Dependence on Antidepressants & Halting SSRIs

PROTOCOL FOR THE WITHDRAWAL OF SSRI ANTIDEPRESSANTS

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Following the benzodiazepine crisis of the 1980s, psychiatrists and general practitioners turned with relief to the antidepressants, which the Royal Colleges of Psychiatrists & General Practitioners assured us and our patients did not cause dependence and were not addictive. I shared this belief. And indeed antidepressants are not addictive in the sense that they lead to altered motivational hierarchies such that an individual would mortgage their livelihoods and all they hold dear for further supplies of the drug. But patients are worried about being "hooked" on antidepressants and antidepressants can hook in the sense of making you physically dependent.

In the 1960s the concept of therapeutic drug dependence on antipsychotics and antidepressants emerged and it became clear that some individuals might never be able to halt these drugs. Withdrawal from antipsychotics for instance could lead to tardive dyskinesia, which it was later recognised could emerge in the course of treatment(1). The fact that "withdrawal" could emerge while still on treatment with drugs that were not euphoriants and did not disrupt motivational hierarchies was completely incompatible with theories of addiction then and now. This, allied to the need to contain the use of opiates, LSD and amphetamines in 1960s, led to an eclipse of the concept of therapeutic drug dependence. Since the 1960s we have had a demonisation of some drugs and glorification of others. The bad drugs are supposedly characterised by dependence even though LSD and other bad drugs do not cause physical dependence. The good drugs are supposed to be free of this problem.

Against this background, therapeutic drug dependence on benzodiazepines provoked a crisis. Patients resented being hooked and resented not being warned about the risks of getting hooked and further resented being blamed as authors of their own misfortune. The emergence of the SSRI antidepressants offered the possibility of an almost "political" compromise.

From 1960 to 1990, the antidepressants were generally prescribed only to severely depressed patients, and in these patients evidence of relapse on discontinuation could often reasonably be seen as evidence of relapse of an illness. This position became harder to maintain in patients who had formerly been cases of Valium but who now became cases of Prozac, Seroxat, Lustral and Effexor. These patients did not have the severe conditions that might have been expected to lead to early relapse on discontinuation. Reports of withdrawal streamed in to regulators.

SSRIs

SSRI stands for selective serotonin reuptake inhibitor. This does not mean these drugs are selective to the serotonin system or that they are in some sense pharmacologically "clean". It means they have little effect on the norepinephrine/noradrenaline system. There are 6 SSRIs on the market:

SSRI	US TRADE NAME	UK TRADE NAME
Fluoxetine	Prozac	Prozac
Paroxetine	Paxil	Seroxat
Sertraline	Zoloft	Lustral
Citalopram	Celexa	Cipramil
Escitalopram	Lexapro	Cipralex
Fluvoxamine	Luvox	Faverin
Venlafaxine	Effexor	Efexor

Note: Venlafaxine in doses up to 150mg is an SSRI, over 150 mg it also inhibits noradrenaline reuptake.

FEATURES OF WITHDRAWAL/WITHDRAWAL SYMPTOMS

The common symptoms on withdrawal from SSRIs break down into two groups(2). The first group may be unlike anything you have had before and include:

Dizziness Headache Muscle Spasms Tremor Electric Shock-like Sensations Other Strange Tingling or Painful Sensations Nausea, Diarrhoea, Flatulence Dreams, including Vivid Dreams Agitation

The second group overlaps with general nervousness and may lead to you or your physician to think that all you have are features of your original problem. These symptoms include:

Depression Lability of Mood Irritability Agitation Confusion Fatigue/Malaise Flu-like Feelings Insomnia or Drowsiness Mood Swings Sweating Feelings of Unreality Feelings of being Hot or Cold

These symptoms appear in anything between 20% to 50% of patients taking SSRIs, sometimes within hours of the last dose. Paroxetine and Venlafaxine appear the most problematic agents at the moment but similar symptoms are liable to occur with all SSRIs and to a lesser extent with tricyclic antidepressants. In milder cases problems may clear up after a week or two, but in others symptoms may continue weeks or months after the last dose and for some patients it may not be possible to stop treatment. Specialist help may benefit some patients in this latter group, if only to provide suggestions on antidotes to continuing drug induced problems such as loss of libido.

IS THIS WITHDRAWAL?

There are three ways to distinguish withdrawal from SSRIs from the nervous problems that the SSRI might have been used to treat in the first instance.

First if the problem begins immediately on reducing or halting a dose or begins within hours or days or perhaps even weeks of so doing then it is more likely to be a withdrawal problem. If the original problem has been treated and you are doing well, then on discontinuing treatment no new problems should show up for several

months.

Second if the nervousness or other odd feelings that appear on reducing or halting the SSRI (sometimes after just missing a dose) clear up when you are put back on the SSRI or the dose is put back up, then this also points towards a withdrawal problem rather than a return of the original illness. When original illnesses return, they take a long time to respond to treatment. The relatively immediate response of symptoms on discontinuation to the reinstitution of treatment points towards a withdrawal problem.

Third the features of withdrawal may overlap with features of the nervous problem for which you were first treated - both may contain elements of anxiety and of depression. However withdrawal will also often contain new features not in the original state such as pins and needles, tingling sensations, electric shock sensations, pain and a general flu-like feeling.

Before starting to withdraw, it should be noted that many people will have no problems. Some will have minimal problems, which may peak after a few days before diminishing. Symptoms can remain for some weeks or months. Others will have greater problems but these can be helped by the management plan outlined below.

Finally however there will be a small group of people who are simply unable to stop. It is important to recognise this latter possibility in order to avoid punishing yourself. Specialist help may make a difference for some people in this latter group, if only to provide possible antidotes to attenuate the problems of ongoing SSRIs such as loss of libido.

MANAGEMENT OF WITHDRAWAL

Withdrawal from SSRIs is something to be done in consultation with your physician. You may wish to show this to your GP. Over-rapid withdrawal may even be medically hazardous, particularly in older persons.

0. Convert the dose of SSRI you are on to an equivalent dose of Prozac liquid. Seroxat/Paxil 20mg, Efexor 75mg, Cipramil/Celexa 20mgs. Lustrat/Zoloft 50mgs are equivalent to 20mg of Prozac liquid. The rationale for this is that Prozac has a very long half-life, which helps to minimise withdrawal problems. The liquid form permits the dose to be reduced more slowly than can be done with pills.

0. Stabilise on the Prozac for a week, then halve the dose.

0. If there has been no problem with step 2, the dose can be further halved. Alternatively if there has been a problem from this point on the dose can be reduced even more slowly in weekly increments.

0. From a dose of Prozac 10mgs liquid, consider reducing by 1mg every few days over the course of several weeks - or months if need be. With Prozac liquid this can be done by dilution.

0. If there are difficulties at any particular stage the answer is to wait at that stage for a longer period of time before reducing further.

0. Withdrawal and dependence are physical phenomena. But some people can get understandably phobic about withdrawal particularly if the experience is literally shocking. If you think you may have become phobic, a clinical psychologist may be able to help manage the phobic problem.

0. Self-help support groups can be invaluable. Join one. If there are none nearby, consider setting one up. There will be lots of other people with a similar problem.

There is anecdotal evidence and some theoretical grounds to believe that another option is to substitute St John's Wort for the SSRI. If a dose of 3 tablets of St John's Wort is tolerated instead of the SSRI, this can then be reduced slowly - by one pill per fortnight or even per month.

Some people for understandable reasons may prefer this approach. But it needs to be noted that St John's Wort has its own set of interactions with other pills and its own problems and you may wish to consult your physician if this is the option you choose.

FOLLOW-UP

The problems posed by withdrawal may stabilise to the point where you can get on with life. But in either this case or in cases where it is not possible to withdraw, it is important to note ongoing problems and to get your physician or someone to report them if possible.

There are clear effects on the heart from SSRIs. The list above does not include cardiac problems occurring during the post-withdrawal period. Such problems if they occur may however be related to withdrawal and should be noted and recorded.

SSRIs are well-known to impair sexual functioning. The conventional view has been that once the drug is stopped, functioning comes back to normal There are indicators however that this may not be true for everyone. If sexual functioning remains abnormal, this should be brought to the attention of your physician, who will hopefully report it.

Withdrawal may reveal other continuing problems, similar to the ongoing sexual dysfunction problem. It is important to report these. The best way to find a remedy is to bring the problem to the attention of as many people as possible.

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