

BENZODIAZEPINE DEPENDENCY AND WITHDRAWAL

Frequently Asked Questions (FAQ) file

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1. WHAT IS A BENZODIAZEPINE?

Benzodiazepines are a large class of commonly prescribed tranquillisers, otherwise referred to as central nervous system (CNS) depressants, anxiolytics and sedative-hypnotics. They include alprazolam (Xanax), bromazepam (Lexotan, Lexomil), chlordiazepoxide (Librium, Nova-Pam), clonazepam (Klonopin, Rivotril), clorazepate (Tranxene), diazepam (Valium, D-Pam, Pro-Pam), estazolam (ProSom), flunitrazepam (Rohypnol), flurazepam (Dalmane), halazepam (Paxipam), ketazolam (Anxon), loprazolam (Dormonoc), lorazepam (Ativan), lormetazepam (Noctamid), medazepam (Nobrium), midazolam, (Versed, Hypnovel, Dormicum), nitrazepam (Mogadon, Insoma, Nitrados), oxazepam (Serax, Serapax, Serenid, Benzotran), prazepam (Centrax), quazepam (Doral), temazepam (Restoril, Euhypnos, Normison, Sompam), triazolam (Halcion, Hypam, Tricam). See: [Benzodiazepine Drug Index](#) for links to monograph and drug information sites.

Some lesser known benzodiazepines: brotizolam, camazepam, clotiazepam, cloxazolam, delorazepam, etizolam, fludiazepam, haloxazolam, oxazolam, nimetazepam, nordazepam, pinazepam, tetrazepam, tofisopam. See: [Benzodiazepine Drug Index](#).

All benzodiazepines have five primary effects. They are:

- A. **Hypnotic** (tending to make you sleepy);

- B. **Anxiolytic** (tending to reduce anxiety/produce relaxation);
- C. **Anti-seizure** (tending to reduce the probability of having seizures and convulsions);
- D. **Muscle relaxant** (tending to reduce muscle tension and associated pain);
- E. **Amnesic (amnestic)** (tending to disrupt both long and short term memory).

There may be secondary effects as well. Different benzodiazepines exhibit these primary effects to varying degrees. For example, diazepam (Valium) is a relatively powerful hypnotic (sleep inducer), whereas the more modern benzodiazepines such as alprazolam (Xanax), lorazepam (Ativan), and clonazepam (Klonopin) are less powerful hypnotics, but are very powerful anxiolytics. Do not assume that because one benzodiazepine makes you sleepier than another that this benzodiazepine is more potent than those which do not produce sleepiness to the same degree. Often, the reverse is true.

Benzodiazepines have been referred to as being part of a larger class of drugs known as "minor tranquillisers". As applied to benzodiazepines, this is almost certainly a misnomer, and the label has fallen into relative disuse in the past ten years. However, you may encounter this term from time to time.

Benzodiazepines are most commonly prescribed for anxiety conditions, especially panic disorder (PD) and generalised anxiety disorder (GAD). They are also sometimes prescribed for seizure disorders. Klonopin, for example, is often prescribed for epilepsy. Benzodiazepines are also prescribed for insomnia and other sleep problems, such as restless leg syndrome (RLS). Benzodiazepines are also frequently prescribed as muscle relaxants.

By far the most common benzodiazepines prescribed today are Valium, Xanax, Ativan and Klonopin. Valium (diazepam) is particularly common in the UK. Valium has become less common in the United States over the past 15 years, while Xanax and Klonopin have experienced increased popularity in the United States over this time. In certain Latin American countries, it appears that the drug Lexotan (bromazepam) is very popular.

All benzodiazepines can cause physical dependency, otherwise commonly known as addiction.

2. HOW DO BENZODIAZEPINES AFFECT YOUR BODY?

Benzodiazepines are general central nervous system (CNS) depressants. They are all very similar chemically. All benzodiazepines act by enhancing the actions of a natural brain chemical, GABA (gamma-aminobutyric acid). GABA is a neurotransmitter, an agent which transmits messages from one brain cell (neuron) to another. The message that GABA transmits is an inhibitory one: it tells the neurons that it contacts to slow down or stop firing. Since about 40% of the millions of neurons all over the brain respond to GABA, this means that GABA has a general quietening influence on the brain: it is in some ways the body's natural hypnotic and tranquilliser. This natural action of GABA is augmented by benzodiazepines which thus exert an extra (often excessive) inhibitory influence on neurons.

The way in which GABA sends its inhibitory message is by a clever electronic device. Its reaction with special sites (GABA-receptors) on the outside of the receiving neuron opens a channel, allowing negatively charged particles (chloride ions) to pass to the inside of the neuron. These negative ions "supercharge" the neuron making it less responsive to other neurotransmitters which would normally excite it. Benzodiazepines also react at their own special sites (benzodiazepine receptors), situated actually on the GABA-receptor. Combination of a benzodiazepine at this site acts as a booster to the actions of GABA, allowing more chloride ions to enter the neuron, making it

even more resistant to excitation. Various subtypes of benzodiazepine receptors have slightly different actions. One subtype (alpha 1) is responsible for sedative effects, another (alpha 2) for anti-anxiety effects, and both alpha 1 and alpha 2, as well as alpha 5, for anticonvulsant effects. All benzodiazepines combine, to a greater or lesser extent, with all these subtypes and all enhance GABA activity in the brain.

As a consequence of the enhancement of GABA's inhibitory activity caused by benzodiazepines, the brain's output of excitatory neurotransmitters, including norepinephrine (noradrenaline), serotonin, acetyl choline and dopamine, is reduced. Such excitatory neurotransmitters are necessary for normal alertness, memory, muscle tone and co-ordination, emotional responses, endocrine gland secretions, heart rate and blood pressure control and a host of other functions, all of which may be impaired by benzodiazepines. Other benzodiazepine receptors, not linked to GABA, are present in the kidney, colon, blood cells and adrenal cortex and these may also be affected by some benzodiazepines. These direct and indirect actions are responsible for the well-known adverse effects of dosage with benzodiazepines.

Contrary to a popular misconception, benzodiazepines do not actually increase the organic synthesis of GABA. As stated, they enhance the action of existing GABA. Actually, benzodiazepines can, over time, decrease the synthesis of GABA in certain areas of the brain. This is one of numerous theories attempting to explain the occurrence of "paradoxical" symptoms (see below).

3. HOW QUICKLY CAN I BECOME ADDICTED TO A BENZODIAZEPINE?

The time it takes to form a physical dependency on a given benzodiazepine varies widely. The following variables may play a role: the size of your dose, the regularity with which you consume your dose, and most importantly, your personal body chemistry. People have been known to form dependencies in as little as 14 days of regular use at therapeutic dose levels. Your probability of forming some degree of dependency is significant, probably at least 50%, by the time you have been using them daily for 6 months. After a year of continuous use, it is highly likely that you have formed a dependency. It is unclear whether certain benzodiazepines are associated with a more rapid onset of dependency than others.

4. WHAT ARE THE DOSE EQUIVALENCIES AMONGST VARIOUS BENZODIAZEPINES?

There are no clearly definitive equivalencies for various benzodiazepines. This author has personally seen at least a dozen different benzodiazepine equivalency charts and no two are alike. The table below has been chosen because it reflects the clinical experience of [Professor Ashton](#) in having helped over 300 people to withdraw from benzodiazepines by use of a Valium substitution method (see below).

Alprazolam
Bromazepam
Chlordiazepoxide
Clonazepam
Clorazepate
Diazepam
Estazolam
Flunitrazepam
Flurazepam
Halazepam
Ketazolam
Lorazepam

Lormetazepam
Nitrazepam
Oxazepam
Prazepam
Quazepam
Temazepam
Triazolam

Thus, 1mg of alprazolam (Xanax) or clonazepam (Klonopin) is the equivalent of 20mg of Valium; 1mg of lorazepam (Ativan) is the equivalent of 10mg of Valium.

These dose equivalencies are important for a number of reasons, the most significant of which is the issue of switching to a different benzodiazepine such as Valium prior to tapering (see below). These figures are taken from [Professor Ashton's Manual](#) (see below) and several other sources. See for example the [Benzo Equivalence Table](#) on this site.

You may find a doctor who will want to switch you from Xanax to Valium at a 1mg to 10mg equivalency. This is a recipe for a very difficult cross-over. Whatever the precise therapeutic dose equivalencies, the above equivalencies should be observed in switching from one benzodiazepine to another for purposes of withdrawal (see below).

5. WHAT IS A "HALF-LIFE", AND HOW IS THE CONCEPT IMPORTANT TO BENZODIAZEPINE DEPENDENCE?

Half-life is a numerical expression of how long it takes for a drug to leave your body. Technically, the "half-life," expressed as a range, is the time it takes for half of the amount consumed to be eliminated from your body, and so on. There is some controversy as to how long benzodiazepines may actually remain in your body after you have discontinued them entirely. Benzodiazepines are fat soluble and can persist in fatty tissues. However, benzodiazepines no longer show up in blood screenings beyond 30 days after discontinuance. This either means they are totally eliminated by that time, or that they persist in amounts too small to have any long term effect.

The importance of half-life is that a longer half-life generally makes for an easier withdrawal because your blood levels remain relatively constant, as opposed to the up and down roller coaster that you experience with short half life benzodiazepines. Furthermore, longer half-life benzodiazepines require less dose micro-management. For example, Valium can be taken once every 12 hours, or in some cases, once every 24 hours. Xanax, however, must be taken once every 4-6 hours to maintain constant blood levels. This is a practical impossibility for some people.

The following is a list of benzodiazepines with their corresponding half-lives, expressed as a range in hours:

Alprazolam
Bromazepam
Chlordiazepoxide 24 - 100
Clonazepam 19 - 60
Clorazepate 1.3 - 120
Diazepam 30 - 200
Estazolam
Flunitrazepam 18 - 26
Flurazepam 40 - 250
Halazepam 30 - 96

Ketazolam	30 - 200
Lorazepam	
Lormetazepam	10 - 12
Nitrazepam	15 - 48
Oxazepam	
Prazepam	30 - 100
Quazepam	39 - 120
Temazepam	
Triazolam	1.5 - 5

There is a misconception that longer half-life benzodiazepines prolong the withdrawal recovery process by remaining in your body tissues for longer. However, there is no evidence that longer half-life benzodiazepines represent any greater risk for Protracted Benzodiazepine Withdrawal Syndrome (see below) than shorter half-life benzodiazepines. This method of using a longer half-life equivalent is well understood in addiction medicine circles, and is employed with other classes of drugs as well. For example, people who are experiencing withdrawal symptoms from an antidepressant such as Paxil (Seroxit, paroxetine) are often given Prozac (fluoxetine) as a substitute for purposes of withdrawal, because Prozac has a longer half-life. Perhaps a more typical example is the use of the drug Methadone in heroin detoxification, which is employed in part because of its relatively long half-life.

6. WHAT DOES "TOLERANCE" MEAN?

Tolerance is the process by which the receptors in your brain become habituated to the action of a drug. When tolerance is reached, more of the drug is required to achieve the same effect. With benzodiazepines, and probably with many other classes of drugs as well, tolerance is virtually always associated with some degree of physical dependence. If you find that you are experiencing tolerance, this is a clear warning sign that you may have formed a dependency.

7. IF MY DOCTOR HAS PRESCRIBED A BENZODIAZEPINE AND INSTRUCTED ME TO TAKE IT FOR A MEDICAL AND/OR PSYCHOLOGICAL REASON, IS THERE ANY REASON I SHOULD DISREGARD MY DOCTOR'S ADVICE AND DISCONTINUE THE BENZODIAZEPINE?

Yes, there may be. Unfortunately, there are many well-intended physicians who simply do not understand the seriousness of long-term benzodiazepine use.

Regular benzodiazepine use almost always causes some degree of deterioration in cognitive functioning, which progresses with continued use.

Long term benzodiazepine use also causes lethargy and decreased energy levels that result in impairment in work productivity and disinclination towards exercise.

Furthermore, benzodiazepines, and all other classes of sedatives, frequently cause and/or worsen depression. This is why people are often given antidepressants after being given a benzodiazepine for anxiety. Antidepressants have their own complications and potential for dependency (see below).

Benzodiazepines can also cause what is sometimes referred to as a "emotional anaesthesia", or "emotional blunting," in which the user's ability to experience powerful emotions is impaired. This has been described as "the inability to feel pleasure or pain" in the medical literature (e.g. Ashton C H, Toxicity and Adverse Consequences of Benzodiazepine Use, 1995). Long-term benzodiazepine users often describe their experience as "sleepwalking through life".

Benzodiazepine use can also cause what are referred to as "paradoxical" symptoms in a minority of

users. Paradoxical symptoms are contrary to the intended therapeutic purpose, including outbursts of rage, increased anxiety, and sleeplessness. Paradoxical symptoms can be caused by the drug's interaction with the psychological makeup of the user, or may be a biological reaction to use of the drug that people sometimes refer to as "toxicity". Paradoxical symptoms are sometimes mistaken for withdrawal, and vice versa. See: [Benzodiazepines: Paradoxical Reactions & Long-Term Side-Effects](#). For further discussion on the long-term effects of benzodiazepines see: [Benzodiazepines and their effects](#) by Professor Ian Hindmarch.

The above effects occur to varying degrees, depending on the individual. Some individuals may not experience many of the effects at all. However, one effect is common to virtually all users: a physical dependency will eventually form. Benzodiazepine dependency is particularly serious as the withdrawal syndrome (see below) can be extremely difficult and protracted. Furthermore, the development of tolerance often makes long term use non-feasible, and withdrawal becomes a necessary eventuality.

Benzodiazepines are often misprescribed for conditions to which they are not appropriate, such as depression. Furthermore, they are often prescribed for anxiety conditions for which the individual could be treated effectively with other therapeutic techniques.

There are, however, legitimate therapeutic benefits for benzodiazepines, particularly if they are used in the short term (no more than 2 weeks of continuous use), or for situational anxiety/panic (for example, one dose of Xanax per month as the need arises.) Furthermore, many users of benzodiazepines, including some who have used them regularly for more than a year, are able to discontinue them with little difficulty.

Nothing in this FAQ is to be construed as advising any individual to ignore the advice of his or her physician. Decisions regarding the use or discontinuation of any benzodiazepine should be made in consultation with a physician. However, in this area you must also undertake considerable self-education in addition to listening carefully to your doctor's advice. Fortunately, there are many available resources to accomplish that (see below). Where a doctor does not appear to be up to date with current medical literature regarding benzodiazepine dependency and the withdrawal syndrome, seeking a second and third medical opinion can be a desirable option.

8. WHAT IS THE BENZODIAZEPINE WITHDRAWAL SYNDROME?

The Benzodiazepine Withdrawal Syndrome is believed to be caused by a dampening of the action of GABA as neuroadaptivity causes GABA to become dependent on stimulation from the benzodiazepine to initiate its primary action. In other words, when you have become dependent upon a benzodiazepine, your GABA is unable to perform its natural action without the presence of the benzodiazepine. This results in a wide variety of over-activity in different areas of your brain, causing a vast and diffuse array of symptoms. These symptoms are believed to be various manifestations of neurological over-excitation as the cells in your brain become especially sensitive to the action of excitatory neurotransmitters. The most extreme manifestation of this over-excitation is a seizure event.

The Benzodiazepine Withdrawal Syndrome is noted both for its relative severity and, in some cases, its lengthy duration, as compared to withdrawal from other classes of drugs.

Withdrawal either occurs through the development of tolerance without an attendant increase in dose, or through a decrease in dosage below your "tolerance point". Your tolerance point is the dose point below which the functioning of your receptors becomes impaired due to a deficiency in stimulation from the drug. Your tolerance point may be lower than your actual dosage, such that you can sometimes cut your dose by some amount without experiencing withdrawal symptoms.

Generally, a drug's withdrawal syndrome is the mirror of its primary effects. Thus, for

benzodiazepines, you can expect sleeplessness (the mirror of its hypnotic effect), anxiety (the mirror of its anxiolytic effect), muscle tension/pain (the mirror of its muscle relaxant effect), and seizures in rare cases (the mirror of its anti-seizure effect). The only exception is that the Benzodiazepine Withdrawal Syndrome does not "mirror" the amnesic effect. On the contrary the Withdrawal Syndrome often results in increased impairment of memory and cognitive functioning. However, in all cases, after the withdrawal is complete and in total remission, cognitive functioning will gradually return to the level that it was at before you began using the drug.

For a more complete list of symptoms, see below.

9. WHAT ARE THE SYMPTOMS OF BENZODIAZEPINE WITHDRAWAL?

The following is a list of symptoms. As they have been reported by enough individuals they are statistically likely to be legitimate withdrawal symptoms. Keep in mind that there are a wide variety of other symptoms that have been reported that may be legitimate withdrawal symptoms as well, but have not been reported by enough individuals to be statistically significant. The determination of statistical significance is not based on hard data, but on the observations of this author in reading through thousands of posts from people in withdrawal, as well as several books and articles on the subject.

This list is broken down into psychological and physical symptoms. The double asterisk (**) indicates symptoms that occur to some degree or another, at one time or another, in virtually every person experiencing benzodiazepine withdrawal. Single asterisk (*) are symptoms that are common, and occur in most people. Others are symptoms that are common enough to be verifiable withdrawal symptoms, but probably occur in a minority of cases.

Psychological symptoms: anxiety** (including panic attacks), depression**, insomnia*, derealisation/depersonalisation* (feelings of unreality/detachment from self), obsessive negative thoughts*, (particularly of a violent and/or sexual nature) rapid mood changes* (especially including outbursts of anger or rage), phobias* (especially agoraphobia and fear of insanity), dysphoria* (loss of capacity to enjoy life; possibility a combination of depression, anxiety, and derealisation/depersonalisation), impairment of cognitive functioning*, suicidal thoughts*, nightmares, hallucinations, psychosis, pill cravings. Note that it is far more common to fear psychosis than it is to actually experience it.

Physical Symptoms: abnormal sensitivity to sensory stimuli* (such as loud noise or bright light), muscle tension/pain**, joint pain*, tinnitus*, headaches*, shaking/tremors*, blurred vision* (and other complications related to the eyes), itchy skin* (including formication, ie sensations of insects crawling on skin), gastrointestinal discomfort*, electric shock sensations*, paraesthesiae* (numbness and pins and needles, especially in extremities), fatigue*, weakness in the extremities* (particularly the legs), feelings of inner vibrations* (especially in the torso), sweating, fluctuations in body temperature, difficulty in swallowing, loss of appetite, "flu like" symptoms, fasciculations (muscle twitching), metallic taste in mouth, nausea, extreme thirst (including dry mouth and increased frequency of urination), sexual dysfunction (or occasional increase in libido), heart palpitations, dizziness, vertigo, breathlessness.

Here, I have cited only the most commonly reported withdrawal symptoms. For more comprehensive lists of withdrawal symptoms see the [Symptoms Index](#) on this site.

10. I AM EXPERIENCING ONE OR MORE OF THE SYMPTOMS LISTED ABOVE, BUT I HAVE NOT BEGUN TAPERING MY BENZODIAZEPINE. IS IT POSSIBLE THAT THE SYMPTOMS ARE NOT RELATED TO BENZODIAZEPINE USE, OR COULD I ALREADY HAVE STARTED WITHDRAWAL WITHOUT EVEN TAPERING?

You are probably experiencing tolerance withdrawal. When you reach tolerance, your brain needs more of the drug to stimulate the activity of GABA, and you begin to experience withdrawal symptoms. Some people find that no matter how much they increase their dose, they are unable to obtain complete relief. This may be caused by a fast, upward tolerance spiral, or by toxicity (see above). Complete withdrawal is necessary where this occurs.

Some people mistakenly form a belief that the drug has stopped working, and no longer alleviates their anxiety disorder when in fact they are experiencing anxiety brought on by tolerance withdrawal. Unfortunately, physicians will usually reinforce this misperception and advise you to increase your dose as a result or prescribe an additional benzodiazepine and/or antidepressants.

11. WHAT FACTORS DETERMINE HOW SEVERE MY WITHDRAWAL WILL BE?

It is impossible to predict how severe your particular withdrawal will be, or which of the 30 or so common symptoms you are likely to experience. Duration of use, dosage, type of benzodiazepine, age, your personal body chemistry, and your method of withdrawal may all play a part. It is unclear which, if any, of these factors relate to the duration of your withdrawal syndrome as opposed to the severity.

There is some evidence that the newer, high potency benzodiazepines, especially Xanax, Klonopin, and Ativan may be associated with more severe withdrawal syndromes. However, this evidence remains anecdotal.

Bear in mind that there is wide variation in people's withdrawal experiences. For example, one person may take a low dose of a benzodiazepine for a short period of time, and suffer a very severe withdrawal. Another individual may take a high dose of the same drug for much longer, and experience very manageable withdrawal symptoms. Furthermore, an individual Valium user may have a harder time than an individual Xanax user.

12. IF I DISCONTINUE MY BENZODIAZEPINE, WON'T THE UNDERLYING CONDITION THAT MY DOCTOR PRESCRIBED THE BENZODIAZEPINE FOR RETURN?

It may or may not. It depends on what your underlying problem was, and what post-withdrawal measures you take to manage the condition, if necessary. Sometimes, the underlying problem is simply "gone" by the time you have withdrawn from a benzodiazepine. Many physical and psychological conditions are a transitory response to a temporary condition in your life, such as a traumatic event. Often, people take habit forming drugs such as benzodiazepines to alleviate the symptoms of these transitory conditions, and continue taking them long after the condition would have gone away on its own.

Other conditions are less transitory, such as chronic, long term panic disorder (PD). However, it is important to bear in mind that there are other treatments for these conditions, both of a pharmacological and a non-pharmacological nature. Anxiety and stress can be managed in a variety of different ways that are not as harmful to your body as benzodiazepines.

Often, when people complete their benzodiazepine withdrawal, they find an emergence of an underlying psychological problem that was masked by the benzodiazepine use for many years. People also often feel the resurfacing of emotions that may have been suppressed for a long time. Thus, there is sometimes a period of difficult adjustment even after the withdrawal symptoms subside. However, people often find the end result of this period of adjustment to be very rewarding.

13. I HAVE DECIDED TO DISCONTINUE THE USE OF MY BENZODIAZEPINE. WHAT ARE THE FIRST STEPS I SHOULD TAKE?

Your first step is to educate yourself. That means reading this FAQ and seeking out many of the resources referred to herein. Your second step is to see a doctor who understands the seriousness of benzodiazepine dependency, and be as well armed with information as possible going into that visit. Your third step is to approach your withdrawal with a clear plan in mind, to set goals for yourself, and to begin the withdrawal process with confidence. Do not listen to horror stories from others who have had unusually bad experiences in withdrawal. Everyone's experience is different, and many people are able to withdraw with very manageable symptoms.

14. IS COLD TURKEY (ABRUPT, TOTAL DISCONTINUANCE OF THE DRUG) AN ACCEPTABLE METHOD OF WITHDRAWING FROM A BENZODIAZEPINE?

No. There is nearly complete uniformity of opinion both in the medical profession and in the benzodiazepine recovery community that cold turkey is a dangerous and unacceptable method of withdrawal. Cold turkey withdrawal may cause seizures, and is also associated with a higher probability of withdrawal psychosis. Seizures are almost non-existent in those employing a taper method, with the limited exception of people who have taken a benzodiazepine for a seizure disorder. Furthermore, psychosis is rare in those who taper their benzodiazepine slowly.

There is a misconception that cold turkey withdrawal, though it may cause more severe symptoms, will bring about a faster remission of symptoms. This is based on the idea that a slow taper "prolongs the agony of withdrawal." This notion is erroneous. In fact, there is some anecdotal evidence that cold turkey withdrawal may lengthen the course of the withdrawal syndrome, and may even cause the Protracted Withdrawal Syndrome (see below).

15. OK, IF I AM GOING TO TAPER MY BENZODIAZEPINE, HOW SHOULD I STRUCTURE THE TAPER?

There are two very general rules, and one exception to the rule that is discussed below. The first rule is, the slower the taper, the milder the withdrawal symptoms. The second rule is, the smaller the cuts you are able to make, the milder the withdrawal symptoms. These are related, though separate, issues.

For example, you might decide to cut your dose by 1/4mg every month, or alternatively, cut your dose by 1/8mg every two weeks. Either way, you are tapering at the same rate. In this author's opinion, the second option is a far superior method of tapering. Any cut is a shock to your brain and body. Cold turkey is the largest cut of all and the shock caused by such an abrupt withdrawal is so severe that even after resumption of your drug at the previous dose, it may take weeks or months to "stabilise", and in some cases, you may never stabilise from a cold turkey withdrawal until after you have completed your taper.

This logic further extends to the size of your cuts. The smaller the cuts you make, the less the shock to your system, and the less pronounced the withdrawal symptoms triggered by the cut. It is not recommended that any individual cut represent more than 10% of your total dose at a given time. Thus, it is preferable to make smaller and smaller cuts as you go, though this can be very difficult as you approach the end of your taper.

Always make the smallest cuts possible. That means taking the smallest dose size available and splitting it into 4 pieces, which can be done easily with or without a razor blade or pill-cutter. For example, with Valium, you can split the smallest (2mg) tablet into 4x0.5 mg pieces. With Klonopin, you can split the smallest (0.5mg) tablet into 4 pieces of 0.125 or 1/8th mg. If you are on a high dose and feel that you are able to taper rapidly at first because you are above your tolerance point (see above), space your cuts close together (no closer than 1 cut every 3 days), but make the smallest cuts possible. If or when you begin to feel withdrawal symptoms, you can start to space your cuts further apart (up to about 4 weeks). Generally, the higher potency benzodiazepines such as Xanax, Klonopin, and Ativan force you to make larger cuts (see below), and therefore you must

space your cuts at least 3 weeks apart toward the end of your taper. Of course, even where you are able to make very small cuts with lower potency benzodiazepines such as Valium, you can make these small cuts relatively far apart if this is your most comfortable method of withdrawal.

There is a method of tapering that involves mixing the drug with either water or a dry carrier like sugar to produce a "titration" which allows for very minute reductions, such as 1% every other day. This method has been employed with success by some people. In England, doctors have created a liquid titration kit to assist users in withdrawing comfortably. There is some promise that this method can substantially diminish the withdrawal syndrome. Unfortunately, these titration kits are not available in North America.

If you are unable to use a titration method, you may wish to consider switching to Valium, assuming, of course, that you are not already using that particular benzodiazepine (see below). This method has been used with success, particularly in England, for many years. Professor Heather Ashton has detailed taper schedules available that are based on switching to Valium (see below).

There seems to be a limited exception to the slow taper rule where people find that they have a "toxic" reaction to taking the benzodiazepine (see "paradoxical symptoms" above). There is a tricky distinction between toxicity and withdrawal symptoms. The usual way to tell the difference is to try increasing your dose. If the symptoms reduce or stay the same, your symptoms are likely attributable to withdrawal. If your symptoms increase, you may be experiencing toxicity, and should probably consider a faster taper (6 to 8 weeks). However, do not make a hasty decision to taper fast. Make certain that you are experiencing toxicity first. Generally speaking, your symptoms are far more likely to be related to withdrawal than toxicity.

One cause of toxicity may be the taking of more than one psychoactive drug simultaneously. For example, taking a benzodiazepine with an antidepressant and a narcotic or pain killer.

16. SHOULD I SWITCH TO ANOTHER BENZODIAZEPINE SUCH AS VALIUM BEFORE TAPERING?

Keep in mind that some people feel that switching to Valium is not for everyone and many have tapered their drug of dependency and have recovered very well. However, if you are considering this recommended method, there are three reasons that are often cited for switching to Valium for purposes of withdrawal.

First, Valium has a far longer half-life than most other benzodiazepines (see above). This allows for a steady, smooth reduction in dose over time. It also permits you to take your dose less often. In some cases, you can take your entire daily dosage before bedtime. This reduces problems of micro-managing your dose by taking another pill every few hours. It also can aid in sleep, which can be a large issue during withdrawal.

Second, Valium is low in potency relative to most other benzodiazepines and comes in tablets of 2mg, 5mg and 10mg. As a practical matter, you can make cuts as small as 0.5mg. This is the equivalent of somewhere between 1/20th and 1/40th mg of Xanax or Klonopin. Given the importance of making the smallest cuts possible, particularly as you approach the end of your taper, this is a very large benefit.

Finally, some people, including some experts believe that the newer, high potency benzodiazepines such as Xanax, Klonopin, and Ativan tend to produce more severe withdrawal syndromes. So far the evidence of this is purely anecdotal. There do not appear to be any studies that conclusively correlate severity of withdrawal with benzodiazepine type.

If you do decide to switch to Valium it is important to observe the proper dose equivalencies. These

are special equivalencies for purposes of switching to Valium. (see table above)

The cross-over process also needs to be carried out gradually, usually in stepwise fashion, substituting one dose at a time. Many people have suffered because they have been switched too quickly. Making the changeover one dose (or part of dose) at a time avoids this difficulty. Depending on the size of your dose, the period of dose substitution may be anywhere from 3 weeks to about 3 months.

Valium is a more potent sleep agent than most high potency benzodiazepines even at the equivalent therapeutic dose and many people may find it initially more sedating. However, most benzodiazepine users rapidly develop a tolerance to the sleep inducing (hypnotic) effects of benzodiazepines, so that it is likely that this oversedation will recede within the first few weeks.

During this period of dose substitution, sometimes cuts to your total dose are made, and other times, slight increases are made. If you experience extreme oversedation and no withdrawal symptoms, that is a sign that the equivalency dose is too high for you, and you may wish make a small cut in your total dose as you cross over. If, on the other hand, you begin to experience heightened withdrawal symptoms during cross-over, you may wish to make a small increase in your dose during cross-over. Because the proper equivalencies vary from person to person, the cross-over process can be a matter of trial and error. However, it is important to understand that the end result of switching to Valium should be that you are relatively stable after the switch is complete, meaning that you are experiencing either no withdrawal or very mild withdrawal symptoms.

Professor Ashton has circulated detailed protocols based upon switching to Valium and explaining the method in detail (see above and below).

Librium is another long acting benzodiazepine that is sometimes (but rarely) used as a substitute. This author has insufficient information regarding the effectiveness of Librium substitution to provide a meaningful comment at this time. It is not necessary to switch from Librium to Valium. Librium may be tapered directly, although there is a problem in that it comes only in 5mg capsules in North America. Ideally, for Librium withdrawal, the capsule should be opened and the contents halved to make 2.5mg cuts. Of course, if it is possible to make even smaller cuts, that is most preferable.

17. MY DOCTOR HAS ASKED ME TO SWITCH TO A DRUG CALLED "PHENOBARBITAL" FOR DETOXIFICATION. IS THIS A GOOD IDEA?

No. Although this method of "detoxification" is commonly practised in the USA, it has long been abandoned in the UK and is even regarded by some authorities as barbaric. It is best avoided.

18. SHOULD I CONSIDER GOING INTO AN IN-PATIENT DRUG REHABILITATION FACILITY OR DETOX CENTER TO GET OFF MY BENZODIAZEPINE?

Only in a relatively small percentage of cases do people have successful experiences withdrawing from benzodiazepines on an in-patient basis. The problems with detoxification centers are multi-fold. First and foremost, detox facilities are geared towards treating drug abuse behaviours, not providing support for withdrawal. The facilities often do not understand the necessity of tapering benzodiazepines slowly. Often, they will require you to taper over a 3-6 week period. Some will even take you off your benzodiazepine over a one week period with a Valium or Phenobarbital substitute. These facilities usually will not keep you as an in-patient for more than about 6 weeks. The result is that you may end up coming off the drug in an overly rapid fashion, while receiving classes on drug abuse but no specific support for managing withdrawal. The experience after leaving the facility can often be very rough, as you may be left in a state of fairly intense withdrawal that can persist for a long while. In short, people with benzodiazepine dependencies often feel worse after they leave these facilities than before they entered.

Clinical experience suggests that benzodiazepine withdrawal works best where the patient controls his or her own taper schedule in conjunction with the advice of a physician knowledgeable about benzodiazepine dependency. Detoxification centers, even where they might permit a relatively slow taper, will usually take the control of the process away from the patient and force the patient into a rigid protocol.

However, detox centers should be considered in two circumstances. First, if you have a problem abusing benzodiazepines either alone or in combination with other drugs, an in-patient setting is often appropriate to enforce the discipline of tapering the drug, and to educate you on how to avoid drug abuse. (But see the discussion on 12 step programs below.) If you feel that you lack the necessary self-discipline to taper yourself slowly and gradually and have no spouse or other caregiver who will manage your taper for you, you may wish to consider going in to a facility.

Second, in the rare circumstance where your withdrawal syndrome is so severe that you are unable to take care of yourself and you have no live-in spouse or other caregiver, you may wish to consider the in-patient option.

Before choosing a detox facility, you should call at least five different facilities and make, at a minimum, the following enquiries:

- a. Will they permit you to taper your benzodiazepine slowly?
- b. Do they have staff who have direct experience with patients in benzodiazepine withdrawal?
- c. Do they have an in-house psychiatrist and/or psychologist to provide support?

If the answer to these questions is yes, yes, and yes, the chances are that you have found the best possible detox facility. However, it is still inadvisable to withdraw on an in-patient basis unless you are in either of the two circumstances discussed above.

19. WHAT IS THE LENGTH OF THE WITHDRAWAL PROCESS?

It varies tremendously. For people with mild dependencies, the withdrawal process typically encompasses 1-4 weeks of symptoms. This generally applies to most, but not all, people who have used a benzodiazepine for less than six months. It also applies to a percentage of people who have used a benzodiazepine for more than one year. For people with severe dependencies, 6 to 18 months total recovery time, including the taper process, is typical. Generally, one may expect 6 months to a year of diminishing symptoms after a taper is complete.

There is also an uncommon phenomenon called the Protracted Withdrawal Syndrome (see below).

20. IS IT OK FOR ME TO SOMETIMES "CHEAT" DURING MY TAPER AND TAKE A LITTLE MORE OF MY BENZODIAZEPINE IF I HAVE TO GO THROUGH A STRESSFUL EVENT?

In the opinion of this author, anyone withdrawing from benzodiazepines should avoid the temptation to temporarily increase the dose at all costs, unless it is to avoid seizures or psychosis. If one has poor self-discipline, giving in on a single occasion to increase the dose in order to cope better with some stressful event may lead to a pattern of "giving in" which will ultimately lead to total relapse. If confronted with a stressful event, my advice is avoid the stressful event if possible. If not, make sure a supportive individual is there with you and tough it out.

It is always acceptable to "go sideways," (stay at the same dose as opposed to cutting) for a while in order to stabilise if your symptoms are particularly severe.

If you feel that you must increase your dose a little to stabilise yourself because you have tapered too quickly, do so. However, the better solution is to avoid tapering too quickly in the first place (see above).

21. WILL I NEED TO QUIT WORK OR GIVE UP OTHER IMPORTANT ASPECTS OF MY LIFE DURING BENZODIAZEPINE WITHDRAWAL?

Going through withdrawal while managing the demands of everyday life is a difficult balancing act. It cannot be emphasised strongly enough the extent to which stress can worsen your withdrawal symptoms. That means stress related to jobs, relationships, or anything else. What you need to understand, going into your withdrawal process, is that you will have to make adjustments in your life-style. The amount of adjustment will depend on the severity of your withdrawal on the one hand, and the stress level brought on by your lifestyle on the other. Some people can work through withdrawal; others cannot. Some people resign from their jobs, some take leaves of absence, some work through it with considerable difficulty, and still others work through it with mild difficulty. While in withdrawal, the best advice is to reduce your stress by the maximum amount that is feasible given the demands of your life.

22. MY DOCTOR HAS PRESCRIBED AN ANTIDEPRESSANT TO TAKE DURING MY WITHDRAWAL. IS THAT A GOOD THING TO DO?

Most doctors who prescribe antidepressants for benzodiazepine withdrawal, or for any other purpose, will prescribe one of the modern class of SSRIs (Selective Serotonin Reuptake Inhibitors) which includes Prozac (fluoxetine), Paxil (Seroxat, paroxetine), Zoloft (Lustral, sertraline), Celexa (Cipramil, citalopram), and Serzone (nefazodone). Or they sometimes prescribe one of two even more recently developed drugs: Effexor (Efexor, venlafaxine) and Wellbutrin (Zyban, bupropion). Doctors often prescribe these particular drugs because, in addition to their antidepressant properties, they are recognised as anxiolytics (anti-anxiety agents). Ironically, all of these drugs are known to heighten anxiety and agitation, though this side effect often diminishes after the first few weeks of use. Even the SSRIs such as Paxil and Zoloft which are thought to have a primary sedative effect often cause heightened anxiety when you are in withdrawal. This heightened anxiety may be one reason that people in benzodiazepine withdrawal often discontinue the use of these drugs after a short period of time.

Among those who have taken antidepressants for long periods of time during withdrawal, the experiences are mixed. Some seem to benefit, others do not. Still others feel that their symptoms are worsened. Generally, due to the potential for creating complications of your other withdrawal symptoms, antidepressants should only be taken where you are suicidally depressed. That does not mean that you are simply pondering or even obsessing about suicide. It means that you feel that, barring some kind of pharmacological intervention, you **will** do something self-destructive. Otherwise, antidepressants should generally be avoided during withdrawal.

Another issue is that most antidepressants are documented to be addictive and, in fact, there is evidence that the withdrawal syndrome can be very pronounced and similar to benzodiazepine withdrawal in many cases. See this site's page of [antidepressant news, articles and links](#).

There are a few scattered reports of people who have benefited from the use of an earlier class of antidepressants known as "tricyclics". One of these is doxepin (Sinequan, Adapin, Zonalon, Triadapin), which has a primary sedative effect as opposed to the stimulant effect of the SSRIs. Tricyclics also have their own set of complications and side effects. Consult your physician and check the written warnings for tricyclics to make sure that you do not have any of a number of medical conditions that may be complicated by the use of tricyclics. As with SSRIs, some are known to cause primarily sedation, where others are known to have stimulant properties.

The best advice with antidepressants or any other prescribed adjunct drug is to proceed with

caution. If you decide to take an antidepressant, you may want to start at a very low dose to see how well you tolerate the drug before increasing to the dose recommended by your physician.

23. ARE THERE ANY OTHER DRUGS BESIDES ANTIDEPRESSANTS TO CONSIDER DURING BENZODIAZEPINE WITHDRAWAL?

There are several. And your doctor may suggest one or more. Again, the best advice is to proceed with caution and carefully research any new drug you are considering. A few are mentioned below.

Tegretol (carbamazepine): an anti-seizure drug. Some studies have shown this drug to be effective in reducing certain physical withdrawal symptoms. Others have shown it to be ineffective. Testimonials regarding the use of Tegretol are mixed.

Neurontin (gabapentin): primarily a pain medication and used as an adjunctive anti-seizure drug, Neurontin has been implicated as alleviating certain physical withdrawal symptoms. Testimonials are mixed and they are too few for reliable generalisation.

Beta blockers (e.g. Inderal): these may help with heart palpitations, hypertension, as well as shakes/tremors. Some beta blockers cross the blood/brain barrier, and may be mildly addictive, though the official medical literature states that they are non-addictive. However, that same literature also recommends that they not be discontinued abruptly. Do not take a beta blocker unless you are seriously troubled by any of the above-mentioned symptoms. Even then, you should either take them at the lowest dose possible, or take them situationally (as the symptom emerges). Beta blockers do not directly reduce anxiety, but they can alleviate some of the physical symptoms associated with panic attacks, which may indirectly help to reduce the associated anxiety level.

There have been some reports that tiagabine (Gabitril) and possibly pregabalin (yet to be licensed) help with sleep and anxiety in withdrawal. However, there have been no controlled trials and it is not clear whether these drugs themselves cause withdrawal effects. In practice, additional drugs are seldom needed with very slow benzodiazepine tapering.

24. ARE THERE ANY PARTICULAR DRUGS A DOCTOR MIGHT PRESCRIBE THAT DEFINITELY DO NOT HELP WITHDRAWAL?

Yes. BuSpar (buspirone), a commonly prescribed anti-anxiety agent, is virtually certain to be totally ineffective in alleviating withdrawal symptoms. This conclusion is supported by studies (e.g. Ashton C H, Buspirone in Benzodiazepine Withdrawal, 1991). Furthermore, this author has never heard a single testimonial from anyone who claims to have benefited from this particular drug in withdrawal. Other drugs which have been found to be of little or no value in withdrawal trials include Clonidine (Catapres, an anti-anxiety drug sometimes used in alcohol detoxification), nifedipine (Adalat) and alpidem.

25. WHAT ABOUT HERBS AND OTHER HOMEOPATHIC REMEDIES - DO ANY OF THOSE HELP THE WITHDRAWAL SYMPTOMS?

Maybe. Everyone's experience is different. Acupuncture, massage therapy, and chiropractic have been commented on, but there is little conclusive data as to their effectiveness in relieving withdrawal symptoms. As for herbal remedies, all of the following have been mentioned as occasionally helpful to one person or another: Valerian, Kava Kava, St. John's Wort, 5htp, SAME, Melatonin, GABA, Chamomile, and Rescue Remedy***.

With very few exceptions, the majority of these have been found to be helpful in only a few cases, and several people have felt that their withdrawal symptoms were heightened by taking one or more of these substances. Of the entire group mentioned, only two have been singled out by a fairly large

number of people as especially helpful: chamomile tea and [Rescue Remedy](#)***. Keep in mind that even those herbal substances which you find helpful may only work where your symptoms are relatively mild. For example, chamomile tea might relieve mild agitation, but is very unlikely to bring you out of a full blown panic attack. However, there are breathing and relaxation methods that can help to alleviate panic attacks.

Kava is noted as creating more adverse reactions than some of these other substances, and is probably the least recommended of the group for experimentation. However, all herbal drugs have been noted by one person or another as producing unpleasant side effects or as simply being ineffective. Herbal drugs are generally not regulated and there are occasional reports of these substances containing toxins, though these occurrences are becoming particularly rare in industrialised countries in recent years, due to heightened media scrutiny of homeopathic drugs.

It is also important to understand that herbal medicines are drugs. These plants contain organic, bioactive substances that cross the blood brain barrier and act upon your brain just as synthetic drugs do. In fact, many pharmaceuticals are synthesised versions of bioactive substances naturally occurring in plants and animals. The only difference is, you get a much higher purity of the substance in synthetic form than you would in organic form.

Herbs can also have toxic and deleterious effects. Fortunately, most herbal medicines are low enough in potency that they are well tolerated and non-addictive.

However, it is important to start at a low dose and pay close attention to your body's reaction to the use of an herbal medicine just as it is with a synthetic one. Generally speaking, you will have a strong sense of how well you are tolerating a particular substance shortly after you beginning taking it, often after the very first dose.

This FAQ does not recommend, negatively or positively, the use of herbal remedies for anxiety disorders such as GAD or PD. This FAQ is about benzodiazepine dependency and withdrawal, not about alternative treatments for anxiety disorders. The only opinion intimated herein is that some people may experience some relief from certain herbal remedies during the withdrawal process. Many, if not most, experience no relief at all.

In general, herbal medicines are safer to experiment with during withdrawal than synthetic ones are. Therefore, you may wish to consider these possibilities before trying another potentially addictive synthetic drug. However, keep in mind that even if you experience some form of relief from an herbal remedy, there are no panaceas for benzodiazepine withdrawal syndrome, and only time will ultimately produce total recovery.

26. WHAT ABOUT USING CAFFEINE DURING WITHDRAWAL?

You should **totally** abstain from the use of caffeine during benzodiazepine withdrawal. It is a stimulant and is known to worsen withdrawal symptoms. If you use caffeine to ward off migraine headaches, try to find another remedy that does not contain caffeine. You should refrain from the use of all other stimulants as well. For example, do not use "non drowsy decongestants" that contain the drug "pseudoephedrine". That is a stimulant that will likely cause heightened agitation, which is the last thing you need during withdrawal.

27. WHAT ABOUT EATING SUGAR DURING WITHDRAWAL?

There is considerable anecdotal evidence, in the form of testimonials from people in withdrawal, that sugar can exacerbate withdrawal symptoms. Shirley Trickett, in her book *Free Yourself From Tranquilizers*, indicates that benzodiazepine withdrawal causes hypoglycaemia. This is one theory as to why sugar may cause problems during withdrawal. Another is that sugar may stimulate the

production of adrenaline. In much the same way that it may cause hyperactivity in children, it can cause heightened agitation during withdrawal.

Whatever the reason, there is substantial anecdotal evidence that consuming sweets, particularly in large quantities, can greatly complicate withdrawal.

28. WHAT ABOUT CONSUMING ALCOHOL DURING WITHDRAWAL?

Alcohol consumption, even in relatively small amounts, is not advised during benzodiazepine withdrawal. Many people report that alcohol, a sedative that should cause a reduction in anxiety, actually heightens withdrawal symptoms, particularly those of derealisation and depersonalisation.

Even if you find that alcohol has a calming effect on withdrawal symptoms, regular alcohol use creates a toxicity that will almost certainly prolong your recovery process. And even if you are able to withdraw successfully from benzodiazepines while consuming alcohol on a regular basis, which is unlikely, you will have probably substituted one addiction for another.

29. WHAT FOODS SHOULD I EAT (OR AVOID) DURING WITHDRAWAL?

First of all, you should probably drink lots of liquid, perhaps double your ordinary intake. Some people feel that this may hasten the recovery process. The evidence of this is inconclusive. However, drinking large quantities of liquids helps to flush toxins from your system is generally good for digestion. Even if it provides no specific relief in withdrawal, it is generally a healthy practice.

As for food, there are various theories about what should and should not be consumed. Some people develop fixations about their diets during withdrawal, associating a new withdrawal symptom with whatever food they consumed most recently, and concluding that this food is something to be avoided during withdrawal.

Shirley Trickett (see above), in her book *Free Yourself From Tranquilizers*, recommends a hypoglycaemic diet. This consists of eating three small meals per day, and having at least 2-3 snacks spaced out between the meals. The regimen consists of roughly equal parts complex carbohydrates, protein, and fat, with very little or no sugar intake.

Whatever diet you decide is appropriate, the most important consideration during withdrawal is that it is a healthy diet. While the evidence regarding the effect of one particular food versus another is not conclusive, there is strong evidence that a healthy diet makes for an easier withdrawal. Another way of looking at it is in the converse: when you eat junk, your body rebels and causes you to experience discomfort. While this is true even when you are not in withdrawal, it is true more so in withdrawal because your body is already in a state of trauma. That trauma is virtually certain to be compounded by an unhealthy diet.

There are a wide variety of opinions about proper diet and nutrition during withdrawal, and to discuss all of them is outside the scope of this FAQ.

30. I SMOKE CIGARETTES. SHOULD I QUIT DURING WITHDRAWAL?

Nicotine, the primary drug contained in tobacco, is an addictive drug like benzodiazepines, although it is vastly different in its chemical structure and mechanism of action. Unlike benzodiazepines, the primary symptom of Nicotine withdrawal is a craving for the drug. However, other symptoms, especially agitation and insomnia, have been noted as Nicotine withdrawal symptoms. Therefore, it is inadvisable to withdraw from Nicotine while you are in the process of benzodiazepine withdrawal. If you plan to quit smoking (which is always a good idea for health reasons), it is preferable that you accomplish this before you begin benzodiazepine withdrawal. Failing that, you should wait until you

have fully recovered from benzodiazepine withdrawal before discontinuing cigarettes.

The only exception to this guideline is where you are carrying a child. In that circumstance, it is critical that you stop smoking immediately. Benzodiazepine withdrawal should also be accomplished during pregnancy, as there is clear medical evidence that a child born of a benzodiazepine dependent parent may experience symptoms consistent with benzodiazepine withdrawal. Where you are dependent on a benzodiazepine and carrying a child, a more rapid taper schedule than is generally desirable may be advisable. Withdrawal during pregnancy, as in all other situations, should be done with close consultation with a physician who is knowledgeable regarding benzodiazepine dependency.

31. SHOULD I EXERCISE DURING BENZODIAZEPINE WITHDRAWAL?

Yes. Aerobic exercise has consistently been found in studies to reduce both anxiety and depression. Some people believe that aerobic exercise may even shorten the course of withdrawal.

Strenuous aerobic exercise is often difficult for people in withdrawal, as it causes an influx of adrenaline that can heighten withdrawal symptoms. In some cases, people have reported experiencing panic attacks after intensive exercise. Where you are unable to engage in vigorous exercise, it is recommended that you engage in as much low impact aerobic exercise as possible. Brisk walking is a good form of aerobic exercise that some people have reported as having an immediate, calming effect. Relatively non-strenuous swimming is also a good option.

32. I HAVE TERRIBLE INSOMNIA DURING MY WITHDRAWAL. SHOULD I TAKE SOMETHING TO HELP ME SLEEP?

Opinions vary on the subject. While it should not slow your recovery process to take an over-the-counter drug with sedative properties, some people feel that taking virtually any other drug makes their withdrawal symptoms worse. Many others, however, have found that various synthetic and organic drugs are helpful as sleep aids. These include, but are not limited to, antihistamines (such as Benadryl), Dramamine, Valerian, 5Htp, chamomile, warm milk, and Melatonin.

It is important to be cautious regarding your decision to ingest any psychoactive chemicals, be they organic or synthetic, during withdrawal. Therefore, it is prudent to avoid taking sleep aids if you are suffering from only mild insomnia. If, however, your insomnia is severe, as it often can be during certain stages of withdrawal, you may wish to consider taking one or more sleeping aids, particularly as serious sleep deprivation may worsen withdrawal symptoms.

It should go without saying that you cannot take a different benzodiazepine for sleep. That might be effective in inducing sleep, but it is the equivalent of increasing your dose and reversing your recovery process. The same holds true to varying degrees for barbiturates, alcohol, opiates and narcotics.

You should also avoid the sedative drugs Ambien (zolpidem) and Imovane (zopiclone) which are chemically different from benzodiazepines but have the same effects on the body and act by the same mechanisms.

Any of the above-mentioned over-the-counter sleep aids or herbal sedatives may be useful. However, it has often been observed that tolerance to the sleep effects of these substances, including for example Melatonin, can develop rapidly. It is therefore recommended that you alternate more than one sleep remedy, so that no one remedy is employed more than 2 or 3 times per week.

It is important to note that virtually all tranquilisers, including antihistamines, can produce paradoxical symptoms of agitation and heightened insomnia for some users. If you feel that any

substance you are consuming as a sleep aid is making your withdrawal symptoms worse, discontinue that substance immediately.

33. WHAT CAN I TAKE FOR PAIN MANAGEMENT DURING WITHDRAWAL?

Many people experience muscle and joint pain during withdrawal. This can occur to varying degrees. Only a very small fraction of people have reported adverse reactions to over-the-counter pain relievers. These should be used as a first resort. Do not use prescription pain relievers unless your pain is extremely debilitating.

34. ARE THERE ANY PARTICULAR DRUGS THAT ARE KNOWN TO COMPLICATE WITHDRAWAL?

There is some evidence that antibiotics, especially the quinolones, e.g. Ciprofloxacin (Cipro) can complicate withdrawal. A considerable number of people withdrawing from benzodiazepines have reported quite serious adverse reactions and side-effects after using this class of drugs. There are similar reports from people who are still taking the drug as well as those who are suffering from the post-withdrawal syndrome. The fact that these antibiotics affect the central nervous system (CNS) certainly accounts for this phenomenon. People suffering from benzodiazepine withdrawal (including tolerance withdrawal) also have a tendency to suffer from a weakened immune system. Some people have actually refused to take antibiotics for pneumonia, which is inadvisable and potentially fatal. However, antibiotics should only be taken by the benzodiazepine patient when they are critical to his/her overall health. The use of older antibiotics which do not affect the CNS is always advised.

35. I AM WELL INTO MY TAPER, AND MY SYMPTOMS ARE EITHER NO BETTER OR ARE WORSE. WHEN CAN I EXPECT MY SYMPTOMS TO GET BETTER?

There is no way to tell. Sometimes, people's symptoms begin to diminish before their taper is complete; sometimes shortly after the taper is complete; sometimes quite a while after the taper is complete. The important thing to remember is that in all cases the healing process is moving forward, whether it is immediately apparent or not, and that you will eventually begin to feel better.

36. I HAVE COMPLETED MY TAPER, AND HAVE FELT MUCH BETTER FOR A WHILE, BUT NOW I FEEL WORSE AGAIN. WHY?

This is a typical experience. Benzodiazepine withdrawal recovery occurs in fits and starts. The fact that you have experienced relief for a time means that you will experience it again. As time goes on, generally these recurring episodes are spaced further apart, and diminish in intensity. Benzodiazepine withdrawal leaves you vulnerable to stress for quite a long time even after you are almost totally healed. It is often reported that people who have felt withdrawal free for six months have had sudden, intense withdrawal episodes brought on by traumatic or stressful events. It is probably helpful to get counselling if you continue to have ongoing anxiety issues long after your taper is complete. This does not mean that you are not still experiencing withdrawal. It means that the purpose of withdrawing in the first place was to find alternative, less toxic methods of managing anxiety problems.

37. WHAT IS THE PROTRACTED WITHDRAWAL SYNDROME?

The Protracted Withdrawal Syndrome (PWS) is not a phenomenon with a single, unitary definition. Many people who have no experience with benzodiazepine dependency, which includes almost half of the medical community, do not recognise any form of withdrawal syndrome as persisting beyond about 30 days. Part of the problem is that the average physician sees very few people with serious benzodiazepine dependency, and when they do, the symptoms are often misinterpreted or misdiagnosed. Another problem is that statistics actually show that, indeed, about 70% of people

with a benzodiazepine dependency are able to complete withdrawal in less than a month. However, it is important to understand that this statistic takes into account large numbers of people who have used a benzodiazepine for only a few weeks or months. For people who have used benzodiazepines for years, a 6 to 18 month course of withdrawal is actually the norm. For doctors who have not seen significant numbers of people in this circumstance, that scenario is viewed as "protracted", because withdrawal syndromes rarely persist more than 30 days for virtually every other class of drug.

What those few doctors and recovering victims who truly understand benzodiazepine dependence know is that the 6 to 18 month scenario is just a typical outcome for any serious dependency. In those circles, PWS is roughly defined as significant, debilitating, and continuous (not minor or occasionally occurring) symptoms persisting beyond about one year after total cessation of the drug. One of the true ironies here is that just as there is debate among the truly ignorant as to whether the very common 6 to 18 month scenario exists, there is also a debate among people in recovery and addiction medicine circles as to whether true PWS (beyond about 18 months) is a real phenomenon. Most people in these circles believe it is.

Professor Ashton and others believe that PWS is a real phenomenon. What causes it is at this point is unknown. However, there are two things to keep in mind about PWS. First, even if you are in the category of people with a serious dependency, the statistical likelihood of you experiencing PWS is quite small, probably less than 1 in 10. If you are two years out and have occasional, mild symptoms, that is not PWS. It is typical. If you have significant, debilitating symptoms beyond a year, that is PWS and it is atypical but not unheard of. However, the second thing to keep in mind is that there is no evidence that benzodiazepine withdrawal syndrome can ever be permanent. Even in the rare cases that symptoms persist for years, they gradually diminish over time until they are gone.

As you taper, do not concern yourself with whether or not you will experience PWS. You probably will not, and even if you do, that is something to manage if and when you get there.

38. SHOULD I USE A 12 STEP PROGRAM LIKE NARCOTICS ANONYMOUS TO HELP ME RECOVER FROM MY BENZODIAZEPINE ADDICTION?

This is a personal choice, and opinions vary considerably in the benzodiazepine recovery community. Some feel that most people who have a benzodiazepine dependency are not drug abusers. Rather, they are people who have taken a medication according to their doctor's instructions for a specific medical and/or psychological condition, have never exceeded the recommended dosage, have never experienced a "high" or intoxication from the drug, and have never experienced a specific craving for the drug. This is where the term "accidental addict" is rooted. Often, people who fit this mould feel that 12 step programs such as NA are not suitable for them, because those programs are aimed at conditioning people to avoid abuse type behaviours. People with a benzodiazepine dependency are often seeking support and guidance on how to manage their withdrawal syndrome, not training on how to avoid drug abuse.

Still others not only feel that these types of programs have helped them, but feel that they would not be alive today without them. It is important to note that a sizable percentage of benzodiazepine dependents do exhibit patterns of abuse. The clearest signs are taking dosages far in excess of what your doctor has prescribed, and/or having a history of abusing other drugs in the past or simultaneously with your benzodiazepine. 12 step programs may be more appropriate for people in that category.

One factor that many have found helpful in the withdrawal process is spirituality, e.g. a connection with some form of higher power(s). Some have found that 12 step programs help them understand the importance of spirituality. Others have found their own spirituality without the assistance of any such program.

39. WHO IS PROFESSOR HEATHER ASHTON?

Professor C Heather Ashton, DM, FRCP, is a British psychopharmacologist (an expert on psychiatric drugs) who ran a benzodiazepine withdrawal clinic in Newcastle, England between 1982 and 1994. During that time she helped over 300 patients to withdraw from their benzodiazepines with a high rate of success. Her DM degree is an Oxford University Doctorate in Medicine. One of her papers is an observation of the outcome of her first 50 cases. In that study, only three patients relapsed, and the others made it through with varying long term outcomes - mostly positive. Professor Ashton is undoubtedly one of the world's foremost authorities on benzodiazepine addiction and recovery.

Professor Ashton almost always switches her patients to Valium (see above) unless, of course, Valium is their drug of dependency. She also recommends a very slow taper.

She has written a manual for benzodiazepine sufferers. It is available for online at: www.benzo.org.uk/manual/index.htm. This manual is an excellent resource for anyone beginning the process of withdrawal. Professor Ashton is not the only expert on the subject, but she is one of the more knowledgeable ones. She is far more knowledgeable than this author.

40. ARE THERE ANY OTHER RESOURCES THAT WOULD BE HELPFUL TO ME IN UNDERSTANDING BENZODIAZEPINE DEPENDENCY AND WITHDRAWAL?

Yes. There are lots. Please refer for example to the following pages on this site:

- [Comprehensive Links Page](#)
- [Support & Contacts](#)
- [Benzo Books & Other Resources](#)
- [Professor Heather Ashton](#)
- [Doctors & Experts](#)

The reader is encouraged to do his or her own research, as there are undoubtedly more resources both on the Internet and in print which are relevant to this topic.

***Rescue Remedy is a product name.

This FAQ neither promotes nor discourages the use of any specific product.

End of the Frequently Asked Questions (FAQ) file.