# DEPENDENCE on 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" to 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.

**Features of Withdrawal**

The common symptoms on withdrawal from SSRIs break down into two groups.[2] A first group with odd and novel features include:

Dizziness
Flu-like Symptoms
Headache
Muscle Spasms
Electric Shock-like Sensations
Other Strange Tingling or Painful Sensations
Nausea
Dreams, including Agitated Dreams

And a second group, which overlaps with general nervousness in a manner that may lead physicians and patients to suspect a return of the original problem:

Depression
Irritability
Agitation
Confusion
Fatigue
Insomnia
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 original nervous problems.

1. If problems begin or within hours or days of reducing or halting a dose then they are more likely to be manifestations of withdrawal. If the original disorder has been treated, then on discontinuing treatment no new nervous disorder should show up for several months after discontinuing treatment.

2. If the problems that appear on reducing the SSRI clear up on reinstituting the SSRI, this points towards a withdrawal problem. When original illnesses return, they take a long time to respond to treatment.

3. While the features of withdrawal may overlap with features of the original nervous problem, withdrawal will also often contain new features such as pins and needles, tingling, rushing or electric shock sensations, pain and a general flu-like feeling.

**Management of Withdrawal**

1 SSRI withdrawal may be medically hazardous. Extra care should be taken in older patients with any compromise of physical functions

2. Convert the SSRI to the equivalent dose of fluoxetine liquid. The long-half life of fluoxetine should attenuate withdrawal problems and a liquid formulation allows slower reductions of dose. An alternative is clomipramine, which comes in 25mg and 10mgs openable capsules.

3. Stabilise the above for a week and then halve the dose for a week.

4. Depending on the emergence of problems, halve further every week or two. If there are difficulties, wait before reducing further.

5. From a dose of fluoxetine 10mgs liquid or clomipramine 10mg the dose can be reduced by 1mg every few days or every few weeks. In the case of fluoxetine liquid this can be done by dilution.

6. There is anecdotal evidence and some theoretical grounds to believe that St John's Wort can substitute for the SSRI. A dose of 3 tablets can then be reduced slowly – by one pill per fortnight or per month. Some may prefer this approach, even though St John's Wort has its own set of interactions with other pills and its own problems.

7 Antidepressant withdrawal and dependence is an unequivocally physical problem. But some people can get phobic about withdrawal particularly if the experience is literally shocking. A phobic patient could be referred to a clinical psychologist for phobic management.

8. There is a great need for patient self-help groups in this area that would ideally have some point of medical contact.

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[1] Healy D (2001). Psychiatric Drugs Explained. Churchill Livingstone, Edinburgh; Healy D (2001). The Creation of Psychopharmacology. Harvard University Press, Cambridge Mass.
[2] Rosenbaum JF, Fava M, Hoog SL, Ashcroft RC, Krebs W (1998). Selective serotonin reuptake inhibitor discontinuation syndrome: a randomised clinical study. Biological Psychiatry 44, 77-87;