

Guidance for psychological therapists:

information for GPs advising patients on antidepressant withdrawal

The *Guidance for Psychological Therapists: Enabling Conversations With Clients Taking or Withdrawing from Prescribed Psychiatric Drugs*¹ was published in December 2019. I was invited to play a small part in its production as I am a campaigner bringing to the attention of governments, the NHS, and the public the difficulties that some people have with severe and protracted physical symptoms when trying to withdraw from SSRI antidepressants.

We know from the advance research quoted at the beginning of the *Guidance* that 96.7% of therapists work with clients who take at least one psychiatric drug. Of the therapists surveyed, 93.1% reported they would find it either 'useful' or 'very useful' to have professional guidance to help them work more competently and confidently with such clients.¹ This prompted the development of the *Guidance* as an accessible source of information for therapists about each class of psychiatric drug, how it works, what it is prescribed for, and what is known about its effects on the body and while it is exiting the body. Anything specifically written about a drug is referenced, and everything is evidence based.

PERSONAL EXPERIENCE WITH SEROXAT

Back in December 1996 I found myself with a prescription for Seroxat/paroxetine. According to my GP's diagnosis, I had what I understood to be a physical problem: an imbalance of serotonin in my brain, '*similar to a diabetic who needs insulin*', was what the GP said. This was apparently why I had intermittent insomnia when I went away on business and why I had premenstrual tension, which included anxiety among its symptoms.

The timing of my first Seroxat prescription was during the mid-1990s Defeat Depression Campaign, when GPs were actively encouraged to inform patients '*... clearly when antidepressants are first prescribed that discontinuing treatment in due course will not be a problem*'² and

to reassure patients that they are '*not addictive*'. But it has become clear that antidepressants are dependence forming and, when some patients attempt to withdraw or stop the drug, the body notices its absence and unpleasant withdrawal symptoms ensue.³ I spent many years trying and failing to withdraw from Seroxat, developing a movement disorder along the way. I finally underwent 4 years of appalling withdrawal.

WITHDRAWAL FROM SSRIs

The Defeat Depression Campaign was successful in changing wary public opinion. Now, 24 years on, some patients are still being given the same story about chemical imbalances, a theory that has never been proven, and about withdrawal not existing. People are suffering not just physical withdrawal symptoms, but also the devastating effects of their doctor and family and friends not believing that any extreme physical symptoms being displayed are a result of drug withdrawal.

Why would a family member believe you if your doctor doesn't? And why would your doctor believe you if their guidelines state that antidepressant discontinuation symptoms occur over a couple of weeks and are self-limiting?

Much of the work driving the ongoing campaign to publicise the extent to which SSRI withdrawal can cause harm is from patients' lived experience. A key finding from the 2019 Public Health England review report,⁴ which has initiated an update of NICE guidelines, is the need for: '*Further research on the prevention and treatment of dependence on, and withdrawal from, prescribed medicines*', and specifically for SSRIs, for: '*Better understanding the incidence, duration, nature and severity of withdrawal from antidepressants, including long-term and enduring side effects.*'

Therapists do need to know that the problem presented by the client might be

due to the effects of a psychiatric drug, and that this may compromise the therapy approach. I would have liked more in the *Guidance* drawing attention to the fact that a therapist may be confronted with a client displaying extreme symptoms of suicidal ideation, agitation, mania, hallucinations, and akathisia, and to be clear that these may be drug related, as opposed to the client's 'mental health problem', particularly if they have recently started their dose, or altered or stopped it.

The *Guidance* emphasises that '*it is not the role of the therapist to tell a client either to take, continue to take or withdraw from psychiatric drugs, nor to decide when, if or what drugs need to be withdrawn*'.¹

Providing or facilitating a different perspective, though, is a key element of therapy and the *Guidance* enables a different dialogue from that which tends to take place in a GP's surgery. The fact that withdrawal might be a reason for a person's symptoms, as opposed to relapse, which has been the ongoing belief, leaves open the very real possibility of that person being well as opposed to still being ill.

Working with the client, encouraging them to follow up with their prescriber to put in place a slow and careful tapering programme may well take them on the journey of wellness that is surely the goal.

Stevie Lewis,

Campaigner for better recognition and support for prescribed drug dependence, Monmouthshire.

Email: stevie.lewis.2017@btinternet.com

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