BACK TO LIFE

The Great Escape from Tranquilliser Addiction

SSRIs and Sleeping 'Z' Drugs Pills

COUNCIL FOR INFORMATION

ON TRANQUILLISERS AND ANTIDEPRESSANTS

Pam Armstrong

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ABOUT THE AUTHOR

Pam Armstrong is a founder member of C.I.T.A. She is a nurse, teacher and sociologist and also has formal qualifications in counselling. She has used all her skills to develop new methods of support for patients who want to withdraw from the benzodiazepines. As a pharmacist, I am well aware of the extent of the problem of benzodiazepine addiction and the difficulties experienced by so many patients. This book will be an invaluable aid to all those who are withdrawing from these tranquillisers.

Geraint Short, B.Sc. M.R.Pharm S. Vice Chairman, C.I.T.A.

In 1992 I wrote the original comments about Pam Armstrong and now in 2007 I am glad to write again.

CITA is still successful and has added 'Z' drugs and antidepressants to its remit.

I am delighted to read Pam Armstrong's new updated book and hope this international version will help even more people when they are ready to come off their tablets and to do this as successfully as possible.

PREFACE

"Back To Life" brings together thoughts, feelings, ideas and experiences to do with the problem of tranquilliser addiction. Some are my own, some have been gleaned from other professionals but many of the most important have come from the addicts themselves. Benzodiazepine addicts are an enormously diverse group but, in spite of that diversity, their views are remarkably consistent. Many of those views are included in this book. The title is a literal description of the recovery from tranquilliser addiction; patients truly come *back to life.* After withdrawal, many of our clients have found that their values and attitudes to life have been transformed. The chemical constraints of the benzodiazepines had deprived them of the will to act and the situations that they had come to tolerate were often deeply unsatisfactory. Freed from their chemical prisons they regained their motivation and self respect and with them their ability to control the course of events.

We must solve our problems ourselves or not at all. Chemical crutches are just that . . . temporary supports to be discarded as soon as possible. Use physical crutches for too long and you lose the use of your limbs. Use chemical crutches for too long and you could lose the use of your mind.

INTRODUCTION

What encouragement can I give when life gets really miserable during withdrawal? Keep going! There is no other way back to life. Benzodiazepine withdrawal symptoms may mimic the symptoms of mental and physical diseases. Remember, if you persevere these symptoms will disappear; if you were ***really*** ill they would not be banished so easily. You will gain nothing by going back and you could lose everything. If you discipline yourself to approach tranquilliser withdrawal slowly and carefully, you will succeed. There are no prizes for getting there first. Remember the tortoise and the hare.

CHAPTER 1

WHAT IS C.I.T.A.?

C.I.T.A. (The Council For Involuntary Tranquilliser Addiction now known as Council for Information on Tranquillisers and Antidepressants) was born from the belief that tranquilliser addiction should be handled separately and not linked to the problems of opiate addiction or alcohol abuse. There are three million tranquilliser users in Britain and the lives of 15% of the population of Britain and the western world have been blighted by the benzodiazepines. If this was an infection, it would be an epidemic. The problem must become the sole responsibility of an organisation not a side issue.

The founders of C.I.T.A. were Peter Ritson, an ex-tranquilliser addict, and myself. Peter took `Dalmane', a sleeping tablet, for twelve years and then stopped suddenly. The effect was catastrophic. His withdrawal symptoms, which included double vision and numbness of the limbs, led to a diagnosis of multiple sclerosis. When he discovered, to his intense relief, that the diagnosis was incorrect, he was horrified to realise that they had been caused by an officially approved drug. I am a nurse and when I became involved with C.I.T.A. I approached the problem from a nurse's point of view. Since then, Peter's experiences and those of the other tranquilliser victims I talk to every day, have entirely changed my views on drugs, particularly the benzodiazepines. Health professionals must start to listen to what their patients tell them.

For the first six months of our existence, C.I.T.A. was only two people, and we spent most of our time getting ourselves known and visiting the many people too ill to come to us. Gradually, we were joined by ex-tranquilliser users who wanted to help others in the battle of recovery. We would probably never have succeeded without the accommodation so generously offered by Sefton Council for Voluntary Services in Waterloo, Liverpool. Without it we would have fallen at the first hurdle. Becoming a Registered Charity was another significant step. It took us almost twelve months but gave us the credibility that we need to raise the funds that allow us to perform our work adequately.

Peter Ritson is convinced that people who take tranquillisers long-term have irrational thought patterns. Consequently, the recognised skills of counselling, which depend on logical thought, are inappropriate for patients who have taken tranquillisers for long periods and are still taking them. I agree with him. What tranquilliser addicts need from us and from those who surround them is information, support and copious reassurance. Thoughtless and insensitive remarks make withdrawal even more

difficult. Encouragement and help, so that they persist with withdrawal at all costs, are our guidelines.

C.I. T.A. has three main aims:

1. To support those withdrawing from tranquillisers and to help them back into normal society.

2. To raise society's awareness of the dangers of the benzodiazepine tranquillisers.

3. To support General Practitioners in a team effort to help tranquilliser addicts withdraw successfully.

We make no apologies for drawing attention to the problem so energetically; nothing will be achieved while society remains in ignorance. The media have helped us a great deal, and we are very grateful. Many journalists have a personal interest in the problem of tranquilliser addiction which has led them to investigate the subject enthusiastically . . . to very good effect. However, we have been disappointed by the lack of reliable continued funding. We have had to rely almost entirely on donations and we are very grateful for them.

C.I.T.A. unfortunately falls between two stools. Initially we set up the organisation as a local group but publicity has made us into a national body. Because of this, local authorities suggest that we apply for funding at national level. The D.H.S.S., on the other hand, ask us to apply locally! We are acutely aware of the huge need for our services nationwide and have now separated our local work from the wider service that we provide. Nationally, we provide information packs and a helpline (telephone number 0151 932 0102, internationally +44 151 932 0102), manned by ex-tranquilliser addicts and a nurse. The information packs contain advice on coping with withdrawal symptoms, articles on the subject, and a letter explaining our methods to the client's GP. Locally we hold a weekly meeting and relaxation class and we also work with our clients individually either in their own homes or at our office. We regularly have visitors from other parts of Britain; in many areas of the country virtually no help is available. We welcome these visitors, although we realise that visiting us is not an option open to everyone.

In 2005 CITA changed its name to reflect the huge number of people who requested help with problems relating to antidepressants. In February 2005 the acronym C.I.T.A. officially changed its meaning to ‘Council for

Information on Tranquillisers and Antidepressants'. It is this broadening of our remit which has led me to add a section on antidepressants to my book and to update it on other ways as well, adding sections on other relevant sections such as 'Z' sleeping tablets, and Tahitian Noni juice and other subjects as well as very practical charts to help with your withdrawal. I hope in doing so I have made this book even more user friendly and helpful.

CHAPTER 2

HOW THE PROBLEM STARTED

Although nothing is gained by allocating blame for the problem of tranquilliser abuse, the history of the drugs concerned is interesting. Barbiturates, notoriously addictive and fatal in overdose, were the drugs of choice for sedation in the forties and fifties. The benzodiazepines had been discovered by a Polish chemist in the thirties but their tranquillising effect remained unknown until the late fifties. The first benzodiazepine tranquilliser, 'Librium' (chlordiazepoxide) was marketed in 1961 and was quickly followed by `Valium' (diazepam), which appeared in 1962. Doctors greeted these new drugs, which appeared to offer a safe alternative to the barbiturates, with considerable relief. They could now prescribe a drug for the relief of anxiety or for sleeplessness that was safe even when patients took very large overdoses. When we consider the situation faced by a doctor advising an anxious patient, it is easy to see how the benzodiazepines became so widely prescribed. Anxious patients expect to be offered not just a kindly word from the doctor, but a prescription to take away with them. Doctors are often too busy to talk to patients and to discuss alternative approaches to treatment with them. If the patients' expectations can be met by prescribing a safe tablet which relieves his anxiety then the problem is solved to everyone's satisfaction . . . or so it seemed.

What was important was that benzodiazepines worked extremely well and very quickly. In some cases their effect was almost miraculous and this instant gratification was at the centre of the problem. Distraught and anxious patients want to feel better immediately, and the benzodiazepines have exactly this effect. Patients thought, "This is marvellous, the doctor has cured me!" . . . and everybody was happy. Paradoxically, if the drugs had been less effective the problems we are now facing might never have arisen. If tablets take time to work, there is a natural tendency to forget to take them. This is a common problem with antidepressants, which take up to two weeks before producing any improvement. Worse still, their initial effect is often to make patients feel even worse than they were before they started treatment. Understandably, some patients are reluctant to go on taking them. The instant improvement and feeling of well-being produced by the benzodiazepines causes a psychological attachment to the tablets and to the reassurance that they provide. Safe in the belief that the drugs were safe and non-addictive, patients had no reservations about taking them indefinitely. Unfortunately, by the time they had started to think about

stopping treatment many were already addicted. Both doctors and society had made the dangerous assumption that, because a drug works for a short period, it will go on working indefinitely. Strangely, we do not make the same assumption about antibiotics; we know perfectly well that we need take them for a few days only. If the idea that the benzodiazepines should be used for short courses of treatment had been accepted earlier, doctors and society would have gained a great deal more understanding of these drugs.

It is ironic that, in many cases, benzodiazepine withdrawal symptoms mimic those for which the drugs were originally prescribed–leading the prescriber and the patient to believe that tablets are essential . . . that the patient really needs them. Because of this, many families have often, in annoyance, said to their relative, "You were better on those tablets so you obviously needed them . . . why stop taking them?", not realising that the tablets had become the source of the problem. This feature and the fact that names like 'Valium', 'Librium' and `Mogadon' became so familiar meant that real understanding of the problem was slow to dawn. It was difficult to accept the very real dangers that lay concealed behind those friendly comfortable names. The benzodiazepine story shows how difficult it is for us to accept that things with which we have become familiar can carry hidden dangers. The time taken for the public at large to accept the reality of the link between smoking and lung cancer is another example of the same problem.

Although the possibility of benzodiazepine addiction was rumoured for several years, most authorities remained sceptical. The drugs were still being prescribed and many considered that the rumours were mere scare mongering. Patients and doctors were happy in the belief that their favourite tablets worked as well as ever. Realisation was slow to dawn. During the many years that the benzodiazepines have been available, society has made no great efforts to look for alternative ways of coping with stress. Instead we retain our attachment to the drugs . . . what can we offer instead? Doctors are faced with a dilemma; how do they deal with patients addicted to benzodiazepines? Very little support is available to GPs faced with this problem. Understandably, they are tempted to avoid the issue by writing a repeat prescription.

In January 1988, the government body responsible for drug safety, the Committee on Safety of Medicines, issued a bulletin on the problems of benzodiazepine abuse (Problems No 21, Concerning Benzodiazepines), which suggested that the use of the drugs should be drastically curtailed. We can only applaud this warning, late as it is. Unfortunately it does not consider the sheer numbers of addicted patients doctors have to deal with and their need for specialised care, or the additional funds

required. This has also been the case of the sudden banning of Halcion by the C.S.M. (Committee on Safety of Medicine). The government has not devoted enough thought to the benzodiazepine crisis. Efforts to apportion blame and sue doctors and drug companies avoid the real issue. The individuals affected need help and understanding.

The benzodiazepine story teaches us a painful lesson. There is not, and never will be, a pill for every ill. We have learned to turn to drugs almost as a reflex action, dismissing the possibility that human problems may respond to simple remedies. If we cannot sleep, we do not buy thicker curtains to black out the light, or ear plugs to block out the noise; we turn to the drugs which have left such a painful legacy. The story says a great deal about our Western world in the twentieth century. Alternative methods for dealing with stress take time and effort and oblige us to put something of ourselves into achieving our goal. We prefer instant answers. Over and over again we see people who give up because they do not feel better at once. An improved life style and a better way of coping with stress have to be worked at. The result, a future life worth living, surely deserves the effort. Television has made us spectators, not participants and we press a button to be part of anything we wish. Western society sits and watches and expends no effort. This attitude dominates every sphere of life. We want to be entertained; we want things to be done for us; we are passive, subservient. Similarly, and understandably, patients suffering withdrawal symptoms want to recover suddenly and miraculously. We must understand that the damage caused by a drug put into the body for many years takes a long time to undo. There are no short cuts. Time and perseverance are essential, together with an understanding of what has happened to the sufferer. For the past twenty years, there have been no new developments in our ways of coping with anxiety. Benzodiazepines provided an instant answer; why look for anything else? Now the situation is different, and the search for other ways of dealing with stress and anxiety is under way.

In the black depths of withdrawal, lack of concentration and sheer wretchedness may prevent perseverance. However, other ways of coping should be offered before resorting to tablets, for this is the time when those methods may succeed. Patients may be able, at this stage, to sort out their problems logically, without chemical help, and they could benefit from the proven techniques of counselling. Patients may be introduced to Yoga and relaxation techniques so that they can adopt them as methods of coping. If they are encouraged sufficiently to take up these methods their lives may take on a new calmness which will stand them in good stead in the future. However, they must be prepared to work hard to master these new coping skills. Some people gain comfort from

relaxation tapes, although I have one reservation. which is that the clients may become too dependent on them. It is important to encourage the growth of coping skills rather than to encourage the use of tapes that limit scope and leave clients unable to relax without them. In a sense they have become addicted to the tape!

CHAPTER 3

WHAT TRANQUILLISERS DO TO YOU

As you endeavour to reduce benzodiazepines you realize, often unexpectedly how much they are influencing the functioning of your body both mentally and physically. The effect of benzodiazepines takes over insidiously and you are often totally unaware of how much they are affecting you until you try to stop them.

Benzodiazepines used for short term are very useful drugs for calming anxiety, inducing sleep, relaxing muscles and stopping seizures. They are also very effectively used as pre-medication. It is only when they are used long term that they become problematic in that they are difficult to stop.

Benzodiazepines work very quickly and very effectively which makes them very attractive drugs to anyone who is anxious or suffering insomnia, however, the problems creep up on you as you continue to take them and realise the hold they have on you.

How They Work

Benzodiazepines act by enhancing the action of the brain chemical GABA (gamma – aminobutyric acid) by binding on GABA receptors. GABA has a natural inhibitory effect on the brain by causing neurons in all areas of the brain to stop firing or slow down. "Since 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 some ways the body's natural hypnotic and tranquilliser". [1] The inhibitory effect of benzodiazepines on the brain disturbs the balance. The action of the endorphins is reduced because they work on a use it or lose it basis and the excessive calm means that the endorphin action will naturally be reduced.

The adrenaline reflex is dampened down causing less reaction to life events; however, after a while this effect may lessen as you become uses to the drug. When this happens you may start to feel anxious

again and need more benzodiazepines to maintain the action. Some people may only start to feel anxious as they start to reduce their benzodiazepines.

1. Aston H. 2002

Benzodiazepines: How They Work, How to withdraw. (University of Newcastle)

When you take a tranquilliser because you are anxious, not sleeping, have aching muscles or are afraid of something, you feel better almost immediately. The instant effect of the drugs means that the first stage of addiction to them is psychological. The benzodiazepines have created a problem because, when you first take them, they are too effective. By the time this early effect has worn off, addiction is often established. As soon as the problem is recognised it is important to seek help immediately. While taking tranquillisers, the initial feeling of well-being is often followed by a period during which you continue to feel good. Gradually the drugs affect both mind and body. Slowly but surely anxiety increases, small problems become larger, fears increase, the telephone or doorbell becomes terrifying and answering them becomes something to be avoided. Going out becomes something to be feared and the person may become agoraphobic. Others, unless they force themselves, can never leave their house alone. When asked to explain why they feel as they do, they cannot answer and this inability disturbs them. Families become frustrated for they find the problem hard to understand. Guilt can complicate the situation; the sufferer feels that he letting people down, particularly his children. It is especially difficult for children to understand why Mum or Dad cannot take them out and do not seem to be like other parents.

Long-term tranquillisers also cause irritability and sudden mood swings. These, combined with the guilt that these feelings produce, can make their lives, and the lives of those close to them, very miserable. Patients may also resent those who are trying to help them, partly because the sufferer hates needing help, and partly because the other person can do things that they cannot. Those around the patient become thoroughly bewildered and do not know how to deal with him. Partners who cannot understand or cope often abandon the struggle and leave. Fear of going out can lead parents to keep children home from school so that they are not alone or obliged to go shopping. This causes further guilt because they feel that they are ruining their children's' future. Parents hate their children to see their own failures and inadequacies but it is often heartening to see how long-suffering and understanding children can be.

The essence of tranquilliser suffering is contained in one word: "fear". Life comes to consist of unexplained, irrational, uncontrollable fear. That fear is associated with a variety of physical symptoms; diarrhoea, irritable bowel, headaches, skin rashes, disturbed vision, queasy stomachs, shaking and vague aches and pains. Long-term tranquilliser use reduces self-esteem and confidence and this loss is often associated with fear. The sufferer feels useless and a burden to others. Because of these feelings he hates himself. He may lose the ability to rationalise and to understand why he feels as he does. Clients often feel bewildered and trapped in an unbearable situation. They see no way out. In many cases, the sufferer comforts himself by dwelling on how things used to be. It is common for an addict to hark back to events in the past that showed what a strong, successful popular character he once was. These sad recollections reveal his acute awareness of the consequences of tranquilliser addiction.

Patients must realise that their lives have been damaged by tranquillisers, not by any failing within themselves. This realisation is the essential first step of their journey back to life, a step which takes a great deal of effort. Some sufferers prefer to believe that the way they feel is due to a character defect, which needs treatment. This belief allows them to avoid making an effort, which can be painful and exhausting, to overcome their problem. Happily, most people are reassured when they realise that their situation has a definite external cause, and that they can do something about it. When you realise what tranquillisers have done to your life you may feel bewildered and amazed. How could a prescribed drug do this to you? The same confusion is felt by some doctors who find it difficult to accept that these tablets, whose familiar, comfortable, names they are so used to prescribing, have caused such havoc. It is important that society appreciates the dangers of tranquillisers and is aware of the severe damage that they have inflicted on all too many lives. Awareness is increasing but there is still a very long way to go.

CHAPTER 4

WHY THEY DO IT

Those who have suffered the strange and diverse symptoms of long-term tranquilliser use and withdrawal are often curious to know just what causes these strange effects. The most probable explanation is that these drugs disturb the balance of the mechanisms of the brain by excessively enhancing the action of GABA.

People taking benzodiazepines often feel that they are handling the stresses of life more effectively than before, at least in the short term. The reality is that the drug has just reduced their awareness of life so that they react less dramatically. Because they can deal with the reduced flow of stimulation they think they are coping successfully with life. In fact their perception has become a distorted blunted version of reality.

As treatment continues on benzodiazepines the brain and nervous system appear to fight to return to normal. This may be why the symptoms of anxiety return in many cases and their only way to keep these symptoms suppresses would be to increase the dose of benzodiazepines.

The agonisingly amplified symptoms experienced by those who “cold turkey” or even just stop too quickly is caused by the too sudden release of the excessive calming effects of benzodiazepines on GABA. The nervous system calmed down and dulled by the tranquilliser suddenly becomes acutely sensitive and overloaded. I liken this to the lid being lifted off a pressure cooker. During the time that the drug has been ingested at the full dose a dull grey world becomes the every day reality so the return of normal sensations and the sudden sharpening of experience can be very disturbing. These sensations along with feelings of unreality, changing perceptions of people, places and objects, and sometimes not even knowing who you are anymore for many people are milestones on the road back to normality. If this is understood then it is easier to cope with these strange changing thoughts and perceptions.

Gradual withdrawal returns the receptors to normal more gently and allows time for adjustment chemically, behaviourally, psychologically and emotionally and it is far more sensible to withdraw the drugs more slowly to minimize the shock to the system.

In my experience those who withdraw slowly recover far more quickly

than those who stop more suddenly so there is no advantage in abrupt cessation. The length of time taken to recover seems to be determined by the length of time the system takes to calm down and get back to normal once the effects of the benzodiazepine are removed. Recovery is therefore very idiosyncratic and impossible to predict how long it will take for any individual. Indeed it is unwise to guess because of the disappointment which follows when the prediction proves to be inaccurate.

Many people have taken benzodiazepines for ten years or more and so it not surprising that it may be a slow process to return to normal. The first few months after stopping the tablets are often the most difficult. Whilst still taking the drug, even though withdrawal is taking place it is much easier to accept the symptoms. When the drug is no longer being ingested it becomes harder for people to believe that the symptoms are still coming from the drug withdrawal, this is often the stage when most support is required. It is at this point that there is least belief by the individual that full recovery can take place. It is vital the perseverance takes place in order for the system to have a chance to return to a balanced state once more. Being able to talk to someone who understands the problem is very helpful and it means that the person is far less likely to resort to taking the benzodiazepine once more. It is at this time that a good listening ear at the end of a helpline may really make a difference.

CHAPTER 5
TYPES OF DRUGS

There are many misconceptions about tranquillisers; this book is intended to dispel them. Information is vital whether you are a tranquilliser addict yourself or a relative or friend of an addict. Too often, sufferers have remained unnecessarily bewildered and confused for many years. They see no escape from the trap they are in and often believe that they have some severe mental or physical illness. If the information they needed had been available to them, much of their anxiety could have been avoided. Those close to tranquilliser addicts need to be perceptive, supportive and understanding. When the effects of tranquillisers are damaging the lives of both the sufferer and of those close to him these qualities can be difficult to maintain.

The drugs that we are concerned with belong to one group called the benzodiazepines. The individual drugs differ slightly but, for all practical purposes, they are identical and it is important to understand that if you are addicted to one benzodiazepine you are addicted to all of them. Tranquillisers addicts must be wary of withdrawing from one drug in the group and then accidentally being prescribed another which could undo all the time and effort put into withdrawal. One of the most common problems during withdrawal is insomnia. Unfortunately the most frequently prescribed sleeping tablets are themselves benzodiazepines and, unless you are aware of this, you could very easily lose all the benefits of withdrawal by taking a prescribed sleeping tablet. Here is a list of the most common benzodiazepines.

COMMON BENZODIAZEPINES	Brand Name	Action
DAY-TIME TRANQUILLISERS		
DIAZEPAM	VALIUM	LONG
LORAZEPAM	ATIVAN	SHORT/MEDIUM
CHLORDIAZEPDXIDE	LIBRIUM	LONG
OXAZEPAM	SERENID	MEDIUM
KETAZOLAM	ANXON	LONG
CLORAZEPATE DIPOTASSIUM	TRANXENE	LONG
PRAZEPAM	CENTRAX	LONG
CLOBAZAM	FRISIUM	LONG
MEDAZEPAM	NOBRIUM	LONG
ALPRAZOLAM	XANAX	VERY SHORT
CLONAZEPAM/KLONPIN	RIVOTRIL	LONG
BROMAZEPAM	LEXOTAN	MEDIUM

SLEEPING TABLETS

NITRAZEPAM	MOGADON	LONG
FLURAZEPAM	DALMANE	LONG
TRIAZOLAM	HALCION	VERY SHORT
LORMETAZEPAM	NOCTAMID	MEDIUM
TEMAZEPAM	NORMISON/EUHYPNOS	MEDIUM
FLUNITRAZEPAM	ROHYPNOL	LONG

'Z' DRUGS

ZOPICLONE	DORMANOCT	SHORT/MEDIUM
ZOLPIDEM	STILNOCT	SHORT
ZALAPLON	SONATA	SHORT

Sleeping Tablets

The drug companies, for obvious commercial reasons, give similar drugs different names to suggest that they have different uses. Because of this, many people have found (to their surprise) that they were taking several benzodiazepines, each for a different reason. Sleeping tablets are a very bad way of treating insomnia and the reasons for sleeplessness should be established before they are even considered. In the past, tablets have been prescribed far too readily, causing problems of addiction without improving sleeping patterns. Sleeping tablets rarely work for more than fourteen nights. If you take them for longer you damage your sleep pattern rather than improve it. You will soon find that you sleep fitfully with the tablets, and not at all without them.

Psychologically, sleeping pills cause great problems. We all have high expectations of sleep and quickly weaken when we are deprived of it. However, we often sleep for far longer than we need and patients often visit their doctor to complain of insomnia after missing only one or two nights' sleep. When the problem of insomnia first arises, you should think of ways of dealing with it that do not involve drugs. There are several practical and simple alternative ways of improving the quality of sleep, but

unfortunately, while sleeping tablets were regarded as safe and effective, these methods were often ignored. If noise is preventing sleep, ear plugs are a more rational solution than a benzodiazepine sleeping pill. Other straightforward remedies like a hot milky drink or relaxing before bed-time, taking some fresh air or using a herbal remedy from a health food shop are all worth considering. If medication is really necessary; `Welldorm' or chloral hydrate are tried and tested products completely unrelated to the benzodiazepines.

We also find that Noni juice taken at bedtime helps with sleep. (See Chapter 21).

Longer and Shorter Acting Tranquillisers

There are two types of benzodiazepine, longer- and shorter-acting. The older drugs like 'Librium' (chlordiazepoxide), 'Valium' (diazepam) and `Mogadon' (nitrazepam) are longer acting. Their effect lasts up to twelve hours so they produce a hangover effect next day when taken as sleeping tablets and a feeling of fatigue when used during the day. Drug companies tried to produce shorter-acting tranquillisers, free from this hangover effect, leaving the user completely clearheaded. The results were drugs like `Ativan' (lorazepam), 'Normison' (temazepam) and 'Halcion' (triazolam). Unfortunately, short acting tranquillisers cause addiction more rapidly than the older longer acting drugs. Because of their short, sharp action they produce a feeling of well being very quickly, which makes them dangerously attractive. Patients often find it difficult to believe that they could possibly have become addicted to a drug like 'Ativan' so very quickly. Our experience suggests that there may be a greater tendency to increase the dose with the shorter acting tranquillisers than with the older longer acting products because of the short period of relief the newer drugs produce. This is particularly noticeable when the short acting drugs are used as sleeping pills. The period of sleep they provide is so brief that the patient takes more and more drug in a desperate attempt to sleep all night.

'Z' Drugs

In the 1990's a new breed of sleeping tablet came on the market; Zimovane (Zopiclone), Silnoct (Zolpidem), Sonata (Zaleplon). These are often referred to as the 'Z' drugs. Beware of these they have been shown to be virtually the same as the benzodiazepines in their action.

In 2003 I acted as a patient advocate for the NICE(National Institute of Clinical Excellence), the British body which analyses and discusses in great depth drugs and other medical technologies. NICE decided that 'Z' drugs really were so similar to benzodiazepines that doctors were advised to change patients to benzodiazepines. I suggested to NICE that diazepam should be recommended as the benzodiazepine to which patients should be transferred in order that they would be in a better position to reduce, but they did not take this advice and recommended Temazepam. I do not see the logic in this as people then have to change again in order to reduce and diazepam is an acceptable sleep agent and indeed works better and for longer for most people. To me this was a lost opportunity to advise about withdrawal. For more information on 'Z' drugs see the separate chapter describing withdrawal from them.

CHAPTER 6

WHY YOU SHOULD WITHDRAW

Some people think that patients are well while taking tranquillisers, and that illness and problems of withdrawal only happen when withdrawal begins. If the benzodiazepine enables the patient to lead a normal life, they say, why bother to withdraw it? In our experience most patients on benzodiazepines do not feel well. On the contrary, most are only too aware that something is wrong, but they do not know what. Many fear terrible illnesses, either mental or physical. Others have endured tests, x-rays, whole body scans, even spells in hospital in a fruitless effort to find out what is wrong with them.

The tranquilliser problem has three stages:

1. Starting to take the tablets; suddenly feeling good and wanting to continue.

2. Tranquilliser-induced illness after long-term medication. Patients experience acute anxiety with totally irrational fears, agoraphobia and inexplicable physical symptoms.

3. Withdrawal; in some cases the problems become more severe. However, if the patient understands what is happening and has support he will realise that, with perseverance, these problems can be overcome. This awareness makes it much easier for him to cope with the problem.

Some long-term tranquilliser addicts convince themselves that their symptoms are an unavoidable consequence of ageing. Repeated visits to the doctor with strange, persistent, undiagnosable symptoms have provided no relief. Only when withdrawal is complete do they realise just how well they *can feel.* Long-term tranquillisers dull the senses; colours are grey, sounds muffled, and there is a lack of awareness of the world around them. Many people experience real ecstasy when they re-discover the world of true perception during recovery. Some, quite literally, sing for joy. During long periods of tranquilliser use, feelings die and sufferers become unable to relate to their partners, friends or children. Sadly, marriages and relationships often break up, and, by the time the client seeks help, relationships may already have been destroyed. Many people deeply regret missing precious years with their children. Events which have taken place during the years of addiction,

marriages, births and deaths have sometimes vanished from memory. Action taken now will ensure that no more valuable time is lost.

Bereavement is a time when certain emotional processes must take place; there are no short cuts. Tranquillisers block this emotional readjustment and, after withdrawal, they may grieve for a death which happened many years before. Masking problems is never the answer. Learning to cope with them is what is needed . . . building on one's own resources, not numbing them. If you need help then go and get it; attend marriage guidance sessions, seek anxiety management courses. Often your doctor will know where to get help. The Citizens Advice Bureau is another useful source of information.

In time tranquillisers destroy the ability to cope with life. Everything becomes frightening. The telephone and doorbell terrify the sufferer. It is difficult for clients to realise that these extreme personality changes are caused by the drugs they have taken for so long. This realisation is the essential first step on the road back to life.

CHAPTER 7
THE C.I.T.A. WITHDRAWAL METHOD

If you have taken tranquillisers for longer than a few weeks, it is time you stopped. Start withdrawing the drug *now. ...* don't wait for the right time. If you have been on long-term tranquillisers you probably always feel anxious and you will never feel that the time is right to withdraw. On the other hand, if you are taking the drug to help you cope with some huge personal disaster, wait until things have settled down again before you start to withdraw. Some clients have been told that they are the sort of people who must always take tranquillisers. This is absurd ... such people do not exist! These drugs are meant to be taken for a very short time, no more than a few weeks. If you take them for longer, you are not taking the tablets to treat the original complaint, but because you are becoming addicted to them. *Nobody needs an addiction.* Age is no barrier to withdrawal; if you want to withdraw, there is no reason why you should not do so. Many older people feel far more alert and able to lead useful lives when they are not constantly drugged. Often, elderly people taking long term tranquillisers are wrongly labelled as senile simply because of the effects of the drug.

Once you have decided to change things and have sought help from your family, your doctor and possibly a self-help group you can start CITA's tranquilliser withdrawal programme. The first stage is to switch from your tranquilliser to a longer long acting one. We prefer diazepam because the tablets are easy to break up to give very small doses which simplifies gradual withdrawal. If you are already on diazepam you are one step nearer your goal before you start, but you must be strict about your dose. It is important to keep tranquilliser blood levels steady, so never alter the dose on your own account. Don't be tempted to skip a dose because you feel better ... you might need twice the dose on the following day. It might be wise not to cut down the dose on a particularly bad day but it is important that you do not increase it. The vital thing is to stick to the set dose regardless of how good or bad you feel. The chart below gives the equivalent dose of diazepam and other benzodiazepines mg for mg.

Using the CITA withdrawal method we advise transferring to diazepam all in one process in one day. We are aware that other organizations advise changing more slowly and if a client is on a very large dose of the original dose or is very keen to do it slowly than we will support them to do it gradually.

Our reason for doing it in one go is based on keeping it simple as clients get confused if they are taking two different drugs and also because we are keen to get rid of the action of the original drug particularly if it is more short acting. Also we have found the way we do it works well and clients have been happy with the method.

EQUIVALENT DOSES

OTHER BENZODIAZEPINES			DIAZEPAM (VALIUM)
Ativan (Lorazepam)	1 mg	=	10 mg
Normison (Temazepam)	1mg	=	¾ mg
Nitrazepam (Mogadon)	1 mg	=	1½ mg
Flurazepam (Dalmane)	1 mg	=	1 mg
Oxazepam (Serenid)	1 mg	=	¾ mg
Clorazepate (Tranxene)	1 mg	=	1½ mg
Chlordiazepoxide (Librium)	1 mg	=	¾ mg
Triazolam (Halcion)	1 mg	=	20 mg
Alprazolam(Xanax)	1mg	=	12mg
Prazepam(Centrax)	1mg	=	1mg
Medazepam(Nobrium)	1mg	=	1mg
Bromazepam(Lexotan)	1mg	=	2mg
Loprazolam	1mg	=	8mg
Lormetrazepam(Noctamid)	1mg	=	8mg
Flunitrazepam(Rohypnol)	1mg	=	10mg
Clonazepam(Rivotril)	1mg	=	20mg

C.I.T.A. uses these conversion figures and finds that they work well. They can only be approximate and may need adjustment according to the needs of the individual client. Older people, for example, might find that they need rather lower doses than the direct equivalent would suggest, often three quarters to half the dose for the over seventy age group.

N.B. These conversion figures are different from those in the BNF and have been devised from 20years experience with clients withdrawing from benzodiazepines.

Conversion to diazepam offers several advantages:

Clients realise the true size of the doses they take.

Diazepam can be withdrawn more gradually than a short-acting tranquilliser.

Diazepam tablets can be divided fairly accurately into pieces so the dose can be reduced by small amounts and clients can easily divide their dose as they wish throughout the day.

Diazepam comes as a syrup which can be diluted to give the really small doses needed during the final stages of withdrawal. Patients withdrawing from diazepam usually sleep quite soundly.

If you have previously varied your dose from day to day you must first decide what dose you can manage on. Do not start with a dose far less than you need to help you to cope. If you do you will probably be tempted to increase it later. Start with a realistic dose and stabilise on it for a couple of weeks. If you are on a high dose of a short-acting tranquilliser you may find it difficult to persuade your doctor to prescribe the equivalent dose of diazepam. Few doctors realise that the newer short acting tranquillisers are very much more potent, mg for mg, than the older long acting drugs. Normally doctors are reluctant to prescribe more than 40 mg of diazepam a day so if you were taking 5 mg Lorazepam daily you would probably have to convert to 40 mg diazepam instead of the exact equivalent of 50 mg. The general rule is to convert to the exact dose and then subtract between an eighth and a fifth. This is not a rigid requirement and the important thing is to find the equivalent dose that suits you as an individual. The aim then is to reduce the dose by about 1 mg a fortnight. Once it has fallen to between 2mg and 4mg a day the

fortnightly reductions will probably have to be less than 1mg. With diazepam syrup you can reduce the dose by very small amounts quite easily. If the starting dose of diazepam is higher than 20mg it is easier to make fairly substantial fortnightly reductions and it may be possible to cut down by 2mg to 2.5 mg at a time.

Most people develop a routine for their reductions, but there are no hard and fast rules, the method should suit your life style. Really, it does not matter how slowly you cut down as long as you are getting there. Many people feel that their own body tells them when the time is right to lower the dose. The effects of a cut in dosage usually occur one to two days later and then settle down again. Cutting down, adjusting to the effects of the cut then stabilising on the lower dose, soon become part of a regular routine. When you convert to a long acting tranquilliser you will often feel extremely sleepy for several days. If you normally sleep very badly, this can be a welcome blessing but it worries some people, and it is important that you are aware of the possibility in advance. Doctors and self-help groups should prepare clients and provide plenty of support during this period. C.I.T.A. maintains daily contact with clients throughout this particularly trying first few days. Reassurance and encouragement give essential support to clients in their fight against the temptation to turn back.

Knowing what to expect throughout withdrawal removes a lot of the fear that clients can experience during this period. Most people who have abandoned the attempt to withdraw have given up because they were frightened by the withdrawal symptoms and never knew what to expect next. At this stage self help groups can be extremely useful by simply introducing clients to people who have already withdrawn successfully. Meeting people who listen and show an interest and who know the feelings that they are experiencing can provide a great deal of comfort. Families must also try to be positive and encourage their relative, reinforcing the work of the self-help group. The family is there when others are not, and they must gently push the addict through withdrawal, despite set-backs and distressing symptoms. However difficult withdrawal may be it carries hope for the future. To endure the problems of withdrawal with a clear end in sight is infinitely preferable to the endless suffering of continued addiction. It is important to realise that going back gains nothing and can lose a great deal. Clients must devote all their attention and energies towards the single goal of a drug free future. The one certainty about tranquilliser withdrawal is that if you persist you will succeed. Once you have withdrawn completely time will ensure that your true personality and your natural ability to cope with life make a welcome reappearance.

Everyone wants to know how long the process of withdrawal will take. This is an extremely difficult question to answer because every individual is different. The rule of thumb at one time was that withdrawal took one month for every year of addiction but it is unwise to apply this too strictly. It is probably unwise to give any firm estimate. If the prediction turns out to be too optimistic, clients are inevitably disappointed, start to worry and become less highly motivated. In practice, as time goes on, the good days start to outnumber the bad until withdrawal symptoms only occur very occasionally. At that stage the client is familiar with the pattern of his particular withdrawal symptoms and they no longer frighten him. He is well on the way to complete withdrawal. It can be very off-putting at the outset to say that withdrawal symptoms can continue for several years but it is, unfortunately, perfectly true. This does not mean that every day will be sheer hell. It means simply that symptoms can recur, and you must be able to recognise them. Withdrawal symptoms will taper off, but not always evenly and some times they will recur unexpectedly. Again there is very wide individual variation, some people will have acute symptoms late in the withdrawal process and others will have few or none. When they near the end of the withdrawal period many people ask "Well what now? What do I do if I can't cope in the future?" The important thing is not to think of taking tablets as the first response to a new problem or anxiety. You must become familiar with other, non-pharmaceutical, methods of handling your difficulties. You must never forget that resorting to chemicals to help you deal with your problems created your addiction in the first place.

Some organisations teach techniques of anxiety management before starting withdrawal. We believe that it is extremely difficult for people who are taking tranquillisers to learn to manage their own anxiety. They find it very hard to concentrate and their jumpiness and nerviness make it difficult for them to grasp new ideas. After withdrawal, we use yoga breathing to provide an alternative method of coping with the stress of life. We have found this type of breathing to be highly successful and invaluable for teaching the correct breathing methods which play such an important part in the overall management of anxiety. At our weekly meetings, we practise the simple relaxation and abdominal breathing exercises which we believe are vital techniques. These useful methods of relaxing and coping give an answer to that terrifying question: "What do I do when I've taken the last little piece of tablet?"

Tahitian Noni

Initially it was thought that Noni would help by supporting the immune system and thus helping keep people healthy during withdrawal. However, we discovered that if small amounts of Noni juice are taken each day during withdrawal then recovery seems to be quicker after the drugs cease to be taken.

Little and often is the secret with Noni.

See chapter covering this topic.

CHAPTER 8

COPING WITH WITHDRAWAL SYMPTOMS

I shall deal with some of the most common withdrawal symptoms here but there are many others. Remember that nobody ever suffers from all of them at once and that you have probably already experienced some of them while you were taking the tablets. They tend to come in turn, rather than all at once and you are most unlikely to encounter all of them.

Agoraphobia

This is a symptom of fear, and tends to be a fear of meeting people than of simply going out. Paradoxically, many people started to take tranquillisers to cure agoraphobia. More often, however, they develop it because of the tablets. Agoraphobia ranges from an inability to go out at all, through being unable to go out unaccompanied, to simply not wanting going out but being able to do so with an effort. Though there is no doubt that agoraphobia is real and that it is caused by the action of the chemical on your body, your attitude can make it better or worse. It is important that you fight against any disinclination to go out. Once you give in to it agoraphobia can overwhelm you so, at all costs, try not to surrender to it. You are the only person who can arrest its progress. We help you deal with this problem, and the closely related one of Panic Attacks, by teaching you a technique called: "Desensitization by Paradoxical Intent". I will describe the technique in detail when we discuss Panic Attacks.

Usually, as withdrawal continues, the agoraphobia lifts. Sometimes it lifts very quickly, soon after converting to diazepam. Remember that it will go, but that you must fight it because your attitude is so important. It is not helpful for others to take over your responsibilities completely, making it possible for you not to go out at all.

Lack of Self Esteem and Confidence

This is universal amongst tranquilliser sufferers and is closely related to agoraphobia. Both prevent the sufferer from seeking help because they become too withdrawn to make the first approach. Why long-term tranquilliser users suffer from this lack of confidence is unknown. It is an insidious symptom and it is particularly hard for the sufferer to appreciate that the chemical, rather than any change within themselves, is responsible for it. I have heard people say that they are unable to look in the mirror because they dislike themselves so intensely. This can cause grave problems

for a man who needs to shave! Very little can be done to counter these feelings of worthlessness except to help clients to understand that the feelings are caused by the drugs, and will go eventually. Relatives and friends can help by building the sufferer's confidence and by being careful not to reinforce his feelings of worthlessness. If the addict persists with withdrawal his confidence will, almost miraculously, return to normal.

Guilt and Shame

Many tranquilliser sufferers feel guilty and ashamed; guilty that they have become addicted and ashamed to admit that they are drug dependent. The guilt is often directed towards partners and children because the addict feels unable to supply their needs. Because he resents others' ability to cope better than him, his guilt often leads to irritability and anger. This can be very bewildering for his family who, although they may not understand, are trying their best to help. These feelings can destroy personal relationships. Society reinforces the tranquilliser sufferer's feelings of guilt and shame because, in spite of publicity, there is still a general belief the addiction shows weakness and should be hidden. It is difficult to admit to an employer that you are addicted to tranquillisers, and it can, be a sure way to lose a job. Rarely, if ever, is "tranquilliser addiction" written on a sick note. It is usually disguised as "depression", "anxiety state", "nervous debility" or one of a host of similar vague but acceptable diagnoses.

We believe that more and more publicity together with the courage of those who are prepared to say: "This is what has happened to me, I have been addicted to tranquillisers" is the only way to lift the stigma of tranquilliser illness and addiction. Employers, doctors, addicts and society in general all need to acquire a deeper understanding of the problem. This is why we are so grateful when the media devote their attention to the problem.

Fear

Fear is the dominant symptom associated with long-term tranquilliser use. Ironically, it was one of the commonest symptoms for which the drugs were initially prescribed. The fear which remains is often quite irrational; fear of the telephone or doorbell for instance. Some clients develop morbid fears of cancer, or of some impending disaster. Others have undergone exhaustive medical tests with entirely negative results but are still convinced that they have some dreadful disease. Some describe strange and disturbing mental sensations as if one half of their

mind is tormenting the other with all that they fear most acutely. Many people contact C.I.T.A. in an extremely disturbed state because of these psychological symptoms. All these feelings, disturbing as they are, gradually disappear as withdrawal continues. They are symptoms of benzodiazepine withdrawal, not signs of mental illness.

Panic Attacks

Panic attacks are very common. They affect people who have never taken tranquillisers, patients on long term tranquillisers and those withdrawing from tranquillisers, quite indiscriminately so there is no point in taking tranquillisers to stop them. Panic attacks are often brought on by shallow breathing which decreases the level of carbon dioxide in the blood. Usually a panic attack is triggered by a specific event. To control the attacks you need to identify the cause of the attack and you try to learn to control your breathing.

When people feel anxious they breathe very shallowly which causes feelings of panic, dizziness, pins and needles and muscle spasms. You must learn to control this feeling of panic. Establishing control removes the element of fright. We teach you to establish control with a technique called "Desensitization by Paradoxical Intent" (DPI). Older methods of dealing with the problem involved setting small goals which were raised at each attempt until the patient was eventually able to confront the full cause of his fear and panic. For instance, on the first day he would walk to the gate, on the second day to the lamp-post, on the third to the corner of the street and so on. The problem was that patients often panicked as they moved from the goal that they reached yesterday towards the goal that they should attain today. DPI avoids the problem by talking the patient through a situation which provokes panic and persuading them to confront the true cause of their feelings. Once they can accept and understand these feelings they can begin to control them.

An example shows the method in action. Our client lived in a block of high rise flats and found that she could only get as far as the lift door before experiencing a severe panic attack. After she had completed withdrawal her confidence had improved but she was still unable to use the lift unless she was accompanied. We explained the idea behind DPI to her and gently urged her to imagine that she was now entering the lift alone. We repeated the process with her over a long period until she could control the feelings of panic that her imaginary journey provoked. Now she has recovered from her agoraphobia and is able to go out alone whenever she likes, without panic.

Understanding the cause of panic attacks is important. These are usually brought on by the effects of adrenaline and rapid, shallow breathing (hyperventilation), resulting in palpitations, sweating, unsteady legs, and trembling. Withdrawing from benzodiazepines often leads to continual over-production of adrenaline, and thus panic attacks. Understanding that these attacks are not physically dangerous makes them less frightening. Deliberately extending the diaphragm while breathing in, holding this, then gently breathing out slowly, (abdominal breathing), restores the balance of gases. Also consciously developing a link between the onset of a panic attack and controlling this by correct breathing has a deeply calming effect.

When you first start DPI it may seem inconceivable that anyone would want to bring on a panic attack deliberately. Improbable as it may seem, the deliberate production of panic attacks does work. Slowly you will find that your response becomes less and less dramatic. Eventually your feelings of panic will disappear altogether. Do not dismiss DPI just because it sounds improbable. It can be extremely effective.

It also can be extremely useful to practice abdominal breathing and try to consciously do breathing exercises two or three times every hour. You will forget sometimes but at least aiming for this means that you will become comfortable with abdominal breathing and also may mean that you may avoid some panic attacks but feel more able to cope by using this breathing if a panic attack comes on.

Problems with Sleeping

Do not be surprised if your sleep is disturbed during withdrawal. In many cases, sleep was difficult while taking the benzodiazepine, and there is no improvement during withdrawal. If sleep is a particular problem, it may be advisable to take most of your diazepam dose before bedtime. Getting plenty of exercise also encourages sleep and sitting around all day is unlikely to make you feel tired at bedtime. Sleeping tablets of any kind are a mistake. You must make a real effort to readjust your sleep pattern instead. Many sufferers get into bad habits during withdrawal and sleep late in the mornings or doze in the afternoon. To their surprise they then find it impossible to sleep at night. However tempting it may be, it is important to get up fairly early, and not to sleep during the day. When you go to bed, it is wise to take a book or magazine to read and a warm milky drink like Horlicks. If insomnia is a real problem it is wise to sleep alone so as not to disturb your partner. You should accept sleeplessness as a symptom of withdrawal which will disappear as you

gradually get better. Worrying about sleep is the worst way to deal with insomnia. If sleep does not come, sit up and read or go and make a warm drink, don't lie in bed and think about insomnia.

Dreams and Nightmares

Many people complain of vivid dreams and nightmares during withdrawal. Believe it or not this is a good sign! Before withdrawal, most people do not dream. Drug induced sleep is "dead" sleep with little of the rapid eye movement which occurs during dreaming. As withdrawal proceeds dreaming starts again producing the vivid nightmares which can be so disturbing. These dreams, however disturbing they may be, show that your sleep is returning to normal. Our dreams, even those we forget, are important to our continued good health. Dreaming helps our minds to adjust to the past and to reconcile it with the present which is why recollected dreams have such a fractured timescale. Non-dreaming sleep does not allow us to make this adjustment. Nightmares and dreams are a positive sign that your body is readjusting successfully to life without tranquillisers.

PHYSICAL SYMPTOMS

I can deal with only some of the Physical symptoms of withdrawal here. These symptoms can affect almost every part of the body and we meet new ones every day. Despite all I have said about the connection between the tranquilliser and the withdrawal symptoms it is essential to seek medical advice when severe symptoms first appear. Tranquilliser addicts are not immune from ordinary physical illnesses!

Many symptoms are related to two things:

1. **Adrenaline**

2. **Hyperventilation**

Long-term use of tranquillisers causes overproduction of adrenaline and a continual feeling of panic and fear. Understanding this connection makes the panic easier to deal with. The best way to use up adrenaline is to exercise and clients who use exercise to help withdrawal tend to do very well. Sitting staring at four walls is not a good way of dealing with adrenaline and tea, coffee and tobacco make its effect even worse. It is a

good idea to drink less tea and to give up coffee altogether. Coca Cola also stimulates adrenaline and is best avoided. It is difficult to give up smoking during withdrawal but nicotine is a powerful stimulant and can make you feel even more panicky. Smoking less may help, although you may want to smoke even more; try to curb this urge.

You may find that drugs called beta-blockers are helpful. Your doctor will have to prescribe them for you so you will first need to talk to him about your symptoms. These drugs control some of the effects of adrenaline, particularly the shaking and trembling and some clients have only managed to complete withdrawal because they have been able to use them to control these symptoms. C.I.T.A.'s medical adviser recommends beta-blockers in the "Protocol letter" that we send to our clients' GPs. For medical reasons, some people cannot take beta-blockers. Your doctor will know whether they are suitable for you.

Although our aim is to persuade people to manage without drugs altogether it is foolish to take things to extremes and avoid those which can help you to end your addiction. Most people with experience of benzodiazepine withdrawal agree that beta-blockers can be useful and that antidepressants can be especially valuable if depression becomes really intense. They also help you to sleep well. These other drugs are short term *props* to support you during the most difficult phase of withdrawal. They do not have the addictive capacity of the benzodiazepines and you will not run the risk of substituting one addiction for another. Some people turn to alcohol to help them deal with withdrawal symptoms and as an aid to sleep. Unfortunately, alcohol itself can precipitate withdrawal symptoms. There is also a real danger of becoming drunk very quickly, and the hangover and depression that follow often bring an irresistible temptation to go back onto the tranquillisers. Alcohol is best avoided.

Is anything enjoyable good for withdrawal symptoms? Yes, sex helps use up adrenaline, and is a very enjoyable form of exercise which, generally speaking, improves your view of life! Although libido tends to diminish during withdrawal it always comes back. Some people experience quite the opposite effect, a great increase in their need for sex during withdrawal. You may be one of them!

Aches and Pains

It is easy to understand the aches and pains in muscles during withdrawal when you realise that the benzodiazepines are muscle relaxants. Now withdrawal is taking place, your muscles are no longer relaxed and they complain about the work that they have to do causing aches and pains all over your body. These aches and pains are brought on by over sensitivity of nerve endings. Your central nervous system was depressed and the nerve endings' perception of sensation was dulled by the benzodiazepine. Now the nerve endings are coming back to life and producing sharp sensations. Some people find that their clothing hurts their skin and may also complain of a burning sensation in various areas of the body. Other clients complain of pain in old wounds, on operation scars; wherever there is a weak point, there is a likelihood of pain during withdrawal.

Some tingling sensations and cramps are due to over breathing. Abdominal breathing may ease these symptoms. Some clients suffer severe pains in the gums and jaw and should beware of having teeth extracted unnecessarily. If facial pain becomes very severe, a pain killer called Tegretol may be effective. Tregretol is a treatment for trigeminal neuralgia, jaw pain similar to that felt during tranquilliser withdrawal. You will need a prescription for Tegretol so first talk to your doctor. All these aches and pains disappear when withdrawal is complete. Another fairly common and rather alarming symptom is the feeling that your legs have suddenly turned to jelly and some people feel as if they are walking on a thick layer of cotton wool. There is no obvious explanation of either symptom and they never persist after withdrawal is complete.

Gastric Irritation

Many clients complain of gastric irritation which can be very distressing. Antacids may help and a product called `Gaviscon' is very effective in controlling heartburn during withdrawal. Strangely, some clients were originally prescribed tranquillisers for stomach irritation. As treatment continued the tranquilliser itself has started to irritate the stomach and the stomach problems resolve after the tranquilliser is withdrawn.

Bowel Problems

Bowel symptoms like diarrhoea, flatulence and distended abdomens are very common during withdrawal. Medical tests are often carried out with negative results. Once withdrawal is complete these bowel

problems will disappear and if you stick to the recommended diet they will improve even more rapidly. Sometimes, an irritable bowel syndrome that has been giving trouble for years disappears after withdrawal.

Benzodiazepines, initially given as a treatment, have gradually worsened the condition.

Arthritis

Although they are effective muscle relaxants, benzodiazepines worsen arthritis in the long run. Many arthritic clients describe a noticeable improvement in their symptoms after withdrawal.

Rashes and Hot and Cold Flushes

Some patients experience rashes which usually come and go quite quickly, and do not require treatment. Feelings of burning and extreme heat and sweating are common and often clients wake up, sweating profusely, during the night. Conversely, some clients experience sudden sensations of cold. All these unpleasant problems are known withdrawal symptoms and they will disappear eventually

Eye Problems

Eye problems, burning eyes, double vision and photophobia are common and many eye tests are carried out, usually with negative results. Sunglasses may help during withdrawal. All these effects are caused by nerve endings coming back to life. Some people suffer double vision and difficultly in focusing. This may be due to the effect the muscle relaxant effect of benzodiazepines and then of reducing this by withdrawing the drugs.

A Tight Band around the Head

Some clients find that the muscles in the neck become very tense and that their shoulders hunch up. There is a great deal of tension in the neck muscles during withdrawal and sometimes these muscles tend to shorten. Practising abdominal breathing and getting someone to massage your neck and shoulders may help to relieve this discomfort. Hunched shoulders are a sign of tension which produces extreme discomfort. Try consciously not to hunch your shoulders, especially when sitting. Walking in the fresh air often helps to relieve tension. This will also help relieve tension, headaches and pain in scalp muscles.

Tinnitus and Noises in the Head

Many people describe noises within the head and/or noises in the ear(known as tinnitus). Both these symptoms are very common in withdrawal. Sometimes they will settle and disappear once withdrawal has been completed but sometimes the symptoms will stay, particularly the tinnitus, and varies from person to person.

Mouth Ulcers, Skin and Dental Problems

It is important that your vitamin intake is sufficient. A multivitamin or vitamin B complex tablet each day might help. Withdrawal is exhausting and leads to feelings of debility. You should follow the withdrawal diet and take the vitamin supplements recommended by C.I.T.A. They are described a little later.

Sinus Problems

Many clients suffer from inflamed mucous membranes which cause severe sinus discomfort. Steam inhalations and menthol lozenges often help. Sinus problems usually ease up significantly as you persist with withdrawal. Some people through withdrawal suffer excess mucus, other find that they can from time to time feel that mouth; throat, etc. can feel very dry.

Balance Problems

Some clients experience problems with balance when reducing their tablets. Some describe feeling it is as if they are on board on ship. It is not clear why this happens, it is thought this may be to do with the cerebellum or it may be related to the effects of adrenaline which causes these jelly legs and cotton wool type feelings in the legs and the head. Some people seem to feel these sensations are all associated with each other. Where the problem is distinctly one of balance it may be necessary to take a drug treatment such as stemetil or stugeron. However, if possible let these problems settle down naturally as a drug has caused the problem.

Nausea Problems

Some clients experience feelings of sickness and perhaps dizziness from time to time during withdrawal. Usually this is short lived but if you need to take something, Buccastem is an over the counter remedy, some people find stem ginger very helpful and a natural remedy. Should sickness become very severe you may need to see your doctor.

Hyperventilation Problems

Hyperventilation is the process of fast shallow breathing which occurs when humans are anxious. It is a particular in benzodiazepine withdrawal and leads to panic attacks.

When hyperventilation takes place it does not allow optimal gaseous exchange in the lungs resulting in an inadequate mixing of carbon dioxide and oxygen. Oxygen can only work adequately if there is sufficient contact with carbon dioxide. The brain picks up on the lack of oxygen and this leads to stimulation of the adrenal cortex to produce further adrenaline which contribute to sensations of panic.

It is helpful to learn to breathe more deeply and more slowly. I encourage clients to extend the diaphragm as they breathe in through the nose and then hold the breath for a slow count of three and then very slowly let the breath out for a count of seven. This remedies the effect of hyperventilation and thus has a calming effect. I encourage clients to do this breathing two or three times every hour and to bring it into action should they feel a panic attack coming on.

Once panic attacks have been controlled a few times it has the effect of convincing the sufferer that they have some control over their panic and this in itself usually means that panic attacks will happen less often. I have heard panic attacks described as ‘a fear of fear’ and this means that people can bring on panic attacks by being afraid of them. Feeling you can control panic an attack gives you confidence and makes them less likely to occur.

CITA runs relaxation classes helping people to relax and using this breathing technique as an important part of the relaxation process. We also auricular acupuncture at our group meetings, this helps induce relaxation, helps with insomnia and detoxification.

OVERVIEW

The symptoms of withdrawal can mimic an alarming variety of illnesses, both mental and physical.

Remember they are symptoms and not diseases . . . symptoms that show you are progressing along the road that leads

back to life . .

DO NOT GIVE UP!

CHAPTER 9

TRANQUILLISERS AND HORMONES

Benzodiazepines can affect hormones in both male and female, producing disturbed periods, breast secretions, falling hair, enlarged prostate glands, loss of libido and even changes in voice. These symptoms do not happen to everyone, but they should be considered as a possibility. All of them disappear after withdrawal. Nevertheless, they can be confusing to the sufferer. Many women have believed that they were going through the menopause during tranquilliser withdrawal and did not appreciate that tranquillisers were causing the problem. Period disturbances should always be investigated, but if no cause is found it may be that benzodiazepines are causing the problem.

Premenstrual Tension

Some women find that tranquilliser withdrawal adds to the problems of premenstrual tension and that taking vitamin B tablets, evening primrose oil, or a diet comprising of fresh food rather than processed and plenty of fresh fruit and vegetables may ease the problem. Menstruation may make withdrawal difficult and some women find it difficult to persist with withdrawal during their periods. Self-help groups can provide useful support for women with this problem. Vaginal infections like thrush are common during withdrawal but they respond to normal treatment. Cystitis may also be a problem during withdrawal and it is important to drink plenty of fluid and keep the vaginal area especially clean.

Benzodiazepine withdrawal has been linked with prostate enlargement and an enlarged prostate should always be investigated to eliminate the possibility of malignancy. However, if the condition is benign it may be wise to delay surgery, especially in a younger man, as the condition may well resolve after withdrawal. Urinary frequency may be a problem in both sexes and, like the other symptoms; it should be investigated if it persists. If there is no other cause, then it is fairly safe to assume that withdrawal is the reason. Perseverance will resolve the problem.

CHAPTER 10

ALCOHOL AND TRANQUILLISERS

It is ironic that tranquillisers are prescribed for some sufferers to help them to recover from alcohol addiction. In many cases, the patient became addicted to benzodiazepines as well as alcohol and it is now recognised that the benzodiazepines are not an effective treatment for alcohol addiction. Some people may be naturally more prone to addiction than others. This is an arguable proposition but it is easy to see how tranquillisers, given to help one addiction, might be the start of another. Alcohol often becomes a problem during tranquilliser withdrawal and it can prevent full recovery from tranquilliser addiction. Addicts who substitute alcohol for tranquillisers are unlikely to achieve their goal. This problem is greatest amongst our many male clients. Unfortunately the socially acceptable macho male image makes drinking acceptable or even creditable. Learning to "hold your drink" is still a universal male rite of passage. It is far easier for a man to admit to heavy drinking than to taking tranquillisers.

Benzodiazepines and alcohol are a lethal mixture. Both are powerful nervous system depressants and one potentiates the action of the other. In a patient who is already depressed, alcohol and tranquillisers may make the depression extremely dangerous. Alcohol destroys the sound discipline necessary for withdrawal by removing the normal inhibitions. It also intensifies the withdrawal symptoms that so many addicts can barely cope with when sober. Many people get drunk much more quickly than normal when they consume alcohol as well as taking tranquillisers. Alcohol and benzodiazepines both reduce inhibitions and behaviour seen under their influence is often quite out of character. Sometimes clients find it very difficult to believe that they behaved so badly because alcohol and tranquillisers have obliterated the memory of their uninhibited aggression. Driving a car after taking tranquillisers is exceedingly dangerous and this is often underestimated.

The habit of social drinking, especially for men, makes it particularly difficult to avoid alcohol. Many men fear that they will lose their friends if they do not drink, a chance they will not take. This is a barrier, which can be extremely difficult to overcome. Often it is not until the sufferer realises just how much is at stake that he is prepared to discipline himself. The

sufferer's partner often finds it impossible to tolerate the lack of self-discipline caused by alcohol. Withdrawal goes well until the client starts to drink, after which the plan collapses like a pack of cards. Hangovers lead to lying in until midday, an inability to cope in the afternoons, and insomnia the following night. Often, it is only when the partner makes it quite clear that they will no longer tolerate the situation that clients realise that alcohol is destroying them. The problem faces both male and female clients but women seem better able to avoid it. The importance alcohol in male society means that male tranquilliser addicts are always more at risk from alcohol abuse.

CHAPTER 11

SELF-HELP GROUPS

Self-help groups are springing up all over the country, often started by people who have recovered from tranquilliser addiction and want to help others. These groups serve many purposes, and for many people they provide a vital key to recovery. The sufferer loses his feeling of isolation and discovers that other people are putting his feelings into words. Often they want to shout, "I've felt that too!" It is amazing to see how withdrawn, timid people suddenly emerge from their shells when they meet others with the same problem. Often, people cannot pluck up courage to come on their own and most groups encourage other members of the family to attend as it helps them to realise that their relative is not alone with the problem.

Some self-help groups first see people on their own so that they are familiar with their history before the client attends the meeting. Sometimes, because of agoraphobia, this interview may need to be carried out in the person's own home and many groups now offer home visits. However, those who do manage to come to meetings, even though they need to be accompanied, tend to do best. People are generally more successful when they play an active part in trying to solve their problem. Self-help groups will usually help to formulate a withdrawal plan and they should do this as a team, working alongside the client's doctor. C.I.T.A. always maintains contact with GPs, because sometimes doctors need to be encouraged to take a greater part in supporting the patient's efforts to withdraw. Self-help groups can provide support for doctors who are often worried about the amount of time they need to devote to the management of tranquilliser withdrawal. If a client feels he can contact someone whenever he experiences a new symptom or when symptoms are really severe, he will gain the courage to continue. Self-help groups must always remember that, although symptoms may be caused by withdrawal many still need investigation. Tranquilliser addicts are not immune to other illnesses and when people call the CITA helpline we are very aware of the possibility of other health conditions being present and we are careful not to assume that everything is due to benzodiazepines.

Self-help groups provide their own network of support and there is often a wonderful sense of camaraderie among their members. I am often surprised at how often the members contact each other, and how concerned they are for each other's well-being. Social events and outings are usually a feature of such groups, and help to make life worth living. Often, clients become interested in helping their group as a whole, and this reawakens their

interest in life. It is helpful if tranquilliser support groups maintain contact with one another to pool their knowledge and experience and contribute new ideas to help their clients. It is especially valuable for established groups to pass their knowledge and experience on to groups in the process of formation.

How other people can help

Maintaining a close relationship with a tranquilliser addict can be extremely demanding. It can also be very rewarding, and if you really love them, you will be desperate to help them back to normal life. Your role is vital! You may have suspected that their symptoms were those of a serious illness and you may well have been around when all sorts of hospital tests were carried out. You will be relieved to know that much of their irrational, changeable, and often unbearable behaviour was due to tranquillisers, and will disappear as they recover. Their behaviour is not related to their feeling for you, so you must try not to be negative in your response to it.

Although they may not be ill in the normal sense of the word they are truly "tranquilliser sick". Their tablets have forced mind and body into a chemical strait jacket and their true personality has vanished. You must try to be forgiving and, with your love and support the real person, the one you first met, will re-emerge.

Understanding what is happening is as important for you as for the sufferer. Show a genuine interest in the problem. Lack of obvious concern is extremely discouraging and gives the impression that you have abandoned hope. In any case, you will be surprised at what you discover and you may even feel rather guilty about your previous attitude. Never, ever, ever say to a tranquilliser sufferer trying to withdraw:- "You were better when you were taking the tablets". Always be positive about withdrawal, pushing gently ahead towards a drug free future. Attend meetings with your relative if you can. This will increase his confidence and show him that you are really interested. If you suspect that someone has been unfairly dismissed by his employer because of his addiction a doctor or self-help group can often provide a useful letter of support. A person with the strength of character to fight tranquilliser addiction successfully is a person worth employing.

Encourage the rest of his family and friends to be understanding because the sufferer will probably be unable to. You are the best person to explain the reasons behind his unpredictable behaviour and variable health.

CHAPTER 12

DIET

A healthy diet is something over which we all have control and it makes sense to pay particular attention to diet during withdrawal when most people feel under the weather and have a tendency to infections; skin may be spotty, there may be cracks around the lips and hair may fall out more readily than usual. Eating plenty of protein is important. Meat, poultry, and fish are very good sources of protein and so are pulses like beans and lentils. Fresh fruit and green vegetables are essential to good health, and are particularly important during withdrawal. Try to eat five pieces of fresh fruit or vegetables every day. It is important for our general health to avoid processed meat and poultry but it is especially important in withdrawal to eat fresh foods and avoid the processed versions. It may be helpful to take a multivitamin pill each day and vitamin B complex tablets may also be useful.

Fibre, an important part of our diet, is found in wholemeal bread, brown rice and potatoes, particularly when they are baked in their jackets. Cassava, plantain and yams are good ways of taking fibre too, as are unsalted nuts and dried fruit. Tinned beans are another good way of getting fibre, and are ready cooked so they are handy for a quick meal, served on wholemeal toast. Breakfast cereals, especially those containing bran, are also a good source of fibre.

High fat diets are unhealthy for everybody, including those who are withdrawing from tranquillisers. Most people have already switched from frying their food to grilling it. About a third of the fat the average British person eats comes from dairy products, mostly butter and milk, and about a quarter comes from meat and meat products like sausages and meat pies. Another quarter is contained in margarines, cooking fats and oils, and about a sixth comes from other foods such as crisps, chocolates, biscuits and cakes. There are two types of fats–saturated fats and unsaturated. The main problem with eating too much fat is that it contains too many calories and makes you overweight. Secondly, too much saturated fat raises the level of cholesterol in the blood. Cholesterol blocks the arteries and increases the risk of a heart attack. Sugar also provides large numbers of "empty" calories whereas almost all other types of foods provide nutrients as well as energy.

Sugar is more a laboratory chemical than a food; processing sugar removes all the goodness that was originally in the sugar beet or cane. Tranquillisers cause blood sugar to rise which is probably why people on benzodiazepines feel so ill first thing in the morning; their blood sugar level has fallen more than normal over-night. It may be helpful to keep a boiled sweet by the bed to raise blood sugar level quickly first thing in the morning. However you must resist the tendency to eat too much sugary food during withdrawal. It is also wise to avoid tea, coffee and Coca Cola all of which contain caffeine. Coca Cola also contains a lot of sugar; one glass contains about five teaspoons. Fresh fruit juice is far better for you, and helps provide extra vitamins and minerals.

Caffeine, a stimulant, will aggravate the symptoms of withdrawal because it is a stimulant. This also applies to nicotine and, although it is difficult to stop smoking during withdrawal, it is important to keep smoking under control. It is dangerous to eat too much salt, which can lead to raised blood pressure. If you do not add extra salt to your food it will be much safer for your health. Generally try to avoid too many dairy products, but at bedtime, a warm milky drink soothes and relaxes the body encouraging you to sleep. Milk also contains tryptophan, which helps you to sleep.

Food allergies can aggravate withdrawal. The only way to find out which food causes the problem is to live on a very bland diet for several days, and then to re-introduce each food in turn, and see when problems start. Some clients may need to live on a soft diet for a short time during withdrawal because of jaw pain or problems with swallowing. Lentil or vegetable soups are nourishing and tasty and you can control what goes into them. Liquid diets like 'Complan' contain a great deal of sugar and you should take this into account. Luckily, most people manage with a perfectly normal diet throughout withdrawal.

Carbohydrates are vital in withdrawal but foods like pasta, brown bread and rice are far better because they keep the blood sugar steady whereas more refined carbohydrates such as cakes and biscuits tend to raise the blood sugar only for it to fall very rapidly. These drops in blood sugar result in severe withdrawal symptoms.

BAD FOODS IN WITHDRAWAL	***ALTERNATIVES***
1. All types of sugar Including natural sugars Like honey; canned fruit In syrup, Puddings, Pastries and sweets	If you must sweeten foods, use a substitute – Sweetex, Hermesseatas, Sweet and Low. Try to eat fresh fruit and live yoghurts. Nuts and dried fruits are Useful additions.
2. White bread and rolls	Wholemeal bread.
3. Chocolate; cream biscuits; All forms of sweet biscuits,	Digestive & Wholemeal Cakes and sweets Biscuits; Oatcakes; Wholegrain crispbread

FOODS TO AVOID	***ALTERNATIVES***
Cereals	
Frosted cereals, Processed cereals Such as Ready Brek;	Bran enriched cereals like All Bran. Shredded Wheat, Wheatabix. Fruit adds sweetness to cereal And makes it more interesting.
Drinks	
Avoid tea, coffee, Coca cola and all Sugary drinks.	Natural fruit juice; Low calorie drinks; Soda water; Semi-skimmed milk or Soya; Meat or Vegetable extracts like Marmite or Bovril.

CHAPTER 13

THE PHILOSOPHY OF TRANQUILLISERS

Tranquillisers, taken for short periods, can be life saving. Long-term tranquilliser use, on the other hand is life destroying. Why drugs like the benzodiazepines should have this disastrous long-term effect is a mystery. The chemists and physicians who originally developed this group of drugs never intended them to be used indefinitely. They were to be used for brief periods to help patients to cope with episodes of severe anxiety, and, used in this way, they worked, and still work, very well. Whatever their benefits when used as the makers intended, their long term effects are the opposite of beneficial. Our experience shows that the tranquillisers and the problems for which they were initially prescribed are two entirely separate issues. Instead of solving that original problem the benzodiazepine has produced another entirely new one, tranquilliser addiction. The addiction destroys the patient's ability to solve his problems for himself. Until he frees himself from the addiction those problems remain insoluble. The addiction must be dealt with first.

We believe that counselling in the true sense of the word is inappropriate for long-term sufferers because it depends on a capacity for logic and reasoning that the benzodiazepine has destroyed. Later, counselling may help to deal with underlying problems as they come to the surface. During withdrawal the sufferer desperately needs to escape from his situation and demands information, support and reassurance. Once he knows what must be done, his need for reassurance becomes very great. He continually wants to know that the symptoms he is feeling are indeed symptoms of withdrawal not of some sinister mental or physical illness. "Am I going mad?" is a question he will ask over and over again, desperately seeking confirmation of his sanity.

Peter Ritson, C.I.T.A.'s co-founder felt, during his withdrawal, that although he remained convinced that he was sane he was perfectly aware that his behaviour, at times, bordered on insanity. An observer, he is certain, would have classified him, during some periods of his withdrawal, as temporarily insane. We feel very strongly that referring long-term tranquilliser-users to a psychiatrist until they have withdrawn completely is a waste of time and money. Until the client's mind is free from the effects of the chemical no psychiatrist can ever arrive at a useful diagnosis. A more important consideration is that a consultation with a psychiatrist confirms the patients' belief that they are mentally ill. This conviction, once acquired, is extremely difficult to lose. It can lead to a profound change in the individual's perception of himself and his problems. Some clients, once they

regard themselves as "officially" mentally ill, cease to accept responsibility for their own behaviour.

During long-term tranquilliser use and withdrawal addicts feel that their true personality is lost. They are aware that their behaviour is antisocial but are strangely unable to control it and they find this extremely distressing. We must convince them that their true personality will return and that it may even be enhanced by the suffering they have undergone and capable of greater understanding and tolerance than before. Tranquillisers change mind and body, depress the spirit, and make life a constant ordeal. The greatest problem is the lack of understanding of the changes and the fear that the problems stem from some terrible weakness within the addicts themselves.

The crux of the problem is that the symptoms of anxiety are almost identical to the symptoms of tranquilliser withdrawal. This is why so many people have become convinced that benzodiazepines are essential to their survival. As soon as they stop taking their tablets they are overwhelmed by anxiety. Convinced that this anxiety represents the return of the problem that the drugs were initially prescribed for, they start treatment again. Each repetition of this experience confirms the patient's belief that his anxiety can only be controlled by taking the benzodiazepine. The reappearance of the symptoms of anxiety after missing a few tablets has also encouraged doctors to believe that their patients need tranquillisers indefinitely. This tranquilliser myth has been accepted for more than a quarter of a century.

While taking benzodiazepines, natural coping mechanisms are suppressed and personal growth and development stop. During withdrawal both mind and body need to rebuild themselves to reorganise the mechanisms of coping. This takes time, guidance and motivation. Sufferers must be patient, and appreciate that what took years to destroy will not be rebuilt overnight. The medical profession and support agencies must learn to appreciate this. Expecting people to recover too quickly leads them to doubt that benzodiazepines were really the cause of their problem.

Benzodiazepine mis-use has produced millions of unnecessarily disturbed people throughout the Western world. Many of those millions are convinced that they are pathologically neurotic. They are not. They are, through no fault of their own, the victims of a massive epidemic of involuntary drug abuse.

The message that C.I.T.A. is determined to convey is simple:

Nobody ever *needs* benzodiazepines for longer than a few weeks.

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NOBODY NEEDS AN ADDICTION

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CHAPTER 14

CHILDREN AND TRANQUILLISERS

We have not seen any examples of young children on long-term benzodiazepines. Many adults, however, have become addicted to tranquillisers prescribed during adolescence. We recently helped one young man to withdraw from an extremely large dose of `Ativan' originally prescribed to help him to deal with examination nerves before his 'A' levels. An eighteen year old client who we helped recently had been given `Ativan' to help her to handle the stress of her parents' separation. Her subsequent addiction to the tablets caused more distress than the original domestic upset and she is convinced that she could have handled the situation perfectly well without chemical help. Another client was prescribed 'Valium' at the age of fourteen as part of the treatment of a speech impediment. Sixteen years later she was still taking the tablets, having become thoroughly addicted in the meantime. Her speech impediment remained and she was desperately worried by her unplanned pregnancy. We hope that prescribing benzodiazepines long-term for young people is now a thing of the past. Unfortunately, many children experiment with their parents' tablets, and we know of at least one child who became addicted to his mother's `Ativan' tablets as a result.

Children often suffer directly as a result of their parents' addiction. Often they have never known their parent when he or she was free from the influence of a benzodiazepine and they accept their parents' behaviour as entirely normal. Agoraphobic parents, in deep distress, often keep their children home from school to help with shopping, or to relieve their loneliness. These parents are often too ill to feel concerned about the child's schooling. We are trying to increase awareness of this issue so that children are not left to carry the burden alone. Often the children themselves approach us to ask for help with their parent and we try to counsel the children and help them to support their distressed parents so that they find the strength to withdraw. The mood swings associated with long-term benzodiazepines can be very frightening to children, although they can often be surprisingly understanding when the situation is explained to them. Some children have, very movingly, thanked us for "giving me my Mummy back" when they have seen how their mother has been transformed by her recovery after ten years or more of tranquilliser addiction.

Ironically, many women, originally prescribed tranquillisers for post-natal

depression, stayed on the tablets for so long that they became unable to care for their children. We have met many such women, one of whom was still taking tranquillisers when her daughter was twenty-four years old and married, with children of her own. Benzodiazepines were prescribed for post-natal depression because doctors confused tranquillisers with antidepressants. They now understood the differences between them and realise how dangerous it can be to treat a depressed patient with a benzodiazepine.

CHAPTER 15

OLDER PEOPLE AND TRANQUILLISERS

Older patients often find it extremely difficult to break their addiction. They feel that the effort and suffering involved are hardly worth the effort and sometimes they may be right. Many elderly people, however, badly want to stop taking their tablets. C.I.T.A. has helped several clients in their seventies and eighties who have withdrawn successfully and who certainly do not regret the experience.

Many clients, their relatives and, indeed, many doctors ask an obvious question about tranquilliser abuse in old age: why bother to come off the tablets so late in life? There is one very powerful answer and that is that these drugs can speed the appearance of the signs of ageing. The confusion of old age is almost identical to the confusion caused by the benzodiazepines and many old people have been classified as senile because of the effects of the drugs rather than the appearance of true dementia. Many patients with apparent senile dementia have become smart, alert, articulate men and women once again after their tranquillisers have been gently withdrawn. Eighteen months ago, I visited an elderly confused lady in her own home where her daughter was caring for her because she was too befuddled to care for herself. Using the C.I.T.A. method she transferred from lorazepam to diazepam, and began slowly to reduce the dose. About three months after my first visit, she telephoned to say that she would like to attend our weekly meeting. I gave her careful instructions as to how to find us and arranged to meet her when she arrived. When I met her the following week I could scarcely believe the transformation. The sad confused old woman had been replaced by a smart, lively, well-groomed lady in early middle age. She had, quite literally, come back to life.

Many old people lead an existence dominated by tablets and their shelves and cupboards look like a chemist's shop. This is an unhappy consequence of the tendency to prescribe drugs for everything, including the side effects of the drugs themselves. Attitudes have now changed, and many doctors taking over the care of an elderly patient insist that the first step must be to stop taking all their medication. Many patients improve dramatically as a direct result. Provided that benzodiazepines are not withdrawn abruptly, we applaud this approach.

We would never discourage a client from withdrawing simply because of

age and if there is the merest glimmer of motivation, we strongly encourage them to start withdrawal. Our experience shows, however, that in some elderly patients we should aim for a substantial dose reduction rather than complete withdrawal. Older people drugged with benzodiazepines run a high risk of falling and fracturing bones, another good reason for attempting withdrawal. We have just started to search through the records of casualty ward admissions from a large number of hospitals to see if there is any clear correlation between taking benzodiazepines and broken bones. Broken bones are expensive to treat and this research could prove beyond doubt that withdrawing benzodiazepines saves money.

Benzodiazepines sap interest and dull the perceptions so that life loses its sparkle and savour. These effects are felt most acutely by the elderly who sometimes come back to life only with very great difficulty. If the drugs were only prescribed for brief periods the problem would be less severe. If the benzodiazepines were never prescribed for elderly people the problem would not arise. Older people face some special problems when they start withdrawal. When they transfer to diazepam, for example, they often need smaller doses than younger individuals. However, those responsible for the care of the elderly during withdrawal must make sure that the dose is not reduced too quickly because older patients are often not fully aware of the effect of a drop in dosage for forty-eight hours or more. Do not assume that or less acute senses will make withdrawal any easier for the old. Their progress must be followed extremely carefully. Old people can find the symptoms of withdrawal particularly terrifying. We feel that it is very important to inform relatives or friends of older clients of exactly what withdrawal entails. If they do not have this understanding they may be tempted to encourage the client to start taking his tablets again.

However, our experience and that of others is that the elderly with support can do very well and if they can be encouraged to withdraw may take on a new lease of life.

CITA's experience has been that the elderly often have easier withdrawal experiences than younger people but doctors often are loathe to instigate withdrawal because they feel it is not fair, or because they feel it will involve extra work for themselves. Our philosophy is that age should not be a barrier to withdrawal if the person wishes to withdraw (1)

(1) Sweeney et al. Evaluation of an essay for cutting benzodiazepines in GP practice British Journal of General Practice, 1994; 44; 5-8.

CHAPTER 16

TRANQUILLISERS AND THE MEDIA

C.I.T.A. has been delighted by the media's role in publicising the benzodiazepine problem and increasing the public's awareness of the issues involved. Unfortunately they have not given a balanced picture. Broadly speaking they have adopted two distinct approaches, the first of which concentrated on the legal aspect, who are the guilty men– someone must be made to pay. Emphasising the severity of the problem but making no suggestion as to how individuals could help themselves tended to frighten addicts and their families. The second approach was to trivialise the problem, suggesting that benzodiazepine addiction was not proven and that withdrawing from the drugs was simple and painless. This disturbed many clients who had experienced extreme difficulty during their own withdrawal and now felt that they should have managed things better. Neither the *shock-horror* approach nor the later downgrading of the problem gives an accurate picture of the difficulties faced by our clients. No-one should write or broadcast about a tranquilliser addiction without making some effort to imagine themselves in the position of the addict. The essential point that, unlike addiction to alcohol, opiates or amphetamines, benzodiazepine addiction is entirely involuntary has, regrettably, not featured prominently in media coverage of the problem.

The T.V. programme which has probably played the greatest role, firstly with the benzodiazepines and now very proactively with SSRIs has been the BBC TV show ‘Panorama’ which has taken up a campaign regarding, in particular the SSRI Seroxat and also the prescribing of such medication to people under eighteen years of age.

Daily newspapers in particular ‘The Daily Mail’ have also taken up the SSRI stories energetically and given a very public voice to such erudite campaigners as Professor David Healy of University of Bangor in Wales and Charles Medawar founder of the private drugs watchdog ‘Social Audit’

The result of all this exposure and campaigning was an Expert Governmental working party set up by the MHRA which eventually recommended that all SSRIs and SNRIs (except Prozac) should not be prescribed for the under 18 year olds in the UK.

The media continues to be interested in the subject and ‘Panorama’ and

other TV shows regularly use CITA to promote helpline services for those concerned after they have heard the programmes. This book acts as a resource for many viewers. I have also been involved with online debates after, in particular the benzodiazepines programmes.

I am hopeful that the media may raise awareness regarding the very difficult and dangerous issue of benzodiazepine and SSRI (amongst other drugs) available online. I feel the public need to be aware of the extreme dangers of buying drugs this way and I have endeavoured to help clients who have brought drugs online and ended up on huge doses, only to suddenly find their supply has stopped leaving them in very serious withdrawal without access to a prescriber and unable to confide in their doctors what they have done. I do feel that the media could have a vital role to play here in raising awareness to this problem and fuelling a debate as to what to do to police this problem.

CHAPTER 17

UNITS FOR TRANQUILLISER WITHDRAWAL

C.I.T.A. would like to see money being put into specialised units solely devoted to the management of tranquilliser addicts. At the moment, those admitted for in-patient care enter psychiatric hospitals, or a psychiatric ward in a General Hospital. We believe that this is very often unnecessary, and that it can increase the patient's distress. In our experience, many tranquilliser addicts receive unnecessary psychiatric care. A patient who has been labelled "mentally ill" is not easily encouraged to begin the painful process of withdrawal. The staff of these specialised tranquilliser withdrawal units would be sensitive to the problems of withdrawal (ideally they would be ex-addicts who had experienced withdrawal themselves). The centres should certainly not be called "psychiatric units". The people who would benefit from these new units are those who find the discipline of withdrawal impossible to maintain during their everyday lives. In our experience a large number of clients fall into this category. Some have taken a haphazard mixture of short-acting benzodiazepines and cannot convert readily to diazepam. Others have become heavily dependent upon alcohol as well as tranquillisers. Sometimes family pressures are so intense that they prevent the client from starting withdrawal despite his genuine commitment. A specialised centre would give him a sensitive caring environment in which to manage his withdrawal.

These centres would provide an ideal solution to some of the most intractable problems of tranquilliser withdrawal but they cannot be provided without adequate funding.

Over the years campaigning has taken place both to raise awareness and to encourage Governmental support in the UK to provide specialised units for withdrawal. Letters, petitions and Early Day Motions have so far brought no success. In November 2006 a meeting was held at the House of Commons sponsored by Jim Dobbin MP to bring a cross party committee of MPs with a view to setting up specifically designed units and counsellors and nurse funded by Central Government.

CHAPTER 18

FUNDING

When C.I.T.A. was set up we believed that once the need was established the funding would follow. This has not been the case. Over twenty years later we are still largely unfunded, and almost entirely dependent upon donations. The government provides millions of pounds for the management of opiate addiction but the tranquilliser problem attracts a derisory few thousand. The reason for this discrepancy is probably that opiates are illegal drugs closely associated with organised crime. The benzodiazepines, on the other hand, are entirely legal and the people who are addicted to them tend to be timid and withdrawn. They have no need to steal to maintain their habit and offer no threat to the established order of things, so their problems can safely be ignored.

Yet the real cost of the benzodiazepine problem is enormous as the indirect cost, in terms of unemployment and invalidity benefit for those who might otherwise be able to work is huge and rarely taken into account. The cost of investigating benzodiazepine withdrawal symptoms to eliminate the possibility of organic disease is another vast expense. Unfortunately, asking government to pay to solve a problem caused by drugs prescribed by doctors who work, indirectly, for that government is unlikely ever to meet with an enthusiastic response. C.I.T.A. is not interested in finding culprits to blame for the problem. We all, governments, voluntary agencies, health professionals and the addicts themselves, need to work together to find a long term solution.

We are hoping that a new all-party committee set up by Jim Dobbin MP may result in some changes but it remains to be seen.

High profile deaths such as that in 2008 of Film star, Heath Ledger, where prescription drugs such as Lorazepam and diazepam are cited as part of the cause may help to raise awareness of the dangers of such drugs so often completely ignored and underestimated by doctors.

CHAPTER 19

WORKING TOGETHER

Your experience with tranquillisers has probably made you very wary of all drugs and medicines. Remember that many people are only alive because of the medicines or tablets, which they take every day and try to avoid developing a phobia about all drugs and medicines. You should always be aware of exactly what drugs you are taking. It is amazing how many people have taken medicines and tablets for years without ever asking what they are for. Some have taken benzodiazepines, especially as sleeping tablets, without the slightest idea of what the tablets contained.

We need to change our attitude towards the medical profession so that patients begin to regard their doctor as someone approachable who he can talk to and question. The automatic acceptance of the doctor's authority and the belief in medical infallibility has both played a part in creating the benzodiazepine problem. Doctors, for their part, must get used to telling people why they prescribe the drugs they do, and they should be prepared to discuss the possible dangers of the drugs, as well as their expected benefits. Doctors are now trained to answer questions and discuss problems and communication skills are now taught routinely in medical schools. A long-standing problem is that medical students are selected almost entirely because of their academic ability. The ability to listen to people, to sympathise with them and to begin to understand their problems is scarcely taken into consideration. Happily, there are signs that the medical profession are well aware of this problem and that they are starting to deal with it.

The benzodiazepine fiasco has taught us a very valuable lesson. Drugs cannot replace the skills of talking and listening. One doctor recently confessed that benzodiazepines had severely reduced his ability to listen to what his patients were telling him. He realised that his communication skills were badly in need of practice. Like many of his colleagues he now realises the value of saving time at the end of a surgery to talk out a problem with a particularly distressed patient. Our self-help support groups can provide an invaluable back-up service for doctors faced with a large number of patients who need to talk about their problems. We also give them the opportunity to meet others with similar problems so that experiences can be shared.

C.I.T.A. works very closely with doctors. One of our most useful services is to keep doctors up to date with the latest research on the management of benzodiazepine addiction so that they are aware of new techniques and developments that could help them to deal with their own addicted patients. In the Merseyside area, we have a very good relationship with doctors and regularly visit surgeries to give talks and lectures.

C.I.T.A. runs designated benzodiazepine withdrawal clinics within the North West of England and these are inexpensive and highly successful. These clinics involve half day sessions in doctors surgeries where about eight people are seen attending either weekly or alternate weeks for withdrawal plans and monitored withdrawal. On average about 70% of clients referred to these clinics will withdraw completely and a further 10% will reduce their dose significantly.

In the benzodiazepine withdrawal clinics there is a partnership between doctors, patients and counsellors and a description of this form of clinic was published as a letter in 'The British Journal of General Practice' in 2002 (1) and later forwarded to The Health Select Committee as a model which could be replicated throughout the country.

Although clinics for SSRIs have not yet come to fruition GPs are very interested in withdrawal programmes for these drugs and we hope that clinics may follow in the near future. I feel the difficulty here (apart from funding) is that there is a realisation generally among the medical profession that benzodiazepines are a problem, whereas I don't feel that there is full realisation yet regarding SSRIs antidepressants, in spite of the publicity.

There have been a number of reports published in the last few years, including the Norwich Union Healthcare Report and The London School of Economics Depression Report as well as N.I.C.E. (2), (3), (4) guidelines which point out that provision of counsellors with suitable training and skills (Cognitive Behavioural Therapy being the favourite) would enable doctors to prescribe a great deal mind altering medication and would at least as effective.

I have no doubt that readily available and well trained counsellors will eventually become the 'norm' in doctors practices but in the meantime many more people are becoming hooked on benzodiazepines and antidepressants.

I am involved with a group of people who are fronted by American Psychiatrist Dr. Peter Breggin. This organisation is called The International Center for the Study of Psychiatry and Psychology and they believe that there is better and more humane way to treat people with mental health

problems than just prescribing drugs. I particularly like the comments made by Dr Peter Breggin (5) “My approach varies somewhat from patient to patient but overall I try to create a safe and caring relationship in which to explore the nature of the patient’s suffering and conflict, and through which to help the patient find a more effective approach to life”

References

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   Health Care Report (2004)

3. London School of Economics chaired by Professor Lord R. Layard
   The Depression Report – A New Deal for Depression and Anxiety Disorders (2006).

4. N.I.C.E.
   Depression Guidelines (2004)

5. Breggin P.
   The Antidepressant Fact Book (2001)
   Perseus Publishing

CHAPTER 20

THE FUTURE

How are we to manage anxiety in the benzodiazepine-free future? Since the appearance of these drugs, the Western world has stopped looking for new ways of handling stress. We look to the medical profession for instant solutions to all our problems. In the past, people turned to the priest or to a member of their family who would talk to them. Often, being able to talk is the only therapy needed, keeping problems inside increases stress and anxiety. If priests and family were unable to help they were also unable to prescribe addictive drugs, so they rarely made things even worse!

Sufferers who turn to the medical profession will get medical remedies. The medical profession is very good at solving problems with a definite medical cause but doctors are no better than anyone else at handling emotional problems, which is one of the reasons why they accepted the benzodiazepines so enthusiastically. These drugs seemed to offer an easy medical solution to their patients' intractable emotional problems. Most doctors now realise their inadequacies and refer patients to organisations which offer counselling, advice on coping skills or practical help with practical problems like bad housing or marital troubles.

Counselling within GP surgeries is available in may Primary Care Trusts but so often the waiting lists are several months long and pushes doctors to prescribe benzodiazepines or antidepressants while the patient awaits counselling. Ironically these drugs then can prevent the patient being in touch with their feelings when their counselling appointment becomes available.

C.I.T.A. runs relaxation classes and uses auricular acupuncture and anxiety management and we are pleased with the results. Relaxation enables the client to view problems in a new light and makes him give himself time to reflect. The breathing which is encouraged in these exercises is the abdominal breathing which allows those taking tranquillisers to control the panic attacks and feelings of anxiety which sometimes overwhelm them. If these alternative coping methods become incorporated into people's lives, they will have less need to turn to drugs for help. Clients trying to withdraw are often unwilling to persevere ... they want instant cures and non-existent medical "magic wands". Anxiety management takes time, and must become part of life. If courses are offered to you, you should attend them even if it demands a real effort; only you can help yourself. Any amount of help may be on offer, but

your life will remain unchanged unless you participate.

Our aim is a normal everyday existence, free from benzodiazepines. The drugs will remain useful in emergencies, for short-term use and for pre-medication before surgery. Their use should, as far as possible, be confined to the hospital setting where patients can be carefully supervised.

CHAPTER 21

TAHITIAN NONI JUICE AND BENZODIAZEPINE WITHDRAWAL

In 2003 a pharmacist advised me that Tahitian Noni juice might help our clients. He suggested that it might improve the immune system and might also help the receptors to return to normal after withdrawal.

Over the years we have had a number of products recommended and mostly they have made little difference. However, because we knew the pharmacist was very well informed we decided to find out more.

The type of Noni juice recommended was a Tahitian juice; it came in a glass bottle, contained no preservatives and was very pure. We brought a few bottles of the juice and suggested to our clients that it might help and would certainly do no harm. Many of us at CITA also decided to try the juice ourselves to improve our immune systems.

What we have discovered is that if clients take a small amount, 1 - 2 tablespoonful every day as they reduce gradually the withdrawal becomes much easier and when the drug is stopped at the end of a gradual reduction the withdrawal does not go on. It stops soon after he drug is stopped. However, it is vital to keep taking the juice every day. Little and often is what is required. Some people have taken larger amounts than recommended, this does not work and can produce a strong feeling of detoxification, which is off putting and not needed.

If you have already reduced more than a very small amount of benzodiazepines then the amount of Noni you take must be started at just one/two teaspoons.

It appears that the Noni juice may remove the excess benzodiazepines from the body as you reduce. It does not remove the dose, which you take on a daily basis (this would cause strong withdrawal symptoms). It is for this reason that anyone who has either started reducing before Noni is started or who has already come off benzodiazepines must start on a very small dose and gradually increase the dose every two weeks by a further teaspoonful until you are taking a tablespoonful per day.

It is vital that everyone taking Noni should also drink plenty of water (about two litres a day is the ideal amount or more if you can manage it).

A word of warning!. There are many cheap Nonis available either in health stores or via the Internet. These are a false economy for the following reasons.

1. They are in plastic bottles and plastic degrades Noni juice.

2. They contain preservative which is not helpful to anyone particularly those withdrawing from their tablets. It defeats any claim that the juice is organic.

3. When analysed it has been shown that many cheap Nonis contain very much smaller amounts of Noni. In fact you are getting poor value for money.

4. Tahitian Noni juice is licensed by the FDA and also by the EU authorities and this is your proof that it is pure and cannot be contaminated. Cheaper juices cannot honestly make this claim.

NB What is described here is CITA's experience with Tahitian Noni juice since June 2003. there have been no scientific studies carried out regarding benzodiazepines and Tahitian Noni juice but we hope that these mat eventually be carried out.

CHAPTER 22

TAHITIAN NONI JUICE AND SSRI ANTIDEPRESSANTS AND OTHER ANTIDEPRESSANTS

Tahitian Noni juice is extremely helpful for those withdrawing from antidepressants for several reasons.

1. It helps control blood sugar and sharp drops in blood sugar cause many of the withdrawal symptoms from these drugs such as shaking, nausea, anxiety, brain fog, lack of concentration, depression. For best results you should also eat little and often and avoid refined carbohydrate such as sweets, cakes and chocolate as they will exacerbate the drops in blood sugar.

2. The juice helps to gently remove the drug from your system in a way that you can tolerate. Antidepressants are fat soluble like benzodiazepines and therefore may remain in the body for a very long time. Dr Ann Blake Tracy tells us that in the case of people who have died and had a post mortem the amount of drug left in the body even years after ceasing the drug was far higher than expected.(1)

3. Tahitian Noni seems to help to naturally keep the spirits elevated. One of my clients said 'It just makes me feel more optimistic'.

4. It is thought that Tahitian Noni may help to clean up the receptors so that they more quickly adjust after the drug has ceased to be taken.

The dose recommended is 2 to 3 tablespoonfuls to begin with and rising to 4 to 5 tablespoonfuls. Although there are some slight feelings of detoxification in some people these symptoms are not as strong as with benzodiazepines. In periods of severe withdrawal you may decrease the dose and then return to the normal dose once more.

Our research has shown that the best Noni juice is Tahitian Noni juice not the most expensive not the cheapest but the purest and the one recommended by doctors such as Dr Neil Solomon and Dr Heinecki – often called 'The

father of Noni'. It is also the one on which all scientific research has been carried out.

To purchase Tahitian Noni juice at wholesale price in the USA call 1-800-445-2969 and quote distributor No. 1676825.

For living elsewhere please telephone 044 (0) 151 281 5496

Reference:

1. Blake Tracy A.
Prozac, Panacea or Pandora (2001)
Cassia Publications, USA

NB. As with advice concerning benzodiazepines and Tahitian Noni juice what is published here is CITA's experience with clients and Tahitian Noni juice. We hope that in the near future scientific rails may be carried out.

CHAPTER 23

WORDS OF ENCOURAGEMENT

After all the practical advice I would like to offer some encouragement with regards to withdrawal from prescribed medication whether it be benzodiazepines or antidepressants.

Whether you feel these have helped you or not there comes a time to come off the drug and this so often is when the difficulties occur because drug companies offer little or no effective withdrawal programmes and all to often doctors claim to know how to withdraw people when they do not and often drastically underestimate the difficulties experienced by their patients.

The importance of slow and gradual withdrawal must be emphasised. The charts shown in this book illustrate this.

There are a few people who have provided inspiration and whose information has provided back-up for my work. These people are Professor Heather Ashton from Newcastle University, England. Professor David Healy of Bangor University, Wales who are informed and enquiring experts on benzodiazepines and SSRIs respectively also Charles Medawar of the Social Audit who has tirelessly written about the problems and politics of prescribed drugs particularly mind altering medication and Dr. Peter Breggin of International Center for the Study of Psychiatry and Psychology of which I am a member, and Dr. Ann Blake Tracy author of 'Prozac Panacea or Pandora'

These six people have dared to speak out and at times have counted the cost. They all believe that it is important to have more education and practical knowledge about the drugs we take and in particular workable practical knowledge about how to withdraw from these drugs all believing like myself that drug companies should supply withdrawal plans that are really effective.

For many the experience of taking prescribed mind altering medication has not been a helpful one but for those for whom it has, it is sad that the good experience is undone by the difficulties of stopping the drug.

In spite of the difficulties and often painful process of effective withdrawal from benzodiazepines or SSRI antidepressants, successfully breaking free from them is both rewarding and worthwhile and as my book title suggests for many has allowed then to come 'Back to Life'.

CHAPTER 24

Withdrawal of 'Z' drugs

Zopiclone	-	Zimovane
Zolpidem	-	Stilnoct, Ambien
Zaleplon	-	Sonata
Eszopiclone	-	Lunesta

The 'Z' drugs came on the market in the early 1990's, sold as different to benzodiazepines. This group of drugs was named cyclopyrrolones.

They were never marketed by the makers to be taken every night, but inevitably this is what happened.

The problems which they cause are really identical to benzodiazepines, I acted as a patient advocate a few years ago when a comparative analysis was carried out by the National Institute for Clinical Excellence a governmental medical drug watchdog in the UK. The conclusion reached at these meetings was that the 'Z' drugs are benzodiazepines by another name. The fact that they are said to be more selective in the receptors on which they work seems to make no difference to the outcome in most cases if the drug is taken every night.

At CITA we have most success reducing the 'Z' drugs by suggesting people transfer to Diazepam as with reduction from benzodiazepines and the withdrawal process is then the same as with benzodiazepines.

Sometimes there is resistance to this both by clients and by the medical profession, have not yet found a good scientific argument for this. Reducing using the 'Z' drugs is difficult because they are not made in small enough doses, for instance Zopiclone is made in 3.75mg doses, but the drop from 7.5mgs Zopiclone to 3.75mgs is quite difficult and usually causes insomnia. The drop from 3.75mgs to 0mgs is even greater as 3.75mgs Zopiclone represents at least 3mgs Diazepam, even if the client manages to break the 3.75mgs in half representing a 1½mgs diazepam equivalent. This is still quite a large dose to stop all at once and is likely to result in insomnia.

There has also been a warning on the box of Zopiclone advising against breaking the tablet in half. No one seems to know why! Perhaps it's simply to stop people reducing Zopiclone at all and ensuring people stay on it – call me cynical if you like!

The transfer to diazepam is usually fairly smooth. The equivalent dose we have found to be is 6mgs Diazepam to 7.5mgs Zopiclone.

Sometimes it takes a few days to get over the changes; I usually suggest people take the diazepam slightly earlier as reports have come in from clients that it takes a bit longer to get to sleep on the diazepam. There is also sometimes resistance to the idea that this is after all 'Valium'. People do not like the name and the fact that it is used for 'nerve' problems and anxiety.

Sometimes once the client has experienced the increased insomnia when cutting the 'Z' drug they will be willing to try the diazepam method. The prejudice surrounding Valium caused by bad publicity over the years (including the song by the Rolling Stones describing it as 'Mothers Little Helper') is hard to break down.

I believe it may be this prejudice which makes doctors unwilling to encourage this method with their patients.

Once the patient has transferred to diazepam then the mode of withdrawal follows the same pattern as the benzodiazepines.

As clients are particularly concerned about sleep this withdrawal may need to be particularly slow to maintain reasonable sleep patterns.

It is clearly important to consider sleep hygiene:

1. Avoid caffeine drinks.

2. Do not eat a heavy meal late in the evening.

3. Have a light supper to help the blood sugar to be maintained during the night.

4. Take exercise during the day.

5. Get some fresh air.

6. Keep the bedroom free of the TV as this is not healthy and watching TV prior to going to bed may increase insomnia.

7. Read a little before bed, this can help reduce sleep.

8. Drink milk before bed, or a milky drink as milk contains tryptophan – a sleep inducer. Other foods containing tryptophan are bananas, lettuce, and turkey.

9. If you can't sleep get up for a while, do not lie there tossing and turning.

10. If it is too light in the room get a black out curtain. If it is noisy then try ear plugs (they are very cheap to buy and can be effective)

11. Do not keep looking at the clock as this makes matters worse by causing further anxiety

When you are clear of your benzodiazepines or indeed of the 'Z' drug, you can try other remedies of a more natural kind. Tahitian Noni juice has been found to help with sleep as it may help boost melatonin a natural sleep chemical. Try about 1 -2 tablespoons of Tahitian Noni as you are going to bed. If you have not taken it during withdrawal you may need to persevere for a few nights before it works effectively as its effect builds up. Do not take it early in the evening as it works on serotonin during the day and will have the effect of making you feel more awake. However, taken right at bedtime it will make you sleepy. Please note, Tahitian Noni juice does not contain melatonin or serotonin, it simply makes the body use them better.

Tahitian Noni does not interact with any other product or drug. It is not herbal it is fruit. (See chapter on Tahitian Noni for full explanation of how Tahitian Noni juice taken in small amounts throughout withdrawal can substantially reduce symptoms after you have stopped your 'Z' drug or benzodiazepines). Indeed, in our experience the last few reductions before finishing the drug may seem relatively easy and then when you stop completely the symptoms seem to disappear completely. This research is based on our experience with clients as it has proved complicated to arrange 'double blind studies'. However, we would be pleased to find any one who might help us to do this.

Reducing with 'Z' Drugs Without Converting to Diazepam

If you have to reduce using your 'Z' drug you follow a similar plan of action as with the benzodiazepines reducing by as little as you can using the 'Z' drug itself. Break the drug up and reduce by a small amount every two weeks. Use the 3.75mg Zopiclone tablets if you are reducing Zopiclone.

CHAPTER 25

SSRIs and Related Drugs

Withdrawal and Other Advice

UK Name	USA Name	Generic Name
Prozac	**Prozac**	**Fluoxetine**
Seroxat	**Paxil**	**Paroxetine**
Cipramil	**Celexa**	**Citalopram**
Cipralex	**Lexapro**	**Escitalopram**
Lustral	**Zoloft**	**Sertraline**
Faverin	**Luvox**	**Fluvoxamine**
Efexor	**Effexor**	**Venlafaxine**
Zispin	**Remeron**	**Mirtazepine**
Cymbalta	**Yentreve** (Sold as a drug for urinary incontinence)	**Duloxetine**

General Advice

Before you take an SSRI (Selective Seretonin Reuptake Inhibitor) be aware that:

1. They take at least four weeks to work for most people
2. They do not work well for everybody
3. They can be very difficult to come off.

Ask for other help first such as counselling, psychotherapy or anxiety management.

Take more exercise as it increases the endorphin level in the body so it may help you.

Improve your diet: eat plenty of green vegetables and drink two litres of water per day. Eat more oily fish to improve intake of omega 3 oils, you may wish to take omega 3 capsules to supplement your intake.

If you must take something try St John's Wort, but make sure you take 900-1000mgs
of the active ingredient hypericin. It may say hypericum on the main label which is the latin name for St John's Wort. Check in the small print to see how much hypericin it contains.

Give St John's Wort four weeks to work before giving up on it. Recent reports have found it to be every bit as effective as antidepressants and it is much easier to stop.

Stay on St John's Wort for at least 3 months once you find that it works for you and reduce it over two or three weeks when you want to stop it.

WARNING

It is likely to stop the contraceptive pill working and may cause miscarriage if you are pregnant.

Buy your St John's Wort at a pharmacy so you can discuss the implications of any other medication you are taking as it does interact with:

1. Antidepressants
2. Aminophyline (a rare drug used for breathing but usually only for babies)
3. Drugs used in organ transplants
4. Some drugs for migraine
5. Thyroxine
6. Digoxin
7. Warfarin

Do not be put off by this list as there are also many drugs which SSRI antidepressants interact with and it is also important to note that SSRI antidepressants should not be taken with <u>any herbal remedies</u>.

I come across many people who are taking herbal alternatives with SSRI antidepressants and indeed with tricylics and MAOIs and they are simply not safe and at the least will give you a severe headache.

Those who do decide to take an SSRI antidepressant should ask to be prescribed the lowest dose to start with. This dose is often quite sufficient, as there has been some criticism that these drugs are often prescribed at doses which are too high ('Medicines Out of Control', Medawar C. 2004)

Ask the doctor to monitor you while you are on the antidepressant and be aware of any changes in your behaviour, i.e., feeling suicidal or aggressive. These feelings may not occur and you may gradually simply feel better. If there is going to be a problem with suicidal feelings this is often in the first few days.

Should the drug produce suicidal feelings then clearly these will be less dangerous if you are aware what they are. Should you experience these feelings then you probably will decide the drug is not for you and stop them (at this early stage stopping abruptly should not be a problem). However, speak to your doctor about these feelings so that he/she can advise you and also so that the doctor is aware that people are experiencing such problems. It is important that doctors appreciate that sometimes these drugs can produce suicidal feelings and not always blame the illness. (1)

The normal minimum length of time to stay on an antidepressant if it is benefiting you is three months and most people stay on these drugs for six months and much longer. While you are on a SSRI or SNRI antidepressant and when you are withdrawing from them avoid alcohol. The combination of the drug and the alcohol can be very dangerous and may affect the way you feel and your behaviour may become very reckless and out of character.

While you are taking SSRIs and when you reduce them you are likely to experience cravings for sugar, i.e. refined white sugar, sweets, biscuits, cakes, etc. It is important to avoid these and to eat unrefined carbohydrates such as pasta, brown rice, oatcakes and brown bread. The reason for this is that the drugs raise your blood sugar and then your body will try to reduce the blood sugar producing symptoms such as lack of concentration, shaking, depression and lethargy. Eating less refined carbohydrates will help to steady the blood sugar whereas those found in refined sugar products such as chocolate, biscuits and cakes will exacerbate the situation by further raising the blood sugar, which then means that the sharp drop when the blood sugar is lowered will be very unpleasant and produce severe symptoms of shaking, low mood, lack of concentration. "During SSRI treatment the blood sugar may drop and after treatment it may spike" (2). "The adverse effects upon the pancreas appears to be causing an imbalance in the blood sugar levels" (3).

When you decide that you wish to come off your antidepressant it is very important that you come off slowly over several months. The plans for withdrawal with each of the drugs are described here with charts to help you. The following are also helpful hints: (Please see charts at the end of the book)

1. Avoid alcohol.

2. Eat little and often and avoid refined sugars.

3. Tahitian Noni juice has been found to help enormously with the blood sugar. Also it helps with detox and with the reprogramming process of the receptors when you reduce the drug. People have also reported that it helps to keep the mood stable.

4. Should you suffer a virus or infection while withdrawing you may find that withdrawal becomes more difficult. This is because viruses or bacterial infections tend to speed up the withdrawal process by removing the drug more quickly from the receptors.

Should you need to take antibiotics it is important that you take probiotics which help to put back the good bacteria taken out by antibiotics. The best ones we have found are Bioculture or Acidophilus Plus. These are because of the very large number of bacteria they contain.

For many people withdrawal symptoms continue for quite a while after stopping the drug. There is no set time for this and it varies from person to person.

Do not be tempted to take anything to speed up the withdrawal many people have tried various alternative remedies. Do not do this you will suffer very severe symptoms of withdrawal such as panic attacks, shaking and severe anxiety. The drug being removed too quickly from the body is a very bad idea as you will feel extreme symptoms of withdrawal.

The Tahitian Noni juice helps with ‘detox’ and the gentle ‘detox’ is not too much to cope with. Remember Tahitian Noni is not herbal.

Our plans and protocols set out the withdrawal process for you on the next few pages.

The withdrawal process for paroxetine requires liquid as withdrawing from the tablet form has proved impossible for so many. You may wish to change

to St John's Wort at some point during the last millilitre of your withdrawal. This is described in the protocols on the next few pages.

Cipramil also can be reduced using liquid although it is possible to reduce using either tablets or liquid with this drug.

Our experience has been that you should start taking St John's Wort as soon as you stop the paroxetine rather than have a gap in time between the SSRI and St John's Wort. You may also switch to St John's Wort from any of the other SSRIs, however, it is best to do this in the final stages of your reduction (There is no definite point at which to do this – call the CITA helpline on 0151 932 0102 to discuss this or for a personal consultation, for which there will be a charge, call me 0151 281 5496).

Start St John's Wort on 900 – 1000mgs hypericin (the active ingredient), purchase this at a pharmacy to discuss interactions with any other drugs you are taking (see previous list)

Some people are finding it helpful to use a substance called 5HTP. This is a serotonin precursor which means that it is a substance which helps the body produce serotonin – it is not serotonin itself. It must not be taken while you are still ingesting your antidepressant but like St John's Wort can be taken straight after cessation of the antidepressant. You may take up to 4 x 100mgs tablets per day but it is wise to start with 100mgs and gradually increase. 5HTP may aid sleep as serotonin becomes melatonin in the presence of darkness and taking 5HTP at night can be very effective.
Please Note: You cannot take 5HTP and ST John's Wort together.

SIDE EFFECTS

There are many possible symptoms which may occur both on your SSRI and in withdrawal. Some people may suffer none of them or very few. The symptoms tend to come and go, that is one or two tend to occur for a few weeks and then these are superseded by different symptoms.

Some common symptoms: craving for sweet foods, craving for alcohol (due to effects of blood sugar), nausea, dizziness, poor balance, agitation, low mood, over elated mood, stomach problems because much serotonin is contained in the gut area, muscle aches and pains and stiffness because SSRIs cause muscle constriction.

Some people become very agitated either on SSRIs or coming off them. This may mean you cannot keep still, if this is the case you may be suffering from akathisia. This can be unsafe to ignore, please tell your doctor and ask to

withdraw from the drug if this is severe. You may require sedation for a few days or even weeks; unfortunately the only way to sedate you may be diazepam. However, if you are only mildly agitated this will settle down without other drugs. Most people who have taken diazepam for a short time to help with SSRIs have been able to stop diazepam fairly easily using our methods.

Please Note that if you are taking both benzodiazepines and SSRIs or SNRIs antidepressants it is less clear cut which drug to reduce first. When taking tricyclic antidepressants the rule is always to reduce the benzodiazepine first to give support from the antidepressant and help prevent depression during withdrawal. However, when withdrawing SSRIs and SNRIs reduction tends to cause anxiety symptoms causing many people to resort to benzodiazepines. If, however, you have just come off benzodiazepines it would clearly be very disappointing to have to go back on them. I therefore find it is easier to reduce the antidepressant first and use the benzodiazepine for support. You may wish to do this. Once you have reduced your antidepressant you can then try either 5HTP or St. John's Wort as described here to help with low mood while reducing your benzodiazepines.

If you are using Tahitian Noni to help you withdraw from your SSRI in our experience it will help you to stop the diazepam as it stops it building up in the body. To understand Tahitian Noni and its use in drug withdrawal please see the chapter on Tahitian Noni juice.

When withdrawing from SSRIs as with benzodiazepines you may find that your withdrawal symptoms becomes a great deal worse when you have a virus or bacterial infection. This deterioration will improve when the illness gets better. If you are taking antibiotics we believe that they worsen the way you feel as they disturb the gut and while you are taking the drug this may affect the way it is digested. However, it also may happen after the drug has been stopped and so far I am not sure why. It is helpful to take strong probiotics when you are taking antibiotics. It is now believed by our pharmacy advisors that probiotics can be taken alongside antibiotics and still be effective. The products we have found strong enough are Bioculture and Acidopholous Plus. You may contact CITA to discuss how to get these products.

We believe that any virus or bacterial infection may make you feel worse because it speeds up withdrawal removing the benzodiazepine from the receptors in a way that is difficult to cope with. The experience of CITA has been that the 'flu injection' may do the same. However, the effects of the flu injection settle down within a few weeks and therefore it is important to have the flu injection if you need it.

A final word of warning; many pain killers interact with SSRI antidepressants and yet they are regularly prescribed together. Tramadol and Pethedine are particularly unsafe with SSRIs, so point this out to your doctor should they be prescribed.

For personal consultations or mentoring schemes with myself, for which there will be a charge, please call 0151 281 5496.

The SSRI and SNRI withdrawal plans now follow. Successful withdrawal it seems must be slow in order to avoid shock to the system. My experience with many hundreds of clients is that speedy reduction slows down recovery so it is well worth going slowly and also allowing yourself to take plenty of rest as the withdrawal process causes extreme tiredness.

The concept with all the drugs is similar that is you reduce a small amount on only one day of the week at a time, you then wait one or two weeks before you reduce on a second day of the week and so no. You do not reduce on consecutive days until you have to. For instance you would reduce first on a Monday and perhaps Friday and Monday, Wednesday and Friday and keep going in this way. You can clearly follow the chart for your drug and tick off each day as you go. This way you will clearly know the route to your withdrawal and recovery.

The methods of withdrawal described here are based on the protocols for withdrawal devised by Professor David Healy of Bangor University. The protocol has been tweaked as clients have used it and we have learnt more about SSRI withdrawal. Professor Healy has been very supportive and endeavoured to answer questions and provide more information in support of the programme.

References:

(1) Healy, David
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International Journal of Risk & Safety in Medicine, 12 (1999) 151-156, IOS Press

(2) Breggin, Peter
'The Antidepressant Text Book' (2001)
Perseus Publishing

(3) Blake Tracy, Anne (1994)
'Prozac, Panacea or Pandora'
Cassia Publications

APPENDICES

Withdrawal charts for the various antidepressants:

UK Name	USA Name	Generic Name
Prozac	**Prozac**	**Fluoxetine**
Seroxat	**Paxil**	**Paroxetine**
Cipramil	**Celexa**	**Citalopram**
Cipralex	**Lexapro**	**Escitalopram**
Lustral	**Zoloft**	**Sertraline**
Faverin	**Luvox**	**Fluvoxamine**
Efexor	**Effexor**	**Venlafaxine**
Zispin	**Remeron**	**Mirtazepine**
Cymbalta	**Yentreve**	**Duloxetine**

Pages

Other Charts

101 & 102 Triptafen	Amitriptyline
103 & 104 Gamanil	Lofepramine
105 & 106 Molipaxin	Trazodone
107 Molipaxin Liquid	Trazodone Liquid
108 Phenelzine	Nardil
110, 111 & 112 Trimipramine	Surmontil
113 Prothiaden	Dosulepin/ Dothiepin
114 Anafranil	Clomipramine
115 CITA Protocol letter	

CONCLUSION

During withdrawal many people become convinced that their true personality is disappearing.

They feel as though they are looking at themselves from a distance and their real self seems to be vanishing.

Successful withdrawal . . . coming back to life . . . restores that vanished personality and often strengthens it and gives it new sensitivity drawn from the experience of suffering and rebirth as the true self emerges from the influence of the drug.

Your rebirth will be a joyous, wonderful, event for you and for those closest to you.

GUIDANCE – PRINCIPLES OF ANTIDEPRESSANT REDUCTION
CIPRAMIL TABLETS SHEET 1

	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Start line for 60mg	3	3	3	2½	3	3	3	3	3	3	2½	3	3	3
	2½	3	3	2½	3	3	3	2½	3	3	2½	3	3	3
	2½	3	2½	3	2½	3	3	2½	3	2½	3	2½	3	3
	2½	3	2½	3	2½	3	2½	3	2½	3	2½	3	2½	3
	2½	3	2½	2½	2½	3	3	2½	3	2½	2½	2½	3	3
	2½	2½	2½	3	2½	2½	3	2½	2½	2½	3	2½	2½	3
	2½	2½	2½	3	2½	2½	2½	2½	2½	3	2½	2½	2½	2½

Start line for 50mg	2½	2½	2½	2½	2½	2½	2½	2½	2½	2½	2½	2½	2½	2½
	2½	2½	2½	2	2½	2½	2½	2½	2½	2½	2	2½	2½	2½
	2	2½	2½	2	2½	2½	2½	2	2½	2½	2	2½	2½	2½
	2½	2	2½	2	2½	2	2½	2½	2	2½	2	2½	2	2½
	2	2½	2	2½	2	2½	2	2	2½	2	2½	2	2½	2
	2	2	2½	2	2½	2	2	2	2	2½	2	2½	2	2
	2	2	2	2½	2	2	2	2	2	2	2½	2	2	2

Start line for 40mg	2	2	2	2	2	2	2	2	2	2	2	2	2	2
	2	2	2	1½	2	2	2	2	2	2	1½	2	2	2
	1½	2	2	2	1½	2	2	1½	2	2	2	1½	2	2
	2	1½	2	1½	2	1½	2	2	1½	2	1½	2	1½	2
	1½	2	1½	2	1½	2	1½	1½	2	1½	2	1½	2	1½
	1½	1½	2	1½	1½	2	1½	1½	1½	2	1½	1½	2	1½
	1½	1½	1½	2	1½	1½	1½	1½	1½	1½	2	1½	1½	1½

CIPRAMIL TABLETS SHEET TWO

	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Start line for 30mg	1½	1½	1½	1½	1½	1½	1½	1½	1½	1½	1½	1½	1½	1½
	1½	1½	1½	1	1½	1½	1½	1½	1½	1½	1	1½	1½	1½
	1	1½	1½	1½	1	1½	1½	1	1½	1½	1½	1	1½	1½
	1½	1	1½	1	1½	1	1½	1½	1	1½	1	1½	1	1½
	1	1½	1	1½	1	1½	1	1	1½	1	1½	1	1½	1
	1	1	1½	1	1	1½	1	1	1	1½	1	1	1½	1
	1	1	1	1½	1	1	1	1	1	1	1½	1	1	1

Start line for 20mg	1	1	1	1	1	1	1	1	1	1	1	1	1	1
	1	1	1	½	1	1	1	1	1	1	½	1	1	1
	½	1	1	1	½	1	1	½	1	1	1	½	1	1
	1	½	1	½	1	½	1	1	½	1	½	1	½	1
	½	1	½	1	½	1	½	½	1	½	1	½	1	½
	½	½	1	½	½	1	½	½	½	1	½	½	1	½
	½	½	½	1	½	½	½	½	½	½	1	½	½	½

Start line for 10mg	½	½	½	½	½	½	½	½	½	½	½	½	½	½
	½	½	½	0	½	½	½	½	½	½	0	½	½	½
	0	½	½	½	0	½	½	0	½	½	½	0	½	½
	½	0	½	0	½	0	½	½	0	½	0	½	0	½
	0	½	0	½	0	½	0	0	½	0	½	0	½	0
	0	0	½	0	0	½	0	0	0	½	0	0	½	0
	0	0	0	½	0	0	0	0	0	0	½	0	0	0

KEEP THIS CHART WITH MEDICATION: **Basic Dose=20mg 1 tablet: 40mg 2=tablets: 60mg=3 tablets**

CITA HELP LINE TELEPHONE NO. 0151 932 0102 **Above numbers refer to number of tablets**

CIPRAMIL IS ALSO AVAILABLE IN 10mg TABLETS.

GUIDANCE – PRINCIPLES OF ANTIDEPRESSANT REDUCTION
CIPRALEX – ESCITALOPRAM –LEXAPRO(USA NAME)

Week	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Start line for 20mg Tablets	20mg	20mg	20mg	20mg	20mg	15mg	20mg	20mg	20mg	15mg	20mg	20mg	15mg	20mg
	20mg	15mg	20mg	15mg	20mg	15mg	20mg	15mg	20mg	15mg	20mg	15mg	15mg	20mg
	20mg	15mg	15mg	20mg	15mg	15mg	15mg	20mg	15mg	15mg	15mg	15mg	15mg	15mg
	15mg	15mg	15mg	15mg	15mg	15mg	15mg							

↑ 20mg TABLET LINE ↑

Week	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Start line for 15mg tablet	15mg	15mg	15mg	15mg	15mg	10mg	15mg	15mg	15mg	10mg	15mg	15mg	10mg	15mg
	15mg	10mg	15mg	10mg	15mg	10mg	15mg	10mg	15mg	10mg	15mg	10mg	10mg	15mg
	15mg	10mg	10mg	15mg	10mg	10mg	10mg	15mg	10mg	10mg	10mg	10mg	10mg	10mg
	10mg	10mg	10mg	10mg	10mg	10mg	10mg							

↑ 15mg TABLET LINE ↑

Week	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Start line for 10mg	10mg	10mg	10mg	10mg	10mg	5mg	10mg	10mg	10mg	5mg	10mg	10mg	5mg	10mg
	10mg	5mg	10mg	5mg	10mg	5mg	10mg	5mg	10mg	5mg	10mg	5mg	5mg	10mg
	10mg	5mg	5mg	10mg	5mg	5mg	5mg	10mg	5mg	5mg	5mg	5mg	5mg	5mg
	5mg	5mg	5mg	5mg	5mg	5mg	5mg							

↑ 10mg TABLET LINE ↑

Week	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Start line for 5mg tablet	5mg	5mg	5mg	5mg	5mg	0mg	5mg	5mg	5mg	0mg	5mg	5mg	0mg	5mg
	5mg	0mg	5mg	0mg	5mg	0mg	5mg	0mg	5mg	0mg	5mg	0mg	0mg	5mg
	5mg	0mg	0mg	5mg	0mg	0mg	0mg	5mg	0mg	0mg	0mg	0mg	0mg	0mg
	0mg	0mg	0mg	0mg	0mg	0mg	0mg							

KEEP THIS CHART WITH MEDICATION: Tablet Dosage 20mg, 15mg & 5mg
CITA HELP LINE TELEPHONE NO. 0151 932 0102 Above numbers refer to number of tablets

GUIDANCE – PRINCIPLES OF ANTIDEPRESSANT REDUCTION

CIPRAMIL DROPS 20MGS IN 10 DROPS

	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Week 1/2	9	10	10	10	10	10	9	9	10	9	10	9	10	9
3 / 4	9	9	9	9	9	9	9	8	9	9	9	9	9	8
5 / 6	8	9	8	9	8	9	8	8	8	8	8	8	8	8
7 / 8	7	8	8	8	8	8	7	7	8	7	8	7	8	7
9 / 10	7	7	7	7	7	7	7	6	7	7	7	7	7	6
11 / 12	6	7	6	7	6	7	6	6	6	6	6	6	6	6
13 / 14	5	6	6	6	6	6	5	5	6	5	6	5	5	5

Week 15/16	5	5	5	5	5	5	5	4	5	5	5	5	5	4
17/18	4	5	4	5	4	5	4	4	4	4	4	4	4	4
19 / 20	3	4	4	4	4	4	3	3	4	3	4	3	4	3
21 / 22	3	3	3	3	3	3	3	2	3	3	3	3	3	2
23 / 24	2	3	2	3	2	3	2	2	2	2	2	2	2	2
25 / 26	1	2	2	2	2	2	1	1	2	1	2	1	2	1
27 / 28	1	1	1	1	1	1	1	0	1	1	1	1	1	0
Week 29/30	0	1	0	1	0	1	0	0	0	0	0	0	0	0

KEEP THIS CHART WITH MEDICATION:
CITA HELP LINE TELEPHONE NO. 0151 932 0102

GUIDANCE – PRINCIPLES OF ANTIDEPRESSANT REDUCTION

CYMBALTA/DULOXETINE

Week	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Start line for 60mg tablets 2 x 30mg tablets	60mg	60mg	60mg	30mg	60mg	60mg	60mg	60mg	60mg	60mg	30mg	60mg	60mg	60mg
	30mg	60mg	60mg	30mg	60mg	60mg	60mg	30mg	60mg	60mg	30mg	60mg	60mg	60mg
	30mg	60mg	30mg	60mg	30mg	60mg	60mg	30mg	60mg	30mg	60mg	30mg	60mg	60mg
	30mg	60mg	30mg	60mg	30mg	60mg	30mg	30mg	60mg	30mg	60mg	30mg	60mg	30mg
	30mg	30mg	60mg	30mg	30mg	60mg	30mg	30mg	30mg	30mg	60mg	30mg	60mg	30mg
	30mg	30mg	60mg	30mg	30mg	30mg	30mg	30mg	30mg	60mg	30mg	30mg	30mg	30mg

↑ 60mg TABLET LINE ↑

Start line for 30mg tablet	30mg	30mg	30mg	30mg	30mg	30mg	30mg	30mg	30mg	30mg	30mg	30mg	30mg	30mg
	30mg	30mg	30mg	0mg	30mg	30mg	30mg	30mg	30mg	30mg	0mg	30mg	30mg	30mg
	0mg	30mg	30mg	0mg	30mg	30mg	30mg	0mg	30mg	30mg	0mg	30mg	30mg	30mg
	0mg	30mg	0mg	30mg	0mg	30mg	30mg	0mg	30mg	30mg	0mg	30mg	30mg	30mg
	0mg	30mg	0mg	30mg	0mg	30mg	0mg	0mg	30mg	0mg	30mg	0mg	30mg	0mg
	0mg	0mg	30mg	0mg	0mg	30mg	0mg	0mg	0mg	0mg	30mg	0mg	30mg	0mg
	0mg	0mg	30mg	0mg	0mg	0mg	0mg	0mg	0mg	30mg	0mg	0mg	0mg	0mg

↑ 30mg TABLET LINE ↑

KEEP THIS CHART WITH MEDICATION Duloxetine Tablets are available in 60mg and 30mg sizes

CITA HELP LINE TELEPHONE NO. 0151 932 0102

GUIDANCE – PRINCIPLES OF ANTIDEPRESSANT REDUCTION
VENLAFAXINE/EFEXOR

	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Start line for 225mg (3 Tablets)	3	3	3	2½	3	3	3	3	3	3	2½	3	3	3
	2½	3	3	2½	3	3	3	2½	3	3	2½	3	3	3
	2½	3	2½	3	2½	3	3	2½	3	2½	3	2½	3	3
	2½	3	2½	3	2½	3	2½	3	2½	3	2½	3	2½	3
	2½	3	2½	2½	2½	3	3	2½	3	2½	2½	2½	3	3
	2½	2½	2½	3	2½	2½	3	2½	2½	2½	3	2½	2½	3
	2½	2½	2½	3	2½	2½	2½	2½	2½	3	2½	2½	2½	2½

	MON	TUE	WED	THU	FRI	SAT	SUN	MON	TUE	WED	THU	FRI	SAT	SUN
Start line for 187.5mg	2½	2½	2½	2½	2½	2½	2½	2½	2½	2½	2½	2½	2½	2½
	2½	2½	2½	2	2½	2½	2½	2½	2½	2½	2	2½	2½	2½
	2	2½	2½	2	2½	2½	2½	2	2½	2½	2	2½	2½	2½
	2½	2	2½	2	2½	2	2½	2½	2	2½	2	2½	2	2½
	2	2½	2	2½	2	2½	2	2	2½	2	2½	2	2½	2
	2	2	2½	2	2½	2	2	2	2	2½	2	2½	2	2
	2	2	2	2½	2	2	2	2	2	2	2½	2	2	2

	MON	TUE	WED	THU	FRI	SAT	SUN	MON	TUE	WED	THU	FRI	SAT	SUN
Start line for 150mg (2 tablets)	2	2	2	2	2	2	2	2	2	2	2	2	2	2
	2	2	2	1½	2	2	2	2	2	2	1½	2	2	2
	1½	2	2	2	1½	2	2	1½	2	2	2	1½	2	2
	2	1½	2	1½	2	1½	2	2	1½	2	1½	2	1½	2
	1½	2	1½	2	1½	2	1½	1½	2	1½	2	1½	2	1½
	1½	1½	2	1½	1½	2	1½	1½	1½	2	1½	1½	2	1½
	1½	1½	1½	2	1½	1½	1½	1½	1½	1½	2	1½	1½	1½

EFEXOR TABLETS SHEET TWO

	MON	TUE	WED	THU	FRI	SAT	SUN	MON	TUE	WED	THU	FRI	SAT	SUN
Start line for 112.5mg	1½	1½	1½	1½	1½	1½	1½	1½	1½	1½	1½	1½	1½	1½
	1½	1½	1½	1	1½	1½	1½	1½	1½	1½	1	1½	1½	1½
	1	1½	1½	1½	1	1½	1½	1	1½	1½	1½	1	1½	1½
	1½	1	1½	1	1½	1	1½	1½	1	1½	1	1½	1	1½
	1	1½	1	1½	1	1½	1	1	1½	1	1½	1	1½	1
	1	1	1½	1	1	1½	1	1	1	1½	1	1	1½	1
	1	1	1	1½	1	1	1	1	1	1	1½	1	1	1

Start line for 75mg (1 Tablet)	1	1	1	1	1	1	1	1	1	1	1	1	1	1
	1	1	1	½	1	1	1	1	1	1	½	1	1	1
	½	1	1	1	½	1	1	½	1	1	1	½	1	1
	1	½	1	½	1	½	1	1	½	1	½	1	½	1
	½	1	½	1	½	1	½	½	1	½	1	½	1	½
	½	½	1	½	½	1	½	½	½	1	½	½	1	½
	½	½	½	1	½	½	½	½	½	½	1	½	½	½

Start line for 37.5mg (1 Tablet)	½	½	½	½	½	½	½	½	½	½	½	½	½	½
	½	½	½	0	½	½	½	½	½	½	0	½	½	½
	0	½	½	½	0	½	½	0	½	½	½	0	½	½
	½	0	½	0	½	0	½	½	0	½	0	½	0	½
	0	½	0	½	0	½	0	0	½	0	½	0	½	0
	0	0	½	0	0	½	0	0	0	½	0	0	½	0
	0	0	0	½	0	0	0	0	0	0	½	0	0	0

KEEP THIS CHART WITH MEDICATION: **Basic Dose=75mg 1 tablet: 150mg 2=tablets: 235mg=3 tablets**

CITA HELP LINE TELEPHONE NO. 0151 932 0102 **Above numbers refer to number of tablets.**

Efexor can be prescribed in 37.5mg tablets. **You can reduce more gently and slowly using ½ tablets.**

GUIDANCE – PRINCIPLES OF ANTIDEPRESSANT REDUCTION
LUSTRAL & FAVERIN

Week	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Start line for 150mg of tablets	3	3	3	2	3	3	3	3	3	3	2	3	3	3
	2	3	3	2	3	3	3	2	3	3	2	3	3	3
	2	3	2	3	2	3	3	2	3	2	3	2	3	3
	2	3	2	3	2	3	2	3	2	3	2	3	2	3
	2	3	2	2	2	3	3	2	3	2	2	2	3	3
	2	2	2	3	2	2	3	2	2	2	3	2	2	3
	2	2	2	3	2	2	2	2	2	3	2	2	2	2

2 TABLET LINE

	MOM	TUE	WED	THU	FRI	SAT	SUN	MON	TUE	WED	THU	FRI	SAT	SUN
Start line for 100mg of tablets	2	2	2	2	2	2	2	2	2	2	2	2	2	2
	2	2	2	1	2	2	2	2	2	2	1	2	2	2
	1	2	2	1	2	2	2	1	2	2	1	2	2	2
	2	1	2	1	2	1	2	2	1	2	1	2	1	2
	1	2	1	2	1	2	1	1	2	1	2	1	2	1
	1	1	2	1	2	1	1	1	1	2	1	2	1	1
	1	1	1	2	1	1	1	1	1	1	2	1	1	1

1 TABLET LINE

	MON	TUE	WED	THU	FRI	SAT	SUN	MON	TUE	WED	THU	FRI	SAT	SUN
Start line for 50mg	1	1	1	1	1	1	1	1	1	1	1	1	1	1
	1	1	1	0	1	1	1	1	1	1	0	1	1	1
	0	1	1	1	0	1	1	0	1	1	1	0	1	1
	1	0	1	0	1	0	1	1	0	1	0	1	0	1
	0	1	0	1	0	1	0	0	1	0	1	0	1	0
	0	0	1	0	0	1	0	0	0	1	0	0	1	0
	0	0	0	1	0	0	0	0	0	0	1	0	0	0

KEEP THIS CHART WITH MEDICATION: **Basic Dose=50mg 1 tablet: 100mg 2=tablets: 150mg=3 tablets**
CITA HELP LINE TELEPHONE NO. 0151 932 0102 **Above numbers refer to number of tablets**

GUIDANCE – PRINCIPLES OF ANTIDEPRESSANT REDUCTION
ZISPIN/MIRTAZAPINE

Week	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Start line for 45mg = 30mg 15mg tablets	45mg	45mg	45mg	45mg	45mg	45mg	45mg	45mg	45mg	45mg	45mg	45mg	45mg	45mg
	45mg	45mg	45mg	37.5mg	45mg	45mg	45mg	45mg	45mg	45mg	37.5mg	45mg	45mg	45mg
	37.5mg	45mg	45mg	37.5mg	45mg	45mg	45mg	37.5mg	45mg	45mg	37.5mg	45mg	45mg	45mg
	37.5mg	45mg	37.5mg	45mg	37.5mg	45mg	45mg	37.5mg	45mg	37.5mg	45mg	37.5mg	45mg	45mg
	37.5mg	45mg	37.5mg	45mg	37.5mg	45mg	37.5mg	37.5mg	45mg	37.5mg	45mg	37.5mg	45mg	37.5mg
	37.5mg	37.5mg	45mg	37.5mg	37.5mg	45mg	37.5mg	37.5mg	37.5mg	37.5mg	45mg	37.5mg	45mg	37.5mg
	37.5mg	37.5mg	45mg	37.5mg	37.5mg	37.5mg	37.5mg	37.5mg	37.5mg	45mg	37.5mg	37.5mg	37.5mg	37.5mg

↑ 45mg TABLET LINE ↑

	MON	TUE	WED	THU	FRI	SAT	SUN	MON	TUE	WED	THU	FRI	SAT	SUN
Start line for 37.5mg tablet = 30mg + ½ of 15mg	37.5mg	37.5mg	37.5mg	37.5mg	37.5mg	37.5mg	37.5mg	37.5mg	37.5mg	37.5mg	37.5mg	37.5mg	37.5mg	37.5mg
	37.5mg	37.5mg	37.5mg	30mg	37.5mg	37.5mg	37.5mg	37.5mg	37.5mg	37.5mg	30mg	37.5mg	37.5mg	37.5mg
	30mg	37.5mg	37.5mg	30mg	37.5mg	37.5mg	37.5mg	30mg	37.5mg	37.5mg	30mg	37.5mg	37.5mg	37.5mg
	30mg	37.5mg	30mg	37.5mg	30mg	37.5mg	37.5mg	30mg	37.5mg	37.5mg	30mg	37.5mg	37.5mg	37.5mg
	30mg	37.5mg	30mg	37.5mg	30mg	37.5mg	30mg	30mg	37.5mg	30mg	37.5mg	30mg	37.5mg	30mg
	30mg	30mg	37.5mg	30mg	30mg	37.5mg	30mg	30mg	30mg	30mg	37.5mg	30mg	37.5mg	30mg
	30mg	30mg	37.5mg	30mg	30mg	30mg	30mg	30mg	30mg	37.5mg	30mg	30mg	30mg	30mg

↑ 37.5mg TABLET LINE ↑

ZISPIN/MIRTAZAPINE SHEET TWO

	MON	TUE	WED	THU	FRI	SAT	SUN	MON	TUE	WED	THU	FRI	SAT	SUN
Start line for 30mg tablet	30mg	30mg	30mg	30mg	30mg	30mg	30mg	30mg	30mg	30mg	30mg	30mg	30mg	30mg
	30mg	30mg	30mg	22.5mg	30mg	30mg	30mg	30mg	30mg	22.5mg	30mg	30mg	30mg	30mg
	22.5mg	30mg	30mg	30mg	22.5mg	30mg	30mg	22.5mg	30mg	30mg	30mg	22.5mg	30mg	30mg
	30mg	22.5mg	30mg	22.5mg	22.5mg	30mg	30mg	22.5mg	30mg	30mg	22.5mg	30mg	22.5mg	30mg
	22.5mg	30mg	22.5mg	22.5mg	30mg	22.5mg	30mg	22.5mg	30mg	22.5mg	30mg	22.5mg	30mg	22.5mg
	22.5mg	30mg	22.5mg	22.5mg	22.5mg	30mg	22.5mg	22.5mg	30mg	22.5mg	22.5mg	22.5mg	30mg	22.5mg
	22.5mg	22.5mg	22.5mg	30mg	22.5mg	22.5mg	22.5mg	22.5mg	22.5mg	22.5mg	30mg	22.5mg	22.5mg	22.5mg

↑30mg TABLET LINE↑

	MON	TUE	WED	THU	FRI	SAT	SUN	MON	TUE	WED	THU	FRI	SAT	SUN
Start line for 22.5mg = 15mg + ½ 15mg tablet	22.5mg	22.5mg	22.5mg	22.5mg	22.5mg	22.5mg	22.5mg	22.5mg	22.5mg	22.5mg	22.5mg	22.5mg	22.5mg	22.5mg
	22.5mg	22.5mg	22.5mg	15mg	22.5mg	22.5mg	22.5mg	22.5mg	22.5mg	15mg	22.5mg	22.5mg	22.5mg	22.5mg
	15mg	22.5mg	22.5mg	15mg	22.5mg	22.5mg	22.5mg	15mg	22.5mg	22.5mg	15mg	22.5mg	22.5mg	22.5mg
	15mg	22.5mg	15mg	22.5mg	15mg	22.5mg	22.5mg	15mg	22.5mg	15mg	22.5mg	15mg	22.5mg	22.5mg
	15mg	22.5mg	15mg	22.5mg	15mg	22.5mg	15mg	15mg	22.5mg	15mg	22.5mg	15mg	22.5mg	15mg
	15mg	15mg	22.5mg	15mg	15mg	22.5mg	15mg	15mg	15mg	15mg	22.5mg	15mg	22.5mg	15mg
	15mg	15mg	22.5mg	15mg	15mg	15mg	15mg	15mg	15mg	22.5mg	15mg	15mg	15m,g	15mg

↑ 22.5mg TABLET LINE↑

	MON	TUE	WED	THU	FRI	SAT	SUN	MON	TUE	WED	THU	FRI	SAT	SUN
Start line for 15mg = 1 tablet	15mg	15mg	15mg	15mg	15mg	15mg	15mg	15mg	15mg	15mg	15mg	15mg	15mg	15mg
	15mg	15mg	15mg	7.5mg	15mg	15mg	15mg	15mg	15mg	7.5mg	15mg	15mg	15mg	15mg
	7.5mg	15mg	15mg	7.5mg	15mg	15mg	15mg	7.5mg	15mg	15mg	7.5mg	15mg	15mg	15mg
	7.5mg	15mg	7.5mg	15mg	7.5mg	15mg	15mg	7.5mg	15mg	7.5mg	15mg	7.5mg	15mg	15mg
	7.5mg	15mg	7.5mg	15mg	7.5mg	15mg	7.5mg	7.5mg	15mg	7.5mg	15mg	7.5mg	15mg	7.5mg
	7.5mg	7.5mg	15mg	7.5mg	7.5mg	7.5mg	15mg	7.5mg	15mg	7.5mg	7.5mg	7.5mg	15mg	7.5mg
	7.5mg	7.5mg	7.5mg	7.5mg	7.5mg	15mg	7.5mg	7.5mg	7.5mg	7.5mg	15mg	7.5mg	7.5mg	7.5mg

↑15mg TABLET LINE↑

ZISPIN/MIRTAZAPINE SHEET THREE

Start line for 7.5mg = ½ 15mg tablet	**7.5mg**	**7.5mg**	**7.5mg**	**7.5mg**	**7.5mg**	**7.5mg**	**7.5mg**	**7.5mg**	**7.5mg**	**7.5mg**	**7.5mg**	**7.5mg**	**7.5mg**	**7.5mg**
	7.5mg	**7.5mg**	**7.5mg**	**0mg**	**7.5mg**	**7.5mg**	**7.5mg**	**7.5mg**	**7.5mg**	**0mg**	**7.5mg**	**7.5mg**	**7.5mg**	**7.5mg**
	0mg	**7.5mg**	**7.5mg**	**0mg**	**7.5mg**	**7.5mg**	**7.5mg**	**0mg**	**7.5mg**	**7.5mg**	**0mg**	**7.5mg**	**7.5mg**	**7.5mg**
	0mg	**7.5mg**	**0mg**	**7.5mg**	**0mg**	**7.5mg**	**7.5mg**	**0mg**	**7.5mg**	**0mg**	**7.5mg**	**0mg**	**7.5mg**	**7.5mg**
	0mg	**7.5mg**	**0mg**	**7.5mg**	**0mg**	**7.5mg**	**0mg**	**0mg**	**7.5mg**	**0mg**	**7.5mg**	**0mg**	**7.5mg**	**0mg**
	0mg	**0mg**	**7.5mg**	**0mg**	**0mg**	**7.5mg**	**0mg**	**0mg**	**0mg**	**0mg**	**7.5mg**	**0mg**	**7.5mg**	**0mg**
	0mg	**0mg**	**7.5mg**	**0mg**	**0mg**	**0mg**	**0mg**	**0mg**	**0mg**	**7.5mg**	**0mg**	**0mg**	**0mg**	**0mg**

↑7.5mg TABLET LINE↑

KEEP THIS CHART WITH MEDICATION Zispin Tablets available in 30mg and 15mg sizes
CITA HELP LINE TELEPHONE NO. 0151 932 0102

ZISPIN/MIRTAZEPINE LIQUID METHOD

ONE 15mg TABLET IS EQUAL TO 15ml OF LIQUID

	MON	TUES	WED	THUR	FRI	SAT	SUN	MON	TUES	WED	THUR	FRI	SAT	SUN
Start line for 15ml Liquid = 1 15mg tablet	15ml	15ml	15ml	15ml	15ml	15ml	15ml	14ml	14ml	14ml	14ml	14ml	14ml	14ml
	13ml	13ml	13ml	13ml	13ml	13ml	13ml	12ml	12ml	12ml	12ml	12ml	12ml	12ml
	11ml	11ml	11ml	11ml	11ml	11ml	11ml	10ml	10ml	10ml	10ml	10ml	10ml	10ml
	9ml	9ml	9ml	9ml	9ml	9ml	9ml	8ml	8ml	8ml	8ml	8ml	8ml	8ml
	7ml	7ml	7ml	7ml	7ml	7ml	7ml	6ml	6ml	6ml	6ml	6ml	6ml	6ml
	5ml	5ml	5ml	5ml	5ml	5ml	5ml	4ml	4ml	4ml	4ml	4ml	4ml	4ml
	3ml	3ml	3ml	3ml	3ng	3ml	3ml	2ml	2ml	2ml	2ml	2ml	2ml	2ml
	1ml	1ml	1ml	1ml	1ml	1ml	1ml							

The reduction is 1ml per week, however if you are having difficulty you can remain on the same amount for an additional week

KEEP THIS CHART WITH YOUR MEDICATION

CITA HELPLINE 0151 932 0102

PROZAC LIQUID – WITHDRAWAL METHOD`

1 20mg TABLET IS EQUAL TO 5ml OF PROZAC LIQIUD

PLEASE LET YOUR DOCTOR KNOW BEFORE STARTING THE WITHDRAWAL

WEEK	MON	TUE	WED	THU	FRI	SAT	SUN	MON	TUE	WED	THU	FRI	SAT	SUN
1	5ml	5ml	5ml	5ml	5ml	4ml	5ml	5ml	5ml	4ml	5ml	5ml	4ml	5ml
3	5ml	4ml	5ml	4ml	5ml	4ml	5ml	4ml	5ml	4ml	5ml	4ml	4ml	5ml
5	5ml	4ml	4ml	5ml	4ml	4ml	4ml	5ml	4ml	4ml	4ml	4ml	4ml	4ml
7	4ml	4ml	4ml	4ml	4ml	4ml	4ml	4ml	4ml	3ml	4ml	4ml	4ml	4ml
9	4ml	3ml	4ml	4ml	3ml	4ml	4ml	3ml	4ml	3ml	4ml	4ml	3ml	4ml
11	3ml	4ml	3ml	4ml	3ml	3ml	4ml	4ml	3ml	3ml	4ml	3ml	3ml	3ml
13	3ml	3ml	4ml	3ml	3ml	3ml	3ml	3ml	3ml	3ml	3ml	3ml	3ml	3ml
15	3ml	3ml	2ml	3ml	3ml	3ml	3ml	3ml	2ml	3ml	3ml	2ml	3ml	3ml
17	3ml	2ml	3ml	2ml	3ml	2ml	3ml	3ml	2ml	2ml	3ml	2ml	2ml	3ml
19	3ml	2ml	2ml	3ml	2ml	2ml	2ml	3ml	2ml	2ml	2ml	2ml	2ml	2ml
21	2ml	2ml	2ml	2ml	2ml	2ml	2ml	2ml	2ml	1ml	2ml	2ml	2ml	2ml
23	2ml	1ml	2ml	2ml	1ml	2ml	2ml	2ml	1ml	2ml	1ml	2ml	1ml	2ml
25	2ml	1ml	1ml	2ml	2ml	1ml	1ml	2ml	1ml	1ml	1ml	1ml	1ml	2ml
27	1ml	1ml	1ml	1ml	2ml	1ml	1ml	1ml	1ml	1ml	1ml	1ml	1ml	1ml
29	1ml	1ml	Nil	1ml	1ml	1ml	1ml	1ml	Nil	1ml	1ml	Nil	1ml	1ml
31	1ml	Nil	1ml	Nil	1ml	Nil	1ml	1ml	Nil	1ml	Nil	Nil	1ml	Nil
33	1ml	Nil	Nil	1ml	Nil	Nil	Nil	1ml	Nil	Nil	Nil	Nil	Nil	Nil
35	Nil	Nil	Nil	Nil	Nil	Nil	Nil							

SEROXAT LIQUID – WITHDRAWAL METHOD`

ONE 20mg TABLET IS EQUAL TO 10ml OF SEROXAT LIQIUD

PLEASE LET YOUR DOCTOR KNOW BEFORE STARTING THE WITHDRAWAL

WEEK	MON	TUE	WED	THU	FRI	SAT	SUN	MON	TUE	WED	THU	FRI	SAT	SUN
1	10ml	10ml	10ml	10ml	10ml	9ml	10ml	10ml	10ml	9ml	10ml	10ml	9ml	10ml
3	10ml	9ml	10ml	9ml	10ml	9ml	10ml	9ml	10ml	9ml	10ml	9ml	9ml	10ml
5	10ml	9ml	9ml	10ml	9ml	9ml	9ml	10ml	9ml	9ml	9ml	9ml	9ml	9ml
7	9ml	9ml	9ml	9ml	9ml	9ml	9ml	9ml	9ml	8ml	9ml	9ml	9ml	9ml
9	9ml	8ml	9ml	9ml	8ml	9ml	9ml	8ml	9ml	8ml	9ml	9ml	8ml	9ml
11	8ml	9ml	8ml	9ml	8ml	8ml	9ml	9ml	8ml	8ml	9ml	8ml	8ml	8ml
13	8ml	8ml	9ml	8ml	8ml	8ml	8ml	8ml	8ml	8ml	8ml	8ml	8ml	8ml
15	8ml	8ml	7ml	8ml	8ml	8ml	8ml	8ml	7ml	8ml	8ml	7ml	8ml	8ml
17	8ml	7ml	8ml	7ml	8ml	7ml	8ml	8ml	7ml	7ml	8ml	7ml	7ml	8ml
19	8ml	7ml	7ml	8ml	7ml	7ml	7ml	8ml	7ml	7ml	7ml	7ml	7ml	7ml
21	7ml	7ml	7ml	7ml	7ml	7ml	7ml	7ml	7ml	1ml	7ml	7ml	7ml	7ml
23	7ml	6ml	7ml	7ml	6ml	7ml	7ml	7ml	6ml	7ml	6ml	7ml	6ml	7ml
25	7ml	6ml	6ml	7ml	7ml	6ml	6ml	7ml	6ml	6ml	6ml	6ml	6ml	7ml
27	6ml	6ml	6ml	6ml	7ml	6ml	6ml	6ml	6ml	6ml	6ml	6ml	6ml	6ml
29	6ml	6ml	5ml	6ml	6ml	6ml	6ml	6ml	5ml	6ml	6ml	5ml	6ml	6ml
31	6ml	5ml	6ml	5ml	6ml	5ml	6ml	6ml	5ml	6ml	5ml	5ml	6ml	5ml
33	6ml	5ml	5ml	6ml	5ml	5ml	5ml	6ml	5ml	5ml	5ml	5ml	5ml	5ml
35	5ml	5ml	5ml	5ml	5ml	5ml	5ml	5ml	5ml	5ml	5ml	5ml	5ml	5ml

SEROXAT LQUID SHEET TWO

WEEK	MON	TUE	WED	THU	FRI	SAT	SUN	MON	TUE	WED	THU	FRI	SAT	SUN
37	5ml	5ml	5ml	5ml	5ml	4ml	5ml	5ml	5ml	4ml	5ml	5ml	4ml	5ml
39	5ml	4ml	5ml	4ml	5ml	4ml	5ml	4ml	5ml	4ml	5ml	4ml	4ml	5ml
41	5ml	4ml	4ml	5ml	4ml	4ml	4ml	5ml	4ml	4ml	4ml	4ml	4ml	4ml
43	4ml	4ml	4ml	4ml	4ml	4ml	4ml	4ml	4ml	3ml	4ml	4ml	4ml	4ml
45	4ml	3ml	4ml	4ml	3ml	4ml	4ml	3ml	4ml	3ml	4ml	4ml	3ml	4ml
47	3ml	4ml	3ml	4ml	3ml	3ml	4ml	4ml	3ml	3ml	4ml	3ml	3ml	3ml
49	3ml	3ml	4ml	3ml	3ml	3ml	3ml	3ml	3ml	3ml	3ml	3ml	3ml	3ml
51	3ml	3ml	2ml	3ml	3ml	3ml	3ml	3ml	2ml	3ml	3ml	2ml	3ml	3ml
53	3ml	2ml	3ml	2ml	3ml	2ml	3ml	3ml	2ml	2ml	3ml	2ml	2ml	3ml
55	3ml	2ml	2ml	3ml	2ml	2ml	2ml	3ml	2ml	2ml	2ml	2ml	2ml	2ml
57	2ml	2ml	2ml	2ml	2ml	2ml	2ml	2ml	2ml	1ml	2ml	2ml	2ml	2ml
59	2ml	1ml	2ml	2ml	1ml	2ml	2ml	2ml	1ml	2ml	1ml	2ml	1ml	2ml
61	2ml	1ml	1ml	2ml	2ml	1ml	1ml	2ml	1ml	1ml	1ml	1ml	1ml	2ml
63	1ml	1ml	1ml	1ml	2ml	1ml	1ml	1ml	1ml	1ml	1ml	1ml	1ml	1ml
65	1ml	1ml	Nil	1ml	1ml	1ml	1ml	1ml	Nil	1ml	1ml	Nil	1ml	1ml
67	1ml	Nil	1ml	Nil	1ml	Nil	1ml	1ml	Nil	1ml	Nil	Nil	1ml	Nil
69	1ml	Nil	Nil	1ml	Nil	Nil	Nil	1ml	Nil	Nil	Nil	Nil	Nil	Nil
71	Nil	Nil	Nil	Nil	Nil	Nil	Nil							

GUIDANCE – PRINCIPLES OF ANTIDEPRESSANT REDUCTION
AMITRIPTYLINE (TRIPTAFEN)

Week	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Start line for 150mg	150mg	150mg	150mg	125mg	150mg	150mg	150mg	150mg	125mg	150mg	150mg	150mg	125mg	150mg
	125mg	150mg	150mg	125mg	150mg	125mg	150mg	125mg	150mg	125mg	150mg	125mg	150mg	125mg
	125mg	150mg	125mg	125mg	150mg	125mg	125mg	125mg	125mg	125mg	150mg	125mg	125mg	125mg
	125mg	125mg	125mg	125mg	125mg	125mg	125mg							

Week	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Start line for 125mg	125mg	125mg	125mg	100mg	125mg	125mg	125mg	125mg	100mg	125mg	125mg	125mg	100mg	125mg
	100mg	125mg	125mg	100mg	125mg	100mg	125mg	100mg	125mg	100mg	125mg	100mg	125mg	100mg
	100mg	125mg	100mg	100mg	125mg	100mg	100mg	100mg	100mg	100mg	125mg	100mg	100mg	100mg
	100mg	100mg	100mg	100mg	100mg	100mg	100mg							

	MON	TUE	WED	THU	FRI	SAT	SUN	MON	TUE	WED	THU	FRI	SAT	SUN
Start line for 100mg	100mg	100mg	100mg	75mg	100mg	100mg	100mg	100mg	175mg	100mg	100mg	100mg	75mg	100mg
	75mg	100mg	100mg	75mg	100mg	75mg	100mg	75mg	100mg	75mg	100mg	75mg	100mg	75mg
	75mg	100mg	75mg	75mg	100mg	75mg	75mg	75mg	75mg	75mg	100mg	75mg	75mg	75mg
	75mg	75mg	75mg	75mg	75mg	75mg	75mg							

Start line for 75mg	75mg	75mg	75mg	50mg	75mg	75mg	75mg	75mg	50mg	75mg	75mg	75mg	50mg	75mg
	50mg	75mg	75mg	50mg	75mg	50mg	75mg	50mg	75mg	50mg	75mg	50mg	75mg	50mg
	50mg	75mg	50mg	50mg	75mg	50mg	50mg	50mg	50mg	50mg	75mg	50mg	50mg	50mg
	50mg	50mg	50mg	50mg	50mg	50mg	50mg							

AMITRIPTYLINE (TRIPTAFEN) SHEET TWO

Week	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Start line for 50mg	50mg	50mg	50mg	25mg	50mg	50mg	50mg	50mg	25mg	50mg	50mg	50mg	25mg	50mg
	25mg	50mg	50mg	25mg	50mg	25mg	50mg	25mg	50mg	25mg	50mg	25mg	50mg	25mg
	25mg	50mg	25mg	25mg	50mg	25mg	25mg	25mg	25mg	25mg	50mg	25mg	25mg	25mg
	25mg	25mg	25mg	25mg	25mg	25mg	25mg							

↓ TABLETS AVAILABLE IN 10MG SIZE ↓

Start line for 25mg	25mg	25mg	25mg	10mg	25mg	25mg	25mg	25mg	10mg	25mg	25mg	25mg	10mg	25mg
	10mg	25mg	25mg	10mg	25mg	10mg	25mg	10mg	25mg	10mg	25mg	10mg	25mg	10mg
	10mg	25mg	10mg	10mg	25mg	10mg	10mg	10mg	10mg	10mg	25mg	10mg	10mg	10mg
	10mg	10mg	10mg	10mg	10mg	10mg	10mg							

	MON	TUE	WED	THU	FRI	SAT	SUN	MON	TUE	WED	THU	FRI	SAT	SUN
Start line for 10mg	10mg	10mg	10mg	0mg	10mg	10mg	10mg	10mg	0mg	10mg	10mg	10mg	0mg	10mg
	0mg	10mg	10mg	0mg	0mg	10mg	10mg	0mg	10mg	0mg	10mg	0mg	10mg	0mg
	0mg	10mg	0mg	0mg	10mg	0mg	0mg	0mg	0mg	0mg	10mg	0mg	10mg	10mg
	0mg	0mg	0mg	0mg	0mg	0mg	0mg							

KEEP THIS CHART WITH MEDICATION: Basic Dose=25mg 1 tablet:
CITA HELP LINE TELEPHONE NO. 0151 932 0102

GUIDANCE – PRINCIPLES OF ANTIDEPRESSANT REDUCTION
GAMANIL

Week	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Start line for 140mg 2 tablets (70mg each)	150mg	150mg	150mg	150mg	150mg	150mg	150mg	150mg	150mg	150mg	150mg	150mg	150mg	150mg
	105mg	150mg	150mg	105mg	150mg	150mg	150mg	105mg	150mg	150mg	105mg	150mg	150mg	150mg
	105mg	150mg	105mg	150mg	105mg	150mg	150mg	105mg	150mg	105mg	150mg	105mg	150mg	150mg
	105mg	150mg	105mg	150mg	105mg	150mg	105mg	150mg	105mg	150mg	105mg	150mg	105mg	150mg
	105mg	150mg	105mg	105mg	105mg	150mg	150mg	105mg	150mg	105ng	105mg	105mg	150mg	150mg
	105mg	105mg	105mg	150mg	105mg	105mg	150mg	105mg	105mg	105mg	150mg	105mg	105mg	150mg
	105mg	105mg	105mg	150mg	105mg	105mg	105mg	105mg	105mg	150mg	105mg	105mg	105mg	105mg

↑ 2 TABLET LINE ↑

	MON	TUE	WED	THU	FRI	SAT	SUN	MON	TUE	WED	THU	FRI	SAT	SUN
Start line for 105mg tablet 1½ Tablets	105mg	105mg	105mg	105mg	105mg	105mg	105mg	105mg	105mg	105mg	105mg	105mg	105mg	105mg
	70mg	105mg	105mg	70mg	105mg	105mg	105mg	70mg	105mg	105mg	70mg	105mg	105mg	105mg
	70mg	105mg	70mg	105mg	70mg	105mg	105mg	70mg	105mg	70mg	105mg	70mg	105mg	105mg
	70mg	105mg	70mg	105mg	70mg	105mg	70mg	105mg	70mg	105mg	70mg	105mg	70mg	105mg
	70mg	105mg	70mg	70mg	70mg	105mg	105mg	70mg	105mg	105ng	70mg	70mg	105mg	105mg
	70mg	70mg	70mg	105mg	70mg	70mg	105mg	70mg	70mg	70mg	105mg	70mg	70mg	105mg
	70mg	70mg	70mg	105mg	70mg	70mg	70mg	70mg	70mg	105mg	70mg	70mg	70mg	70mg

↑ 1 ½ TABLET LINE ↑

GAMANIL SHEET TWO

	MON	TUE	WED	THU	FRI	SAT	SUN	MON	TUE	WED	THU	FRI	SAT	SUN
Start line for 70mg 1 tablet	70mg	70mg	70mg	70mg	70mg	70mg	70mg	70mg	70mg	70mg	70mg	70mg	70mg	70mg
	35mg	70mg	70mg	35mg	70mg	70mg	70mg	35mg	70mg	70mg	35mg	70mg	70mg	70mg
	35mg	70mg	35mg	70mg	35mg	70mg	70mg	35mg	70mg	35mg	70mg	35mg	70mg	70mg
	35mg	70mg	35mg	70mg	35mg	70mg	35mg	70mg	35mg	70mg	35mg	70mg	35mg	70mg
	35mg	70mg	35mg	35mg	35mg	70mg	70mg	35mg	70mg	35mg	35mg	35mg	70mg	70mg
	35mg	35mg	35mg	70mg	35mg	35mg	70mg	35mg	35mg	35mg	70mg	35mg	35mg	70mg
	35mg	35mg	35mg	70mg	35mg	35mg	35mg	35mg	35mg	70mg	35mg	35mg	35mg	35mg

↑ 1 TABLET LINE ↑

	MON	TUE	WED	THU	FRI	SAT	SUN	MON	TUE	WED	THU	FRI	SAT	SUN
Start line for 35mg ½ tablet	35mg	35mg	35mg	35mg	35mg	35mg	35mg	35mg	35mg	35mg	35mg	35mg	35mg	35mg
	0mg	35mg	35mg	0mg	35mg	35mg	35mg	0mg	35mg	35mg	0mg	35mg	35mg	35mg
	0mg	35mg	0mg	35mg	0mg	35mg	35mg	0mg	35mg	0mg	35mg	0mg	35mg	35mg
	0mg	35mg	0mg	35mg	0mg	35mg	0mg	35mg	0mg	35mg	0mg	35mg	0mg	35mg
	0mg	35mg	0mg	0mg	0mg	35mg	35mg	0mg	35mg	35mg	0mg	0mg	35mg	35mg
	0mg	0mg	0mg	35mg	0mg	0mg	35mg	0mg	0mg	0mg	35mg	0mg	0mg	35mg
	0mg	0mg	0mg	35mg	0mg	0mg	0mg	0mg	0mg	35mg	0mg	0mg	0mg	0mg

KEEP THIS CHART WITH MEDICATION: Basic Dose=70mg 1 tablet:
CITA HELP LINE TELEPHONE NO. 0151 932 0102 Above numbers refer to number of tablets

GUIDANCE – PRINCIPLES OF ANTIDEPRESSANT REDUCTION
TRAZODONE - MOLIPAXIN

Week	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Start line for 150mg of tablets	3	3	3	2	3	3	3	3	3	3	2	3	3	3
	2	3	3	2	3	3	3	2	3	3	2	3	3	3
	2	3	2	3	2	3	3	2	3	2	3	2	3	3
	2	3	2	3	2	3	2	3	2	3	2	3	2	3
	2	3	2	2	2	3	3	2	3	2	2	2	3	3
	2	2	2	3	2	2	3	2	2	2	3	2	2	3
	2	2	2	3	2	2	2	2	2	3	2	2	2	2

↑ 3 CAPSULES LINE ↑

	MON	TUE	WED	THU	FRI	SAT	SUN	MON	TUE	WED	THU	FRI	SAT	SUN
Start line for 100mg of Capsules	2	2	2	2	2	2	2	2	2	2	2	2	2	2
	2	2	2	1	2	2	2	2	2	2	1	2	2	2
	1	2	2	1	2	2	2	1	2	2	1	2	2	2
	2	1	2	1	2	1	2	2	1	2	1	2	1	2
	1	2	1	2	1	2	1	1	2	1	2	1	2	1
	1	1	2	1	2	1	1	1	1	2	1	2	1	1
	1	1	1	2	1	1	1	1	1	1	2	1	1	1

↑ 2 CAPSULE LINE ↑

TRAZODONE – MOLIPAXIN – SHEET TWO

	MON	TUE	WED	THU	FRI	SAT	SUN	MON	TUE	WED	THU	FRI	SAT	SUN
Start line for 50mg Of Capsules	1	1	1	1	1	1	1	1	1	1	1	1	1	1
	1	1	1	0	1	1	1	1	1	1	0	1	1	1
	0	1	1	1	0	1	1	0	1	1	1	0	1	1
	1	0	1	0	1	0	1	1	0	1	0	1	0	1
	0	1	0	1	0	1	0	0	1	0	1	0	1	0
	0	0	1	0	0	1	0	0	0	1	0	0	1	0
	0	0	0	1	0	0	0	0	0	0	1	0	0	0

KEEP THIS CHART WITH MEDICATION: Dosage 150mg tablet: 50mg and 100mg capsules:

Also in liquid form 50mg = 5ml liquid see following page

CITA HELP LINE TELEPHONE NO. 0151 932 0102

Above numbers refer to number of tablets

TRAZADONE LIQUID – WITHDRAWAL METHOD`

2 50mg TABLET IS EQUAL TO 5ml OF TRAZODONE

PLEASE LET YOUR DOCTOR KNOW BEFORE STARTING THE WITHDRAWAL

WEEK	MON	TUE	WED	THU	FRI	SAT	SUN	MON	TUE	WED	THU	FRI	SAT	SUN
1	5ml	5ml	5ml	5ml	5ml	4ml	5ml	5ml	5ml	4ml	5ml	5ml	4ml	5ml
3	5ml	4ml	5ml	4ml	5ml	4ml	5ml	4ml	5ml	4ml	5ml	4ml	4ml	5ml
5	5ml	4ml	4ml	5ml	4ml	4ml	4ml	5ml	4ml	4ml	4ml	4ml	4ml	4ml
7	4ml	4ml	4ml	4ml	4ml	4ml	4ml	4ml	4ml	3ml	4ml	4ml	4ml	4ml
9	4ml	3ml	4ml	4ml	3ml	4ml	4ml	3ml	4ml	3ml	4ml	4ml	3ml	4ml
11	3ml	4ml	3ml	4ml	3ml	3ml	4ml	4ml	3ml	3ml	4ml	3ml	3ml	3ml
13	3ml	3ml	4ml	3ml	3ml	3ml	3ml	3ml	3ml	3ml	3ml	3ml	3ml	3ml
15	3ml	3ml	2ml	3ml	3ml	3ml	3ml	3ml	2ml	3ml	3ml	2ml	3ml	3ml
17	3ml	2ml	3ml	2ml	3ml	2ml	3ml	3ml	2ml	2ml	3ml	2ml	2ml	3ml
19	3ml	2ml	2ml	3ml	2ml	2ml	2ml	3ml	2ml	2ml	2ml	2ml	2ml	2ml
21	2ml	2ml	2ml	2ml	2ml	2ml	2ml	2ml	2ml	1ml	2ml	2ml	2ml	2ml
23	2ml	1ml	2ml	2ml	1ml	2ml	2ml	2ml	1ml	2ml	1ml	2ml	1ml	2ml
25	2ml	1ml	1ml	2ml	2ml	1ml	1ml	2ml	1ml	1ml	1ml	1ml	1ml	2ml
27	1ml	1ml	1ml	1ml	2ml	1ml	1ml	1ml	1ml	1ml	1ml	1ml	1ml	1ml
29	1ml	1ml	Nil	1ml	1ml	1ml	1ml	1ml	Nil	1ml	1ml	Nil	1ml	1ml
31	1ml	Nil	1ml	Nil	1ml	Nil	1ml	1ml	Nil	1ml	Nil	Nil	1ml	Nil
33	1ml	Nil	Nil	1ml	Nil	Nil	Nil	1ml	Nil	Nil	Nil	Nil	Nil	Nil
35	Nil	Nil	Nil	Nil	Nil	Nil	Nil							

COUNCIL FOR INFORMATION ON TRANQUILLISERS AND ANTIDEPRESSANTS

PHENELZINE/ NARDIL (EACH TABLET – 15MGS)

45mgs (3 x 15mgs)

Week 1	**3**	**3**	**3**	**3**	**3**	**3**	**2**	**Week 2**	**3**	**3**	**3**	**2**	**3**	**3**	**2**
Week 3	**3**	**2**	**3**	**2**	**3**	**3**	**2**	**Week 4**	**3**	**2**	**3**	**2**	**2**	**3**	**2**
Week 5	**2**	**2**	**3**	**2**	**2**	**3**	**2**	**Week 6**	**2**	**2**	**2**	**2**	**2**	**3**	**2**
Week 7	**2**	**2**	**2**	**2**	**2**	**2**	**2**								

30mgs (2 x 15mgs)

Week 8	**2**	**2**	**2**	**2**	**2**	**2**	**1**	**Week 9**	**2**	**2**	**2**	**1**	**2**	**2**	**1**
Week 10	**2**	**1**	**2**	**1**	**2**	**2**	**1**	**Week 11**	**2**	**1**	**2**	**1**	**1**	**2**	**1**
Week 12	**1**	**1**	**2**	**1**	**1**	**2**	**1**	**Week 13**	**1**	**1**	**1**	**1**	**1**	**2**	**1**
Week 14	**1**	**1**	**1**	**1**	**1**	**1**	**1**								

15mgs (1 x 15mgs)

Week 15	**1**	**1**	**1**	**1**	**1**	**1**	**0**	**Week 16**	**1**	**1**	**1**	**0**	**1**	**1**	**0**
Week 10	**0**	**1**	**0**	**1**	**0**	**1**	**1**	**Week 11**	**0**	**1**	**0**	**1**	**0**	**0**	**1**
Week 12	**0**	**1**	**0**	**1**	**0**	**0**	**0**	**Week 13**	**1**	**0**	**0**	**0**	**0**	**0**	**1**
Week 14	**0**	**0**	**0**	**0**	**0**	**0**	**0**								

CIPRAMIL LIQUID REDUCTION CHART

Dosage 40mgs of Citalopram per 1ml of liquid

20mgs of Citalopram per .5ml of liquid

Reduction by .1ml every fortnight

Weeks 1 and 2 take .5ml of liquid

Weeks 3 and 4 take .4ml of liquid

Weeks 5 and 6 take .3ml of liquid

Weeks 7 and 8 take .2ml of liquid

Weeks 9 and 10 take .1ml of liquid

Weeks 11 and 12 take .05ml of liquid

Week 13 stop

It is possible to continue with St Johns Wort at this point. It is best to have no gap between the last dose of Citalopram and St Johns Wort.

Most research on St Johns Wort has been carried out on the 'Kira' made sold at Boots. Speak to the pharmacist about interactions with any other drugs you are on. Start with one a day dose. After 4 weeks on St Johns Wort the makers of Kira have advised that clients who have been on SSRIs or SNRIs will need at least 2 Kira tablets per day. It is important not to go straight onto 2 tablets dose but to start at I tablet a day dose.

The highest dose recommended by the makers of Kira is 3 tablets per day. Do not go on this dose unless you have been on St Johns Wort for at least 2 months.

SURMONTIL (TRIMIPRAMINE)

AT 50MGS – START HERE

	MON	TUES	WED	THURS	FRI	SAT	SUN
Wk 1	1x50mg	1x50mg	1x50mg	1x50mg	1x50mg	1x50mg	1x50mg
Wk 2	1x50mg	1x25mg	1x50mg	1x50mg	1x25mg	1x50mg	1x50mg
Wk 3	1x50mg	1x25mg	1x50mg	1x25mg	1x50mg	1x25mg	1x50mg
Wk 4	1x25mg	1x50mg	1x25mg	1x25mg	1x50mg	1x25mg	1x50mg
Wk 5	1x25mg	1x50mg	1x25mg	1x25mg	1x25mg	1x50mg	1x25mg
Wk 6	1x25mg	1x50mg	1x25mg	1x25mg	1x25mg	1x25mg	1x25mg

AT 25MGS – START HERE

	MON	TUES	WED	THURS	FRI	SAT	SUN
Wk 1	1x25mg	1x25mg	1x25mg	1x25mg	1x25mg	1x25mg	1x25mg
Wk 2	1x25mg	1x10mg	1x25mg	1x25mg	1x10mg	1x25mg	1x25mg
Wk 3	1x25mg	1x10mg	1x25mg	1x10mg	1x25mg	1x10mg	1x25mg
Wk 4	1x10mg	1x25mg	1x10mg	1x10mg	1x25mg	1x10mg	1x25mg
Wk 5	1x10mg	1x25mg	1x10mg	1x10mg	1x10mg	1x25mg	1x10mg
Wk 6	1x10mg	1x25mg	1x10mg	1x10mg	1x10mg	1x10mg	1x10mg

AT 10mg - START HERE

	MON	TUE	WED	THUR	FRI	SAT	SUN
Wk 1	1x10mg	1x10mg	1x10mg	1x10mg	1x10mg	1x10mg	1x10mg
Wk 2	1x10mg	0mg	1x10mg	1x10mg	0mg	1x10mg	1x10mg
Wk 3	1x10mg	0mg	1x10mg	0mg	1x10mg	0mg	1x10mg
Wk 4	0mg	1x10mg	0mg	0mg	1x10mg	0mg	1x10mg
Wk 5	0mg	1x10mg	0mg	0mg	0mg	1x10mg	0mg
Wk 6	0mg	1x10mg	0mg	0mg	0mg	0mg	0mg

Surmontil is available in 10mg and 25mg tablets and in 50mg as a capsule.

CITA helepline is 0151 932 0102.

SURMONTIL (TRIMIPRAMINE)

AT 125MGS – START HERE

	MON	TUE	WED	THUR	FRI	SAT	SUN
Wk 1	125mgs	125mgs	125mgs	125mgs	125mgs	125mgs	125mgs
Wk 2	125mgs	100mgs	125mgs	125mgs	100mgs	125mgs	125mgs
Wk 3	125mgs	100mgs	125mgs	100mgs	125mgs	100mgs	125mgs
Wk 4	100mgs	125mgs	100mgs	100mgs	125mgs	100mgs	125mgs
Wk 5	100mgs	125mgs	100mgs	100mgs	100mgs	125mgs	100mgs
Wk 6	100mgs	125mgs	100mgs	100mgs	100mgs	100mgs	100mgs

AT 100MGS – START HERE

	MON	TUE	WED	THUR	FRI	SAT	SUN
Wk 1	100mgs	100mgs	100mgs	100mgs	100mgs	100mgs	100mgs
Wk 2	100mgs	75mg	100mgs	100mgs	75mg	100mgs	100mgs
Wk 3	100mgs	75mg	100mgs	75mg	100mgs	75mg	100mgs
Wk 4	75mg	100mgs	75mg	75mg	100mgs	75mg	100mgs
Wk 5	75mg	100mgs	75mg	75mg	75mg	100mgs	75mg
Wk 6	75mg	100mgs	75mg	75mg	75mg	75mg	75mg

AT 75mg - START HERE

	MON	TUE	WED	THUR	FRI	SAT	SUN
Wk 1	75mg	75mg	75mg	75mg	75mg	75mg	75mg
Wk 2	75mg	50mg	75mg	75mg	50mg	75mg	75mg
Wk 3	75mg	50mg	75mg	50mg	75mg	50mg	75mg
Wk 4	50mg	75mg	50mg	50mg	75mg	50mg	75mg
Wk 5	50mg	75mg	50mg	50mg	50mg	75mg	50mg
Wk 6	50mg	75mg	50mg	50mg	50mg	50mg	50mg

Surmontil is available in 10mg and 25mg tablets and in 50mg as a capsule.

CITA helepline is 0151 932 0102.

SURMONTIL (TRIMIPRAMINE)

AT 200MGS – START HERE

	MON	TUE	WED	THU	FRI	SAT	SUN
Wk 1	200mgs	200mgs	200mgs	200mgs	200mgs	200mgs	200mgs
Wk 2	200mgs	175mgs	200mgs	200mgs	175mgs	200mgs	200mgs
Wk 3	200mgs	175mgs	200mgs	175mgs	200mgs	175mgs	200mgs
Wk 4	175mgs	200mgs	175mgs	175mgs	200mgs	175mgs	200mgs
Wk 5	175mgs	200mgs	175mgs	175mgs	175mgs	200mgs	175mgs
Wk 6	175mgs	200mgs	175mgs	175mgs	175mgs	175mgs	175mgs

AT 175MGS – START HERE

	MON	TUE	WED	THU	FRI	SAT	SUN
Wk 1	175mgs	175mgs	175mgs	175mgs	175mgs	175mgs	175mgs
Wk 2	175mgs	150mg	175mgs	175mgs	150mg	175mgs	175mgs
Wk 3	175mgs	150mg	175mgs	150mg	175mgs	150mg	175mgs
Wk 4	150mg	175mgs	150mg	150mg	175mgs	150mg	175mgs
Wk 5	150mg	175mgs	150mg	150mg	150mg	175mgs	150mg
Wk 6	150mg	150mg	150mg	150mg	150mg	150mg	150mg

AT 150mg - START HERE

	MON	TUE	WED	THU	FRI	SAT	SUN
Wk 1	150mg	150mg	150mg	150mg	150mg	150mg	150mg
Wk 2	150mg	125mg	150mg	150mg	125mg	150mg	150mg
Wk 3	150mg	125mg	150mg	125mg	150mg	125mg	150mg
Wk 4	125mg	150mg	125mg	125mg	150mg	125mg	150mg
Wk 5	125mg	150mg	125mg	125mg	125mg	150mg	125mg
Wk 6	125mg	125mg	125mg	125mg	125mg	125mg	125mg

Surmontil is available in 10mg and 25mg tablets and in 50mg as a capsule.

CITA helepline is 0151 932 0102.

DOTHIEPIN (PROTHIADEN, DOSULEPIN)

AT 75MGS – START HERE

MON	TUE	WED	THU	FRI	SAT	SUN
75mg	75mg	75mg	75mg	75mg	75mg	75mg
75mg	50mg	75mg	75mg	50mg	75mg	75mg
75mg	50mg	75mg	50mg	75mg	50mg	75mg
50mg	75mg	50mg	50mg	75mg	50mg	75mg
50mg	75mg	50mg	50mg	50mg	75mg	50mg
50mg	75mg	50mg	50mg	50mg	50mg	50mg
50mg	50mg	50mg	50mg	50mg	50mg	50mg

AT 50MGS – START HERE

MON	TUE	WED	THU	FRI	SAT	SUN
50mg	50mg	50mg	50mg	50mg	50mg	50mg
50mg	25mg	50mg	50mg	25mg	50mg	50mg
50mg	25mg	50mg	25mg	50mg	25mg	50mg
25mg	50mg	25mg	25mg	50mg	25mg	50mg
25mg	50mg	25mg	25mg	25mg	50mg	25mg
25mg	50mg	25mg	25mg	25mg	25mg	25mg
25mg	25mg	25mg	25mg	25mg	25mg	25mg

AT 25MGS – START HERE

MON	TUE	WED	THU	FRI	SAT	SUN
25mg	25mg	25mg	25mg	25mg	25mg	25mg
25mg	0mg	25mg	25mg	0mg	25mg	25mg
25mg	0mg	25mg	0mg	25mg	0mg	25mg
0mg	25mg	0mg	0mg	25mg	0mg	25mg
0mg	25mg	0mg	0mg	0mg	25mg	0mg
0mg	25mg	0mg	0mg	0mg	0mg	0mg
0mg	0mg	0mg	0mg	0mg	0mg	0mg

ANAFRANIL - 40mgs

Reduce on one day of the week to 30mgs. Stay on 40mgs on all other days.

The following week reduce on two days to 30mgs but not on two days together.

Reduce the following week on 3 days to 30mgs keeping the days apart.

Keep going like this until you are on 30mgs on each day.

Then start the same process of reduction from 30mgs to 20mgs.

Getting from each dose down to the next dose on 7 days can take 7 weeks but don't worry if you feel you need to spend an extra week at any particular dose – it is your well-being which matters.

Using this method your reduction down to 0mgs will take at least 28 weeks and it is very gentle.

Drink plenty of water while you are reducing (at least a litre per day). Eat little and often to maintain blood sugar levels. These drugs raise blood sugar levels and it is when they drop that symptoms may get worse,

COUNCIL FOR INFORMATION ON TRANQUILLISERS AND ANTIDEPRESSANTS

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BENZODIAZEPINE WITHDRAWAL PROTOCOL

Dear Doctor,

This letter of protocol is to introduce the Council for Information on Tranquillisers and Antidepressants formally Council for Involuntary Tranquilliser Addiction (C.I.T.A.).

C.I.T.A. is a nationally recognised organisation and registered charity, established to raise awareness of the problems associated with tranquilliser addiction. This protocol includes a tranquilliser reduction/withdrawal programme. The Department of Health has CITA listed as a source of information and help to GPs, Nurses and other health professionals.

The problem of Benzodiazepine addiction, which includes tranquillisers and hypnotics (sleeping tablets) is an enormous one. Patients very often do not realise they are addicted, preferring to rationalise by saying that if they do not take their tablets they get a reoccurrence of the symptoms for which the tablets were first prescribed. This may have been years ago.

The symptoms of tranquilliser withdrawal are many and varied, but are identical to symptoms of phobic anxiety states. The common pathway in both circumstances is the inappropriate secretion of large quantities of adrenalin.

The physiological effects of adrenalin are well known to doctors, but not to patients. They therefore misinterpret the palpitations, etc. as a sign of impending demise. This makes them frightened which, in turn, causes further adrenalin secretion, and so the vicious circle goes on, until patients suffer a full blown panic attack. The patient may request further tranquillisers from their doctor, which would only perpetuate the problems of withdrawal.

TO STOP TAKING TRANQUILLISERS SUDDENLY IS DANGEROUS!

So, HOW do you treat someone like this?

Tranquilliser Reduction/Withdrawal Programme

1) All patients are converted to Diazepam 2mg tablets, having several effects:

a) Patients realise the enormous dose they have been taking.

b) Diazepam 2mg tablets allow the client to make stepwise reductions in dosage.

c) Patients/clients are told that they can split the dose as they wish, according to perceived need. (Remember, serum levels vary very little over 24 hours.)

Equivalent Dosage of Benzodiazepine/Other Hypnotic to Diazepam.

1mg OF 'OTHER' BENZODIAZEPINES	EQUIVALENT DOSE IN DIAZEPAM
Ativan (Lorazepam)	10mg
Normison (Temazepam)	¾ mg
Mogadon (Nitrazepam)	1¾mg
Dalmane (Flurazepam)	1mg
Serenid (Oxazepam)	¾mg
Clonazepam	20mg
Tranxene (Clorazepate)	1mg
Librium (Chlordiazepoxide)	¾mg
Halcion (Triazolam)	20mg
Dormonoct (Loprazolam)	8mg
Noctamid (Lormetazepam)	8mg
Frisium (Clobazam)	¾mg
Xanax (Alprazolam)	12mg
Lexotan (Bromazepam)	2mg
Zimovane/Zileze (Zopiclone) *	¾ mg *
Stilnoct (Zolpidem) **	¾ mg **

*** Zopiclone** is not a benzodiazepine but has a similar mode of action and is equally addictive if taken on a regular basis for longer than 2 weeks. Conversion to diazepam followed by slow withdrawal is the most successful way to come off this hypnotic.

**** Stilnoct (Zolpidem)** is another hypnotic which is thought to be addictive if taken for longer than the recommended time. Slow withdrawal is advisable and conversion to diazepam may be helpful in this respect.

The equivalents given are maximum doses. When calculating the equivalent dosage, other factors are taken into account, i.e. age, drug history, medical history, length of time on the dose. At the first consultation it is advised that a small reduction in dose is undertaken. Following an initial period to stabilise the dose, the aim is to reduce the dose by 1mg a fortnight. (Approximate).

N.B. Elderly patients may require lower doses than their younger counterparts. Training and experience assist the tranquilliser worker to assess the most suitable dosage. The dose may sometimes need to be as low as half that for younger people, particularly in the over 70's.

2) Patients must be taught about the reflex action of adrenalin.

As a result, they come to understand the symptoms and become less afraid, therefore producing less adrenalin. They are encouraged to become familiar with this reflex action, so that it becomes less easy to initiate.

3) Use of inappropriate adrenalin.

The inappropriate adrenalin can be used for the purpose for which it was intended, i.e. EXERCISE (appropriate to patients age and state of physical health).

4) Residual adrenalin effects.

Residual adrenalin effects can be blocked using a beta blocker. (If there are no contra-indications to this use). Although if this can be avoided that is still the best course of action, (slow release Beta Blockers are preferable).

5) Urgent Help

In some circumstances patients may be referred or directed to appropriate agencies, for example: Relate or Citizens Advice. However efforts to learn to relax may be futile until after withdrawal.

6) Any underlying depression unmasked can thus be treated appropriately.

7) Stimulants

Patients are asked to avoid stimulants, mainly caffeine, but also nicotine if possible.
N.B. Cocoa contains caffeine.

8) Insomnia

The inevitable insomnia these patients suffer will pass eventually, but may take several months. Patients are encouraged to plan for this. Practical advice given may include : Sleeping alone (so as not to disturb a partner), take a radio or knitting to bed, take a flask containing a warm, milky drink.

When following a tranquilliser reduction/withdrawal programme, the client is offered advice, guidance and support. The client is encouraged to keep control of their programme by making the decision on when and by how much they reduce the dose. The reduction in dosage will be consistent with the guidelines set out in this protocol. These guidelines have proved to be effective in assisting people to successfully overcome tranquilliser addiction.-

It is emphasised that the client/patients reduction and withdrawal programme is to be monitored by their doctor and/or a trained tranquilliser worker. This continued support and guidance given to the patient/client during the period of reduction and withdrawal and beyond, often determines the outcome.

All this seems long-winded, but to a patient and their family, the results are well worth it. If a patient is barely coping with his/her lot, the well-meaning prescription of a tranquilliser immediately renders him/her less able to cope. The quality of life for both the users of tranquillisers and his/her family suffers. Thus, this vicious spiral of emotional, physical and personal problems continues.

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