

HALTING SSRIs
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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 effects on the norepinephrine/noradrenaline system. There are 8 Serotonin reuptake inhibitors on the market:

	UK Trade Name	US Trade Name
Fluoxetine	Prozac	Prozac
Paroxetine	Seroxat	Paxil
Sertraline	Lustral	Zoloft
Citalopram	Cipramil	Celexa
Escitalopram	Cipralex	Lexapro
Fluvoxamine	Faverin	Luvox
Venlafaxine	Effexor	Efexor
Duloxetine	Cymbalta	Cymbalta

Venlafaxine in doses up to 150mg is an SSRI. Over 150 mg it also inhibits noradrenaline reuptake. Duloxetine is a potent serotonin reuptake inhibitor but not selective to the serotonin system.

WITHDRAWAL SYMPTOMS

SSRI withdrawal symptoms break down into two groups.

The first group may be unlike anything you have had before:

Dizziness – “when I turn to look at something I feel my head lags behind”.

Electric Head - which includes a number of strange brain sensations –

“its almost like the brain is having a version of goose pimples”

Electric Shock-like Sensations – Zaps – like being prodded with a cattle prod

Other Strange Tingling or Painful Sensations

Nausea, Diarrhoea, Flatulence

Headache

Muscle Spasms/ Tremor

Dreams, including Agitated Dreams or other Vivid Dreams

Agitation

Hallucinations or other visual or auditory disturbances

Sensitivity to noises or visual stimuli

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

Depression and Anxiety – these are the commonest 2 withdrawal symptoms

Labile Mood – emotions swinging wildly

Irritability

Confusion

Fatigue/ Malaise – Flu-like Feelings

Insomnia or Drowsiness

Sweating
Feelings of Unreality
Feelings of being Hot or Cold
Change of Personality

More generally there is an intolerance of stress.

Any difficulties present may wax and wane and this can be demoralising.

IS THIS WITHDRAWAL?

There are three ways to distinguish SSRI withdrawal 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 or indeed several years.

Second if the nervousness or other odd feelings that appear on reducing or halting the SSRI (sometimes after just missing a single 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 reinstatement 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 on withdrawing. 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, which can be helped by the management plan outlined below.

Finally however there will be a group of people who are simply unable to stop whatever approach they take. Some others will be able to stop but will find problems persisting for months or years afterwards. It is important to recognise this latter possibility in order to avoid punishing yourself. Specialist help may make a difference for some people in these two groups, if only to provide possible antidotes to attenuate the problems of ongoing SSRIs such as loss of libido.

HOW TO WITHDRAW

If there are any hints of problems on withdrawal from SSRIs, the management of withdrawal is something to be done in consultation with your physician. You may wish to show this to your doctor. Over-rapid withdrawal may be medically hazardous, particularly in older persons.

Many doctors suggest you withdraw by taking one pill every other day for a few weeks before stopping. There is no guideline that advocates this or evidence that supports it and the approach is misguided.

One of the first steps to consider is getting a liquid formulation of your antidepressant. This can be done by asking your doctor to approach the local primary care pharmacist who can make an application to one of the specialist companies such as Martindale's or Rosemount that can make up a liquid formulation of almost any antidepressant you might be on – see below.

There are 2 theories about what leads to dependence and withdrawal that dictate slightly differing management plans.

One theory is that the relatively short half life of paroxetine and venlafaxine make these two drugs more problematic. This leads to a withdrawal strategy that advocates switching from paroxetine or other drugs to fluoxetine.

The second is that paroxetine and venlafaxine are relatively more potent serotonin reuptake inhibitors and this theory leads to a switch to less potent serotonin reuptake inhibitors such as citalopram or one of the older antidepressants such as imipramine.

Either approach is facilitated by having access to treatment in liquid form. Paroxetine, fluoxetine and imipramine come in liquid form and anyone having difficulties with withdrawal should insist on access to the liquid form of treatment or either these or a special formulation of the drug they are on.

The Half-Life Approach

1A Convert the dose of SSRI you are on to an equivalent dose of Prozac liquid. Seroxat/Paxil 20mg, Efexor 75mg, Cipramil/Celexa 20mgs, Lustral/Zoloft 50mgs are equivalent to 20mg of Prozac liquid. Or 40 mg of Paxil/Seroxat to 40 mg Prozac. 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.

Some people may become agitated on switching from Paxil/Seroxat to fluoxetine in which cases one option is take a short course of diazepam until this settles down. Whether this agitation is caused by fluoxetine or because for some people the substitution simply cannot be made may be difficult to determine. If the agitation gets better when the dose of fluoxetine is reduced

then its more likely to be caused by fluoxetine, if it gets worse, then it is more likely to be linked to withdrawal.

1B A further option is to convert to a liquid form of whatever drug you are on. Many people cannot change easily from paroxetine tablets to fluoxetine and switching to paroxetine liquid may do the trick instead.

1C Yet another option is to change from paroxetine to a mixture of half the previous dose in the form of paroxetine and the other half in the form of fluoxetine, and then to reduce the dose of paroxetine gradually.

The Reduced Potency Approach

1A Taking this approach, the best option is to change to Imipramine 100mg. This comes in 25mg and 10 mg tablets and also in liquid form. It is the first serotonin reuptake inhibitor. It is much less potent than the SSRIs, and has been used widely for children for a range of problems.

1B As above another option is to have a mixture of 50 mg imipramine with 10 mg paroxetine or fluoxetine.

Next Steps

2 Stabilise on one of these options for up to 4 weeks before proceeding.

3 For uncomplicated withdrawal, it may be possible to then drop the dose by a quarter.

4 If there has been no problem with step 2, a week or two later, the dose can be reduced to half of the original.

Alternatively if there has been a problem with the original drop, the dose should be reduced by 1 mg amounts in weekly or two weekly decrements.

5 From a dose of fluoxetine 10mgs liquid or tablets or imipramine 10mg tablets or liquid, consider reducing by 1mg every week over the course of several weeks - or months if need be. (a syringe is helpful in reducing the dose evenly).

6 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.

Complexities of Withdrawal

Some people are extremely sensitive to withdrawal effects. If there are problems with step 1 above, return to the original dose and from there reduce as tolerated.

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 have become phobic, a clinical psychologist or nurse therapist may be able to help manage any phobic element.

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

An alternate approach is to substitute St John's Wort or an antihistamine for the SSRI, as these both have serotonin reuptake inhibiting properties. 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 or by halving tablets.

If withdrawal problems appear to ease off and then come back, it is worth checking whether this was because the affected person was co-incidentally treating themselves with something like St John's Wort or an antihistamine.

Some people for understandable reasons may prefer this approach. But it needs to be noted that St John's Wort and the antihistamines come with their own set of problems.

While SSRI withdrawal may not be a problem for some people, for others it can last months and indeed years – possibly 2-4 years. Even if it endures for months/years, it does seem likely to clear up in the long run.

In the case of enduring problems, being active is probably important. An enduring problem is likely to be underpinned by some brain change that can only be reversed by encouraging activity in that brain area through physical and mental activity. Gentle but regular exercise and involvement in activities rather than withdrawal seems more likely to stimulate silenced brain areas back into life.

If it seems impossible to withdraw and the option is to stabilise on an SSRI for the foreseeable future, at this point there is no clear indicator as to whether there is a best SSRI to stabilise on. In terms of ongoing problems paroxetine, sertraline, venlafaxine and duloxetine are associated with a high frequency of problems on withdrawal and on this basis seem poor fall-back options. Fluoxetine is associated with proportionally the greatest frequency of reports of drug seeking or “addictive” behaviours, and is problematic from this point of view. By default this leaves citalopram as a fallback option.

FOLLOW-UP

Companies have tried to label withdrawal problems as discontinuation problems or discontinuation syndromes, because of the negative perceptions linked to the term withdrawal.

The problems posed by withdrawal may stabilise to the point where you can get on with life. But whether it is or is not possible to withdraw, it is important to note ongoing problems and to get your physician or someone to report them if possible to the appropriate bodies – such as the FDA/MHRA. New health problems such as diabetes or raised blood lipid levels may have a link to prior or ongoing treatment. If your doctor won't report these problems, you should if you live in a place where this can be done.

There are clear effects on the heart from SSRIs and from some there are likely to be cardiac problems during the post-withdrawal period. Such problems if they occur should be noted and recorded. SSRIs can also increase the risks of haemorrhage, especially if combined with aspirin, and of fractures.

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, such as memory or other problems. 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.

Pregnancy

The single most important group who need to be aware of all these issues are women of child-bearing years. A very large number of pregnancies happen in an unplanned fashion and are several weeks advanced before the woman is aware of the situation. SSRIs, and paroxetine in particular, are now clearly linked to a number of problems in pregnancy, among which are an increased frequency of birth defects, an increased rate of miscarriage, premature birth, low birth weight, a neonatal withdrawal syndrome and pulmonary hypertension in the newborn infant.

One of the biggest problems of SSRI dependence involves women who are on treatment and unable to stop who wish to become pregnant. Getting off an SSRI at present seems more difficult for women than men, even with the incentive of wishing to become pregnant.

1. Rosemont Pharmaceuticals (Tel 0113 244 1999)

These prepare large batches (so may be cheaper) for:

Amitriptyline 10mg/5ml, 25mg/5ml, 50mg/5ml

Lofepamine 70mg/5ml

Mirtazapine 15mg/1ml

Venlafaxine 75mg/5ml

Sertraline 50mg/5ml

Dosulepin 25mg/5ml, 75mg/5ml

2. Cardinal Health, Martindale (Tel 0800 137 627)

This manufacturer will usually prepare what you ask for, so if the antidepressant isn't in the above list opt for this.

Large chain pharmacies like Boots or Rowlands may have their own external supplier who they may prefer to use as they have a contract with them..