Benzodiazepines in Pregnancy: What Clinicians Should Know

Sofia Noori, MD MPH
Psychiatrist, AccessMH4Moms

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Objectives

- Understand the **benefits/risks** of benzodiazepine (BZD) use across the perinatal timeline.
- Apply **prescribing and deprescribing** (taper) best practices tailored to trimester and lactation.
- Communicate clear, **patient-centered counseling** messages that balance maternal mental health with fetal/infant safety.

Poll

Which statement best reflects your current comfort level?

□ I avoid benzodiazepines completely in pregnancy.

□ I prescribe them when clinically indicated.

□ I am comfortable continuing—but rarely initiating.

□ I'm not sure.

American Psychiatric Association website.

Why This Matters

- Anxiety, insomnia, and panic can worsen during pregnancy/postpartum; untreated illness carries obstetric and neonatal risks.
- BZDs are **not first-line** for perinatal anxiety; when used, they should be **short-term/sparing**.

What are benzodiazepines?

- First developed in 1955 with chlordiazepoxide
- Initially prescribed for anxiety and "anxious insomnia"
- GABA-A positive allosteric modulators producing anxiolytic, hypnotic, anticonvulsant effects.
- Placental transfer occurs; fetal exposure proportional to maternal dose.
- Shorter-acting agents without active metabolites (Lorazepam, Oxazepam, Temazepam) preferred in pregnancy/lactation.

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Benzodiazepines: Mechanism & Pharmacology

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You can't set her free. But you can help her feel less anxious.

You know this woman.

She's anxious, tense, irritable. She's felt this way for months.

Beset by the seemingly insurmountable problems of raising a young family, and confined to the home most of the time, her symptoms reflect a sense of inadequacy and isolation. Your reassurance and guidance may have helped some, but not enough.

SERAX (oxazepam) cannot change her environment, of course. But it can help relieve anxiety, tension, agitation and irritability, thus strengthening her ability to cope with day-to-day problems. Eventually—as she regains confidence and composure—your counsel may be all the support she needs.

Indicated in anxiety, tension, agitation, irritability, and anxiety associated with depression.

May be used in a broad range of patients, generally with considerable dosage flexibility.

Contraindications: History of previous hypersensitivity to oxazepam. Oxazepam is not indicated in psychoses.

Precautions: Hypotensive reactions are rare, but use with caution where complications could ensue from a fall in blood pressure, especially in the elderly. One patient exhibiting drug dependency by taking a chronic overdose developed upon cessation questionable withdrawal symptoms. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose; excessive prolonged use in susceptible patients (alcoholics, ex-addicts, etc.) may result in dependence or habituation. Reduce dosage gradually after prolonged excessive dosage to avoid possible epileptiform seizures. Caution patients against driving or operating machinery until absence of drowsiness or dizziness is ascertained. Warn patients of possible reduction in alcohol tolerance. Safety for use in pregnancy has not been established.

Not indicated in children under 6 years; absolute dosage for 6 to 12 year-olds not established.

Side Effects: Therapy-interrupting side effects are rare. Transient mild drowsiness is common initially; if persistent, reduce dosage. Dizziness, vertigo and headache have also occurred infrequently; syncope, rarely. Mild paradoxical reactions (excitement, stimulation of affect) are reported in psychiatric patients. Minor diffuse rashes (morbilliform, urticarial and maculopapular) are rare. Nausea, lethargy, edema, slurred speech, tremor and altered libido are rare and generally controllable by dosage reduction. Although rare, leukopenia and hepatic dysfunction including jaundice have been reported during therapy. Periodic blood counts and liver function tests are advised. Ataxia, reported rarely, does not appear related to dose or age.

These side reactions, noted with related compounds, are not yet reported: paradoxical excitation with severe rage reactions, hallucinations, menstrual irregularities, change in EEG pattern, blood dyscrasias (including agranulocytosis), blurred vision, diplopia, incontinence, stupor, disorientation, fever, euphoria and dysmetria.

Availability: Capsules of 10, 15 and 30 mg. oxazepam.

'Mother's Little Helper'

- In 1963, diazepam (Valium) was introduced and heavily marketed to women as a solution for stress, motherhood, and domestic life.
- At the time, it was considered a low-risk medication, safer than barbiturates
- Between 1968-1982, **Valium was the most prescribed drug in the U.S.**
- In 1978, an estimated 20% of adult American women had taken Valium!

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Uncontrolled anxiety and panic carry their own perinatal risks

- The comparison is NOT medication vs. no medication → it is medication vs. untreated illness.
- Uncontrolled anxiety/panic increases the risk of:
  - Preterm birth
  - Low birth weight
  - Impaired bonding
  - Poor prental care
  - Substance relapse
  - Suicidality

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First Trimester Risks

- Large cohort data suggest small, dose-related increases in overall malformations and cardiac defects.
- Absolute risks remain low: ~65/1,000 exposed vs 51/1,000 unexposed pregnancies.
- Use only when benefits clearly outweigh risks; prefer non-pharmacologic options first.

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Miscarriage Risk Signal

- Case-control and cohort studies indicate an association between early-pregnancy benzodiazepine use and miscarriage.
- Confounding by indication likely—underlying anxiety and insomnia themselves may increase miscarriage risk.
- Discuss uncertainty and individualized risk-benefit balance with patients.

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Late Pregnancy & Delivery

- Exposure near delivery can cause neonatal adaptation issues: hypotonia ('floppy infant'), sedation, and withdrawal symptoms.
- Avoid high doses and long-acting agents near term; notify neonatal team for monitoring.
- Use lowest effective dose; avoid polypharmacy.

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Breastfeeding Safety

- Benzodiazepines pass into breast milk in small amounts; relative infant dose <10% for most agents.
- Lorazepam, Oxazepam, and Temazepam preferred; Diazepam may accumulate due to long half-life.
- Monitor infant for sedation, feeding, or weight issues.

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When to Use Benzodiazepines Perinatally

- Short-term use for severe panic or anxiety when first-line treatments insufficient.
- Consider bridging while SSRI or psychotherapy takes effect.
- Document shared decision-making and clear taper plan.

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Preferred BZAs

Drug	Half-life	Pregnancy
Lorazepam	Intermediate	Preferred
Alprazolam	Short	Less preferred
Oxazepam	Short	Preferred
Temazepam	Intermediate	Reasonable
Clonazepam	Long	Continue if stable
Diazepam	Very long	Less preferred

Clinical Pearl: Avoid switching a stable patient solely because another benzodiazepine is theoretically "cleaner."

Common Benzodiazepines Compared

- Lorazepam: preferred in pregnancy/lactation when clinically indicated.
- Oxazepam & Temazepam: preferred due to lack of active metabolites.
- Clonazepam: often reasonable to continue if stable; avoid unnecessary switching.
- Diazepam: long half-life; greater concern for neonatal accumulation.
- Alprazolam: avoid chronic use when alternatives exist.

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Prescribing Best Practices

- Start low, go slow, and use for the shortest duration possible.
- Avoid concurrent use with opioids or other sedatives.
- Plan tapering before delivery when possible; use non-sedating adjuncts.

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Tapering Guidance

- Avoid abrupt discontinuation; taper 5–10% of dose every 2–4 weeks.
- Support with CBT or CBT-I, sleep hygiene, and non-sedative coping strategies.
- Pause taper rather than reverse if withdrawal emerges.

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Trimester-Specific Tapering Considerations

- First trimester: Introduce alternative treatment before tapering if feasible.
- Second trimester: Continue gradual taper while monitoring anxiety and sleep.
- Third trimester: Aim for lowest dose to minimize neonatal withdrawal.

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Postpartum and Lactation Tapering

- Pharmacokinetics normalize postpartum; reassess dosing to prevent over-sedation.
- If tapering during breastfeeding, schedule doses after feeding.
- Coordinate with lactation consultant and pediatrician.

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Non-Pharmacologic Alternatives

- Cognitive Behavioral Therapy (CBT) for anxiety disorders.
- CBT-I for insomnia; mindfulness-based interventions.
- SSRIs or SNRIs as safer long-term pharmacologic alternatives when indicated.

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Patient Counseling Tips

- Acknowledge maternal distress and validate symptoms.
- Explain absolute vs relative risks and emphasize shared decision-making.
- Offer written materials and coordinate with obstetric and pediatric teams.

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Clinical Decision Framework

- Ask: What is the untreated illness risk?
- Ask: Is the benzodiazepine providing meaningful benefit?
- Consider psychotherapy and SSRI/SNRI when appropriate.
- Use the lowest effective dose for the shortest clinically appropriate duration.
- Shared decision-making is the standard of care.

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Clinical Pearl: Don't Rush to Switch

- Patients stable for years on clonazepam rarely benefit from changing agents solely because of pregnancy.
- Medication changes can destabilize anxiety disorders.
- Treat the patient—not the pharmacology table.

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Counseling Script

- "Most babies exposed to benzodiazepines are born healthy."
- "Our goal is a healthy mother and healthy baby."
- "The safest plan is the one that keeps your illness well controlled while minimizing medication exposure."
- "We will revisit the plan throughout pregnancy."

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Common Pitfalls

- Stopping chronic benzodiazepines abruptly.
- Focusing only on fetal risk while ignoring maternal psychiatric illness.
- Using relative instead of absolute risk during counseling.
- Failing to notify pediatrics when significant exposure continues near delivery.

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Case Pearls

- Patient with panic disorder at 10 weeks: CBT + SSRI + short-term lorazepam bridge.
- Chronic nightly benzodiazepine use in late pregnancy: slow taper and neonatal monitoring.
- Postpartum insomnia: CBT-I ± low-dose lorazepam after feeding.

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Key Takeaways

- Use benzodiazepines only when benefits outweigh risks.
- Prefer short-acting, non-metabolized agents and lowest effective dose.
- Integrate behavioral therapies and coordinate multidisciplinary care.
- Taper gradually and avoid abrupt discontinuation.

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Thank you!

Contact Me:

Sofia@nemahealth.com
Sofia.Noori@yale.edu

Contact ACCESS:

Monday through Friday, 9:00 am – 5:00 pm
833-978-MOMS (6667)

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