

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 system. There are 7 SSRIs on the market:

	Trade Name
Fluoxetine	Prozac
Paroxetine	Paxil
Sertraline	Zoloft
Citalopram	Celexa
Escitalopram	Lexapro
Fluvoxamine	Luvox
Venlafaxine	Efexor

Venlafaxine in doses up to 150mg is an SSRI. Over 150 mg it also inhibits norepinephrine reuptake.

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

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

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 two 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

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.

1A Convert the dose of SSRI you are on to an equivalent dose of fluoxetine liquid. Paxil 20mg, Efexor 75mg, Celexa 20mgs, Zoloft 50mgs are equivalent to 20mg of fluoxetine. The rationale for this is that fluoxetine 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 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 Paxil tablets to fluoxetine and switching to Paxil liquid may do the trick instead.

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

1D An alternative is to change to Clomipramine (Anafranil)100mgs per day. This comes in 25mg and 10mgs capsules, permitting a more gradual dose reduction than with other SSRIs. The 10mg capsules can be opened up and part of the contents emptied out permitting a gradual lowering of the dose.

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 Anafranil 10mg, consider reducing by 1mg every week over the course of several weeks - or months if need be. With fluoxetine liquid this can be done by dilution.

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.

7 If there were problems switching to fluoxetine at a 20mg level, it might be possible to do so, when the dose of Paxil reduces to the 10mg level

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.

For self-help groups, it is important to recognise that SSRI withdrawal may not simply be a rerun of the benzodiazepine problem. With benzodiazepines it was feasible to switch from a shorter acting to a longer acting compound, because essentially these drugs all came from the same family group. This is not the case with the SSRIs, which are all quite different drugs.

There are some 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 or by halving tablets.

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 problems and you may wish to consult your physician if this is the option you choose.

There are likely to be dietary factors that may help or hinder. Some SSRIs affect blood sugar levels, others raise blood lipid levels. This may explain why snacking or grazing seems to be useful for some patients, and taking sugary drinks useful for others. Caffeine or any other foods that can make you more nervous or stimulated should be avoided during this period.

Finally, if there are significant problems on withdrawal, it would be helpful to get your physician to write to the company making the drug you have had problems with. It is possible that these companies, recognising the problem,

have already done research on withdrawal strategies, and might be able to offer strategies or point to other strategies they are aware of.

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 though, Paxil, Efexor and Zoloft appear to be associated with the greatest frequency of problems on withdrawal and it would seem on this basis should not be thought of as 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. Zoloft is linked to a very high of emotional difficulties on withdrawal. By default this leaves citalopram as a fallback option.

FOLLOW-UP

In the United States, companies have tried to label withdrawal problems as discontinuation problems or discontinuation syndromes, because of the negative perceptions linked to the term withdrawal. The use of the word discontinuation in this way is not allowed in Britain for instance.

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. New health problems such as diabetes or raised blood lipid levels may have a link to prior or ongoing treatment.

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 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.