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Our Uneasy Tranquility

Heather Zeiger

As the opioid crisis has consumed national attention, a quieter discussion has emerged about what some are calling another, perhaps intertwined, prescription drug epidemic. In 2017, according to statistics from the National Institute on Drug Abuse, more than eleven thousand Americans died from overdose deaths involving benzodiazepines, a class of anti-anxiety drugs that includes Xanax and Valium. Those deaths—most of which also involved opioids—constituted a sixth of all U.S. overdose deaths that year, and a ten-fold increase since 1999.

While the scope of the crisis is unprecedented, Americans' fraught relationship with anti-anxiety medications, also known as tranquilizers, is anything but new. Tranquilizers have been a staple of American life for at least a century, with the first barbiturate entering the U.S. market in 1904 and the first benzodiazepine in 1960. Although benzodiazepines have been used to treat a variety of mental illnesses and other conditions, including schizophrenia, epilepsy, insomnia, and alcohol withdrawal, the majority of patients have taken them for anxiety. According to recent statistics, roughly one in five adults in the United States experiences an anxiety disorder at some point in a given year, and one in twenty uses a benzodiazepine, the prevailing anti-anxiety medication today.

If another illness affected such a large share of the population over such a long period of time, we might raise the alarm of a public health crisis. The lack of an acute response to a century of anxiety disorders in growing numbers of people suggests that we have come to regard the widespread presence of this condition, and its treatment with psychoactive drugs, as a more or less normal part of modern life. Perhaps our culture has difficulty fully confronting the implications of this situation. Our acceptance of it suggests that anxiety might be not only a common but a reasonable response to cultural circumstances that were made by us but not entirely for us, causing many of us to feel profound unease. We seek autonomy from historical and moral authority, but are overwhelmed by the difficulty of creating our own identity; we try to fit in, while seeking to stand out; we pursue happiness, but fear we might be missing out.

Heather Zeiger *is a science writer living in Dallas, Texas and a research analyst for The Center for Bioethics & Human Dignity, a research center at Trinity International University.*

Addicted to Calm

While the full effects of benzodiazepines—sometimes "benzos" as a shorthand—are still the subject of controversy, their basic mechanism is well understood. They work by enhancing a type of neuroreceptor known as $GABA_A$. Put simply, these receptors are able to "turn down the volume" of the signals passing between brain cells, and the drugs allow the receptors to dampen the volume further, creating a calming effect. Benzos have several clinical uses, including as sedatives and sleep-inducing agents and as anticonvulsants for patients with seizures. Most significant, however, is what doctors describe as their "anxiolytic" effect—their ability to reduce anxiety.

By one school of thought, benzodiazepines have a limited but crucial role in the treatment of certain mental health problems. For example, they can be helpful for patients who have suffered acute trauma, serving as a short-term aid so that longer-term treatments can have a better chance of taking hold. In his book *Brain Lock* (1996), Jeffrey M. Schwartz, a psychiatrist who focuses on cognitive behavioral therapy for obsessive-compulsive disorder, compares psychoactive pharmaceuticals to water wings: Drugs can help in the beginning of therapy much like water wings help children learn to swim, but the goal is to learn how to swim without them. Schwartz is among the thinkers whose approach to mental health problems has a strikingly pre-modern air, emphasizing the cultivation of virtues, the habits of a good and fruitful life, as the ultimate goal, with pharmaceuticals only used if needed to aid this end.

The trouble is that, for many people, benzos actually intensify the problem they are meant to relieve. The biological processes in the human body are tightly regulated by exquisitely balanced feedback loops. When we interrupt these loops with something that produces a stronger effect, over time our bodies will often compensate. This kind of effect is clearly established in the case of opioid dependence. In response to the presence of opioids, the body makes fewer of its own naturally occurring but weaker pain reliever, endorphins, resulting in a more acute response to pain without opioids. Benzodiazepines may create dependence through a similar process. Some research shows that the body adapts to the tranquilizers' inhibition of nerve signals by increasing the production of stimulatory neurotransmitters. This adaptation, the theory goes, leads to physical dependence on the drug to counter the new stimulation, and to withdrawal symptoms once benzodiazepines are no longer present.

Whatever the precise mechanism, physicians have known for decades that benzos can lead to dependence and addiction, especially when they

are prescribed for long-term use. Half of patients who use benzos daily for more than four months develop a physiological dependence, according to a 2010 paper in the *Canadian Journal of Psychiatry*. Withdrawal symptoms are often similar to the conditions that led the patient to take benzos in the first place—anxiety, panic attacks, insomnia—but with the possible addition of nausea, headaches, and occasionally seizures and psychosis. Because long-term use of the drug can lead to dependence that can worsen the underlying condition, many researchers, doctors, and medical organizations have warned against prescribing the drug for longer than a few weeks or months at a time.

A number of other significant side effects are associated with benzodiazepines. Though often prescribed to treat insomnia—a disorder that can be caused in part by anxiety—many benzos interfere with slow-wave sleep, the deepest phase of sleep, which is most directly responsible for feeling refreshed and alert in the morning. Thus, although effective in helping patients fall and stay asleep, benzos may paradoxically make them more fatigued. Benzos can even lead to a rebound effect: As the patient weans off the drug, the insomnia symptoms become worse than before the treatment began.

There is also evidence that long-term use of benzos is associated with decline across a variety of categories of cognitive abilities, including memory, attention and concentration, problem-solving, and general intelligence. Moreover, benzo use is associated with impaired reflexes and coordination, which leads to an increased risk of car accidents and, particularly among the elderly, falls that lead to broken hips and other injuries.

Despite all the warnings, long-term use appears to be prevalent. A 2018 study in *Heliyon* of people using benzodiazepines for various kinds of anxiety found that eight in nine patients used the drugs for more than three months. Patients may be taking benzodiazepines without realizing that this may actually worsen their anxiety over the long term—or they may be choosing short-term relief at the expense of dealing with more distant consequences.

The most significant concern around benzos continues to be addiction. While long-term benzo use can cause physiological dependence, there is more to addiction than just its physical symptoms. Philosophy professor Kent Dunnington argues that something broader than a physiological framework is needed. In his 2011 book *Addiction and Virtue*, which leans heavily on Aristotle and Thomas Aquinas, Dunnington argues that addiction is best understood as a habitual way of orienting one's life around a perceived good—not euphoria itself but moral and intellectual goods

like courage or a sense of belonging. Following this way of thinking, we might say that anti-anxiety drugs offer the person addicted to them not merely a relief from anxiety but a restoration of purpose, a freedom from the debilities that keep him from becoming the person he was "meant" to be. But this freedom eventually proves illusory. When benzodiazepines have severe withdrawal symptoms, what was once a relief from anxiety becomes its source, and so the person becomes enslaved to the substance that was meant to offer freedom.

This perspective on addiction helps us to understand why tinkering with brain chemistry alone does not solve the underlying problem, because anxiety is part of a broader picture of who we want to be, and why. This picture in turn has to be seen in the historical context of the rise of prescription tranquilizers.

When Americans Got Anxious

In the late nineteenth century, American doctors defined a new medical condition, neurasthenia, a kind of exhaustion of energy in the nervous system that became a label for virtually any kind of unhappiness or emotional discomfort. As medical historian Andrea Tone recounts in her 2009 book *The Age of Anxiety*, doctor George Beard called neurasthenia "American nervousness" because its causes, he argued, arose from several features of American life, such as a quickly growing population, climate extremes, overwork, worry, and indulgence of appetites. It was an ill-defined condition that included headaches, anxiety, muscle pain, fatigue, depression, and sleep problems, among many other symptoms. But this new diagnostic category, together with the influence of Freud's work on neuroses, was the beginning of treating everyday forms of anxiety as medical problems.

The theory was that neurasthenia was a problem brought on by modernity: Intellectual people living in industrialized societies would get brain fatigue from living a fast-paced life. This meant, as a 2016 *Atlantic* article on "Americanitis" explained, that white, wealthy Protestants from the North thought that blacks, Native Americans, Catholics, and Southerners didn't suffer from neurasthenia, since they were less intelligent or less modernized. Poorly defined though it was, neurasthenia probably described a very real sense of anxiety felt by many. But the reason that most of the diagnosed were wealthy was likely that they had the luxury to investigate the causes of their anxiety and get treatment, including vacations, baths, and massages, while everyone else had to rely

on alcohol or barbiturates, the dangerous sedatives then often used to relieve these types of conditions. As the market for barbiturates grew in the early decades of the twentieth century, Tone writes, competition increased, prices dropped, and more and more Americans looked to drugs, rather than therapy, for relief.

The hope that anxiety and related conditions could be treated with drugs needs to be seen also as part of the general ascent of pharmaceuticals. Prescription tranquilizers prevailed during a time when medicine had solved some age-old problems, encouraging a sense that anything could be cured with drugs. In the 1940s, antibiotics like penicillin had led to cures for tuberculosis, chlamydia, pneumonia, and even plague, markedly reducing deaths from infection during the Second World War. Corticosteroids came to be used for treating rheumatoid arthritis, and the first medications for hypertension and diabetes were developed. Even schizophrenia, for which there were few options besides heavily invasive treatments like lobotomies and insulin shock therapy, could now be tamed with chlorpromazine, a drug first created in 1951. Tone points to the success of this drug in particular as contributing to the "spirit of pharmaceutical optimism": If even a condition as severe as schizophrenia could be treated with drugs, then surely the more quotidian disorder of anxiety could be too.

In 1955, Miltown—the brand name of the drug meprobamate, and a forerunner of benzodiazepines—became commercially available, initiating two important trends in the market for tranquilizers. First, people went to family doctors rather than psychiatrists for Miltown, thanks in part to a marketing campaign targeting physicians. If doctors were the ones writing the prescriptions, then they would be the ones controlling the sales of Miltown. Secondly, Miltown opened the door for using prescription drugs for something other than curing or managing a physical disease; it was the first drug enjoyed by millions to help them feel better about life.

As Tone reports, by 1956 one in twenty Americans had tried Miltown, and "10 million Americans were estimated to be psychologically unwell—about one of every seventeen people. By 1959, the figure had been revised upward to 17.5 million—one of every ten." Some psychologists even estimated that one in three Americans was affected by neurosis of some kind or another.

When this many people were anxious and were thought to need a tranquilizer, there might have been something more at play than faulty brain chemistry. As Tone explains, Miltown come out at a time when Americans were living with the fear of nuclear apocalypse. Children practiced "duck and cover" and evacuation drills in school, and many people

built bomb shelters at home. A 1961 government-sponsored vinyl record, "If the Bomb Falls," advised Americans to keep some tranquilizers handy "to ease the strain and monotony of life in a shelter." At the same time, the economy was booming and people moved to the suburbs in search of the good life. Doctors saw Miltown as helping America because the drug spurred productivity, efficiency, and social stability as it helped people to stay in the workplace. In these circumstances, it is understandable that large segments of the population experienced some level of anxiety and relied on Miltown to get through it, even if skeptics questioned the wisdom of medicating reasonable anxieties and some doctors wondered where they should draw the line between normal and pathological anxiety.

"Safe" Tranquilizers

Anti-anxiety drugs became a million-dollar industry, and soon Miltown would be replaced by benzodiazepines as the new blockbuster drugs. After the first benzo, Librium (the brand name of chlordiazepoxide), became available in 1960, a new benzo hit the market around every five to ten years. When concerns over addiction and tolerance started hitting the headlines, each new drug claimed to be safer than the previous one.

A pattern emerged: Drug companies needed to profit from a drug before its patent expired; doctors received incentives from drug companies for prescribing their drugs; and patients wanted an inexpensive, convenient way to ease their unease. "In this new and competitive commercial landscape," writes Andrea Tone, "securing physicians' brand loyalty was essential." And many people believed then, as they do today, that it was safe to take these drugs because they were being prescribed by doctors.

By the 1970s, Valium (the brand name of diazepam) had become the most frequently prescribed drug in America. It had been marketed especially toward businessmen and housewives. Tone quotes a brochure explaining that men sometimes need tranquilizers because of the many pressures placed on them. They tend to "dam up their feelings and develop ulcers and high blood pressure." By contrast, "women, being feminine, are irrational, complaining, given to tears." By some counts, the number of prescriptions for women was double that for men.

The American Dream, symbolized by wholesome suburban families, was in danger, belied by the extraordinary number of men and women who needed tranquilizers just to get through a day. Feminists began to draw attention to the trend among women, but, despite some early warnings by researchers, it wasn't until the mid-1970s that memoirs and media

stories brought the broader problem of addiction to public awareness. The picture of an addict was a member of the urban poor, or the rebellious youth using illicit drugs—heroin, cocaine, marijuana. Businessmen or housewives taking prescriptions didn't fit the image, and pharmaceutical companies had downplayed dependence as a possibility for the normal user. But testimonies of addiction, including First Lady Betty Ford's struggle with alcohol and Valium, changed these conceptions. People began to question the safety of Valium, and a stigma grew around it.

By 1985, the patent for Valium had run out, and the time was ripe for tapping into the lucrative market for easing the burdens of life by touting a drug that was less addictive. In 1981 the pharmaceutical company Upjohn had released a new kind of benzo that it claimed was safer than Valium because it had a shorter half-life in the body. Xanax (the brand name of alprazolam) was marketed specifically for panic attacks and anxiety disorders. By the early 1990s, it was Upjohn's top-selling drug.

But Xanax's short half-life also meant users were taking more to get them through the day, which led to more severe withdrawal symptoms. This, in turn, made it easier for patients to become dependent. According to a 2018 review in the *Journal of Addiction Medicine*, there are not many studies comparing different benzodiazepines, and research to date is inconclusive about whether Valium or Xanax has greater addictive potential. One 1990 study mentioned by Tone showed that, for the duration of a week, 73 percent of patients were able to stay off drugs like Valium with a long half-life, while only 43 percent were able to stay off drugs like Xanax with a short half-life. This, as Tone notes, is why people are sometimes given Valium to help wean them from Xanax.

Benzos for Everyone

Today Xanax is the most widely used anti-anxiety drug. As with Miltown, its prevalence has to be seen in the context of history and culture. For example, Tone cites research claiming that in the two weeks following the 9/11 terror attacks, prescriptions for Xanax spiked by nine percent across the country, and 22 percent in New York City.

Xanax use is especially worrisome in teens and pre-teens, who often do not realize the drug is potentially dangerous or addictive, assuming it is safe because it was prescribed. A 2018 *Pew Research* article reported that many of the teenagers who abuse benzodiazepines are not necessarily seeking a high, but those who are will often combine Xanax with other drugs such as opioids. Many of the students who consume Xanax are

high-achievers who take the drugs to "feel normal" or get through the day. A young woman who was interviewed became addicted to Xanax as a high school student. She described it as taking "away everything you have in your mind that's bothering you and everything you feel that hurts, and before you know it, those feelings are just gone."

An eye-opening 2016 article in *Time* magazine, "Teen Depression and Anxiety: Why the Kids Are Not Alright," offers a similar view on the world of hurt and bother from which teens need such escape. Between the early and constant message that they must perform at the highest levels and the pressures brought on by social media, teens have no respite from the culture of performance, and many feel overwhelmed. Social media didn't invent the idea of keeping up with the Joneses—or even the Kardashians—but it certainly made it harder to resist.

According to an analysis by Medco Health Solutions, in the first decade of the 2000s, anti-anxiety medication usage increased by almost fifty percent in children between ages 10 and 19. The same analysis also shows that, as with Valium in the 1970s, anti-anxiety prescriptions for women are still much higher than for men: Among the middle-aged, in 2010 about twice as many women as men took anti-anxiety drugs.

The institutionalized elderly in the United States have also long been prescribed benzos at high rates, although when Medicare stopped covering the drugs in 2006, it led to a roughly forty percent decline in their use among seniors. Studies have shown the potential harm of prolonged benzodiazepine use by the elderly—exacerbating dementia symptoms and increasing the risk of Alzheimer's. The American Geriatrics Society strongly recommends avoiding all benzodiazepines for older adults because of risks associated with cognitive impairment and falls. Yet the elderly continue to be prescribed these drugs at high rates. A recent study found that eight percent of adults between 65 and 80 had used benzodiazepines at some point during 2008, with more recent studies continuing to find similar usage rates. A 2018 study showed that over a quarter of older adults who use the drugs do so over the long term (defined in this case as having a prescription for more than thirty percent of a second year after receiving the initial prescription).

Although many people have found relief in benzodiazepines, particularly for short-term treatment of acute anxiety, others have found them to be addictive. Perhaps there are physiological differences that make some of us more prone than others to developing dependence. Or perhaps some people simply have greater psychological resilience, greater tolerance for anxiety. These are difficult factors to measure. But even a full picture of

these factors cannot explain why the same physiology our ancestors had seems to fail us so regularly as to require mass tranquilization.

The Autonomous Self

In doing away with traditional structures that seemed confining, the modern project also did away with the foundations of culture that offered people a connection to history, a sense of belonging, and given ways for coping with life's ordinary difficulties. We moderns are, at least aspirationally, no longer tied to a past, or an identity, or even a gender, leaving us free to make a myriad of decisions about ourselves. But this freedom can be overwhelming.

Matthew B. Crawford, in *The World Beyond Your Head* (2015), describes the modern "weariness with the vague and unending project of having to become one's fullest self." When that project never ceases, thanks in part to the omnipresence of online life, weariness can turn into anxiety and despair. There are too many variables, too much to consider, and the sheer weight of the responsibility can cause otherwise mentally healthy people to buckle under the pressure.

For Crawford, the modern disconnection from older cultural ties has allowed us to achieve autonomy. But autonomy comes at a price:

> …as autonomous individuals, we often find ourselves isolated in a fog of choices. Our mental lives become shapeless, and more susceptible to whatever presents itself out of the ether. But of course these presentations are highly orchestrated; commercial forces step into the void of cultural authority and assume a growing role in shaping our evaluative outlook on the world.…
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> Our mental fragmentation can't *simply* be attributed to advertising, the Internet, or any other identifiable villain, for it has become something more comprehensive than that, something like a style of existence.

Crawford's definition of autonomy, which he derives from Freud, might help us make sense of why people are attracted to anti-anxiety drugs, and why doctors outside of the United States have been less hesitant to classify them as "lifestyle drugs," alongside pills for erectile dysfunction and weight loss. Autonomy, Crawford writes, "seems to have at its root the hope for *a self that is not in conflict with the world.*" This can lead to two different kinds of cultural pathologies. To not be in conflict with the world, you either have to ignore your environment—a kind of autism, as Crawford puts it, in which a person appears disengaged from

the world—or ignore the individuality of your fellow human beings, a kind of narcissism, in which a person sees others only as extensions of himself.

For most people, who are not already among the disengaged or the self-protecting, the pressure to become one or the other can be distressing. If you are climbing a corporate ladder, you have to "act" as a narcissist. If you are a researcher, you have to "act" as though you can ignore your environment and relationships and obsess over your research. The narcissistic entrepreneur, the socially stunted computer programmer, and the obsessive scientist are heroes of modernity. Their personality traits, which are pathological in one context, are genius in another.

In other words, in some respects if you are mentally healthy you may not succeed in this modern culture—and "mentally healthy" has been redefined *as* being able to function in modern culture. People who were formerly balanced, creative, sensitive, empathetic, and relational are now the sick ones. Anxiety-laden terms such as "highly sensitive person" thus enter our vocabulary to label people who are not as good as others at adapting to this mode of ignoring their environment and minimizing other people.

Or we hear from researchers that we may be experiencing an epidemic of shyness, now recast as "social anxiety." A 2006 review article on the "medicalisation of shyness" in *Sociology of Health and Illness* addressed the argument for and against an actual shyness epidemic. Critics say that the growth of social anxiety may be real, but is a reflection of the "increasing pressure to be ambitious, assertive and communicative." As one researcher put it, pharmaceuticals like benzodiazepines serve as "cosmetic psychopharmacology."

Implicit in the American ideal is the promise of being a high-achieving innovator—and charismatic, likeable, and happy in the process. A lucky few are born with all these traits. Others are self-made by pharmaceutically remaking the self.

American Unhappiness

Anxiety is not just an American malady; France and Japan and other countries consume benzodiazepines at high rates. But there seems to be something in the American mindset that puts us in particular therapeutic need. When the term "Americanitis" was brought into popular usage by William James to describe neurasthenia, he was pointing to an ethos that breeds agitation.

Autonomy itself is part of the American ethos, but particularly the autonomy to define "the pursuit of happiness" according to our own individual whims. A side effect of eliminating any notion of a common morality, authority, or history is that we have also eliminated a common sense of flourishing. One must "pursue" happiness not only without a map as a guide, but without the faintest idea of what the sought-after place is.

Historian Christopher Lasch wrote in *The Minimal Self* (1984) that the removal of the idea of a common life, in freeing "the imagination from external constraints," has at once also "exposed it more directly than before to the tyranny of inner compulsions and anxieties." One prominent type of inner compulsion appears to be what Alexis de Tocqueville observed in America a century and a half earlier, when he wrote that Americans' particular brand of anxiety stems from always looking for the elusive sense of the happiness they *should* have, the fear of missing out:

> I saw in America the most free and most enlightened men placed in the happiest condition in the world; it seemed to me that a kind of cloud habitually covered their features; they appeared to me grave and almost sad, even in their pleasures.…
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> The taste for material enjoyments must be considered as the primary source of this secret restlessness that is revealed in the actions of Americans, and of this inconstancy that they daily exemplify.
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> The man who has confined his heart solely to the pursuit of the goods of this world is always in a hurry, for he has only a limited time to find them, to take hold of them and to enjoy them.…Apart from the goods that he possesses, at every instant he imagines a thousand others that death will prevent him from tasting if he does not hurry. This thought fills him with uneasiness, fears, and regrets, and keeps his soul in a kind of constant trepidation.…

That Americans fear they might die before finding happiness would go some way toward explaining why so many of us seek to induce happiness today through pharmaceuticals: Medicine serves to extend life, and to improve its quality. To Carl Elliott, bioethicist and author of *Better than Well: American Medicine Meets the American Dream* (2003), it also makes sense that "enhancement" drugs—which also include Prozac, Ritalin, Botox, and so forth—have seemed to become necessary to sustain a picture of an ideal American life that emerged in the mid-twentieth century. Discussing Richard Yates's 1961 novel *Revolutionary Road*, Elliot writes: "The whole game of suburb-husband-wife-kids-train-job is a massive exercise in self-deception. You pretend to be working and raising a

family; I pretend to believe you; we all pretend that the entire exercise is not really about money, status, and competition." Tranquilizers and other drugs have stepped in to help—and leave us further dissatisfied. "Why?" asks Elliot.

> Perhaps because in those tablets is a mix of all the American wishes, lusts, and fears: the drive to self-improvement, the search for fulfillment, the desire to show that there are second acts in American lives; yet a mix diluted by nagging anxieties about social conformity, about getting too much too easily, about phoniness and self-deception and shallow pleasure.

To admit that the American Dream is not the path to happiness might mean facing the stark reality that we may not actually know how to "find" happiness, or if that is even possible.

Virtue Therapy

Anxiety, or agitation over life, appears to be especially acute not only in America but more broadly in modern life. But it is not a uniquely modern phenomenon. Indeed, several scholars of classical works believe that going back to a pre-modern view of anxiety would be helpful in describing what many of us now experience and what we might do about it.

The concept of anxiety can be found in classical writings, although sometimes described as worry or emotional distress. According to Christopher Gill's 2013 essay "Philosophical Therapy as Preventive Psychological Medicine," the predominant reasons for emotional distress in classical writings are fear of death and grief over loss, which remain common causes of emotional distress today. But a key difference between classical and modern-day approaches, Gill writes, is that people then used therapy and lifestyle regimens as a way to pre-emptively build emotional resilience before a distressing situation occurred, whereas people now use therapy as a response to emotional distress. The classical approach assumes that anxiety is a normal part of life. The modern approach regards it as a disorder, perhaps a chemical affliction that has reached epidemic levels. The idea of building emotional resilience and cognitive discipline, according to Gill and others associated with a movement that calls itself "modern Stoicism," is where moderns can benefit from classical notions.

The pre-modern regimen of building emotional resilience was tied to an ethical theory in which one cultivated virtues or habits that would lead to the good life. This approach hinges on a clear understanding of

one's purpose in life. A feature of modernity is insecurity and worry over knowing what life is really about. This is not to say that anxiety can be reduced to existential angst, or that physiology plays no role. But having a sense of the purpose of one's life must be part of the package of emotional resilience. And the cultivation of virtues is required to keep this purpose in view—which takes work.

One technique favored by modern Stoics is cognitive behavioral therapy. The conceit of this approach is that there's a difference between the mind and the brain—or between how one's thought patterns are shaped by repeated choices versus by neurochemistry. By acknowledging that there might be cases where the habits are dysfunctional but the brain itself is healthy, as well as cases where the brain is malfunctioning, one can begin to make distinctions between mental and chemical solutions for anxiety problems. Or, as in the case of Jeffrey Schwartz's comparison of drugs to water wings, a chemical solution can sometimes be used as a temporary supplement to a mental solution without being used in lieu of it.

But the predominant trend in America for decades has been to look at mental problems as essentially chemical malfunctions of the brain. Ever since Miltown's spectacular success in the 1950s, pharmaceutical companies have been happy to sustain and exploit this view in treating anxiety, touting increasingly safer tranquilizers. Now, with a fifth of American adults affected by some kind of anxiety disorder, we are in the grip of an epidemic of benzodiazepine overuse, despite the known side effects and risk of dependence.

The long-term and widespread use of tranquilizers suggests that they have not solved the underlying problem. There is no chemical fix for a cultural condition. Our attempts to understand freedom as the removal of all barriers to personal autonomy, including of all suffering and of moral and cultural authority, have left too many of us adrift without an anchor. When this reality becomes overwhelming, we cling to whatever may tranquilize the soul.