Benzodiazepine Tapering: A Marathon, Not a Sprint

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Abstract: Clinicians have prescribed benzodiazepines for a range of symptoms and conditions since the Food and Drug Administration approved chlordiazepoxide in 1960. Between 1969 and 1982, the benzodiazepine diazepam was the most prescribed medication in the United States. Since then, recognition of benzodiazepine's risks—such as falls, psychomotor and cognitive impairment, withdrawal, benzodiazepine use disorder (BzUD), and suicidality—and limited data on long-term safety and efficacy have created challenges for clinicians and patients, including when and how to safely taper these medications. In 2025, 10 professional societies, including the American Society of Addiction Medicine (ASAM), released the Joint Clinical Practice Guideline on Benzodiazepine Tapering. This commentary explores implications for addiction treatment.

Key Words: benzodiazepines, tapering, chemical dependence, substance-related, disorder, substance withdrawal syndrome, protracted withdrawal

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Nearly 9% of US adults report past-year benzodiazepine use, with nearly 14% of those reporting misuse. Rates of benzodiazepine use and misuse are significantly higher among individuals with substance use disorders (SUD).[1,2] Physical dependence, manifested by tolerance and withdrawal, is expected for anyone consistently taking benzodiazepines. Only about 1.5% of people taking benzodiazepines develop BzUD, characterized by compulsive and continued use despite harms.[3]

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Although benzodiazepines are highly effective for managing acute symptoms (eg, anxiety, agitation, insomnia), data are limited for chronic conditions.[4,5] Given the well-defined risks, existing guidelines generally recommend limiting benzodiazepine use to 2–4 weeks, with limited exceptions (eg, treatment-resistant anxiety disorders). However, long-term use of benzodiazepine remains common.[6]

Benzodiazepine tapering presents challenges, even in patients without a BzUD or other SUDs. Withdrawal from benzodiazepines can cause anxiety, irritability, insomnia, hand tremors, and generalized malaise. It can also lead to life-threatening symptoms (eg, seizures, delirium). Withdrawal symptoms may persist for months or years after benzodiazepine discontinuation—known as protracted withdrawal. When patients have underlying anxiety disorders or primary insomnia, it is particularly difficult to differentiate withdrawal from recurrence of the underlying condition.

Recognizing the challenges of benzodiazepine tapering, ASAM, in partnership with 9 other professional societies, developed the Guideline using the GRADE methodology, with input from a patient panel (see Guideline for full methodology).

CORE GUIDELINE RECOMMENDATIONS

The Guideline recommends clinicians regularly reassess the risks and benefits of benzodiazepine prescribing, at minimum with each prescription renewal. Risk/benefit assessments should include screening for benzodiazepine misuse and BzUD, with referral for assessment and treatment when appropriate. Clinicians should consider risks and benefits of continued benzodiazepine use, and risks related to benzodiazepine tapering (eg, withdrawal, destabilization, transition to illicit benzodiazepines). If the overall risks of continuation outweigh benefits, tapering is recommended.

Many patients are nervous about benzodiazepine tapering. Clinicians should work with them to understand their concerns and jointly develop a plan. Patients may need time to become comfortable with the idea of tapering. When safe to do so, clinicians may suggest a small test dose reduction or allow patients to choose a preferred time for the initial dose reduction.

Patients experience significant heterogeneity in response to tapering. Some who have taken high doses of benzodiazepine for years can tolerate relatively quick dose reductions (eg, 25% every 2–4 wk), others who have taken

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lower doses for a few months experience significant withdrawal symptoms, even with slower tapers (eg, 5% every 4 wk). There is no known way to predict a patient's response. Therefore, the Guideline recommends a patient-centered approach, starting slowly—generally a 5%–10% initial reduction in daily dose—and adjusting based on patient response.

Clinicians should monitor patients for withdrawal symptoms with each dose reduction, including after benzodiazepine discontinuation as some patients may experience protracted withdrawal. It is important to monitor and address these symptoms to support positive outcomes and prevent return to use.

TAPERING IN PATIENTS WITH SUD

Use of benzodiazepines confers additional risks for patients with BzUD or other SUDs, with individual risks dependent on the specific substances and mode of use.[7,8] Therefore, the Guideline recommends more regular risk/benefit assessments of benzodiazepine prescribing for patients with SUD. However, clinicians should still make individualized decisions; benefits of benzodiazepines may outweigh risks for some patients.

Addiction treatment specialists often address benzodiazepine-related concerns, including BzUD, benzodiazepine misuse, and tapering benzodiazepines in patients with other SUDs. The same patient-centered tapering principles apply, but the underlying neurocircuitry involved in SUDs complicates treatment. Intense cravings, intolerance of withdrawal symptoms, or recurrence of the underlying condition may lead patients with SUDs to seek out illicit benzodiazepines or increase use of other substances. It is therefore important to offer patients appropriate care for SUD and co-occurring conditions with consideration for their specific risks (eg, use of illicit benzodiazepines) and full biopsychosocial needs.[9]

OVERDOSE RISK

Since 2000, overdoses involving benzodiazepines have increased nearly 10-fold, often involving concomitant opioid use. Clinicians should educate patients taking benzodiazepines on the risks of combining central nervous system depressants (eg, sedatives, alcohol, opioids). They should also offer naloxone and related training to patients at risk for opioid overdose (eg, those prescribed opioids or using illicitly obtained substances). For patients who use illicitly obtained substances, clinicians can support access to fentanyl test strips when permitted by state law.

Clinicians may be concerned about prescribing benzodiazepines to patients with OUD, including those taking methadone or buprenorphine. ASAM's National Practice Guideline for the Treatment of Opioid Use Disorder and a 2017 FDA Drug Safety Communication emphasize the central importance of access to OUD medications.[10,11] Methadone and buprenorphine reduce risk for opioid overdose and overdose death. Clinicians should never withhold access to these medications or arbitrarily limit their doses due to benzodiazepine use or misuse.

CO-OCCURRING CONDITIONS

Co-occurring psychiatric conditions are common in patients with SUD and can complicate benzodiazepine tapering. The Guideline recommends optimizing treatment for psychiatric disorders before or concurrent with tapering. Consultation with a psychiatric specialist may be necessary when considering tapering in patients with significant psychiatric concerns (eg, severe treatment-resistant anxiety disorder).

Patients with SUD experience high rates of trauma, and post-traumatic stress disorder (PTSD).[12] Benzodiazepines are ineffective for the treatment of PTSD and can exacerbate symptoms. The Guideline recommends clinicians strongly consider tapering benzodiazepine medication in patients with PTSD.

The Guideline does not address short-term use of benzodiazepines, such as for management of alcohol withdrawal or acute anxiety.

TRANSITIONING TO LONGER-ACTING BENZODIAZEPINES

Although some patients may benefit from transitioning from short-acting (eg, alprazolam) to longer-acting benzodiazepines (eg, diazepam), determining benzodiazepine equivalents is imprecise and some patients have significant difficulty transitioning.[13] Clinicians should make patient-specific, collaborative decisions.

In instances where patients are taking multiple benzodiazepines, clinicians may recommend consolidating to a single agent or tapering the shortest-acting agent first. For patients using illicitly obtained benzodiazepine of unknown agent and dose, clinicians should carefully titrate the starting dose of a prescribed benzodiazepine to prevent withdrawal symptoms before tapering.

TAPERING WITH PHENOBARBITAL

Some patients with SUD, including those at high risk for severe or complicated withdrawal, may benefit from inpatient tapering with a very long-acting agent (eg, phenobarbital). Although some evidence exists for this strategy, there is no research on long-term outcomes. The patient panel that informed Guideline development expressed strong concerns about the potential harms of this intervention, including severe protracted withdrawal and related suicidality. The Guideline recommends clinicians generally reserve this tapering strategy for situations involving imminent patient safety concerns that cannot be appropriately mitigated by an initial dose reduction.

GUIDELINE IMPLEMENTATION

A large population of patients may benefit from benzodiazepine tapering, particularly older adults for whom the Guideline recommends tapering "unless there are compelling reasons for continuation." Most benzodiazepine prescribing occurs in primary care; however, these settings often have limited capacity to provide recommended levels of monitoring. Addiction specialists have an important role in supporting their colleagues to implement the Guideline. Addiction medicine, addiction

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psychiatry, and medical toxicology experts can help educate and train generalist physicians to support effective tapering. Primary care providers should consult with these experts when patients experience significant challenges and provide referrals when BzUD is suspected.

RESEARCH GAPS

The systematic review that informed the Guideline revealed large evidence gaps regarding benzodiazepine tapering. No comparative effectiveness trials evaluating different tapering strategies were identified, and research that evaluated adjunctive interventions mostly evaluated inflexible tapering schedules with a significantly faster pace than current best practices. Research that would help inform Guideline updates includes:

- Comparative effectiveness of flexible tapering strategies
- Strategies when patients are accessing benzodiazepines illicitly
- Pragmatic strategies for monitoring withdrawal symptoms in primary care
- Strategies for preventing and treating protracted withdrawal
- Supporting patients experiencing challenges (eg, microtapering, adjunctive interventions)
- Comparative effectiveness of adjunctive interventions
- When and how to transition to longer-acting benzodiazepines
- Long-term outcomes of tapering with phenobarbital
- Development of valid benzodiazepine withdrawal scales for outpatient settings
- Objective strategies for assessing benzodiazepine risks and benefits
- Shared decision-making strategies

CONCLUSIONS

Addiction treatment specialists have an important role in supporting efforts to reduce benzodiazepine overprescribing. Benzodiazepine tapering can be challenging for both patients and clinicians, and may require consultation with other specialists (eg, psychiatry, sleep medicine) for patients with complex needs, including to reduce the risk of benzodiazepine reinitiation if underlying health issues are ineffectively addressed. Implementing a patient-centered approach acknowledging these challenges and the heterogeneity of patient experience is essential. Benzodiazepine tapering currently relies on the art of medicine; more research will support greater reliance on science.

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