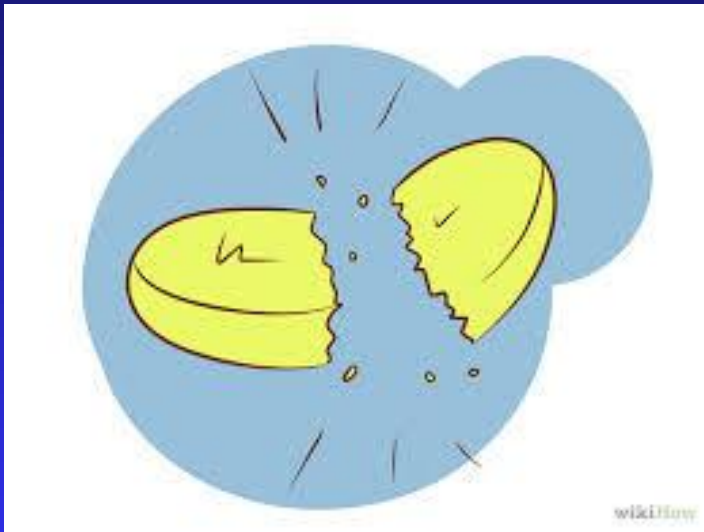
**MED TAPER AT NADIR OF RESTRICTION**



**WHAT IS ADVANTAGE OF STARTING TAPER HERE?**

**SLEEP DRIVE SERVES AS A SAFETY NET**

# MED TAPER DURING CBT-I



**CONSULT PRESCRIBING PHYSICIAN**

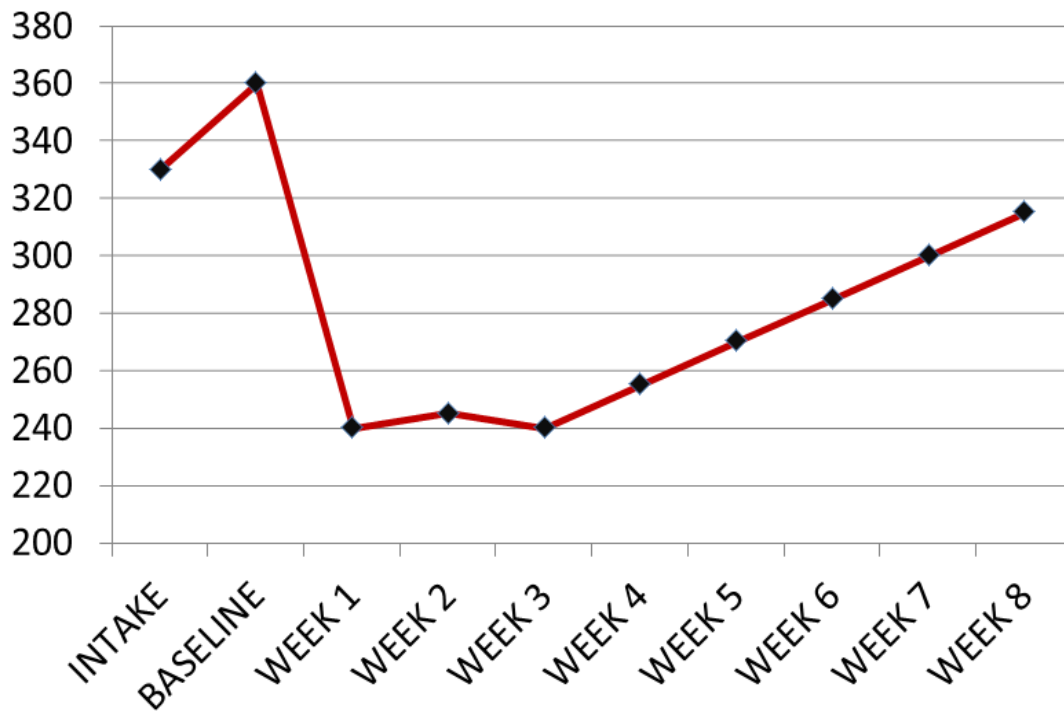
**ASSESS FOR INSOMNIA**

**PROCEED WITH STANDARD CBT-I**

**MED TAPER AT NADIR OF RESTRICTION**

**PROCEED WITH NORMAL EXPANSION**

### TOTAL SLEEP TIME OVER TREATMENT WITH MEDICATION DISCONTINUATION



# RCT FOR MED TAPER

Randomized Clinical Trial of Supervised Tapering and Cognitive Behavior Thera...  
Charles M Morin, Célyne Bastien, Bernard Guay, Monelly Radouco-Thomas, et al  
*The American Journal of Psychiatry*; Feb 2004; 161, 2; Research Library  
pg. 332

## Article

### Randomized Clinical Trial of Supervised Tapering and Cognitive Behavior Therapy to Facilitate Benzodiazepine Discontinuation in Older Adults With Chronic Insomnia

Charles M. Morin, Ph.D.

Célyne Bastien, Ph.D.

Bernard Guay, M.D.

Monelly Radouco-Thomas, M.D.

Jacinto Leblanc, B.C.P.P.

Annie Vallières, Ph.D.

**Objective:** This study evaluated the effectiveness of a supervised benzodiazepine taper, singly and combined with cognitive behavior therapy, for benzodiazepine discontinuation in older adults with chronic insomnia.

**Method:** Seventy-six older adult outpatients (30 women, 38 men; mean age of 62.5 years) with chronic insomnia and prolonged use (mean duration of 19.3 years) of benzodiazepine medication for sleep were randomly assigned for a 10-week intervention consisting of a supervised benzodiazepine withdrawal program (N=23), cognitive behavior therapy for insomnia (N=24), or supervised withdrawal plus cognitive behavior therapy (N=27). Follow-up assessments were conducted at 3 and 12 months. The main outcome measures were benzodiazepine use, sleep parameters, and anxiety and depressive symptoms.

**Results:** All three interventions produced significant reductions in both the quantity (50% reduction) and frequency (80% reduction) of benzodiazepine use, and 63% of the patients were drug-free within an average of 7 weeks. More patients who received medication taper plus cognitive behavior therapy (35%) were benzodiazepine-free after the initial intervention, compared to those who received medication taper alone (40%) and cognitive behavior therapy alone (24%). The patients in the two groups that received cognitive behavior therapy perceived greater subjective sleep improvements than those who received medication taper alone. Polysomnographic data showed an increase in the amount of time spent in stages 3 and 4 sleep and REM sleep and a decrease in total sleep time across all three conditions from baseline to post-treatment. Initial benzodiazepine reductions were well maintained up to the 12-month follow-up, and sleep improvements became more noticeable over this period. No significant withdrawal symptoms or adverse events were associated with benzodiazepine tapering.

**Conclusions:** A structured, time-limited intervention is effective in assisting chronic users of benzodiazepine medication to discontinue or reduce their use of medication. The addition of cognitive behavior therapy alleviates insomnia, but sleep improvements may become noticeable only after several months of benzodiazepine abstinence.

**Keywords:** benzodiazepines, chronic insomnia, cognitive behavior therapy, medication tapering, supervised withdrawal.

*Am J Psychiatry* 2004; 161:332-342

At least 10% of the adult population complains of significant insomnia, and the incidence increases with aging. Chronic insomnia is associated with functional impairments, reduced quality of life, higher risk for depression, and increased utilization of health care services (1-5). The higher incidence of insomnia with aging is paralleled by an increased use of hypnotic drugs among older adults. The rate of hypnotic use in the community is at least twice as high (14%) among those age 65 years and older, compared to younger age groups (3). This rate is even higher among older patients attending medical practices, with 20% of women and 6% of men using sleep medications (6).

The short-term use of hypnotics may be indicated and effective in the treatment of acute insomnia. However, prolonged use of hypnotics, particularly benzodiazepines, is usually not recommended (7-9) because of potential

adverse effects (e.g., memory impairments), altered sleep physiology (e.g., reduced stages 3 and 4 sleep, increased beta activity), and risks of tolerance and dependence (10, 11). In older adults, benzodiazepines may increase the risk of falls and hip fractures (12), motor vehicle accidents (13), and even mortality (14). Prescribing guidelines recommend restricting hypnotic use to no more than 2-4 weeks, yet more than 85% of those prescribed such medications continue using them for more than 1 year, and as many as 30% for more than 5 years (3, 15, 16). Prolonged users are mostly older adults who report greater sleep dissatisfaction, higher psychological distress, and more chronic medical illnesses (2, 17).

Discontinuation of hypnotic medications, particularly benzodiazepines, can pose a significant challenge after prolonged use, even when they have been used at low

76 Subjects (38 men; 38 women)  
Mean age = 62.5 yrs.  
Mean use = 19.3 yrs.  
3 Conditions

10 wk Supervised Med Taper

CBT-I

CBT + Taper

# MED TAPER

PHYSICIAN GUIDED

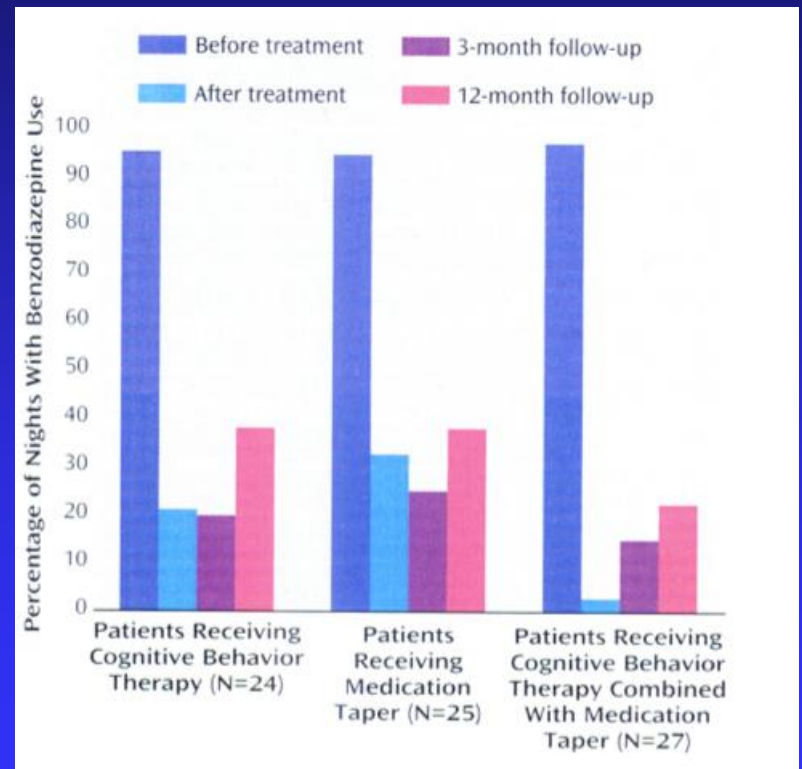
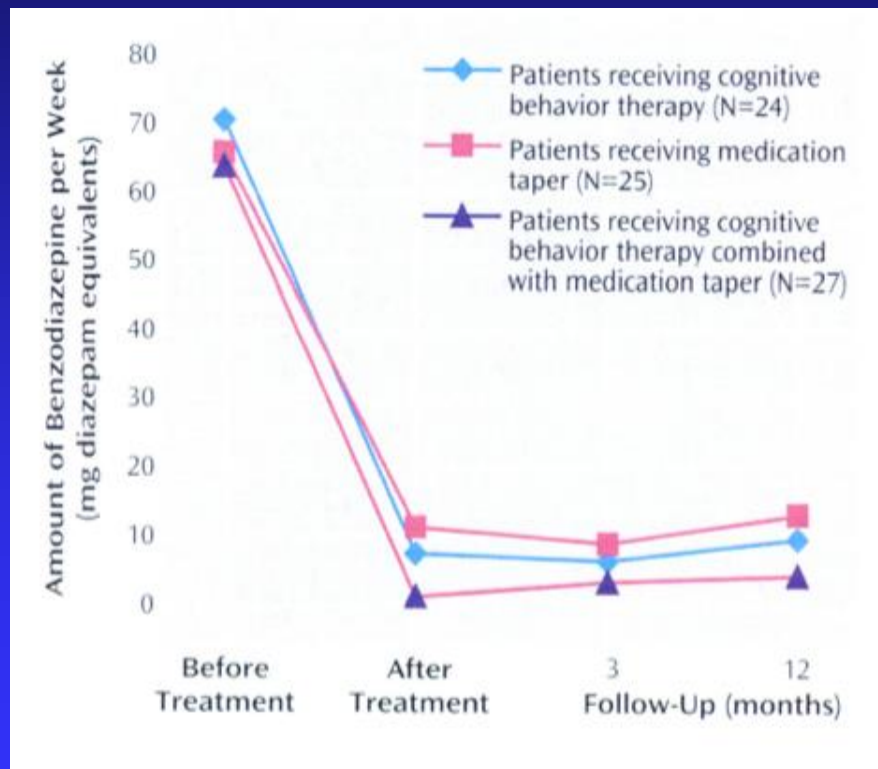
STABILIZATION OF MED AND DOSE

REDUCE 25% OF INITIAL DOSE EVERY 2 WEEKS  
TO MINIMUM DOSE AVAILABLE

INTRODUCE INCREASING MED FREE NIGHTS

SCHEDULED HYPNOTIC USE VS AS NEEDED

# DATA





# WHAT PERCENTAGE WERE MED FREE?

MED TAPER		48%
CBT-I		54%
TAPER + CBT-I		85%

# QUESTIONS



# BREAK

