

June 2017

## Education Program using Non-Pharmacologic Support during Benzodiazepine Reduction in Patients with Anxiety Disorders

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### Recommended Citation

Kearney, K. D., & Wardell, D. (2017). Education Program using Non-Pharmacologic Support during Benzodiazepine Reduction in Patients with Anxiety Disorders. *Journal of Nursing & Interprofessional Leadership in Quality & Safety*, 1 (2). Retrieved from <https://digitalcommons.library.tmc.edu/uthoustonjqualsafe/vol1/iss2/1>

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## Education Program using Non-Pharmacologic Support during Benzodiazepine Reduction in Patients with Anxiety Disorders

### Abstract

A private mental health clinic developed an initiative to aid patients with anxiety disorders to taper their use of benzodiazepines. Based on best practices, a treatment protocol was developed in which patients attended 4 sessions (1 per month) in which they combined instruction in non-pharmaceutical anti-anxiety techniques (guided imagery, mindfulness meditation, deep breathing, progressive muscle relaxation, exercise, emotional freedom) with cognitive behavioral therapy and use of selective serotonin re uptake inhibitors. Participants experienced a reduction in benzodiazepine use. This small scale initiative showed that the holistic approach to anxiety management was an effective plan to decrease the use of benzodiazepines in the treatment of anxiety disorder.

### Keywords

benzodiazepine taper, benzodiazepine reduction, anxiety management, anxiety reduction techniques, anxiety coping skills

## Introduction

Benzodiazepines are commonly used in the treatment of anxiety disorder (Cascade & Kalai, 2008). Despite the drug's effectiveness, the process of weaning clients off of benzodiazepines requires that they use other types of anxiety reducing measures. Using non-pharmacologic methods provides a viable way to decrease certain types of anxiety. Non-pharmacologic measures, along with selective serotonin reuptake inhibitors (SSRIs), have been effective with certain anxieties and could assist in reducing benzodiazepine use (Bandelow et al., 2013). Thus, the project initiative was designed to use SSRIs and non-pharmacologic anti-anxiety techniques along with a support program to taper the dosage of benzodiazepines.

## Background

The American Psychiatric Association (2003) roster of anxiety disorders included Obsessive Compulsive Disorder, Generalized Anxiety Disorder, Panic Disorder with or without Agoraphobia, Phobias, Post-traumatic Stress Disorder, Acute Stress Disorder, and Anxiety Disorder not otherwise specified. Common treatments for anxiety disorders combine therapy and pharmacotherapy, and the drugs in use are selective serotonin reuptake Inhibitors, selective neuroepinephrine reuptake inhibitors, and benzodiazepines (Bandelow et al., 2013).

The high rate of abuse and dependence makes it difficult for individuals to successfully discontinue use of benzodiazepines. Chronic use nationally ranges from 2-8% of the population, and 25%-76% of people with anxiety disorders are at risk for long-term abuse (Bandelow et al., 2013). Some 5% have taken benzodiazepines for a period of six months or more (Konopka, Pelka-Wysiecka, Grzywacz, & Samochowiec, 2013). Inability to cope with stress, lack of resistance, and being unaware of coping skills contribute to dependency on benzodiazepines and under-utilization of non-pharmacological techniques (Merikangas, Burstein, & Schmitz, 2013). Rapid relief of anxiety symptoms and known efficacy are amongst top reasons for use of benzodiazepines. Individuals seeking treatment often want immediate relief for anxiety, and therefore, underutilize non-pharmacological techniques. In a study on the discontinuation of benzodiazepines, the use of non-pharmacological techniques – in comparison to benzodiazepine use alone – produces greater reduction in anxious symptoms (Gosselin, Ladouceur, Morin, Dugas, & Baillargeon, 2006).

Non-pharmacological techniques include, but are not limited to, the following: cognitive behavioral therapy, cognitive behavioral therapy with emotion focused, interpersonal therapy, metacognitive therapy, exercise, mindfulness meditation, worry exposure, applied relaxation, meditation-based stress program, healing touch, meridian tapping, and thought field therapy. In the present initiative, the techniques selected and implemented were as follows: guided imagery, mindfulness meditation, deep breathing, progressive muscle relaxation, exercise, emotional freedom techniques, and cognitive behavioral therapy.

## Local Problem

In a psychiatric practice, a cadre of patients diagnosed with anxiety disorders was deemed candidates for control of anxiety using other forms of medication and anti-anxiety

methods. Since the practice site has no educational program in place that addresses coping skills using non-pharmacological techniques, patients typically have rebound anxiety when attempting to discontinue benzodiazepines, and subsequently, they resort back to its use.

### Initiative Goals

The initiative was planned and designed to decrease the frequency of and taper the use of benzodiazepines using non-pharmacological techniques and individualized support. The aim was to educate clients in the use of non-pharmacological techniques and use these techniques with SSRIs to replace pharmaceutical dependency within 12 weeks of such therapy.

### Ethical Issues

The project was approved by The University of Texas Health Science Center at Houston Institutional Review Board for the Protection of Human Subjects as a quality improvement project. Participants were assigned a number as an identifier for data collection. Data and consent forms were stored at the practice site in locked files independent of patient records, and names were kept confidential.

## Methods

### Planning the Intervention/Procedure

A clinician reviewed non-pharmacologic methods used to decrease anxiety and evaluated evidence-based and best practices specific to non-pharmacologic stress reduction techniques. Using this information, a nurse practitioner and the psychiatrist owner of the practice selected the non-pharmacologic anti-anxiety techniques that would promote safe and improved management of anxiety disorders, support recommended gold standard treatment, and have the potential to reduce liability of the clinician due to overprescribing benzodiazepines. The techniques used were defined as follows:

- *Guided imagery* entails the individual imagining being in a place of comfort, such as a beach or tropical island, and can result in a deep state of relaxation that reduces anxiety and fears (Jain et al., 2011).
- *Mindfulness meditation* encompasses meditation techniques that allow individuals to acknowledge their feelings, emotions, mental state, and acceptance of the present (Hoge et al., 2013). Mindfulness meditation allows a non-judgmental focus on oneself to decrease anxiety.
- *Deep breathing* requires a change in breathing pattern to long and smooth diaphragmatic breathing. Such rhythmical and diaphragmatic breathing possibly serves as autonomic training that improves mood stabilization (Chow & Tsang, 2007). Because individuals with anxiety disorders often have rapid and shallow breathing, deep breathing assists with slowing down the breath.
- *Emotional freedom techniques and thought field therapy* involves the practitioner tapping the patients' hands, face, and body while they reflect on emotions, thoughts, and past events (Irgens, Dammen, Nysæter, & Hoffart., 2012). The authors claim that

tapping expands the body's energy blockades and assists in returning individuals to homeostasis between mind and body.

- *Progressive muscle relaxation* is helpful when anxiety triggers are present (Hoyer et al., 2009). Individuals focus on certain aspects of their body as they progressively relax joints, muscles, and organs (Chow & Tsang, 2007). Releasing tension from the muscles facilitates a more positive mindset.
- *Aerobic and resistance exercise*, recommended for use 3-5 times a week in increments of 30-60 minute sessions (Bandelow et al., 2013), improves symptoms of anxiety, including difficulty with concentration, fatigue, insomnia, irritable mood, and depression (Herring, Jacob, Suveg, & O'Connor, 2012).

### Implementing the Initiative

The team developed a protocol titled *Anxiety Reduction during Benzodiazepine Reduction Protocol* (see Appendix A). Twenty (20) patients who expressed a desire to decrease benzodiazepine use and met the inclusion criteria for anxiety agreed to the program protocol. Likewise, they expressed willingness to adhere to the non-pharmacologic methods. The treatment required four visits scheduled four weeks apart, or one visit per month. The procedure was as follows:

- In the *initial visit*, patients were informed about benzodiazepine use and risks as well as the benefits of non-pharmacological techniques. Participants received written instructions for the non-pharmacological techniques and were instructed to document frequency of their use throughout each month, and to keep a journal of anxious moments and triggers that may have caused anxiety.
- In the *second visit*, patients described improvements in their anxiety management, noted identification of triggers, expressed whether or not non-pharmacological techniques provided benefit, and noted the frequency of benzodiazepine use (same, more, or less). Additionally, the patient received a referral for cognitive behavioral therapy. A selective serotonin reuptake inhibitor (SSRI) was initiated as part of first line treatment for anxiety disorders (if patients were not already taking a SSRI).
- In the third visit, patients reported details of their anxiety management and trigger identification, use of non-pharmacological techniques, perceived level of anxiety, and tolerability and side effects of the SSRI medication. They stated whether or not they started cognitive behavioral therapy.
- In the fourth visit, the practitioner focused on anxiety management as evidenced by continued use of non-pharmacological techniques, response to SSRI treatment, identification triggers, and attendance of cognitive behavioral therapy sessions.
- In subsequent clinical visits following program completion, the nurse practitioner noted verbal reports of continued use of non-pharmacological techniques and documented such in the patients' medical charts.

### Analysis and Outcomes

Each participant completed a questionnaire (Appendix B) that asked for the frequency of use of non-pharmacological techniques, their perceived effectiveness, and changes in benzodiazepine use since the start of the program. Patients also reported on which of the non-pharmacologic techniques they found to be the most beneficial in decreasing their anxiety.

### Outcomes

As shown in Table 1, 85% (n=17) of participants reported a decrease in the use of benzodiazepines. Chi Square analysis showed a significant difference (Chi Square 9.8, df 1,  $p = .03$ ). Three participants reported no decrease in their use of the drug. Participants were medicated with different benzodiazepines (e.g. lorazepam, alprazolam, diazepam, and clonazepam). Six participants who took higher doses of the benzodiazepines with a short half-life, such as alprazolam, reported more difficulty reducing their frequency of using the drug.

Table 1. Decreased Use of Benzodiazepines in Three Months

	Frequency	Percent	Valid Percent	Cumulative Percent
0 (decrease)	3	15.0	15.0	15.0
1 (same)	17	85.0	85.0	100.0
Total	20	100.0	100.0	

### Perception of Benefit and Use of Non-Pharmacological Techniques

Of the 20 participants, 11 (55%) identified Cognitive Behavioral Therapy (CBT) as being the most effective non-pharmacological technique to decrease stress (Table 2). Exercise was the second most effective technique reported, with mindfulness being third, and progressive muscle relaxation, fourth. Participants reported emotional freedom techniques were more complex to use, as compared to techniques such as guided imagery and deep breathing.

Table 2. Non-pharmacological Techniques Most Beneficial in Managing Anxiety

	Number	Percentage
Guided Imagery	n=0	0%
Deep breathing	n=0	0%
Cognitive Behavioral Therapy	n=11	55%
Exercise	n=4	20%
Emotional freedom techniques	n=0	0%
Mindfulness meditation	n=3	15%
Progressive muscle relaxation	n=2	10%

In terms of the frequency of use of non-pharmacological techniques (Table 3), participants were more likely to use deep breathing on a daily basis, while exercise more likely occurred two to three days a week. Patients attending cognitive behavioral therapy sessions mostly did so weekly to every two weeks, depending upon the severity of their anxiety. Participants reported initially seeing the psychologist often, but varied in how often they visited throughout the three months. Some participants felt this activity was helpful but time consuming. Two participants stated that the psychologist listened to their worries, but did not offer advice or insight.

Table 3. Frequency of Use of Non-Pharmaceutical Techniques

Technique	N	Minimum	Maximum	Mean	SD
Guided Imagery	20	1	5	2.95	1.538
Deep Breathing	20	1	5	3.40	1.569
Cognitive Behavioral Therapy	20	1	5	3.75	1.446
Exercise	20	2	5	3.85	1.089
Emotional Freedom Techniques	20	1	5	2.75	1.446
Mindfulness Meditation	20	1	5	3.40	1.353
Progressive Muscle Relaxation	20	1	5	3.10	1.373
Valid n (listwise)	20				

Fifteen participants (75%) reported three months was a sufficient amount of time for the individualized program, while five participants (25%) thought it was not long enough. Five participants (25%) recommended changes to the program and suggested increasing the length, adding more non-pharmacological techniques, extending appointment times to more than once monthly, and adding group therapy sessions.

All participants reported feeling better emotionally and being able to deal with life stressors more effectively. Five participants at the end of the initiative noted that they thought more clearly and could concentrate on the task at hand. Four participants reported that irrational fears decreased. Overall, participants were able to face some triggers of anxiety symptoms once their irrational fears decreased. All participants (100%) reported that (1) using non-pharmacological techniques improved anxiety management, and (2) they were likely to continue using the techniques after the program.

### Follow-up after 3 Sessions

During subsequent follow up visits following program completion, the nurse practitioner documented their continued experiences with using the techniques in their

medical charts. The majority of the participants verbally reported a decrease in benzodiazepine reliance and felt they had more control over their life.

### **Limitations during Initiative Implementation**

A difficulty encountered was missed and rescheduled appointments. However, the nurse practitioner urged patients to reschedule within the same week. In addition, some patients found it difficult to keep a journal of stressful moments and document their anxiety. However, those who did stated that journaling helped to identify the cause of certain anxiety triggers.

Because cognitive behavioral therapy was provided by psychologists outside of the clinic, it was difficult to track the details of what took place during the sessions. In addition, the level of severity of anxiety varied among the participants, which often dictated the frequency of visits per person. Exercise was a difficult non-pharmacological technique to measure. Participants choose different methods, and each participant's number of days exercised varied as well as the length of time expended. Some participants reported exercising previous to the protocol, which may have affected overall anxiety management and explained why they were neutral or disagreed as to the benefit of exercise being beneficial in the questionnaire.

### **Relation to Other Evidence**

Gosselin et al., (2006) found that slow tapering of benzodiazepine dosage in conjunction with cognitive behavioral therapy was an efficacious long term activity for achieving complete cessation. The present initiative found that relapse of benzodiazepine use was less in adults that had a non-pharmacological program in place to assist with tapering.

Voshaar et al. (2008) reported long term taper success is more likely to be achieved if a taper program is offered and patients remain actively in treatment. The authors noted that the outcome of the taper is related to current dosage and the patient's willingness to reduce the dosage. In the present initiative, participants were urged to follow up monthly, and they were encouraged to remain in treatment after the intervention ended.

Herring et al (2011) found that physical exercise produced rapid results as evidenced by subjective reporting of decrease of anxiety symptoms within six weeks. Participants in this study reported exercise assisted with decreasing stress and anxiety overall.

### **Interpretation**

The protocol was expected to provide participants with alternative techniques to manage anxiety as well as assist them as they decreased their benzodiazepine regimen. Modifications to improve the protocol would be to provide participants with additional non-pharmacological techniques such as applied relaxation, worry exposure, and interpersonal therapy. The protocol was appropriate for implementation in a private practice setting that specialized in mental health. The outcome for the first implementation cycle of the project showed that there was a decrease in patient's use of benzodiazepines and the patients were consistent in their use of non-pharmacologic techniques. Outcomes were favorable in that

using non-pharmacological techniques was beneficial in managing anxiety symptoms along with reduced benzodiazepine use.

### **Application to Practice**

The current flow of appointments in the primary care setting focuses on medication management. The clinician assesses the patient's response to medication, including their side effects and effect on mood and sleep. By incorporating the *Anxiety Reduction during Benzodiazepine Protocol*, patient management of anxiety shifts from a regimen that is solely dependent on benzodiazepines to a holistic approach that includes non-pharmacological techniques. An advantage gained is that this approach may help reduce provider liability by reducing the number of benzodiazepines prescribed.

A barrier to implementing the Anxiety Reduction during Benzodiazepine Protocol in practice might be insufficient time to meet with the patients given a usual daily patient load. Reducing the number of patients seen daily to extend the allotted time for appointments is problematic. However, to adjust for extension of patient appointments, judicious use could be made of reimbursement and time codes. For example, the CPT code 99214 can be used for problems of moderate severity and/or visits that are at least 25 minutes, and CPT code 99215 can be used for problems of moderate to high severity and/or visits that are at least 40 minutes. It should be noted that each insurance panel reimburses at different rates according to coding and billing. Sustaining the protocol in practice is possible if the clinician has adequate time to teach non-pharmacological techniques and code higher reimbursement codes to compensate for seeing fewer patients.

### **Discussion**

Health care providers carry the responsibility for educating patients about the risks and benefits of prescribing benzodiazepines for individuals diagnosed with anxiety disorders. One study found that although benzodiazepines are proven to provide relief of anxiety symptoms, they should be administered short term (Kurihara, 2007). Mental health professionals should provide guidance in helping patients to label triggers that may lead to relapse (Parr, Kavanagh, Cahill, Mitchell, & Young, 2008). Providing education, tools, and referrals for utilization of non-pharmacological techniques are essential when tapering benzodiazepines.

A protocol to provide support while discontinuing benzodiazepines may be more successful than gradual dosage reduction alone (Parr et al, 2008). A protocol provides individuals with alternatives for managing anxiety while the benzodiazepine dose is decreased. Clinicians will need to enforce a strict policy in their practice to ensure a continuous prescription of benzodiazepines is not being supplied.

Based on the outcomes of this initiative, more emphasis could be placed on identifying triggers and on providing access to first line treatment, such as Cognitive Behavioral Therapy. The nurse practitioner could also focus on other exercise regimens shown to be effective in reducing anxiety, such as yoga. Emotional freedom techniques probably would need referral to a trained provider to reinforce the technique for better utilization or not be included as it

was seen as too complex. Benefits in the use of non-pharmaceutical techniques could be obtained by allowing the patients to self-select the techniques they wish to practice.

## Conclusion

The Anxiety Reduction during Benzodiazepine Protocol helped participants identify triggers and stressors that increased severity and duration of anxiety symptoms. The use of stress reduction techniques and a focused program to change the medications taken for anxiety showed promise in achieving the goal of decreasing benzodiazepine use and anxiety. A holistic approach to anxiety management is likely to be more appropriate than a treatment plan that is solely based on anxiolytics. Health care providers can educate patients about the risks associated with benzodiazepines, provide support when tapering, and prescribe benzodiazepines as short-term treatment. Selective serotonin reuptake inhibitors can be utilized as a first line treatment. Implementation of the protocol can be effective in reducing Benzodiazepine use, support the use of non-pharmacological techniques, decrease physiological and psychological symptoms of anxiety, and successfully reduce benzodiazepine use.

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## **Appendix A.**

### **Anxiety Reduction during Benzodiazepine Reduction Protocol**

#### **Choice of patients in practice**

Patients diagnosed with an anxiety disorder who desire to reduce frequency of benzodiazepine usage.

- 1) Inclusion criteria for benzodiazepine reduction protocol
  - a) Age 18 and older
  - b) Diagnosed with an anxiety disorder, including anxiety disorder not otherwise specified, generalized anxiety disorder, obsessive-compulsive disorder, and panic disorder with or without agoraphobia, and social anxiety disorder.
  - c) Currently using benzodiazepines for anxiety episodes (?) - or just anxiety
  - d) identified as having difficulty decreasing benzodiazepine usage
  - e) No present use of non-pharmacologic anxiety reducing techniques
  - f) Candidate for use of Selective Serotonin Reuptake Inhibitors
- 2) Willing to use non-pharmacologic anxiety decreasing techniques
- 3) Agree to participating in Cognitive Behavioral Therapy
- 4) Agree to 4 individual visits as per the program protocol

#### **Initial visit:**

1. Educate participants about the benefits and risks of taking benzodiazepines.
2. Discuss possible withdrawal symptoms if benzodiazepines are discontinued abruptly.
3. If potential participant agrees, then the NP will:
  - a. Educate participants about usage of non-pharmacological techniques including Cognitive Behavioral Therapy, Emotional Freedom Techniques, Progressive Muscle Relaxation, Guided Imagery, Deep Breathing, Mindfulness Meditation, and benefits of exercise.
  - b. Refer patient to a therapist to initiate Cognitive Behavioral Therapy.
  - c. Provide participants with handouts including
    1. benzodiazepine education,
    2. identification of anxiety triggers
    3. Types of non-pharmacological techniques
    4. Form to document of frequency of benzodiazepine usage.
4. Initiation or continuation of Selective Serotonin Reuptake Inhibitors

#### **First follow up visit (4 weeks after 1<sup>st</sup> visit):**

1. Participant will report verbally which non-pharmacological techniques seem to be more effective.
2. Participant will report verbally perception of symptom management of anxiety.
3. Follow up to confirm if patient initiated CBT.
4. Provide emotional support for anxiety management.

5. Assist patient in the identification of triggers, and how triggers are being managed
6. Evaluate response to Selective Serotonin Reuptake Inhibitors

Second follow up visit (8 weeks after program implementation):

1. Participant report verbally if anxiety symptom management is improving.
2. Participant report which non-pharmacological techniques seem to be more effective.
3. Provide emotional support for anxiety management.
4. Follow up with patient to determine progress with initiation of CBT.
5. Evaluate response to Selective Serotonin Reuptake Inhibitors

Third visit (3 months, final visit) the NP will:

1. Address any questions or concerns participants' have about Benzodiazepine Reduction Protocol.
2. Patient completes questionnaire to evaluate effectiveness of the protocol.
3. Encourage patient to continue with CBT and utilization of other non-pharmacological techniques used.
4. Discuss with patient the termination of the protocol, and participant will continue as a patient at the practice.
5. Evaluate response to Selective Serotonin Reuptake Inhibitors

## Appendix B.

### Questionnaire for Evaluation of Benzodiazepine Reduction Protocol

1. Which non-pharmacological technique did you find most beneficial in managing anxiety symptoms?
2. Which non-pharmacological technique did you find least beneficial in managing anxiety symptoms?
3. In the table below, rate the level of effectiveness for each non-pharmacological technique by checking the most appropriate box.

Table 1	Strongly Disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly Agree (5)
Guided Imagery					
Deep Breathing					
Cognitive Behavioral Therapy					
Exercise					
Emotional Freedom Techniques					
Mindfulness Meditation					

4. In the table below, please indicate the frequency of using non-pharmacological techniques by checking the most appropriate box.

Table 2	Rarely (1)	Every two weeks (2)	Weekly (3)	2-3 times weekly (4)	Once daily (5)
Guided Imagery					
Deep Breathing					
Cognitive Behavioral Therapy					
Exercise					
Emotional Freedom Techniques					
Mindfulness Meditation					

5. In your opinion, did the use of non-pharmacological techniques help to better manage anxiety? Please give an example.  
e.g. Guided imagery was used by imagining myself on a tropical island when I experienced worry and intrusive negative thoughts, and, consequently, the anxious thoughts slowed down.
6. Did you decrease the use of benzodiazepines within the past three months?
7. Are you likely to continue using non-pharmacological techniques after the program?
8. Is three months a sufficient amount of time to implement the protocol?
9. Do you recommend any additions or changes to the protocol? If so, please list needed change