Acceptability of CBT via the internet for cessation benzodiazepine use

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Abstract

Introduction and Aims: Long-term use of benzodiazepines remains common, and conveys significant risk. Providing psychological intervention in association with gradual dose reduction increases cessation rates above dose reduction alone, but appropriate psychological support is difficult to obtain. This study was undertaken to assess the outcomes of an uncontrolled case series of an internet-based cognitive-behaviour therapy (I-CBT) for benzodiazepine cessation.

Design and Method: Users of benzodiazepines for > 3 months who wanted to reduce or cease benzodiazepines participated in the trial. They completed online assessments and accessed 13 newsletters on managing withdrawal symptoms and developing alternate ways to cope with life events. Therapist assistance was provided by email. Follow-up was at 3 and 6 months and feedback was obtained via comments and emails.

Results: Program ratings and emailed comments of the program were positive. Thirty-two people registered for the program and 14 (44%) completed a 6-month follow-up. Of these, 8 (57%) reduced weekly intake by at least half, including 5 (36%) who ceased use. Shorter duration of use and birth outside Australia predicted greater percentage reductions at 3 months, while being partnered and in paid employment predicted reductions at 6 months.

Discussion and Conclusion: While results were encouraging, controlled research is required to confirm the efficacy of the program, and engagement of both users and prescribers needs further attention.

Keywords: benzodiazepines, cognitive-behaviour therapy, internet, self-management, substance-related disorders.

Introduction

Benzodiazepines remain widely used in management of many problems, including anxiety, insomnia and muscle tension [1-3]. They are recommended only for short term prescription, as long-term use has potentially significant adverse consequences, including cognitive impairment, injury risk, mood and sleep disturbances, and physiological dependence [4]. In one study, 71% of long-term users of therapeutic doses of benzodiazepines reported an inability to stop taking them, due to withdrawal symptoms [5].

Recent meta-analyses of intervention trials have established that a letter from a patient's general practitioner (GP, or family physician) encouraging them to cease long-term benzodiazepine use results in better cessation rates than routine care. Higher rates are achieved when GPs actively use gradual dose reduction (GDR) rather than abrupt withdrawal, and substitutive medication does not raise cessation rates above those from GDR alone. However, adjunctive psychological intervention does increase cessation [6, 7]. A variety of treatments have been trialled, including cognitive-behaviour therapy (CBT) for insomnia [8, 9], anxiety, [10] panic [11, 12] or management of withdrawal [13, 14]. Components often include psycho-education, relaxation and cognitive restructuring [13, 14].

Psychological treatments in previous benzodiazepine cessation trials were conducted face-to-face [7]. For other substance use disorders, alternate delivery modes have been trialled to increase treatment access. Strategies have ranged from written information to more comprehensive computer-based treatments, with some studies using multiple methods [15-17]. For example, a smoking cessation trial used physician advice, written self-help materials, nicotine replacement therapy and eight counselling sessions via

cellular phone [18]. In alcohol use disorders, CBT via mail (using newsletters, worksheets and individualised progress summaries) has demonstrated strong results against control conditions in repeated trials [19, 20]. Self-managed CBTs for panic, phobias [21, 22] and comorbid depression and alcohol misuse [23] have shown comparable benefits to face-to-face programs.

These data suggest that a remotely delivered adjunctive psychological treatment for benzodiazepine cessation may assist benzodiazepine users to cease use. Accordingly, the authors developed a dedicated benzodiazepine cessation treatment program using mailed newsletters delivered to participants on a weekly basis, and intended to be used in conjunction with regular GP contact. This mode of delivering CBT has been referred as Mailed CBT (M-CBT) [24]. A limitation to the approach has been a difficulty in attracting volunteers or referrals. Despite extensive media advertising and personal marketing to GPs, an initial study attracted only six eligible participants to the program. The lack of referrals was consistent with a finding from our qualitative research, that a reason for GPs not commencing benzodiazepine cessation was that such attempts were perceived to be unrewarding in the long term [25]. Some GPs in that study reported being likely to maintain prescribing if the patient was dependent on the drug, or displayed little motivation to change. Furthermore, potential volunteers for the program commonly expressed concerns about a requirement that they maintain regular GP contact, reporting that they did not expect their GP to be supportive.

Alternate avenues for delivering the program were therefore explored. Internet-based delivery offered the prospect of reaching larger numbers of participants directly. Other advantages of internet delivery over a mailed treatment include immediate access to program materials, and more rapid access to support, advice and feedback on

progress. Internet-based treatments have had some success in other problem domains, including depression and anxiety [26, 27]. An internet-based treatment trial on Panic Disorder found that 77% of treated patients no longer met criteria for the disorder, compared with none in a Wait List. A review of internet-based treatments across a range of disorders found that 10 out of 12 studies showed greater improvement than from control conditions [28].

The present study examined the acceptability of internet based delivery of CBT (I-CBT), testing its attractiveness, and conducting a small, uncontrolled pilot trial to test its impact on benzodiazepine use and distress. We predicted that I-CBT would be positively evaluated by participants, and would result in significantly lower benzodiazepine intake and dependence, improvements in distress, and increased self-efficacy in resisting benzodiazepine use and applying alternate coping strategies for psychological problems.

Method

Participant recruitment.

Recruitment to the program was totally web-based, relying on search engines and linkage to other mental health or benzodiazepine-related websites. Participants reported using benzodiazepines daily for more than 3 months. Approval for the project was granted by the Human Ethics Committee of The University of Queensland (2003000063).

I-CBT

The intervention was entitled “Try Another Way—Self-Managed Benzodiazepine Withdrawal Program”, acknowledging that many users had previously tried to stop

using benzodiazepines without sustained success. Materials were hosted on a secure university website. A linked site provided information on cessation of benzodiazepines for benzodiazepine users (BzUs) and GPs. Participants were encouraged to talk to their GP before they changed benzodiazepine dosages, and were asked to keep their GP informed of their progress. An initial newsletter provided guidelines on raising the issue of benzodiazepine cessation with their GP, instructions on planning a slow, tapering regime, and worksheets to record total daily intake and adherence to the plan. Information on withdrawal symptoms was also given.

Component strategies in the authors' mailed version of the program (on which I-CBT was based) were adapted from their research on moderating alcohol use via mail [19, 20]. M-CBT incorporated effective components of alcohol and other drug treatments, such as motivational interviewing [29], problem solving [30] and relapse prevention [31], as well as self-monitoring and therapist feedback. Other units focused on skills for functional recovery, and included features from other psychological treatments, such as homework assignments, stress management, and strategies to boost self-efficacy [32]. M-CBT was also informed by the authors' previous qualitatative study with benzodiazepine users and medical practitioners [24]. Overall, the program aimed to develop competence in resisting benzodiazepine use in adverse situations, and cognitively challenge beliefs that benzodiazepines were the only way to ameliorate distress.

M-CBT had 13 newsletters. Examples of effective techniques and ineffective approaches were obtained from the qualitative study, and worksheets allowed participants to plan their implementation of coping strategies. I-CBT comprised modified versions of these newsletters (Table 1). The first author designed program

materials and provided email support to participants on demand. Emailed support clarified and reinforced program components, rather than adding new material.

Insert Table 1 here

Measures

Participant access and perception of the program. Engagement with I-CBT was assessed via numbers of website visits, of accessed newsletters and emails. Participants also completed a feedback questionnaire after initial access to each newsletter. Their usefulness and useability were rated from 0 (not at all) to 10 (very), and comments were invited. Perceptions of the program were also assessed from email exchanges.

Outcomes. Participants recorded daily benzodiazepine use over the previous week, and weekly consumption was converted to diazepam equivalents. The Severity of Dependence Scale-Benzodiazepines (SDS-B) was used to measure dependence [33, 34] and the Benzodiazepine Withdrawal Symptom Questionnaire (BWSQ) measured the extent of withdrawal symptoms. The Benzodiazepine Refusal Self Efficacy Questionnaire (BRSEQ) measured confidence in refusing benzodiazepines in specific situations [35], and the 21-item version of the Depression, Anxiety and Stress Scales (DASS-21) assessed negative emotional states [36].

Procedure. Recruitment occurred over 12 months. Participants registered interest in I-CBT by completing an initial questionnaire that determined eligibility. If they met entry criteria, they were sent a password (which unknown to them, was common to all participants). They logged onto the website via their email address, and completed a consent form and Baseline assessments. Access was then provided to all newsletters

(which were in a ‘pdf’ format that required downloading to complete worksheets). Participants were advised to access and apply newsletters in numerical order. While we recommended that users attempt to apply strategies before moving to new ones, there was no control over the rate of newsletter access.

Individualised support included monthly emails to assess perceived progress. At 3 months post-registration, participants were emailed a request to complete online outcome measures and report their perceptions of the program. Nonresponders were sent two further emails approximately a week apart, requesting them to log on to the site and complete assessments. The outcome measures were again administered at 6 months. Feedback on assessment results was provided by email, and participants were advised to discuss results with their GP if distress or other symptoms were high.

Results

Website access

Seventy percent of traffic to the website over an 11-month period was via Internet Explorer (1,275 visits). Google was the primary search engine (24%, 428 visits) and access was primarily through other sites, with 59% (1,066 visits) referred from Queensland Health, benzo.org and a website associated with the program. Fifteen percent (277 visits) comprised direct traffic. Fifty-four percent of visits (1,003) were from Australia, and 25% (450 visits) were from the USA.

Insert Figure 1 here

Participant Characteristics

Fifty-four people completed an initial screening questionnaire, and registration was completed by 13 men and 19 women (59%). The mean age of registrants was 45.2 years (SD = 14.6; range = 23-78): 38% (12) were employed either full or part-time, 78% (25) had completed post-secondary education, and 57% (17) were in a current relationship. Thirteen (41%) said they were born in Australia; 12 (38%) were born in the USA, and the remainder were spread across five other countries. The most common reasons for starting benzodiazepine use were panic and anxiety (50%) or sleep problems (19%). The most frequently used benzodiazepines were clonazepam 31% (10) and diazepam 28% (9), with a mean duration of use of 5.0 years (SD = 6.2; Range: 3 months to 30 years) and a mean daily dose of 16.4 mg diazepam equivalents (Median = 10.6 mg, SD = 20.1, Range 1-114). Fifty percent of participants reporting current treatment for a psychiatric disorder were receiving treatment for depression, and 25% were being treated for panic or anxiety. Most (92%; 22) said they had not discussed involvement in the program with their GP, despite being encouraged to do so. Fifty-eight percent reported that they did not drink alcohol, and only 3 (9.6%) said that they drank more than 1-2 times per week. Eighty percent (25) indicated that they never consumed 6 or more drinks on any one occasion during the past year. Forty percent (13) reported smoking tobacco at least weekly in the past three months, but only one (3.2%) said they used amphetamines monthly, and 2 (6.5%) reported weekly use of opioids.

Participant Access

Ninety-one percent of registrants accessed newsletters at least once, and the average number of visits was 7.3 (SD = 8.34, range 1-39). The most accessed newsletter was

the first, with 47 (22%) of total visits to the program. Newsletters 10-13 had the least access, with 9 (4%) of visits.

Perception of the program

Ratings of newsletters. There were 40 responses to requests for feedback on the newsletters. They were rated easy to read (from 0-10, newsletter ratings ranged from M = 9.5, SD =0.8; to M=10 SD =0.0) and as having useful information (M = 5.7, SD = 3.8 to M = 10.0, SD = 0.0). Participants reported reading most material in accessed newsletters (from M = 9.3, SD = 1.2 to M = 10.0, SD = 0.0).

Comments included:

"... [I] found the suggestions in 'Controlling Your Thinking' very helpful, especially the one that says 'I will focus on what is happening now rather than worry about how much worse it might get'."

"Excessive 'worry' and health anxiety got me here in the first place. I am learning to relax using slow deep breathing and positive self-talk as mentioned in this newsletter."

Some respondents said their GP lacked an awareness of difficulties experienced when withdrawing from benzodiazepines, and that they were insufficiently engaged in encouraging and managing cessation.

"I didn't want doctors having so much control over my life. It made me very angry—especially as I got into this mess because doctors didn't explain enough to me in the first place."

Email content. There were 259 emails from participants in total (M = 7.40 per participant, SD = 9.87). A common theme (61 responses) related to the high quality and helpfulness of newsletters, including an appreciation that someone was interested in them and was providing feedback on completed assessments. Responses indicated that

ongoing email support was valued for its provision of an avenue to share achievements and effective strategies. Comments included:

"It was so good to know that someone out there was aware of benzo use and was doing something. And I will be going over the newsletters and re-reading them."

"I'm doing great and I am really proud of myself as I felt I would never get there or find someone who could help me do it. Try Another Way has been fantastic as I have been doing most of the weaning myself. It's good to have a resource to refer to."

There was an awareness of the need to use different methods to stop benzodiazepine use from those applied in the past, frustration over the time it would take, and shame or guilt about using benzodiazepines (13 responses).

"The only way is to not to worry if cutting down [benzodiazepines is] going slowly. I'm having [a] difficult moment, but in my case I must stop taking [them] because I will get to hospital."

The second largest comment category related to reasons for maintaining benzodiazepine use, including the anticipated impact of health problems on dose reduction, concerns over withdrawal symptoms, the long expected duration for dose reduction and a sense of addiction (33 responses).

"There's not much time for me to 'fall apart', and sometimes it's easier to take a tablet each night to sleep, than to suffer the side effects on top of everything else in my life."

"I have gone through some rather rough periods - not knowing if my symptoms of severe insomnia and heightened anxiety were from the withdrawal or a return of my insomnia/anxiety symptoms."

Some participants (N = 13) indicated that their GP was integral to their coping with benzodiazepine reduction.

"I managed to find a great, understanding GP."

"My doctor is keeping an eye on things."

However, most comments about GPs were negative (24 responses).

"I feel that doctor's give out these pills far too easily without warning the patients of the potential long-term effects of these addictive drugs."

There was also concern regarding the absence of specialist clinics, a perceived lack of interest in benzodiazepine dependence by health services (including specialist substance use services), the cost of service access and a lack of understanding by family and friends.

"Family and friends don't understand about this stuff because if they are not going through it...How could they understand? I have no help, and no one to be with me...I'm going to try to get off of these meds, but at times I am so scared and fearful..."

Not all participants (N = 12) found the program materials helpful, and 11 emails reported existing linkages with web-based support groups. Two participants experienced difficulties accessing program materials, due to not being able to open 'pdf' documents online, or reporting that the document downloads took too long.

Outcomes of the pilot

Twenty-one participants (33% male, 66% of registrants) completed the 3-month assessment, and 14 (38% male, 44%) completed the one at 6 months (Figure 1). There was no difference in gender, age, daily benzodiazepine intake, and duration of benzodiazepine use between completers and non-completers at 3 months. Intention-to-treat analyses substituted missing data by the participant's own mean, and results are displayed in Table 2. As the table shows, there were significant changes at 3 months in weekly diazepam dose, dependence and self efficacy. At 6 months, all of the 3-month

reductions were retained. In addition, there were significant improvements in depressive symptoms. Withdrawal symptoms, anxiety or stress did not change significantly.

Insert Tables 2 and 3 about here

At 3 months, eight completers (38%) at least halved their weekly benzodiazepine intake, including 2 (10%) who ceased use. Of 14 participants completing the 6-month assessment, 8 (57%) had at least a 50% reduction in consumption, including 5 (36%) who ceased use (Table 3).

The only significant associations between participant characteristics at Baseline and greater percentage reductions in benzodiazepine dosage at 3 months were a shorter duration of use (r = -.35, p = .049) and not being born in Australia (M = 33.1, SD = 36.6 vs. Australian born: M = 2.2, SD = 32.9; $F(1, 30) = 5.95$, p = .021, η^2 = .166). The only significant predictors of a greater percentage reduction at 6 months were currently being partnered (M = 48.9, SD = 43.5, vs. Being widowed or divorced: M = 15.1, SD = 29.1, or never married: M = 3.8, SD = 9.3; $F(2, 27) = 4.39$, p = .022, η^2 = .245), and currently being in paid employment (M = 49.8, SD = 37.6 vs. M = 18.7, SD = 36.6; $F(1, 30) = 5.47$, p = .026, η^2 = .154). The number of accessed newsletters approached significance as a predictor of 6-month consumption (r = .31, p = .081). Importantly, there were no significant associations between percentage dose reduction at 3 or 6 months, and age, gender, education, English as a first language, or benzodiazepine dose at Baseline.

Discussion

The pilot evaluated the feasibility of delivering M-CBT direct to BzUs via the internet. The program attracted participants from seven countries. Participant feedback on the newsletters was positive, as were most emailed comments about the program. Ongoing email contact was highly valued, both as an opportunity for interaction and a way to obtain additional advice.

Data on recruitment were less positive. Numbers of volunteers were limited, despite multiple links from highly used mental health websites. This has been a challenge shared by other researchers into internet-based interventions. For example, attempts to recruit teenagers to complete a online evaluation of a smoking cessation website also resulted in restricted take-up [37]. Improving engagement with I-CBT may be achieved by increasing the profile of the word "benzodiazepine" in key-word searches, and marketing the program through paid advertising. Recruitment strategies in other studies have also included dissemination of information via discussion boards and web-based fora.

The retention rate of 40%, while lower than ideal, was comparable to retention in previous correspondence-based trials on alcohol misuse[20], and is better than many other internet studies. For example, an alcohol treatment trial by Linke, Murray, Butler, & Wallace (2007) [38] only had a completion rate of 16%. The current program emphasised engagement with an identified therapist, which may have assisted retention, and the addition of online interactivity or financial incentives may enhance it further. Provision of immediate feedback on benzodiazepine intake, assessments and completed worksheets may be especially helpful. Advice could be broken into smaller segments

that are delivered more frequently, and automated reminders to return to the website could be provided.

Overall, outcomes of this uncontrolled pilot trial were encouraging. At 6 months, participants had significantly reduced their weekly benzodiazepine intake, and had increased their confidence in resisting benzodiazepine use. Reductions also occurred in benzodiazepine dependence and in depressive symptoms. While anxiety and stress had not reduced, nor had they increased with the reduction of benzodiazepine use, and the number of withdrawal symptoms fell over time. While a third of participants did not reduce their benzodiazepine consumption substantially, a longer follow-up may be required to assess the full impact of interventions such as these, since up to 15 months may be required for cessation [39].

Previous research demonstrated that GP-managed GDR is effective, although psychological intervention further increases cessation rates. Despite our participants being encouraged discuss their participation in I-CBT with their GP and to request ongoing support, most did not do so. Consistent with our previous qualitative research, participants in the current study reported an expectation that GPs would not provide the support they required.

Associations between degree of change in benzodiazepine use and Baseline variables were inconsistent across the 3- and 6-month assessment occasions, but (with the exception of overseas-born participants showing greater reductions at 3 months) were in expected directions. So, a shorter duration of benzodiazepine use was associated with greater percentage reductions at 3 months. Having a current partner (perhaps indicating access to support) was linked to greater reductions at 6 months, as was being employed. The latter result could reflect several potential factors (e.g. greater self-

control skills, more opportunity for attentional diversion from symptoms). While the link between the number of accessed newsletters and 6-months consumption fell short of the .05 significance level, the association was in the expected direction. These results need clearly need replication and refinement of pathways of action.

Limitations of the current study

This preliminary study did not constitute a controlled trial, and observed changes in benzodiazepine use may have been due to spontaneous recovery. A significant limitation of the current study is that the nature and outcomes of prior attempts to cease benzodiazepines and degree of concurrent assistance during the study are unknown, and it is possible that these participants required less support to cease benzodiazepine use than the population of benzodiazepine users, although they did have a substantial mean duration of benzodiazepine use (6.2 years).

The follow-up period in this study was shorter than ideal, the sample was relatively small, and the number of predictive analyses may have inflated alpha. Substitution by the participant's own mean over available assessments, while relatively conservative (since it includes Baseline assessments), may have overestimated results for some people who dropped out of the study after an initial reduction. More sophisticated ways of dealing with missing data such as Generalized Estimating Equations or mixed models ANOVAs should be used in a larger-scale trial. Overestimation of effects could also have occurred due to social desirability, since the study did not provide independent validation of patient reports.

The recruitment strategy and intervention could also be further improved. Access to the program primarily occurred through third-party traffic rather than from direct hits, suggesting that the program needed greater prominence in searches from commonly

used engines. The current version of I-CBT was limited to a web version of the M-CBT newsletters, rather than constituting an interactive online program. However, responses to the existing program suggested that an interactive version would be positively received, and may have strong impact.

The current study was not designed to address whether face-to-face contact was needed to maximise the impact of psychological treatment for benzodiazepine reduction [40], or to compare the efficacy of internet-based versus face-to-face treatment [41]. Studies on these issues, including related cost-benefit analyses, are critical to the establishment of internet-based interventions for benzodiazepine cessation.

While this study recommended involvement of the person's prescriber, it could not ensure that participants did so. The intervention provided information on appropriate dose reduction regimes, but abrupt, self-initiated cessation could occur, with some potential attendant risk (e.g. of seizure). There were no known complications experienced by the current sample, but a partnership of consumers and prescribers or pharmacists is needed to optimise safety and minimise discomfort. Internet-based information can allow consumers to approach prescribers in an informed manner, and psychological strategies may provide support for withdrawal regimes, but should not replace appropriate pharmaceutical management.

Internet-based interventions are potentially available to people across the world, who may come from very different cultural, linguistic and health service contexts. Widespread, international adoption of internet interventions for benzodiazepine cessation would require that these differences be understood and appropriately addressed in a family of interventions.

Conclusion

This study provided initial support for the viability of internet-based treatment for benzodiazepine cessation. An appropriately powered randomised controlled trial is needed to substantiate the effects in comparison to control conditions. Improvements to the internet program and to the profile of the website could also be made. However, our research suggests that improved marketing of psychological interventions comprises only part of what is needed to address disturbingly high rates of long-term benzodiazepine prescription. Greater incentives may be required for prescribers and suppliers to monitor the problem more effectively and actively engage users in attempts to cease their benzodiazepine use.

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Conflict of interest

None declared.

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Table 1. *Content of I-CBT newsletters*

Number	Content
1.	Introduction to the program – making a decision to reduce benzodiazepine use; stories on cutting back; how to talk to their GPs about benzodiazepine cessation; worksheets to plan weekly dose reduction and record daily intake.
2.	Making Decisions – reviewing benefits and costs of benzodiazepine use; introduction to coping during dose reduction.
3.	Coping With Withdrawal and After – specific strategies to cope with emotions, adverse symptoms, inability to sleep, not eating and controlling negative thoughts; 5-point coping plan for managing adverse symptoms; scale to measure withdrawal symptoms; worksheet to design a coping plan.
4.	Sleeping Better –strategies to reduce sleep problems; stories on overcoming sleep difficulties; worksheets for planning a sleeping routine and monitoring nightly sleep.
5.	Straight Thinking – 6-step approach to problem solving; story on 'straight thinking'; worksheet to develop a straight thinking plan.
6.	Be Active – outlined importance of being active in order to cope with adverse symptoms; checklist of activities and a worksheet to set an activity plan.
7.	Finding a Supporter – how to ask friends or family to provide support; worksheet for developing a support plan.
8.	Eating When You Don't Feel Like It – ideas on what to eat when coping with withdrawal symptoms; worksheet for designing an eating plan.

9.	Coping With Worry – tips on coping with thoughts and feelings; worksheet to plan how to cope with future events.
10.	Planning Your Day - tips on completing key tasks on a daily basis and a worksheet to plan daily activities.
11.	Keeping On Track - tips on persisting in the face of difficulties.
12.	Life After ‘Benzos’ - setting up a post-cessation plan.
13.	Returning To Benzo Use - tips on how to use the ‘Try Another Way’ program, even when benzodiazepine use has recommenced.

Figure 1. *Progress of participants through project*

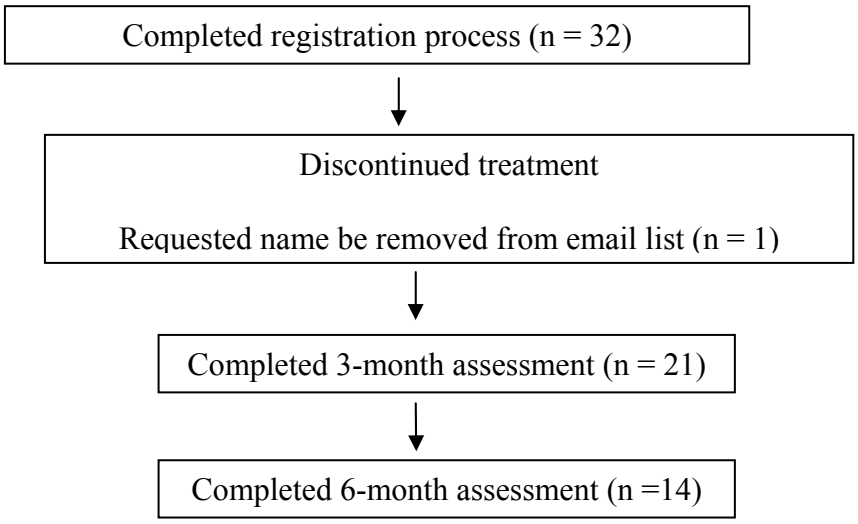

Table 2. *Outcomes using intention-to-treat (n=32)*

Measures	Baseline		3 months follow-up		Baseline vs 3 months			6 months follow-up		Baseline vs. 6 months		
	M	SD	M	SD	F	p	Partial η^2	M	SD	F	p	Partial η^2
Weekly dose (diazepam equivalents)	115.08	140.65	95.20	145.15	7.20	*	0.189	94.33	144.63	7.19	**	0.188
SDS-B	11.13	2.60	9.78	3.69	8.99	**	0.225	8.42	4.65	10.00	**	0.244
BWSQ	13.44	5.58	11.63	6.2	3.49		0.101	11.98	6.52	2.14		0.125
BRSE	60.48	18.38	64.53	17.91	4.48	*	0.126	68.08	18.79	8.10	**	0.207
DASS-depression	21.31	11.35	18.35	11.53	3.32		0.097	16.38	11.43	4.84	*	0.135
DASS-anxiety	17.01	9.31	15.12	9.13	2.22		0.067	14.37	8.67	2.72		0.081
DASS- stress	24.40	8.01	22.69	8.67	1.56		0.048	21.16	9.19	2.96		0.087

*$p < 0.05$, ** $p < 0.01$

Table 3. *Benzodiazepine reductions at 3 and 6 months for participants completing assessments*

Reduction in benzodiazepine use	3 months (N=21)		6 months (N=14)	
	Frequency	% completers	Frequency	% completers
ceased	2	9.5	5	35.7
decrease 75-99%	1	4.8	2	14.3
decrease 50-74%	5	23.8	1	7.1
decrease 25-49%	2	9.5	2	14.3
decrease 1-24%	4	19.0	2	14.3
no decrease	7	33.3	2	14.3