Contents

Foreword: 21st Century Chill ................................................................. 5
Chapter 1: Welcome to the “Age of Anxiety” ................................. 7
  Meet Miltown, the “Happy Pill” .......................................................... 8
  Enter the Benzodiazepines ................................................................. 9
  Mother’s (and Brothers and Sister’s) Little Helpers ......................... 10
  Turning Fear Into Gold .................................................................. 11
Chapter 2: BZD’s in Action .............................................................. 12
  Effects, Intended and Otherwise ...................................................... 13
  Classifications, Indications, & Et Ceterations ................................. 14
  Selling Points .................................................................................. 15
Chapter 3: The Downside, Up Close .............................................. 16
  Overdose: An Overview ................................................................. 16
  Everyday Dangers, Part 1 ................................................................. 17
  Everyday Dangers, Part 2 ................................................................. 18
  Strung & Unstrung: Addiction & Withdrawal ................................. 19
Chapter 4: The Last Word ............................................................... 22
  Unlearning Helplessness ............................................................... 23
tranquilizers.

On paper, they didn’t seem like such a bad idea.

It was all supposed to be so simple: You just turn down the customary stress and static of everyday life by popping a sunny yellow or sky-blue pill three or four times a day, then watch your worries disappear into space. No muss, no fuss, no complicated coping or unnecessary figuring-out of feelings, and certainly no side effects, snide effects, or otherwise-implied effects.

Too bad that’s only the way it was on paper.

Because in real life, tranquilizers never worked that way—at least not only that way. In real life, real people have had real problems—and in some cases, the most real problems of their lives—because they reached for the prescription bottle of Valium or Tranxene or Ativan a time or two too often.

That’s why we put together this booklet. Because the minor tranquilizers turned out to be something other than the bluebirds of happiness (or yellow birds or green-and-black birds, depending) that their promoters—and millions of the rest of us—hoped they were going to be just a few decades ago.
What they’ve turned out to be instead is a complex group of drugs that can cause a complex group of problems when they’re misused or overprescribed. And they have been misused (by millions of people) and they have been overprescribed (by tens of thousands of doctors). And they have caused problems, more than their share of problems, in fact—especially to people who didn’t know what they were getting into when they got into Valium or Serax or one of the other “minor tranquilizers.”

Because the minor tranquilizers are “minor” in name only. In reality, they’re a major problem for thousands of users, one that doesn’t go away just because they don’t like where they got stuck when they got stuck trading their feelings—and large or small parts of their lives—for tranquilizer prescriptions.

We hope you’ll find a comfortable chair and spend a little time with the rest of “Tranx.” What you don’t know about the minor tranquilizers might surprise you. And what you will know by the time you finish reading this booklet may just help prevent problems from happening to you—or to someone you care about.
Welcome to the “Age of Anxiety.”

Nobody likes to feel anxious. Whether you call it tension, stress, or plain-old nerves, the jangled, tingling, heart-pounding experience of inadequacy and dread that makes up anxiety is just plain unpleasant. Period.

In fact, for a while (about the time tranquilizers were first developed, in fact) people even made a big deal out of it, deciding that the late, great Twentieth Century was but the dawning of the “Age of Anxiety,” and rushed around trying to figure out What It All Means and to explain How, exactly, We Got This Way.

No one’s sure if any one ever did figure out what it all really does mean (aside from the obvious fact that a lot of people feel anxious a lot of the time) or how, exactly, we did get this way (assuming, of course, that it hasn’t always been this way), but we are sure that the “Age of Anxiety” turned into the “Age of Tranquilizers” pretty darn quick—at least as soon as the pharmaceutical companies discovered the chemical keys to turn the lock into the New Age.

And the biggest, shiniest keys of all—discovered in the 1950’s and early-1960’s—turned out to be an entirely new category of drugs, a group of chemicals which eventually came to be known as the minor tranquilizers.*

*Throughout this booklet, the minor tranquilizers will be distinguished from the so-called “major tranquilizers,” anti-psychotic mood modifiers such as Thorazine, Prolixin, and others. The major tranquilizers do not produce effects generally experienced as pleasurable, and are thus rarely abused.

In addition (and for purposes of brevity and clarity), we will not discuss a number of other drugs sometimes prescribed as tranquilizers. Drugs in this category include products as diverse as reserpine-based antihypertensives (e.g. Serpasil™), antidepressants with tranquilizing properties (e.g. Sinequan™, Adapin™), and sedating antihistamines (e.g. Atarax™, Vistaril™).
What the minor tranquilizers are, exactly, is a group of synthetic chemicals that produce feelings of tranquility through their action on the brain and central nervous system.

But for a group of drugs that are supposed to produce calm, the minor tranquilizers sure managed to produce more than their share of excitement when they first burst onto the drug scene. They were thought to be virtual “wonder drugs” at the time—safe, effective, and nearly side-effect-free.

Probably the main reason for the chorus of hallelujahs that greeted the minor tranquilizers was that they did look awfully good and awfully safe, especially compared to the collection of chemicals that had been in use for years as “tranquilizers”—alcohol and opiates and bromides and barbiturates.

Still, they weren’t perfect. It just took a while to find that out, that’s all.

**Meet Miltown, The “Happy Pill”**

The first “real” minor tranquilizer marketed in the United States was meprobamate, patented in 1952. Meprobamate proved successful, in fact, too successful, almost from the moment it hit pharmacists’ shelves. The drug, which was marketed under the trade name Miltown (and later Equanil), was the immediate darling of the then up-and-coming psychiatric profession and became a popular recreational drug almost as quickly.

In fact, Miltown was one of the biggest drug abuse phenomena of the 1950’s, probably the first really middle-class drug abuse phenomenon, and the drug quickly established itself as the “happy pill” alternative for harried housewives and stressed-out commuters. It was called a “dehydrated martini” by some, and “Miltown parties” became respectable in more than one suburb, at least until word began to leak out that there were problems—lots of them, in fact—associated with use of the drug.

For one thing, in spite of the fact that meprobamate was thought to have little potential for abuse, and no matter that early advertising for the drug tirelessly pointed out its differences from the barbiturates (which had emerged as the preeminent pre-tranquilizer “tranquilizer”), Miltown quickly proved itself to be nearly the equal to the barbiturates in just about every drug abuse category that’s ever counted—psychology, pharmacology, and all-around addictiveness.

They were found to produce a barbiturate-like “buzz” when taken to excess, along with a constellation of other barbiturate-like problems, right down to the convulsive seizures of withdrawal and the lethality of the respiratory depression of overdose.

All of which happened to confound the drug industry “experts” who’d predicted a long, leisurely product life (and a steady, stable profit curve) for Miltown. But they’d already made piles of money off meprobamate and began hedging their bets as soon as bad reports about Miltown started hitting the evening news.

But by this time, many who knew anything about the burgeoning new psychopharmaceutical industry were already busy placing bets on a new category of minor tranquilizer, hot off the pill presses of the tiny Swiss pharmaceutical maker Hoffman-LaRoche, who happened to own the patent on a fledgling group of tranquilizers that traveled under the vaguely-ridiculous chemical family name of benzodiazepines.
Enter The Benzodiazepines

What Hoffman-LaRoche came up with in 1960 was a brand-new all-purpose minor tranquilizer that went by the appealing name of Librium (which translates from the Latin as the very-benign “to be free”). Librium, known generically as the less-friendly-sounding chlordiazepoxide, immediately picked up where Miltown left off, and then went its older chemical cousin a thing or two better.

And Librium was only the beginning.

In 1963, a sister drug, Valium (from the Latin “to be brave”), appeared and the pair immediately shot to the top of medical drugland’s Most-Prescribed lists. And that was still only the beginning.

Because Valium and Librium represented only the first arrivals of the brand-new benzodiazepine family (BZD’s for short). And as new BZD relatives appeared throughout the next decade (new family “members” showed up just as fast as drug-company research-ers could tickle the benzodiazepine formula into a new shape not already patented), America’s love affair with the new drugs just seemed to grow and grow.

And the BZD’s did look to have everything going for them that meprobamate and the earlier “tranquilizers” didn’t. For one thing, they were found to only mildly depress nor-
mal body functions, which reduces the risk of extreme respiratory depression and fatal overdose.

For another, they seemed not to interfere with higher-level mental processes to the same degree that barbiturates and meprobamate do, which was seen as a definite advantage—especially to the legions of middle-class housewives, business people, and students who constituted the main demographic target groups identified by the manufacturers as likely candidates for the drugs.

And when the manufacturers’ marketing departments went for middle-class “Age of Anxiety” converts (via medical journal ad campaigns aimed at their physicians), they went after them in a big way.

### Mother’s (And Brother’s And Sister’s) Little Helpers

Early ads for the benzodiazepines portrayed them as the natural successors to the old-fashioned nap in the shade as the ideal package for up-to-date relaxation.

One 1969 ad for Librium, headlined “A Whole New World... of Anxiety,” pictured a mini-skirted college coed with the problems of the age etched in the lines of her face.

The text of the ad made it clear that the answer to her problems (which, it pointed out, included insecurity over “today’s changing morality” and apprehension about “unstable national and world problems” provoked by “her newly stimulated intellectual curiosity”) came in a pill and the pill was called Librium.

Valium’s early ads were no better.

One showed a tense, unhappy-looking young man seated in front of an open book in a library, notepad and pen at the ready, alongside the caption: “Symbols in a life of psychic tension: M.A. (class of ’66), Ph.D. (thesis in progress), G.I. (series and complete examination normal-persistent indigestion).” The Rx? Why, Valium, of course—three, even four times a day.

And it wasn’t just Hoffman-LaRoche, Valium and Librium’s manufacturer. A late-60’s (early-women’s lib) ad for Wyeth Laboratories’ Serax pictured a distraught, finger-gnawing housewife imprisoned behind a wall of broom and mop handles, captioned, “You can’t set her free. But you can help her feel less anxious.”

And without even bothering to read the rest of the copy, you know the help Wyeth had in mind was the same “help” the Rolling Stones talked about in their housewives-and-tranquilizers lament from the same period, “Mother’s Little Helper”:

> Doctor, please. Some more of these.  
> Outside the door she took four more.  
> What a drag it is getting old.

But “Mother’s Little Helper” was only a hit for a few months.

The drug companies’ campaigns ran for years (decades, even). And what got remembered and imprinted in the public mind during that entire time was the Truth According to the Drug Companies—that, and little else.
Thus emboldened with the finest public relations that money could buy, the new tranquilizer makers went after their middle-class target groups with a passion. And the passion paid off.

By 1975, Valium (or diazepam) had achieved such widespread acceptance that 61 million prescriptions were written in the United States alone, and worldwide consumption totaled in the uncounted billions. Diazepam’s formula proved so popular, even, that chemists in the Soviet Union and China pirated it—presumably to calm revolutionary, anti-imperialist anxiety.

Today, Valium and the other BZD’s are still mainstays in the chemical “war on anxiety.” And although their numbers have fallen in recent years—total annual prescription sales for diazepam slipped to 10.7 million by 1999, accounting for a mere 15 percent of the total U.S. tranquilizer market of 70 million prescriptions—BZD’s as a group continue as one of the most widely-prescribed class of psychoactive drugs in the world and look to stay that way for a long time to come.

But they’re not as popular as they once were—and for a few dozen very good reasons.

For one thing (and their early advertising to the contrary), they are addictive. According to the U.S. Food and Drug Administration, the number of current benzodiazepine addicts adds up to at least six figures, and approximately 1.5 million current users have taken the drugs longer than the maximum period of time (four months) for which they’re recommended.

Add in the fact that some of these users have been using the drugs much longer than the maximum recommended time—some, in fact, don’t know how they’d live without their little yellow or blue or grey pill three or four (or, in some cases, eight or ten or twenty) times a day, and factor in the 60,000 or so hospital emergency room visits the drugs figure into each year, and you begin to get an idea of why doctors—and a good many patients—are much more cautious about BZD’s today than they once were.

But it’s not as though no one’s taking BZD’s any more. As we mentioned a moment ago, the drugs are still among the most widely-prescribed psychoactive drugs in the world, and look to continue to be for a long time. But to understand why, exactly, we need to look more closely at the pharmacological actions—and the psychological effects—of these drugs, the benzodiazepines.
In spite of the intense interest the benzodiazepines have generated over the past few decades, no one’s really sure exactly *how* the drugs go about the business of turning down nervousness and jitters. But we do know *what* they do, and where they do it.

Most researchers today believe the drugs act in the brain’s thalamus, hypothalamus, and limbic system, the ring of structures beneath the cerebral cortex that forms the so-called “emotional center” of the brain.

Here, the BZD’s function as pharmacological “keys” that turn the locks of the body’s own internal relaxation system.

What that system is, exactly, is still unknown, but researchers think it involves the new class of brain chemicals (known as neuropeptides) that regulate the body’s response to pain and stress.

By interacting with these built-in electrochemical relaxation circuits, BZD’s do the job of triggering emotional tranquilization—and the physical release of muscular tension—about as well as the job can be done.

So far, so good.

But in getting *that* job done, they do a lot of other little jobs on body systems that *don’t* really need to be done—like producing drowsiness, fatigue, and impaired cognition, for example—and it’s here that the first of a range of BZD-inspired problems begin to show up.
In fact, a complete list of unwelcome side effects reported with benzodiazepines reads like a shopping list of characteristics nobody really wants: uncoordination, lethargy, decreased motivation, weight gain, fatigue, sleepiness, impaired cognitive functioning and memory, emotional blunting (even depression or hostility), vertigo, blurred or double vision, decreased sex drive, nausea, constipation, and dry mouth.

And if you think nervousness is a problem, wait till you have the side effects of tranquilization in your life—that’s when you really begin to have something to worry about.

And while not everyone reports all—or necessarily even most of—the side effects listed above, a majority report some of them, especially tiredness and fatigue.

Other, less-frequently-reported effects of the benzodiazepines should also be mentioned. Occasional side effects include sleep disturbances and nightmares, even occasional cardiovascular irregularities—increased heart rate, decreased blood pressure, flushing, and headache—that nobody wants, either, and which can become (or contribute to) major health problems.

Why do the BZD’s cause such a wide range of side effects?
No one really knows the answer to that question, either.

But it is known that certain of the effects of benzodiazepines are dose-related, which means that smaller doses tend to produce fewer side effects while heavier doses (and longer-term dosing) produce more.

Another problem with long-term use is tolerance, the need to take increasing amounts of a drug to produce the same effects.

What tolerance means to a BZD user is that the dose that makes you less nervous during week 1 is not necessarily going to be the same dose that makes you less nervous in week 17. You simply become used to the effects.

And while this can be a good thing (like when users become immune to certain depressant effects of the drugs—drowsiness or lethargy, for example), it can be a bad thing, too—especially when tolerant users increase their dose (sometimes to dangerous levels) to achieve the same effects.

And tolerance doesn’t stop there. Among regular users, another form of tolerance, called cross-tolerance, also develops, which means that a BZD user automatically becomes tolerant to the effects of other CNS depressant drugs. In other words, a person strung out on Valium may need to take dangerously high doses of other depressant drugs to produce their intended effects.

On top of all the other drawbacks we’ve mentioned, the benzodiazepines seem to simply hit certain people harder than others.

Older people, particularly, are more likely to experience side effects, even be judged “senile” as a result of benzodiazepine therapy. Children, too, sometimes experience a disproportionate number of adverse reactions to BZD’s, and for this reason (among others), benzodiazepines are not recommended for use with very young people.
One of Valium’s metabolites, desmethyldiazepam, remains active for up to five days, while another, oxazepam, is so effective all by itself that it’s marketed, under the trade name Serax, by another manufacturer.

Classifications, Indications & Et Ceterations

According to most investigators (including the British Committee on the Review of Medicines) there are no important differences among the benzodiazepines, in spite of the fact that BZD’s are sometimes prescribed for different purposes. All BZD’s are classified medically as anxiolytic (or anxiety-reducing) drugs, except for Dalmane and Restoril, which are usually prescribed for their sedative-hypnotic (or sleep-producing) properties.

Even though there are no important differences in their effects, the BZD’s are often lumped pharmacologically into one of two classes, depending on how long they produce their effects in the body.

Long-acting BZD’s (examples include Valium, Centrax, Dalmane, and Tranxene) produce their effects over a longer period of time than do the short-acting benzodiazepines (like Ativan, Serax, and Restoril). But that doesn’t mean the long-acting drugs go to work slowly—far from it. In fact, just the opposite is true.

That’s because the drugs are absorbed at different rates, depending on the precise configuration of their chemical structure. Valium is among the fastest BZD’s (achieving peak blood levels in about an hour), while Serax is the slowest, needing about three hours to produce maximum blood concentrations—and maximum effects.

Benzodiazepines also vary widely in the length of time they remain in the body—and continue to produce effects.

Some, like Valium, have a long half-life and produce breakdown products (called metabolites) that are themselves psychoactive, and which can remain active for several days. (One of Valium’s metabolites, desmethyldiazepam, remains active for up to five days, while another, oxazepam, is so effective all by itself that it’s marketed, under the trade name Serax, by another manufacturer.)

The short-acting BZD’s—Serax, for example have a much shorter half-life, generally produce no psychoactive metabolites, and are eliminated from the body in as little as one day.

What the longer half-lives of the long-acting BZD’s may mean is still mostly unknown. It’s difficult to track all the effects of metabolites in the body, for one thing. For another, the longer-range effects of the metabolites often happen on top of (and are modified by) the actions of the latest daily dose of the drug. What it all adds up to is a symphony of largely uncharted effects in the body and mind—with a chemical as the main conductor.
**Selling Points**

So with all this going against them, what (you may find yourself wondering about this time) has made benzodiazepines so attractive for quite so long?

Well, surprisingly, the drugs *do* have a lot going for them, especially when you stack them up against meprobamate and the barbiturates.

For one thing, BZD’s usually have little effect, at therapeutic doses, on respiration and heart rate, which represents a very significant benefit, at least for overdose victims. Since the drugs are often prescribed to tense (or otherwise unhappy) people, and since suicide tends to be tried most often by the emotionally-troubled, the benzodiazepines’ wide margin of safety has been a main selling point since they were introduced.

In addition, the drugs are effective at low dosage levels for a variety of applications, as anti-convulsants and muscle relaxants as well as anxiety-stoppers, and this hasn’t really escaped anyone’s attention, either—especially given the milder side effects (and fewer side effects) associated with the drugs and contrasted with meprobamate and the barbiturates.

Finally, there’s this matter of addiction. The benzodiazepines *can* produce a true addiction, one having both physical and psychological components, but the severity of the addiction tends to be less than that produced by Miltown or the barbiturates.

This doesn’t mean kicking a Valium or Ativan habit is easy (it isn’t), but getting straight following a long-term BZD habit tends to be a good deal less life-threatening (if not any less emotionally-traumatic) than does withdrawal from Miltown or most other depressants.

But no matter how you slice it, it’s also not fun.
The Downside, Up Close

**Overdose: An Overview**

Regardless of their wide safety margin, benzodiazepines still manage to figure into a large number of overdoses every year, OD’s of both the accidental and deliberate variety.

However, OD’s are rarely fatal when BZD’s are used alone. According to the U.S. Department of Health and Human Services’ Drug Abuse Warning Network, of the 17,833 emergency-room admissions in which Xanax was mentioned in 1998, only 229 deaths were Xanax-related, and of these only 2 were caused by use of Xanax alone.

Still, where there’s smoke there’s fire, and many BZD users are often users of other depressant drugs. And it’s in combination with other depressants that BZD’s get really tricky—and sometimes deadly.

That’s because BZD’s produce a synergistic effect in combination with other depressants that adds up to something more than simple arithmetic. In fact, it’s as complex as calculus, even trying to predict the combination effects of BZD’s and other depressants—and a lot more dangerous.

What all this means is that a Valium user who takes a Seconal or a Placidyl to get to sleep may have more to worry about than getting to work on time in the morning. Waking up at all could be a problem—especially when you consider all the metabolites and miscellaneous mischief rattling around in the background.

And it’s not only depressant “drugs” that cause problems. Alcohol can also pose major risks when used in combination with BZD’s.
In fact, in a report on the health effects of benzodiazepines published by the National Academy of Sciences, several deaths linked to BZD alcohol combinations were found to be triggered by non-intoxicating amounts of both substances.

That’s not an overdose, that’s simple synergism—and a deadly one, at that.

That’s also why it’s important not to play mix-n-match with BZD’s and all other psychoactive drugs. Because sometimes when your luck runs out, it runs all the way out—and playing chemical connoisseur can make it run out for good.

**Everyday Dangers, Part I**

Still, we should make clear that the dangers cited above clearly don’t apply to everyone taking benzodiazepines. Three hundred and forty deaths do not a killer drug make nor do the seven people who died with a beer in their hand and a Valium in their bloodstream constitute an epidemic. Nevertheless, Valium and the other benzodiazepines do represent a pretty serious danger to people—and not just to the people taking them.

That’s because it’s not just fatal overdoses that define a drug’s “abuse potential.” It’s also the kinds of problems that everyday people live through every day, and there happen to be a lot of those tied to the benzodiazepines, too.

Take impaired mental and physical performance, for example. The early optimism of the drug companies notwithstanding, the BZD’s do interfere with higher-level intellectual functioning and they do slow reaction time and impede coordination—all valuable skills to hang onto, especially at school or work or when you’re behind the wheel of a car. One researcher estimates that as many as 80 percent of Valium users have some degree of impaired intellectual functioning at doses of 5–40 mg a day, which happens to fit well within the therapeutic dosage range suggested by the manufacturer. This impaired functioning can take the form of decreased attention and concentration and can show up, particularly, in the form of a diminished capacity to retain new information.

Driving ability has also been clearly shown to suffer. In one study involving Ativan, drivers exhibited a decreased ability to handle and brake their cars properly following use of only 3 mg a day for three days. Similar impaired performance would be expected with other benzodiazepines, and could even be a factor hours or days after use, given the long half-life of many BZD’s in the body.

And it’s not just the person taking the tranquilizers who happens to be affected.

Some researchers fear that BZD’s may cause birth defects if taken during pregnancy, and early studies back them up, showing a higher-than-normal incidence of cleft lip and palate among rat embryos exposed in utero. And even though there’s far from conclusive proof at present
about a link between the BZD’s and birth defects, the Food and Drug Administration advises against use of the drugs during pregnancy, particularly during the first trimester.

**Everyday Dangers, Part II**

But perhaps the most common, and sometimes the most lasting, dangers of benzodiazepines happen below the surface and never leave a mark—at least not a physical mark—on anyone.

These dangers include the subtle personality changes that can occur in users following extended benzodiazepine “therapy”—a course of treatment seldom therapeutic for anyone, except for the doctor, who gets to take the afternoon off, and for the drug companies, who wind up with bigger profits—and bigger advertising budgets.

And the psychological effects of extended use can be a big problem. That’s because BZD’s plug into one of the most powerful drives that we all carry around inside ourselves: The desire to not be afraid.

They plug into this drive so well, in fact, that they can easily reinforce a kind of “learned helplessness” on the part of the user that, often as not, powered the nervousness or insomnia or fear to begin with. As a result, a BZD user can forget to take on the important challenges of life and retreat into a warm, fuzzy zone of artificial tranquility.

And even though that tranquility zone may be warm and fuzzy, it’s also artificial as can be, and temporary, at that.

And what often gets lost in the process are users’ perceptions of themselves as competent, effective people—and powerful forces in their own lives.

The temptation for many BZD users is to see themselves simply as psychological “cases”—walking, talking bags of skin and blood and symptoms—that do little more for themselves than swallow Tranxene or Librium or Serax and wait for things to get better.

And perhaps this is at the core of what’s really dangerous about the benzodiazepines—the mistaken belief on the part of users (and sometimes even doctors) that the drugs actually do something other than disguise the symptoms of emotional problems. All too often, BZD’s are prescribed instead of (not in addition to) therapy, and they’re taken in the hope that they can do something to clear up underlying problems.

They can’t. Benzodiazepines aren’t medicine. They’re drugs. And all they can do is do what they do very well: disguise symptoms.

And that’s the rest of the problem.
Because sometimes they disguise symptoms so well that you almost need a trained archaeologist, a detective, and a social worker to figure out what the problems were to begin with—before they got covered over with months or years or decades of emotional dry ice and pharmacological “tranquility.”

And that’s why getting strung out—and getting unstrung, later—can be such a difficult, long, hard time.

## Strung & Unstrung: Addiction & Withdrawal

And as if learning to be helpless isn’t bad enough, consider what happens when a long-term BZD user discovers they’re addicted to their “medicine.”

First of all, they might come to this realization when they discover that their problems

<table>
<thead>
<tr>
<th>Trade Name</th>
<th>Generic Name</th>
<th>Dosage Strengths</th>
<th>Recommended Daily Dose</th>
<th>Abuse Potential</th>
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</thead>
<tbody>
<tr>
<td>Miltown</td>
<td>meprobamate</td>
<td>400/600 mg</td>
<td>1200-1600 mg</td>
<td>High</td>
</tr>
<tr>
<td>Equanil</td>
<td>meprobamate</td>
<td>200/400 mg</td>
<td>600-1200 mg</td>
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<td>diazepam</td>
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<tr>
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<td>temazepam</td>
<td>7.5/15/30 mg</td>
<td>7.5-30 mg</td>
<td>Moderate</td>
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</tbody>
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The psychological effects of extended use can be a big problem. That’s because BZD’s plug into one of the most powerful drives that we all carry inside ourselves: The desire to not be afraid.

are back—and look a few times scarier than before.

The first real notice they get along the way may come with the increasingly distressful thought that the drugs don’t work anymore—or at least not as well as they used to, which is cause for serious concern, either way.

At this point they might increase dosage and that might work for a while, but only for a while, and before very long the same unpleasant scared-to-death feeling that says Something’s Wrong Here descends again, this time with considerably more force. And here they either talk their situation over with their doctor or tough it out alone, and one of two things happens: The situation gets better. Or it gets worse.

If it gets better, it gets better because the person faces up to the problem and does something to make it better. If it gets worse, it gets worse because they don’t.

Either way, the process of kicking a long-time BZD habit is tough, agonizing even. Withdrawal symptoms can include anxiety, convulsions, hallucinations, insomnia, headache, depression, transient psychosis, muscle pain and twitching, restlessness, and a general sense that some unnamed and undefined doom or catastrophe is about to happen—a full parade, in short, of the original problems that started the addiction, and then some. Seizures represent a particular danger, and can occur as late as the 12th day of withdrawal.

And it’s important to note that even low doses can cause physical and psychological dependence. One study of 32 people who quit cold turkey after taking an average of only 10 mg of Valium a day (for periods ranging from four months to several years) showed that half experienced withdrawal symptoms, including insomnia, depression, headache, and convulsive seizures.

Another study (this time focusing on 10 Valium users averaging 17 mg a day) reported that all developed withdrawal symptoms. Anxiety, paranoia, and loss of touch with reality predominated. And these people were only averaging 17 mg a day, far below many dosage regimens.

The timetable for the appearance of withdrawal symptoms depends very much on the particular drug a person happens to be strung out on. Symptoms appear much more quickly (sometimes as fast as a single day) with the short-acting BZD’s, like Ativan and Serax, and more slowly with the longer-acting drugs, like Valium and Librium.

In fact, Valium is so slowly eliminated that severe withdrawal symptoms may not show up fully for three to six days.

This isn’t to say that Valium addicts don’t get tense or irritable in the meantime; they do, extremely so. But the full range of problems associated with full-scale withdrawal doesn’t start in earnest until all the psychoactive metabolites of the drug clear out of the
 Withdrawal from the benzodiazepines can be a torturous, life-shattering experience. The withdrawal process is a lengthy one, typically following a bi-phasic (or two-staged) course in which symptoms reach a peak of severity (usually within a week), subside for a while, then come screaming back.

The entire panoply of physiological symptoms usually abates within six weeks, but the psychological scars—the anxiety and dread and “learned helplessness”—can take much longer, even a lifetime, to fully heal.
The Last Word

When the minor tranquilizers were introduced, a good many people (the drug companies, doctors, and patients included) thought that the last word in anxiety control had at last been discovered.

We were wrong.

Because we misunderstood the minor tranquilizers. We underestimated their potential for abuse. And we were just plain wrong about the role that drugs can and should play in helping people come to grips with their lives.

No one’s to blame. But we’re all responsible—then, for making the problem happen; now, for making it go away.

Because there is no magic answer to the problems that plague human beings. (Yes, the problems that plague us now, and the ones that have plagued us since the moment we stepped furtively—and probably fearfully—down from the trees.) The only magic there really is is the magic that happens when people take responsibility for their lives and feelings and go to work on making things better.

And there’s any number of ways to make better the conditions that contribute to the abuse of “minor” tranquilizers. Nerves are only a problem if we say they’re a problem. And helplessness only rules our lives if we let it.
The most exciting discovery that’s come down in the decades since minor tranquilizers were introduced is the understanding that the actions that we take determine our feelings as surely as our feelings determine our thoughts—and the quality of our lives.

**Unlearning Helplessness**

And that’s probably the most exciting discovery that’s come down in the decades since the minor tranquilizers were introduced—the understanding that we are capable and we aren’t helpless, that the actions that we take (even reluctantly) determine the feelings we experience as surely as our feelings determine our thoughts—and the quality of our lives.

Research into the internal body systems that tranquilizers unlock have shown us that activities can change our moods—and diminish our fears. Jogging, aerobics, meditation, even cooking or enjoying a book, can turn on the same relaxation circuits as Valium or Tranxene—more effectively, in fact, and at a much lower price.

So the last word on the minor tranquilizers is simply this: Treat them as drugs, not as medicine. They don’t cure anything. They just buy time and disguise symptoms.

And even though buying time and disguising symptoms can be beneficial to people in times of temporary stress or pain, if you live your life buying time and disguising symptoms, you’ve got a problem. *Another* problem.

If you think you might be addicted to one or another of the minor tranquilizers—or are too dependent on them, however you want to say it—why not get some help?

Because while it is possible to get better all by yourself, it’s also possible—maybe even more possible—to get worse.

We’re not talking about just the possibility of relapse—that’s a factor in the recovery of *anyone* who’s ever been addicted to *anything*—we’re talking about fully resolving the feelings of fear or inadequacy or shame that contributed to the tranquilizer problem to begin with.

Because coming fully back from a tranquilizer addiction doesn’t mean simply learning to not take tranquilizers—it goes without saying that you have to give up tranquilizers if you’re addicted and want to stop. *Fully* coming back involves learning to be *yourself* again—the real you, the vulnerable you, the happy you, the sad you, the *you* you always wanted to be—and not the bundle of neuroses and frozen feelings and personality quirks and helplessness that Valium or Ativan or some other “minor tranquilizer” helped you to become.

And the best place we know of to discover that *you* is in other people—in learning from them, caring about them, and ultimately learning to see yourself in them, and letting them see themselves in you.
That’s the unpaid political announcement in all this. If you have a problem, get help. And if you don’t have a problem, remember some of the points we’ve made and don’t let one get started.

Because once you’re dependent on them, living without tranquilizers is tough. And it can be uncomfortable.

And coming back—all the way back—can take a lifetime.

But when you stop and think about it (and you should stop and think about it if you think you might be dependent on one of the minor tranquilizers), what else are lifetimes for?