Unprescribed Influence: Navigating Benzodiazepine Tapering in the Age of Social Media

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Friday, April 24, 2026 ASAM 57th Annual Conference

Learning Objectives

- Describe strategies for developing a benzodiazepine tapering program tailored to diverse patient needs.
- Apply clinical guidance documents into individualized care plans for patients seeking benzodiazepine tapering.
- Evaluate social media narratives about benzodiazepines and construct patient-centered communication strategies.

Disclosure Information

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April 24, 2026 10:45am – 12:00pm PT

Daniel Bebo, MD, FASAM

No disclosures.

Kristina M. Reinstatler, PharmD, MBA, BCPP, FAAPP

No disclosures.

U.S. Benzodiazepine Use

Benzodiazepine use has declined nationally

Decline occurred despite rising psychological distress during COVID-19

Older adults remain the highest users

Olfson M., et al. *J Clin Psychiatry.* 2026;87(1):25m16125.

Risks with Chronic Use of Benzodiazepines

Current long-term users:

- Working memory deficits
- Processing speed reduction
- Divided attention impairment
- Recent memory problems
- Visuoconstruction difficulties
- Increased Risk of MVA
- Increased all cause mortality in MDD patients

Older adults specifically:

- Cognitive impairment
- Psychomotor effects
- Daytime sedation
- Increased fracture risk

Post-discontinuation:

- Long term recovery

Crowe SF., et al. *Arch Clin Neuropsychol.* 2018;33(7):901-911.
Maust DT., et al. *Psychiatr Serv.* 2019;70(2):97-106.

Overdose & Mortality Risks

Overdose deaths: Up to 70% of opioid overdose deaths also involved benzodiazepines

Mortality data:

Combined benzodiazepine-opioid use: steepest decline in survival	Approximately 2-fold increased mortality hazard (adjusted)	Risk persists even after controlling for comorbidities

High-risk combinations:

Benzodiazepines + opioids	Benzodiazepines + alcohol

Jones JD., et al. *Drug Alcohol Depend.* 2012;125(1-2):8-18.
Xu KY., et al,. *JAMA Netw Open.* 2020;3(12):e2028557.

Assessing Risk for Physical Dependence

- **High Risk for Withdrawal:**
  - Duration: ≥3 months of use
  - Frequency: ≥4 days per week
  - Any dose level
  - Greater risk with higher doses and longer duration

- **Other Risk Factors:**
  - Age, comorbid conditions
  - Concurrent or prior substance use disorder history
  - Prior withdrawal history
  - Pharmacological properties of specific benzodiazepine

Brunner E., et al. American Society of Addiction Medicine; 2025.

Exceptions to Avoid Long-Term Use

- Long-term benzodiazepine use may be appropriate for:
  - Treatment-resistant generalized anxiety disorder
  - Bipolar spectrum disorders
  - Complex seizure disorders
  - Spasticity
  - REM sleep behavior disorder, restless leg syndrome
  - Catatonia
  - Palliative and end-of-life care
- *Consider specialist consultation for these patients*

Crowe SF., et al. *Arch Clin Neuropsychol.* 2018;33(7):901-911
Robertson S., et al. *Am Fam Physician.* 2023;108(3):260-266.

Current Clinical Practice Guidelines

- **2024-2025 ASAM Joint Clinical Practice Guideline**
  - *Partnered with 9 medical societies*

- **<u>Core Principles:</u>**
  - Ongoing risk-benefit assessment throughout treatment
  - Shared decision-making with patients
  - Never abrupt discontinuation in physically dependent patients
  - Individualized, flexible tapering strategies
  - Adjunctive psychosocial interventions

- **Key Recommendation:** Initial dose reductions of 5-10%, not exceeding 25% every 2 weeks (Strong Recommendation, Clinical Consensus)

Brunner E., et al. American Society of Addiction Medicine; 2025.

Proposed Tapering Methods

Method 1: Standard Gradual Taper

- **Initial Phase:**
  - Reduce by 5-10% of current dose every 2-4 weeks
  - Higher maintenance doses can decrease up to 25% initially
  - Lower doses require 5-15% reductions

Method 2: Hyperbolic Tapering

- **For patients experiencing withdrawal symptoms:**
  - Each reduction based on previous dose, not starting dose
    - Example: 10 mg → 9 mg → 8.1 mg → 7.2 mg → 6.5 mg

Brunner E., et al. American Society of Addiction Medicine; 2025.

Flexible vs. Structured Approaches

- **Structured Taper:**
  - Predetermined schedule with specific dose reductions
  - Used in most clinical trials
  - May have higher dropout rates with rigid schedules

- **Flexible Taper:**
  - Patient participates in deciding when to reduce
    - Example: Reduce 60 pills to 48 over 4 weeks; patient chooses which to skip
  - Increases patient agency and buy-in
  - Adjust based on withdrawal symptoms

- **Trial Dose Reduction:**
  - For reluctant patients: suggest single reduction rather than full commitment
  - May increase motivation and self-efficacy

Brunner E., et al. American Society of Addiction Medicine; 2025.

Switching to Long-Acting Benzodiazepines

- **Common Practice:**
  - Convert to diazepam for long half-life and multiple dose options
  - Consolidate multiple benzodiazepines to single agent
- **Evidence:**
  - British National Formulary recommends conversion
  - Ashton Method also recommends
  - Canadian guidelines support continuing same benzodiazepine
  - Limited evidence of superiority for switching
    - One RCT: 68% success with long-acting vs 58% with short-acting (not statistically significant)
- **Caution:**
  - Nonequivalent dosing conversions
  - Variable individual effects
  - Consider patient and provider preference

Brunner E., et al. American Society of Addiction Medicine; 2025.

Practical Implementation Framework

- **Pre-Taper Phase (Months to Years):**
  - Build trust and therapeutic alliance
  - Educate on risks/benefits
  - Engage interdisciplinary team (nursing, pharmacy, behavioral health)
  - Optimize underlying conditions

- **Taper Initiation (Single Visit):**
  - Agree on initial reduction
  - Provide withdrawal symptom education
  - Establish follow-up plan

- **Follow-Up Phase (Ongoing):**
  - Monitor for withdrawal symptoms
  - Adjust taper as needed
  - Reinforce non-pharmacologic strategies
  - Plan for contingencies

Perry C., et al. Department of Veterans Affairs; 2021.

Audience Polling

Which factor most influences your decision to begin tapering a patient's long-term benzodiazepine therapy?

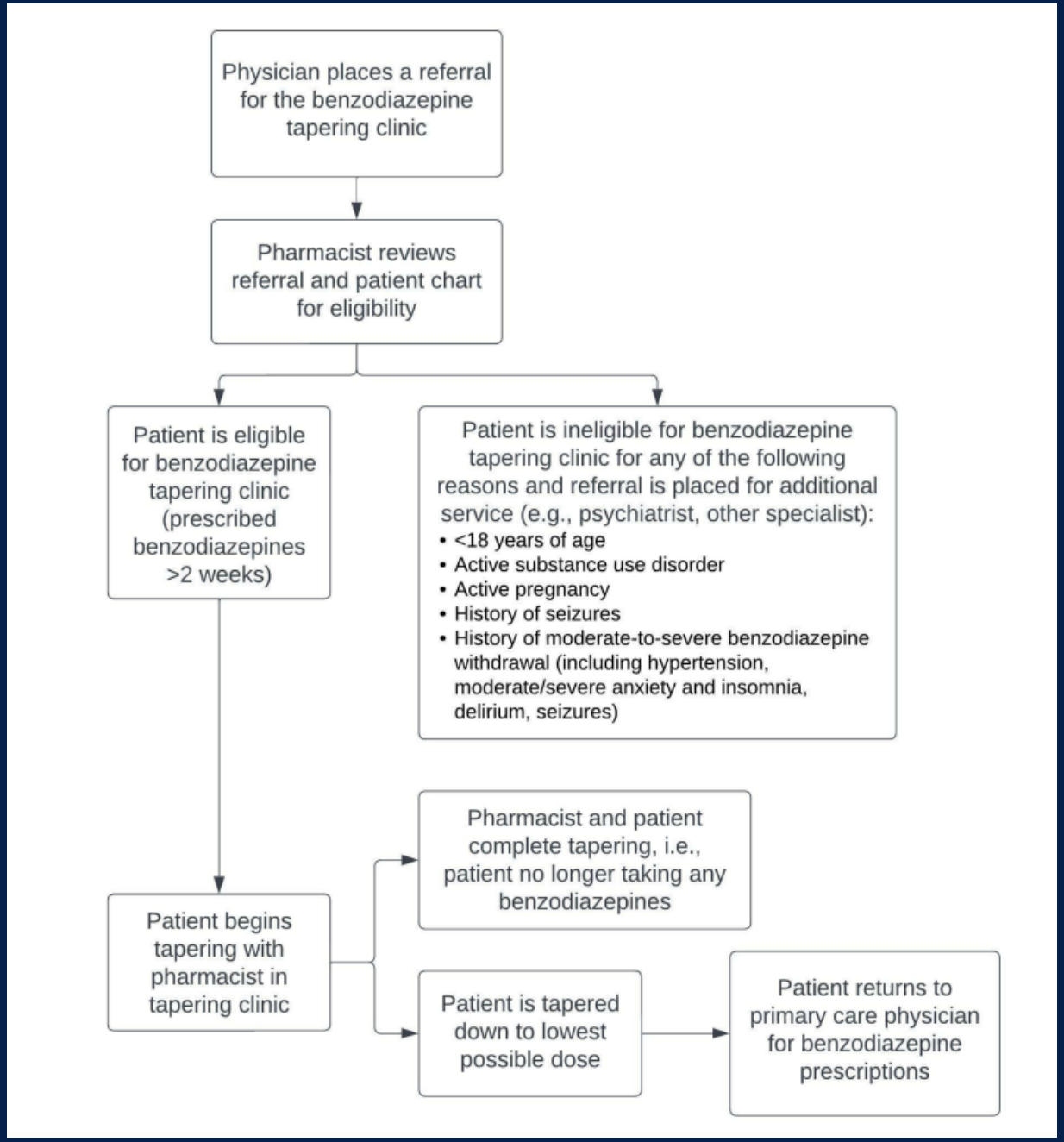
- Duration of benzodiazepine use
- Presence of co-use with opioids/alcohol
- Cognitive or psychomotor side effects
- Patient request
- Guideline recommendations

Clinic Description

- Collaborative Practice Agreement
- Patient-driven tapering schedules
- In-person and telephone appointments
- Referrals from throughout health system
  - 68% women, average age is 49 (range 19-79 yo)

Pharmacist-Led Outpatient Benzodiazepine Tapering Clinic

- Implemented in 2017
- Referral-based clinic
- Operates under a Collaborative Practice Agreement (CPA)
- Patient-centered focus



Gregorian T., et al. *J Am Pharm Assoc* (2003). 2022 Oct 4;63(1):409–415.

Pharmacist-Led Outpatient Benzodiazepine Tapering Clinic

Table 3.

Outcomes of patients enrolled and not enrolled in the outpatient pharmacist-led benzodiazepine tapering clinic

Benzodiazepine outcomes	Enrolled in the benzodiazepine tapering clinic, N=62	Invited but not enrolled in the benzodiazepine tapering clinic, N=97	P-value
Benzodiazepine tapering status			
Completely tapered off benzodiazepines	13 (27%)	3 (4%)	<0.001
Tapered down benzodiazepines	29 (60%)	15 (20%)	<0.001
Unable to taper	6 (13%)	57 (76%)	<0.001
Currently tapering	14 (23%)	22 (23%)	0.50
Any tapering	56 (90%)	40 (41%)	<0.001
Final DEDD, Median (Interquartile range)	11.25 (5.00–20.00)	10.00 (5.00–20.00)	0.40

Gregorian T., et al. *J Am Pharm Assoc* (2003). 2022 Oct 4;63(1):409–415.

Pharmacist-Led Sedative-Hypnotic Deprescribing in Team-Based Primary Care Practice

TABLE 3 Achieving complete abstinence or ≥50% dosage reduction in sedative-hypnotic use among patients taking benzodiazepines vs Z-drugs and those with daily vs intermittent nondaily use

Factors	Total number of patients	Number of patients achieving complete abstinence	Number of patients achieving dosage reduction ≥50%	Number (%) of patients achieving complete abstinence or dosage reduction ≥50%	Fisher's exact test
Benzodiazepines	64*	20	23	43 (67)	$p = 0.55$†
Z-drugs	44*	16	11	27 (61)	
Daily administration	95	31	33	64 (67)	$p = 0.09$†
Intermittent administration	16	5	2	7 (44)	

*Three patients who were taking both a benzodiazepine and a Z-drug at baseline were excluded.

†Nonsignificant differences.

Lui E., et al. *Can Pharm J (Ott)*. 2021 Jun 11;154(4):278-284.

Case Studies

Case One: Cutting the Dose

- AN, 38 yo female
- PMH: generalized anxiety disorder, panic disorder, primary insomnia, hypothyroidism, iron deficiency anemia, GERD
- HPI: Multiple failed medication trials for anxiety and insomnia. Presentation complicated by somatic issues, including unexplained edema, palpitations, weight gain (BMI 48), shortness of breath.
- Other substances: denies alcohol, cannabis, and stimulants
- Patient is interested in stopping benzodiazepines because she doesn't find them effective and has read about long term adverse effects. Indicates that the side effects were not explained to her before starting.
- Referred by primary psychiatrist for taper off clonazepam 2 mg BID.

Case One: Cutting the Dose

- Joined a benzodiazepine group on Facebook
- Read about the Ashton method
- Group leader provided a taper schedule for decreasing by 5% using the cut method
- AN experienced withdrawal effects
- Found achieving the doses challenging

0.25 mg alprazolam

¼ of the tablet

Images: https://www.benzoinfo.com/2018/02/06/why-currently-available-benzodiazepine-dosages-prevent-safe-withdrawal/. Permission given 2.25.26.

How would you treat this patient?

Case Two: The Long Road

- DM, 64 yo male
- PMH: Mood disorder, ADHD, generalized anxiety disorder, migraine, psychogenic non-epileptic seizures, tardive dyskinesia, TIA, erectile dysfunction, prostate cancer
- HPI: DM has been taking alprazolam for over 25 years, routinely three times daily. Initially started for anxiety, depression, and migraines. Retired in 2023 and anxiety and depression have worsened.
- Other substances: Denies alcohol and nicotine. Cannabis (~29% THC) 2-5x/wk, coffee 2-3 cups/day, dextroamphetamine-amphetamine 30 mg XR twice daily

Case Two: The Long Road

- Patient was encouraged by his psychiatric provider to discontinue benzodiazepines. Is not fully committed to the idea but acknowledges his medication therapy is not working to control his anxiety and depression and is willing to try anything to improve how he feels.
- Referred by psych PA to taper off alprazolam XR 2mg three times daily.

How would you treat this patient?

Case Three: A Balancing Act

- WH, 42 yo male
- PMH: cystic fibrosis, asthma, fatty liver disease, tinnitus, vestibular hypofunction of both ears, insomnia, anxiety, hypertension, alcohol use disorder in remission
- HPI: In 2019, WH was hospitalized for a CF exacerbation and experienced ototoxicity from antibiotics, resulting in harm to vestibular system function. Started clonazepam after the failure of multiple antiemetics to control his dysequilibrium. Symptoms worsened in December 2024. Experiences anxiety and panic attacks, mostly independently of vestibular symptoms.
- Other substances: no alcohol for 4 years, denies cannabis and nicotine, 5hr energy in the morning

Case Three: A Balancing Act

- Patient is interested in stopping benzodiazepines because of concerns for long term side effects such as early onset dementia and memory loss. Expresses that he would like to be on less medications. Has anxiety surrounding access to clonazepam.
- Referred by psychologist to taper off Clonazepam 0.5 mg, 0.5-1 tablets twice daily as needed for anxiety. Discussed referral with PCP.

Case Three: A Balancing Act

Day	Date	Sleep Quality	Sleep (hrs)	AM Dose			PM Dose			Total Dose (mg)	Exercise				Driving (hrs)	Notes
				Dose (mg)	Time	Severity	Dose (mg)	Time	Severity		Type	Exercise (mi)	Total Dist (mi)	7-day Avg (mi)		
Wednesday	10/22/2025	Medium	6	0.15	11:00	4	0.50	18:00	6	0.65	Resistance		3.2		1	Easy day, got to exercise midday
Thursday	10/23/2025	Good	6	0.35	9:00	9	0.50	18:00	7	0.85	None	N/A	1.9		5	Trip to Indy and back. 5 hours tota day.
Friday	10/24/2025	Good	6	0.13	11:00	4	0.50	18:00	5	0.63			2.4		2	Easy day, total driving maybe 1.5
Saturday	10/25/2025	Medium	6	0.75	12:00	6	0.00	NA	3	0.75	Walk	3.25	5.0		0	
Sunday	10/26/2025	Bad	4	0.50	12:00	6	0.00	18:00	5	0.50	Walk	3.3	5.3		0	
Monday	10/27/2025	Good	6	0.13	11:00	7	0.50	18:30	6	0.63			2.1		1	Sea legs in the afternoon.
Tuesday	10/28/2025	Good	6	0.13	11:30	7	0.50	18:00	5	0.63			2.1	3.1	1	Sea legs starting around 16:00
Wednesday	10/29/2025	Medium	5	0.25	11:00	7	0.50	18:00	7	0.75			1.4	2.9	6	Drove nearly 6 hours today
Thursday	10/30/2025	Medium	6	0.13	11:30	8	0.50	18:30	5	0.63			1.0	2.8	3	Three more hours of driving today component for a while in the morn
Friday	10/31/2025	Poor	5	0.35	10:45	6	0.50	17:30	6	0.85	Walk	2	4.4	3.0	1	
Saturday	11/1/2025	Awful	4	0.50	10:00	9	0.25	19:00	6	0.75	Walk	3.25	5.7	3.1	0	Terrible sleep was definitely a fact
Sunday	11/2/2025	Good	7	0.25	9:00	6	0.50	18:30	6	0.75	Walk	3.25	6.1	3.3	0	Better today, but not stress-less. D visit)
Monday	11/3/2025	Medium	6	0.00		5	0.75	17:30	9	0.75			2.1	3.3	2	
Tuesday	11/4/2025	Did not record		0.13	10:00	5	0.50	18:00	7	0.63			2.5	3.3	1	
Wednesday	11/5/2025	Medium	5	0.13	11:00	7	0.75	17:30	10	0.88			1.5	3.3	5	Worst day in recent memory. Drov eyes exhausted, nystagmus, neck
Thursday	11/6/2025	Medium	5	0.35	10:00	7	0.50	17:30	8	0.85			2.8	3.6	1	Another pretty bad day. Same sym
Friday	11/7/2025	Medium	5	0.13	10:45	6	0.50	18:00	8	0.63			3.5	3.5	1	Slightly more proactive with medic
Saturday	11/8/2025	Poor	5	0.50	9:30	8	0.25	17:30	7	0.75	Walk	3.4	5.6	3.4	0	Walked 3.4 miles this morning
Sunday	11/9/2025	Bad	4	0.50	8:00	9	0.50	16:00	7	1.00			2.4	2.9	0	Took full 0.5mg in the afternoon to
Monday	11/10/2025	Medium	6	0.25	11:00	6	0.50	18:00	8	0.75			1.3	2.8	5	Drove to Indy in the snow, bad cho
Tuesday	11/11/2025	Medium	5	0.25	11:30	5	0.50	17:00	6	0.75	NOTE		3.3	2.9	1	Exercise data prior to this date was
Wednesday	11/12/2025	Medium	6	0.25	12:30	7	0.50	18:30	9	0.75			3.5	3.2	0	No discernible reason symptom wa
Thursday	11/13/2025	Medium	6	0.25	11:00	7	0.50	18:00	7	0.75			2.8	3.2	0	LKY today
Friday	11/14/2025	Awful	3	0.50	9:00	8	0.25	19:00	7	0.75	Walk	3	5.0	3.4	0	Almost no sleep, symptom is nearl mi tonight anyway.LKY today.
Saturday	11/15/2025	Good	7	0.50	12:00	10	0.25	18:00	8	0.75	Walk	3.25	5.4	3.4	0	Concert this morning, incredibly act morning.
Sunday	11/16/2025	Medium	7	0.25	10:00	6	0.50	20:00	6	0.75	Walk	3.25	5.1	3.8	0	Not a bad day, walked 3.25mi
Monday	11/17/2025	Medium	6	0.25	11:30	6	0.50	18:00	8	0.75			1.7	3.8	1	
Tuesday	11/18/2025	Medium	6	0.25	11:00	5	0.50	17:00	8	0.75			2.0	3.6	1	
Wednesday	11/19/2025	Good	6	0.25	12:00	6	0.50	17:00	7	0.75	Walk	1.5	4.9	3.8	3	Drove to Indy. Squeezed in 1.5mi w

How would you treat this patient?

#benzo:
Online Benzodiazepine Narratives

What Twitter Tells Us

- Machine learning model examined 11,630 tweets about benzodiazepines

- 82% Medical content
- 48% Good efficacy
- 6% Side effects
- 1% Healthcare professionals
- 7% Disclosed lack of adherence to prescription
- 23% Discuss taking BZD with "toxic substances"
- 73% Contents do not follow scientific evidence

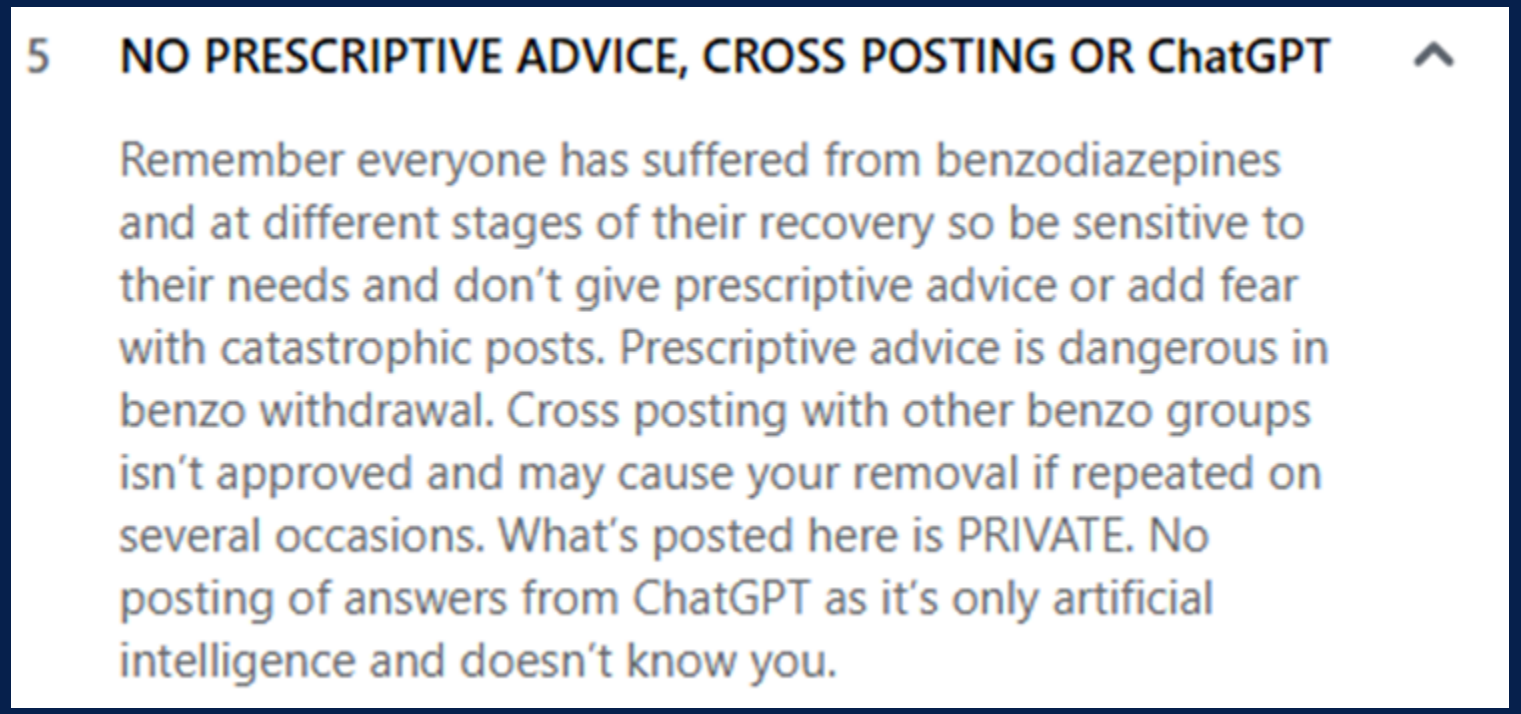
de Anta L., et al. BMC Psychiatry. 2024;24:659.

What Twitter Tells Us

- Tweets related to prescription compliance were the most likely to be liked
- Content of negative personal opinion on benzodiazepines and use alongside toxic substances were most likely to be retweeted
- Over half have references to efficacy, which is unusual
  - Other drug discussions on Twitter tend to focus on side effects or symptoms

de Anta L., et al. BMC Psychiatry. 2024;24:659.

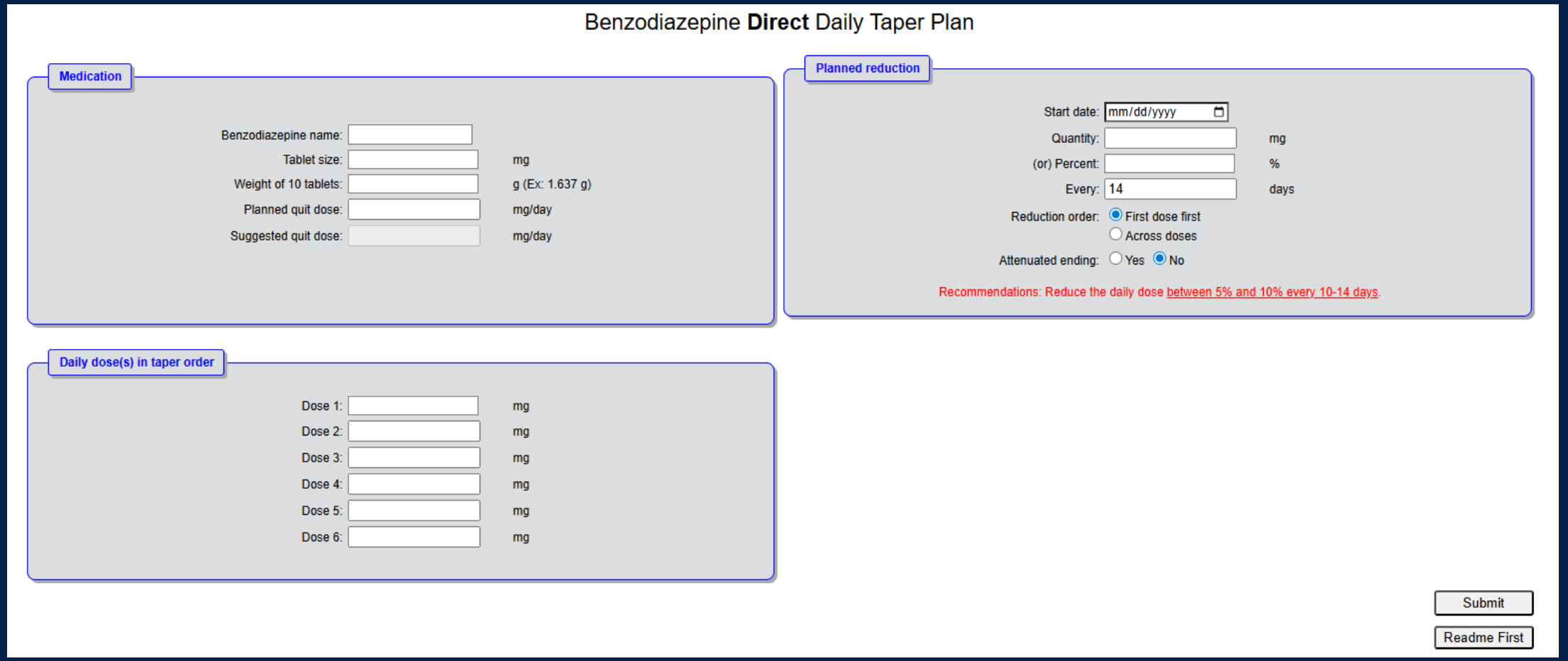
Social Media Support



- Facebook groups
- Forums
- Web pages

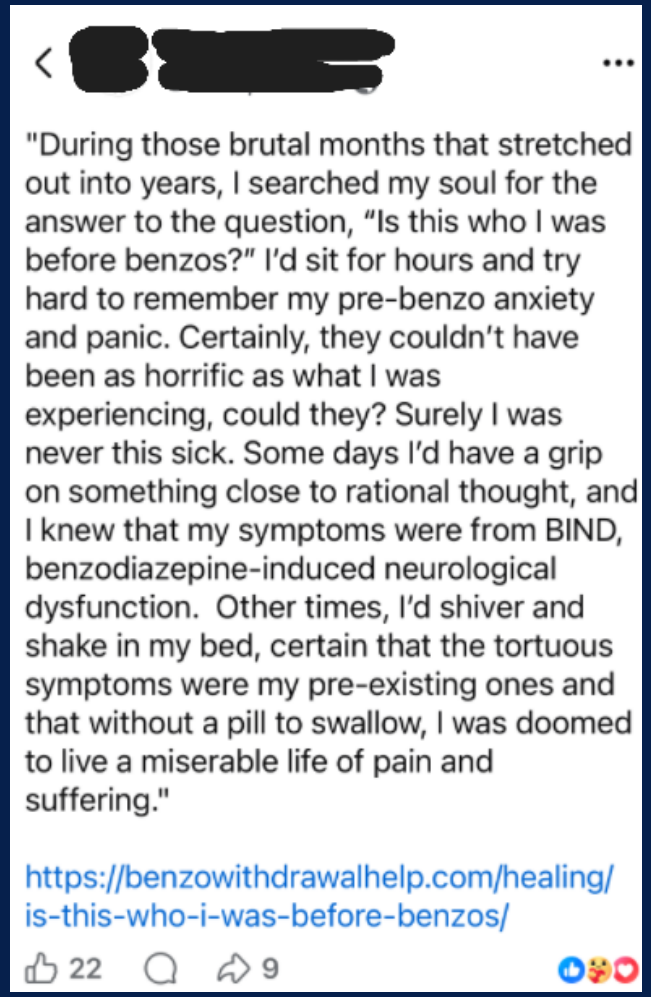
- Many are private
- Rules often outline the importance of not giving prescriptive advice
- Some provide guidance but may not have proper references

Online Resources and Social Media



- Has a disclaimer that it is not a substitute for professional advice, and any taper plan should be discussed with a physician.

Social Media



- Many narratives describe prolonged severe withdrawal
- Residual effects after completion of tapering that last months to years
- Lack of understanding or support from medical community

Myth or Fact?

Prolonged withdrawal syndrome is common with benzodiazepines.

Many people experience BIND (benzodiazepine-induced neurological dysfunction).

Internet Survey on Benzodiazepine Use, Tapering, and Discontinuation

- Survey link was posted online 3 different times in large benzodiazepine-related websites and Facebook groups related to benzodiazepine use
- 1207 respondents identified as survey finishers
- 76% said their health care providers did not tell them benzodiazepines were for short term use and discontinuation may be difficult
- Many felt healthcare professionals treated them as though they did something wrong
- Experienced physical symptoms that persisted for years after discontinuation

Finlayson AJ., et al. *Ther Adv Psychopharmacol.* 2022;12:1–10.

Internet Survey on Benzodiazepine Use, Tapering, and Discontinuation

Table 3. Respondents were asked how severely benzodiazepine discontinuation symptoms affected their professional and private lives.

Domain	Not at all	Mild problem	Moderate problem	Severe problem	Quite severe problem	Enormous problem
Work life	16.2%	4.5%	9.9%	9.9%	9.4%	49.1%
Fun, recreation, hobbies	10.3%	5.9%	9.4%	12.3%	13.3%	48.0%
Social interaction, friendships	12.8%	7.5%	11.2%	11.4%	14.5%	41.7%
Ability to take care of home, others	13.7%	7.8%	13.6%	12.3%	13.3%	38.4%
Relationship with spouse, family	14.3%	8.4%	14.7%	11.2%	12.8%	37.7%
Ability to drive or walk	22.8%	13.8%	15.2%	9.1%	9.0%	29.2%

Note that not all respondents answered this question ($n = 1207$).

Finlayson AJ., et al. *Ther Adv Psychopharmacol.* 2022;12:1–10.

Online Questionnaire on Benzodiazepine Discontinuation

- Four free text questions distributed through private benzodiazepine Facebook groups
- 271 respondents
  - 82% reported they were currently tapering off benzodiazepines
- Identified barriers to tapering
  - Withdrawal symptoms
  - Lack of support from medical professionals
  - Difficulty with availability of tapering resources/tools
- Many expressed they had been harmed by benzodiazepines and regretted ever taking them

Lynch T., et al. *Health Expectations.* 2024;27:e13962.

The Question of Dependence

- 1961: Benzodiazepine dependence first documented
- Low incidence of dependence
  - Estimates from 1978 suggest a dependence rate of 5-10 cases per million patient months
  - More recent data indicates only 9.5% - 30% of people using benzodiazepines develop dependence
- Literature on persistent post-withdrawal disorders is lacking
  - Data show 75% of people on long term benzodiazepines develop mild, transient withdrawal symptoms

Nielsen M., et al. *Addiction.* 2012;107:900-908.
Cosci F., et al. *Psychother Psychosom*. 2020;89:283-306.
Lader, M. *Addiction.* 2011;106:2086-2109.

Social Media

[redacted]

Very good of you to have done this. Just remember that there's probably a good reason that you were given these in the first place and that you may just need to be on some sort of dose of Xanax or another med for any lingering anxiety like I am. I cit from 1mg every six hours (4mg a day) for over 15 years to just .25mg as needed. The "as needed" is what all of my research tells me. This benzodiazepine has ALWAYS been recommended as a "as needed" ONLY in all of the FDA recommendations AND not to be used for more than a few months but unfortunately health care "professionals" hardy ever prescribed it that way in the beginning. Also health care providers are not very well informed on how to wean or tirate from benzodiazepines. It's a shame but it's only recently that doctors are very leary to prescribe these and if they do then they will only prescribe these as little as possible. It's almost as hard to get these as opioids are... Too bad that we all were hooked on these for so long.
Best regards,

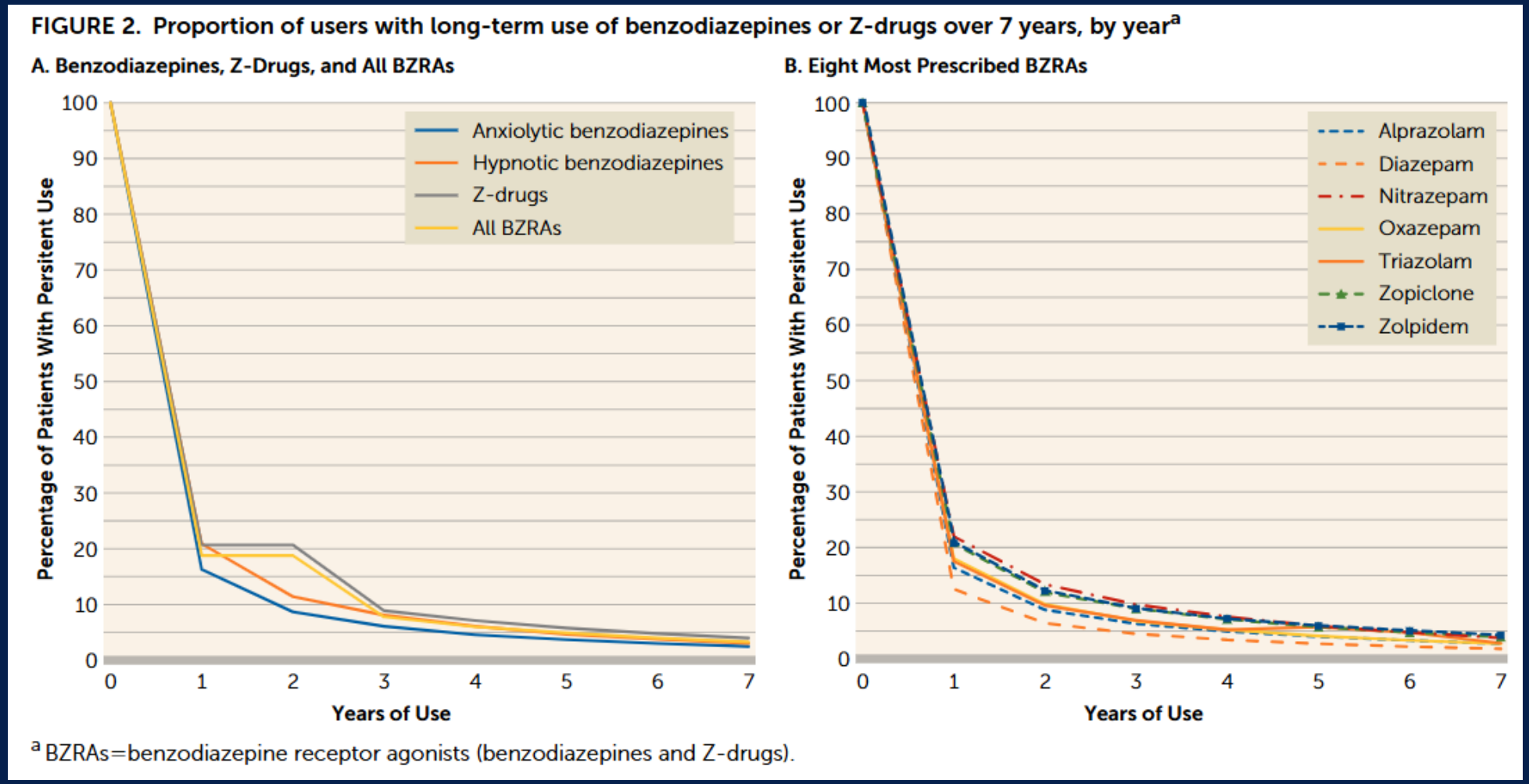
[redacted]

Admitting you have a problem is a huge step. But remember that this is not your fault. Your doctor should have been aware of the issues of their long term prescription and use. My tips that worked for me: 1) try to find a recovery center to handle the withdrawal. It may help to accelerate the withdrawal and will keep you comfortable. 2) Find a good counselor to help you deal with the anxiety and depression. Commit to the cognitive based therapies they recommend. 3) Join a support group like BenzoBuddies and this one. Consider a 12 step program too. Although they are not a perfect fit for Benzos, you connect with people and may get a sponsor to personally support you. 4) MMJ - will help you get a good night's rest when withdrawal would normally keep you up at night. You can do this. I took Ativan for nearly 20 years, and I was able to withdrawal and have been off Benzos for 15 months.

Myth or Fact?

Prescribers don't use benzodiazepines appropriately and routinely escalate doses and/or use them long term.

Long Term Use and Dose Escalation



Rosenquist TW., et al. *Am J Psychiatry.* 2024;181(3):246-254.

Long Term Use and Dose Escalation

US Study of 9821 BZD Users

- 5% prescribed high dose
- 43% had a diagnosis of anxiety or insomnia

Brazilian Study of 40402 BZD Users

- 29.1% had prolonged use
- Prescribing patterns exceeded daily recommended dose

Finnish Study of 129732 BZDR Users

- 39.4% became long term users during the study period

BZD = benzodiazepine
BZDR = benzodiazepine and related drugs

Kroll DS., et al. *J Gen Intern Med.* 2016;31(9):1027-1034.
Barboza Zanetti M., et al. PLoS ONE. 2024;19(9):e0309984.
Taipale H., et al. *JAMA Network Open*. 2020;3(10):e2019029.

Prescribing in Older Adults

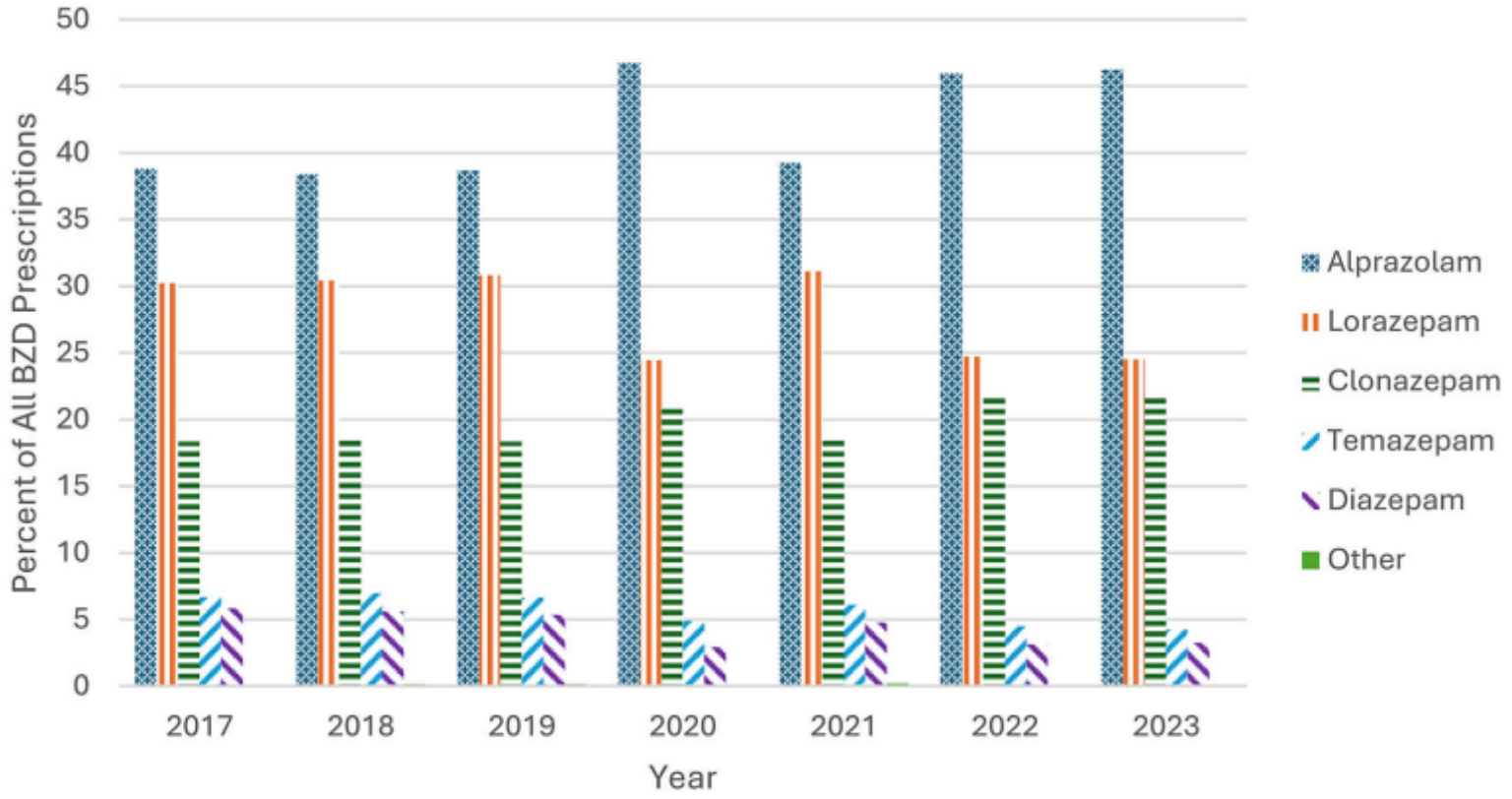


FIGURE 3
Top BZD prescriptions based on yearly percentage. The most frequently prescribed BZDs are ranked in order of number of claims by year studied.

Silvernail O., et al. *Front Med.* 2026;13:1723651.

Social Media

[redacted]

What long term effects? I keep researching - and researching but all the scholarly evidence I can find suggests a very, non consistent relation to development of dimentia. I'm starting to think it's a f[redacted] conspiracy.

··· 3

[redacted]

Same. I couldn't find conclusive evidence to their long term effects, especially if you're on a low dosage. People who get effected are people who has addiction to it and starts popping it a lot and for a long time.

As for myself, I still take them but not as often. Some weeks pass with taking anything. Sometimes I take .5 three days in a row because im having stressful days.

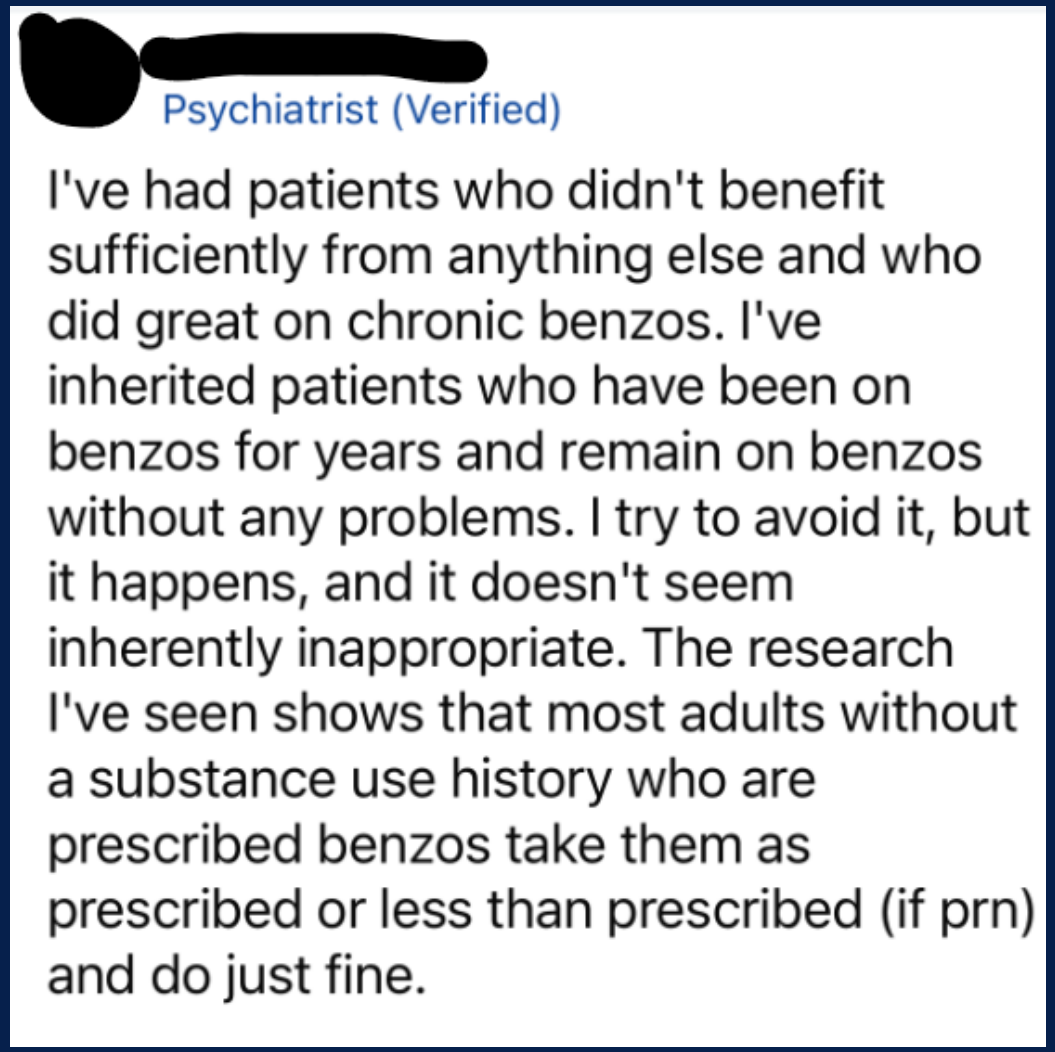
Doctors said there is nothing to worry about if you keep using it this way.

[redacted]

So, there's a shit ton of misinformation about benzos out there, I would not listen to all the noise. Look at actual, demonstrable replicable research. I can link studies later, but by and large the evidence shows that clonazepam is safe at that dose even over the long term. People constantly say on reddit that "you will develop tolerance" however, a review of tolerance mechanisms disagrees:

bad. Current doc eventually put me back on benzos, but only half the dose of what my body was used to, because I told her I would not be going on the cruise that my wife and I had planned and paid for. I told her that I 100% blamed her and her colleagues. At this point, a few months later now, she is considering putting me back on the dose that I was on before I met her, but still wants to try a few things because why not? I mean, they didn't work 25 years ago but maybe they will now lol. And now I realize I'm just rambling but yes, Xanax was the only thing (and I tried them all) that allowe me to have a career and family. I would not be able to in my current state. I'm just glad I have a supportive wife or honestly, I might have just ended it all because of the forced titration. Can't tell the doc that

Social Media



Myth or Fact?

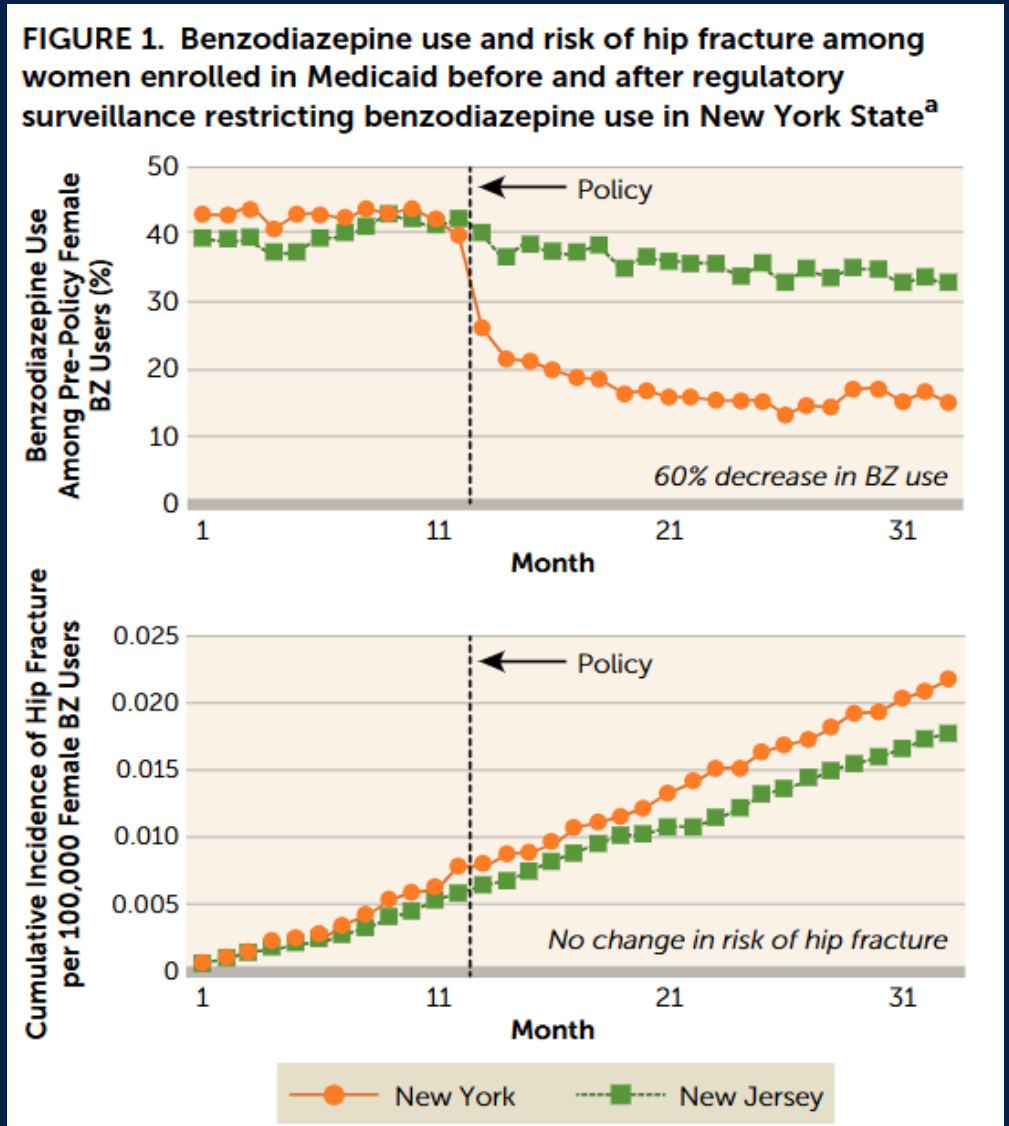
Benzodiazepines are fine to use long term, especially at low doses or as needed.

Dependence & Other Psychiatric Risks

- **Physical dependence:** Risk increases with time, especially with alcohol/substance use
- **Depression:** Worsening symptoms with chronic use
  - Proposed mechanisms: decreased GABA, monoaminergic function, serotonin activity
  - Higher rates of anhedonia with combined antidepressant-benzodiazepine use
- **Suicide risk:** Increased when combined with alcohol or opioid

Brunner E, Chen C, Klein T, et al.(2025
Lim, Bryant; Sproule, Beth A.; Zahra, Zarin; Sunderji, Nadiya; Kennedy, Sidney H.; Rizvi, Sakina J.(2020)

Hip Fractures



- Studies that support an increased risk of falling and hip fractures in people who used benzodiazepines did not control for confounders except dementia
- Subsequent study found no difference in hip fractures even with a 60% decrease in benzodiazepine use in older adults

Soumerai SB., et al. *Am J Psychiatry.* 2024;181(3):186-188.
Ray WA., et al. *N Engl J Med.* 1987;316:363–9.

Final Takeaways/Summary

- Benzodiazepine tapering can be complex and must be highly individualized
- Online resources can be helpful for psychosocial support but may contain misinformation
- All prescribers should discuss risk v benefit of medications with patients before initiating therapy

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Unprescribed Influence: Navigating Benzodiazepine Tapering in the Age of Social Media

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