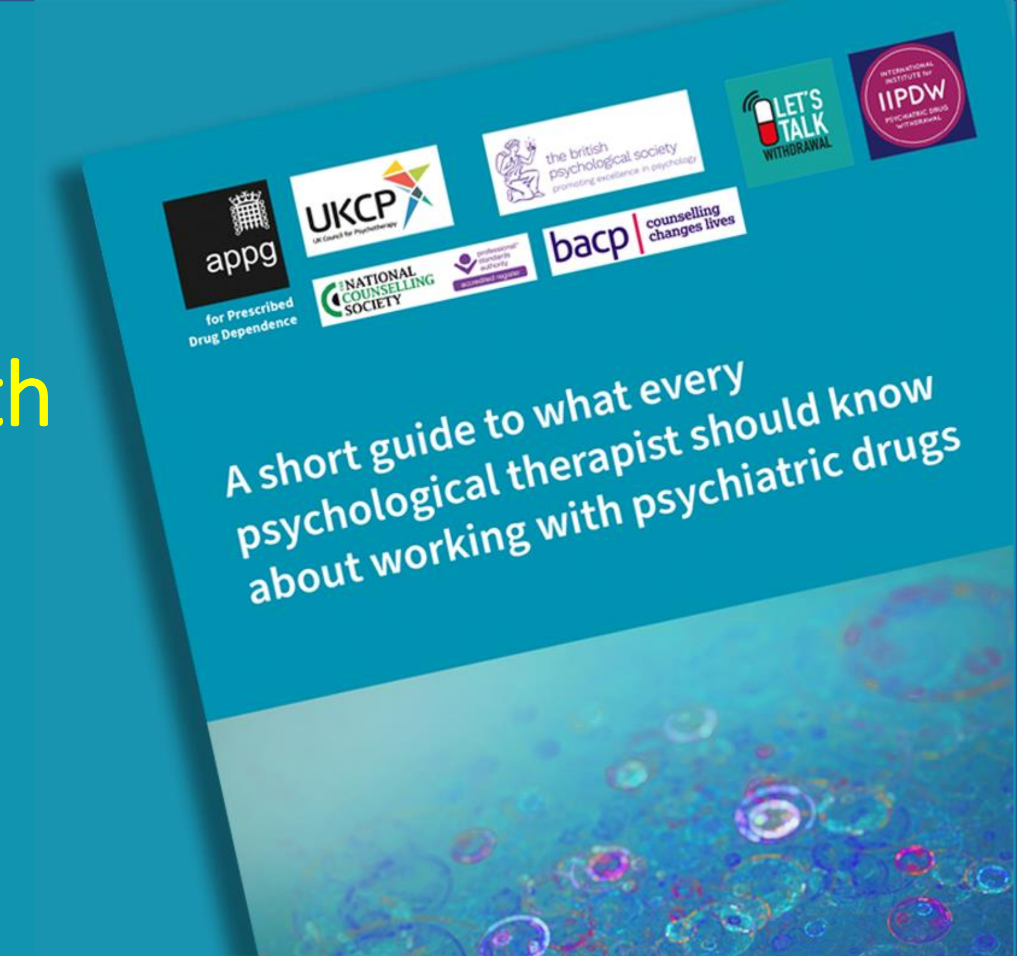
A short guide to beginning work with clients taking prescribed psychiatric drugs.



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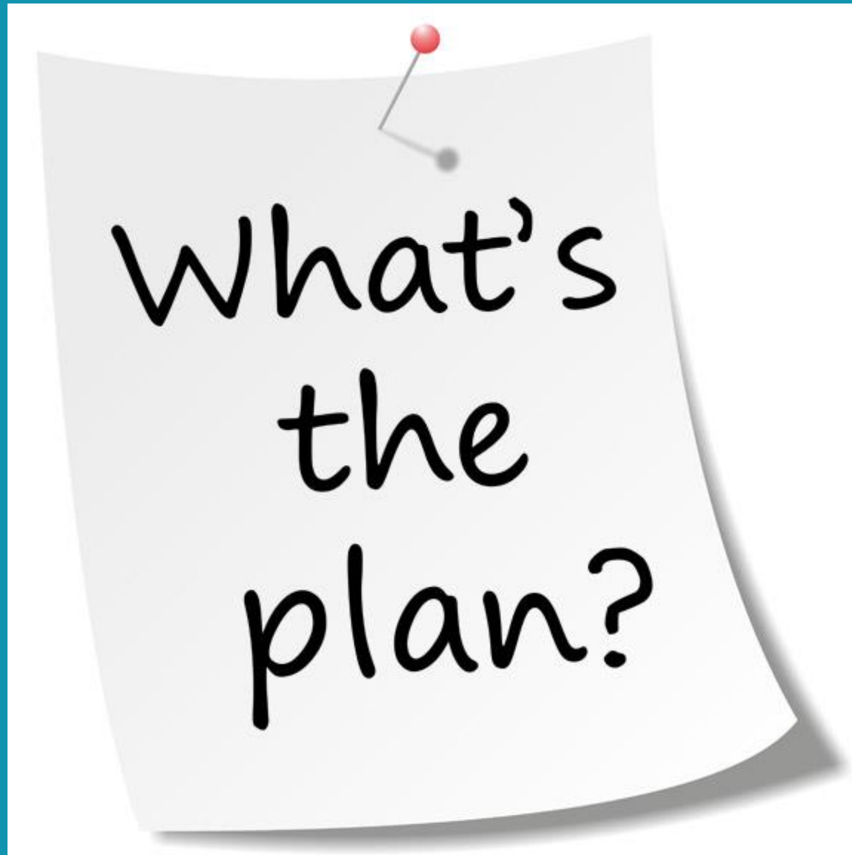
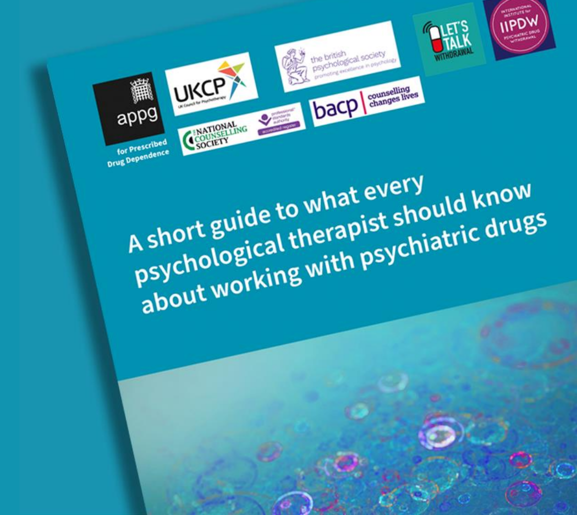




- What is the guidance for?
- Who do we want to help?
- What are some of the core issues to consider when working with prescribed drugs in therapy?
    - *Medical model*
    - *Ethics*
    - *The main effects of psychiatric drugs.*
    - *Implications for practice*
    - *Working with prescribers*

What is the guidance for?

- To extend therapists' knowledge about commonly prescribed psychiatric drugs.

- To provide information and evidence so we can:

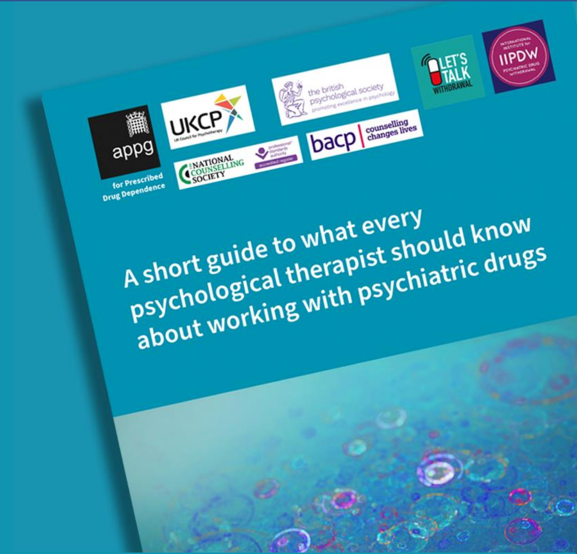
  - ***Support*** *clients' decision-making around prescribed drugs*
  - ***Identify*** *the possible impact of prescribed drugs on the therapeutic process*
  - ***Understand*** *the range of possible withdrawal reactions*
  - ***Avoid*** *misinterpreting withdrawal reactions as a return of the original problem*
  - ***Empower*** *therapists to discuss issues arising from taking or withdrawing from prescribed psychiatric drugs during therapy*

Who do we want to help?

A group of clients:

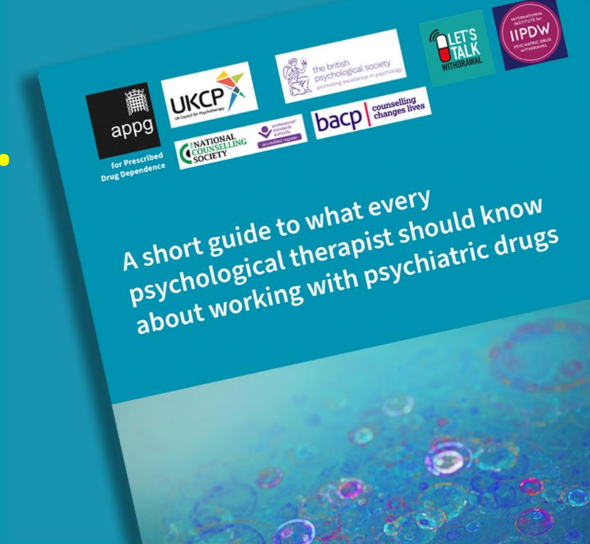
- who are not misusing drugs
- who have taken psychiatric drugs as prescribed and found themselves dependent on them
- whose difficulties with drug dependence have been under-acknowledged
- whose withdrawal reactions are commonly not recognised by prescribers; instead they are mistaken for relapse.
- whose need for psychological support and specialist services has not been recognised.

The 'medical model'



- Where do I locate myself?
- How is my position influenced by:
  - *My place of work?*
  - *My theoretical orientation?*

…and some reflexive questions…..



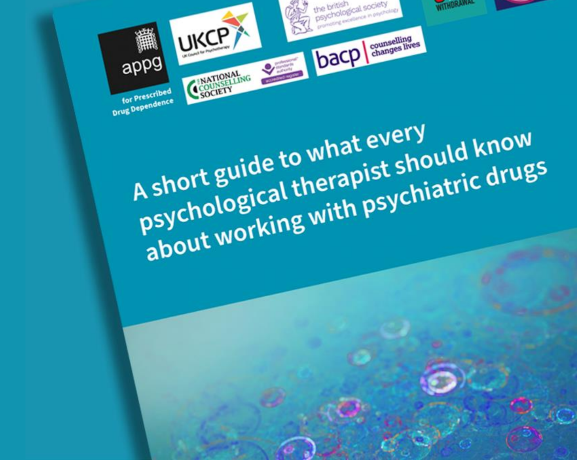
What about…

- my background and training ?
- my own experience of taking prescribed psychiatric drugs ?
- my family and friends?

How might my personal experiences:

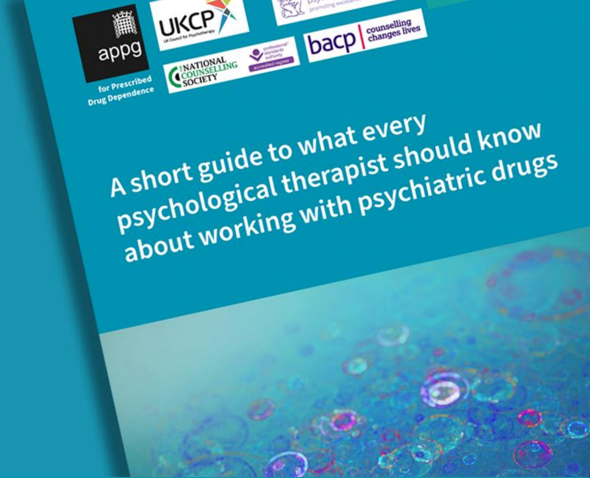
- facilitate or hinder a discussion with the client?
- facilitate or hinder a discussion with my client’s medical prescriber?

Ethical issues



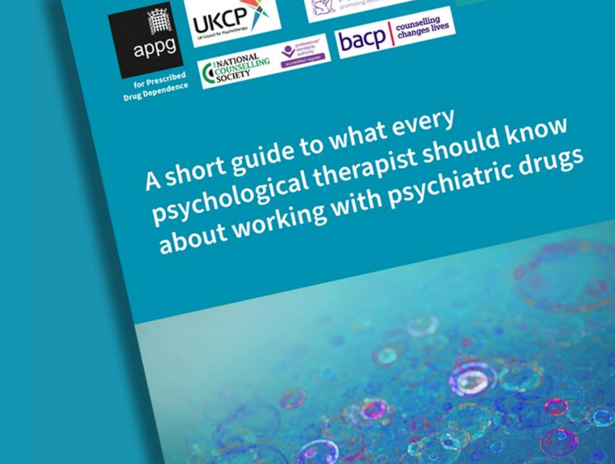
- Working with informed consent
- Respecting a client's best interests
- Keeping knowledge and skills up to date
- Demonstrating accountability and candour
- Working respectfully with colleagues.

Medical information

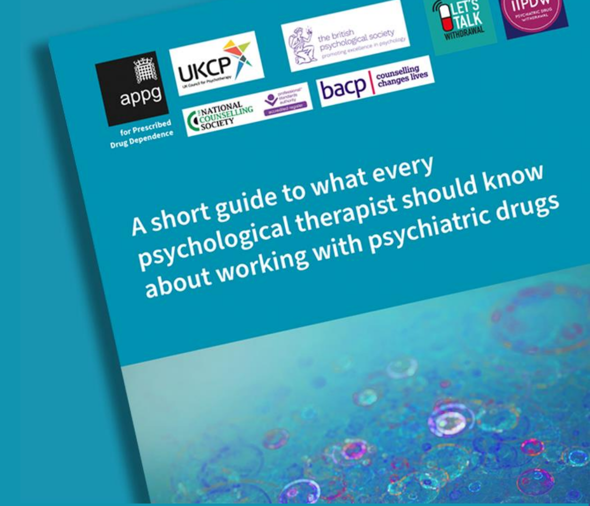


- Sharing information from a reputable source
- Discussing scientific evidence
- Offering a different perspective

Medical advice



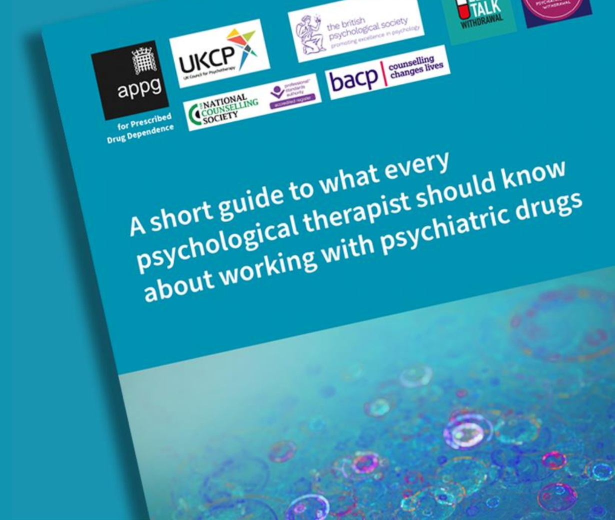
- Offering a diagnosis
- Prescribing drugs
- Offering personal advice on dosage and frequency
- Offering personal advice on withdrawal.



- Clients requiring medical advice should ***always*** be encouraged to talk to their GP, psychiatrist or a knowledgeable prescriber

- Understanding the likely impact of prescribed drugs on the process and progress of therapy is part of our responsibility to ensure the client's **informed consent**.

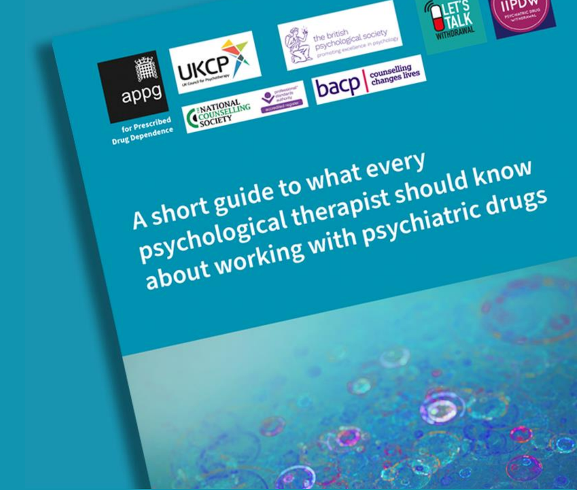
Prescribed psychiatric drugs: *potential effects on thinking*

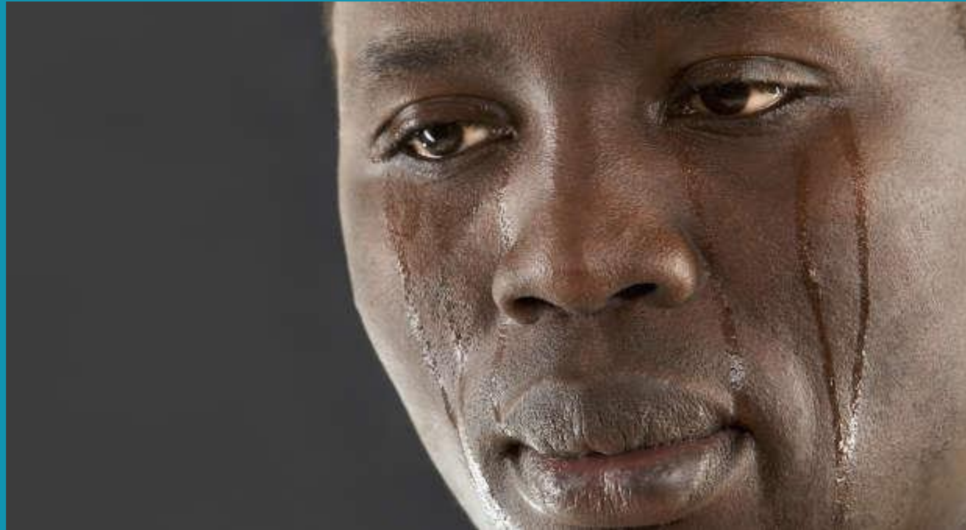


May include:

- loss of memories
- poor recall
- poor concentration
- confusion
- losing track of ideas
- difficulties in making links
- difficulties in structuring thought
- problems staying focused
- inability to retain insights over time.

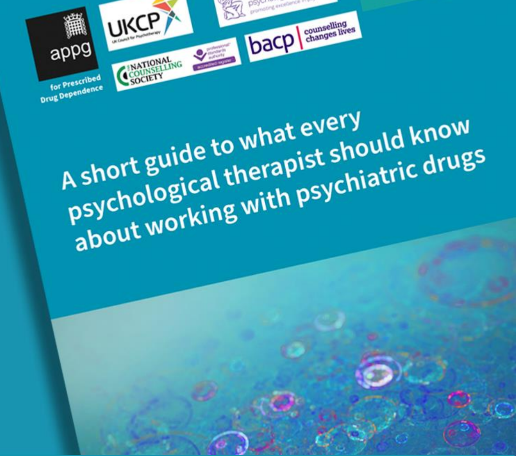
Potential effects on feelings





May include:

- emotional withdrawal or ‘anaesthesia’.
- being uninvolved, distanced or ‘not really there’
- inability to reconnect with feelings relating to past experiences
- suppressed anger, sadness or fear
- lack of emotional congruence.

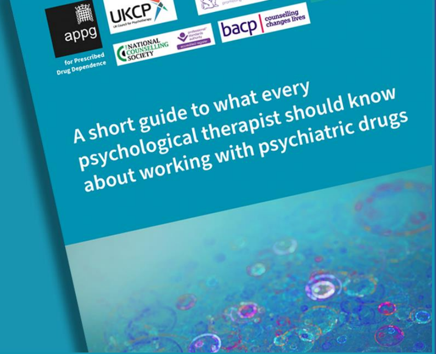


Potential effects on behaviour

May include:

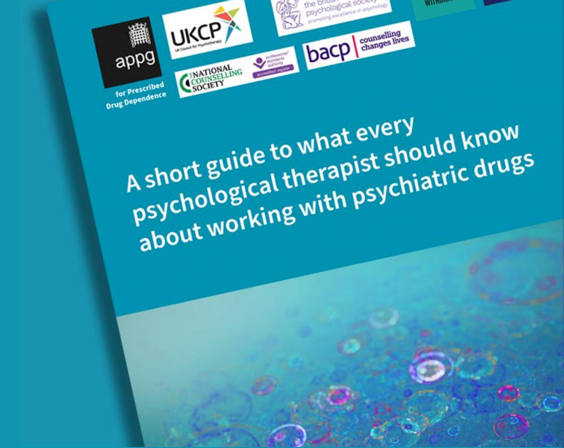
- passivity with the therapist
- passivity outside therapy sessions
- uncooperativeness or over-compliance
- denial of responsibility
- absences due to lateness, cancellations or missed appointments
- apparently poor motivation
- repetitive speech or behaviour
- disengagement from work or social activities.

Implications for practice: the client who is starting, or considering starting, a prescribed psychiatric drug.



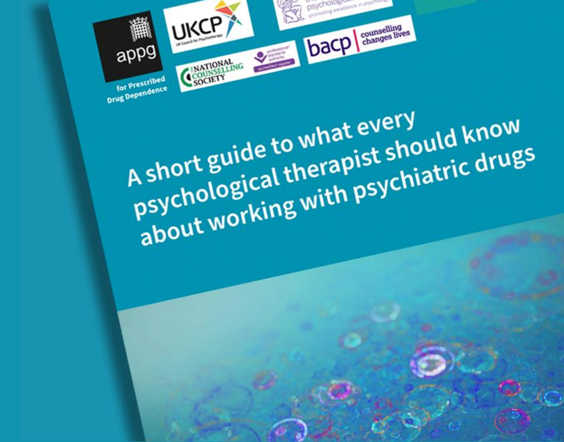
- **Explore** how your client understands their psychological difficulties
- **Find out** if the client ready to discuss their prescribed drugs
- **Inquire** whether the client has discussed any potential for dependence with their prescriber
- **Refer** any specific questions about type, dosage or frequency back to prescriber
- **Signpost** to relevant sources of information and support if appropriate
- **Consider** to what extent taking the proposed drug will affect the client's experience of therapy.

Implications for practice:
Talking to prescribers?



- Has the client asked me to contact the prescriber? Has h/she given consent?
- Is this in the client's best interests?
- Depending on my theoretical model, what are the relevant psychological issues I need to consider before contacting the prescriber?
- How does my work context support (or not) contact with prescribers?
- How can I respectfully support my client's right to make informed choices about their prescribed drug?

Implications for practice:
Legal frameworks?

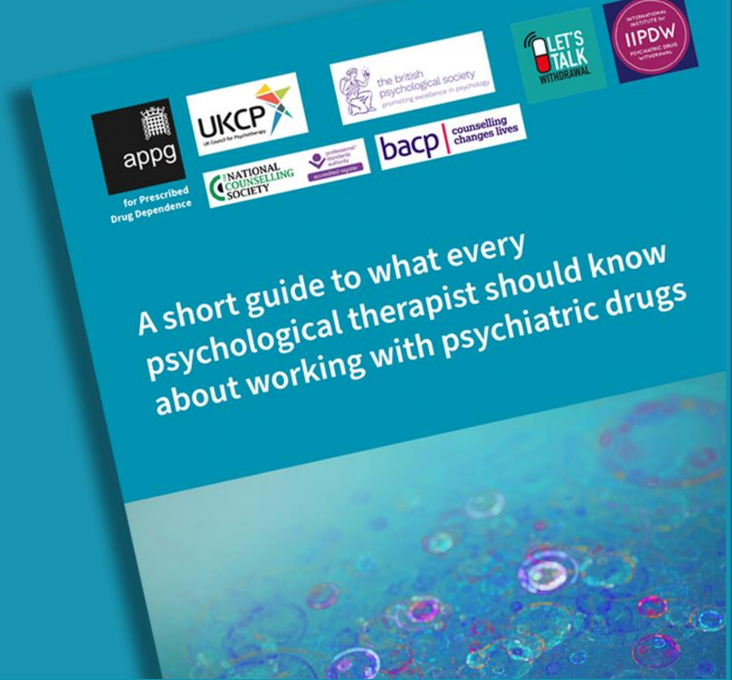


- Mental Health Act
- Community Treatment Orders
- Employment and Support Allowance (ESA)

A short guide to working with clients thinking about or already withdrawing from psychiatric drugs

21st November 2020 – Dr Anne Guy UKCP Reg; MBACP (Accred)

A short guide to… withdrawal

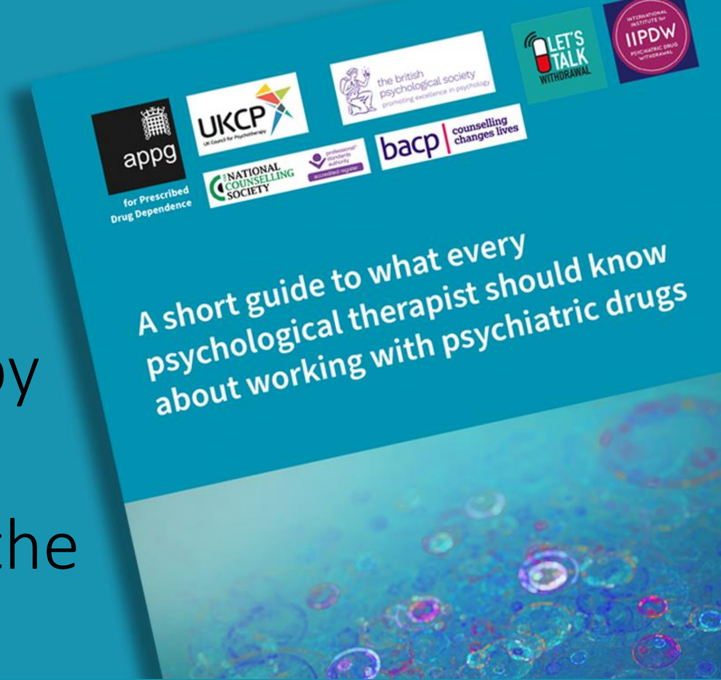


Agenda

- What is withdrawal?
- When can it happen?
- How common is it? How long might it last?
- How does it manifest?
- How well is it understood?
- The three stages of supporting withdrawal
- Integration into practice

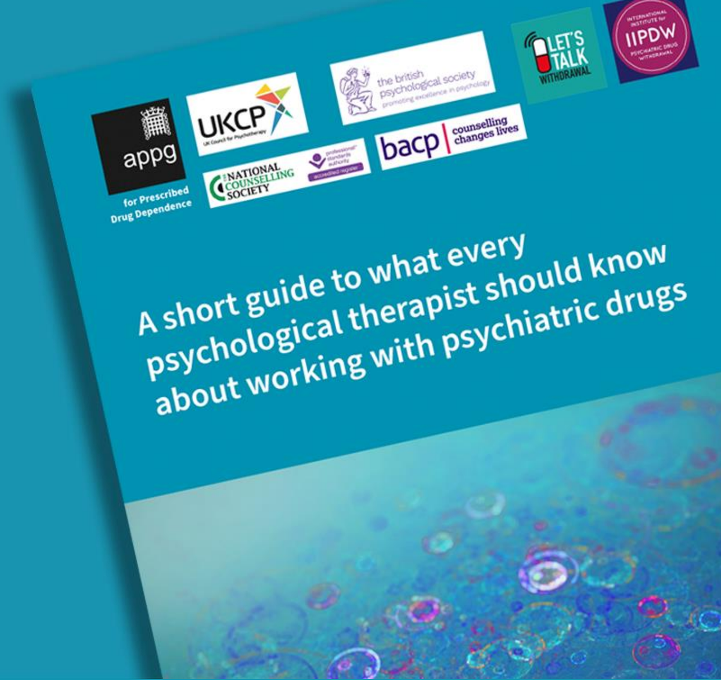
What is withdrawal? [1]

- When someone takes a psychiatric drug, the body views it as foreign and tries to counteract its effects by adapting to it
- Over time higher doses might be needed to achieve the same effect (‘tolerance’)
- When the drug is stopped or reduced the adaptations are no longer opposed by the drug’s presence
- This can lead to unpleasant sensations and experiences that are called ‘withdrawal’
- Withdrawal refers to both the process and reactions to reducing or stopping a drug



When can it happen?

“ I tried stopping taking them, but I felt bad again so went back on them”

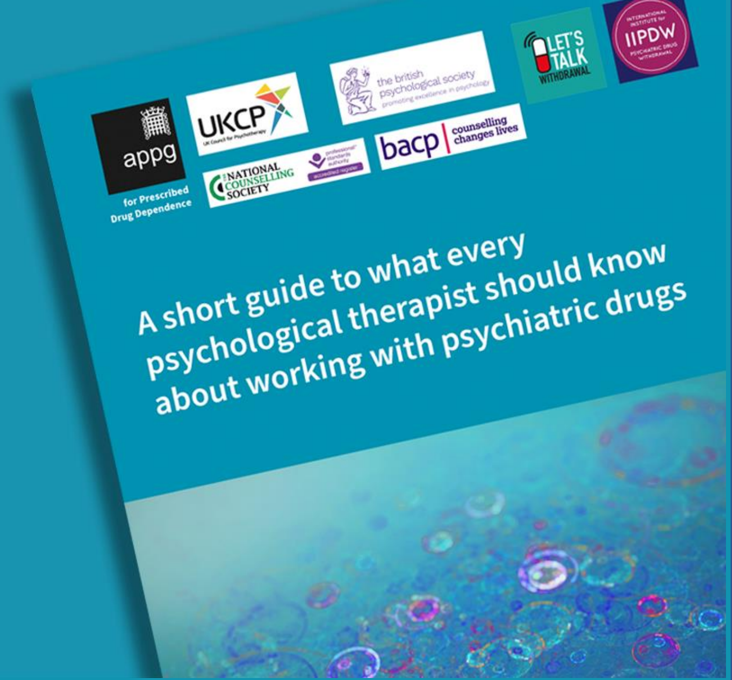


- When someone stops taking a drug completely (cold turkey or ‘CT’)
- When someone misses a dose
- Between doses when at tolerance
- When changing drugs
- When changing the brand of the same drug

“I really notice when I miss taking a dose – I must really need them”

How common is it? [2]

- At least half of people suffer withdrawal reactions when trying to come off antidepressants
- Half of those will experience severe reactions



How long might it last?

- Reports range from 2 weeks to months or even years

How does it manifest?

Some of the most common withdrawal responses include:

- Sweating, nausea, dizziness, abdominal cramps
- Flu like symptoms
- Anxiety, agitation, insomnia, muscle stiffness
- Mood changes
- Tingling, electric shock type feelings. Risk of epilepsy
- Panic attacks, poor memory
- Hallucinations, delusions
- Nightmares

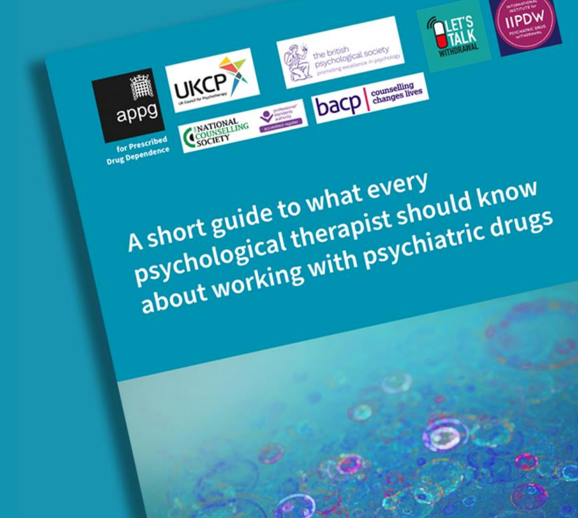
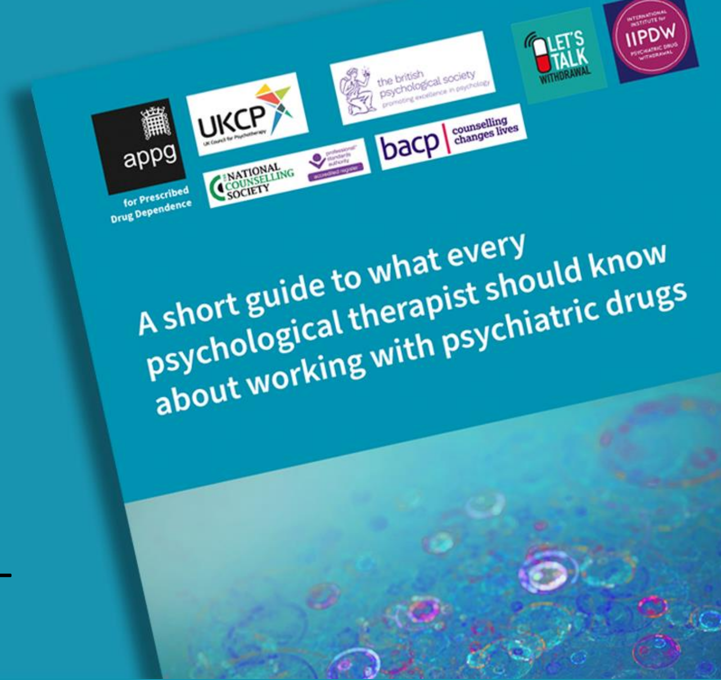


Table 1: Psychiatric drugs, their effects and withdrawal reactions

Drug class	Effects that may be perceived as adverse	Possible withdrawal reactions
Benzodiazepines and Z-drugs Benzodiazepines: Used for anxiety, sedation, alcohol withdrawal e.g. Temazepam, Diazepam Z-Drugs: Used for insomnia e.g. Zopiclone Pregabalin, Gabapentin: Used for anxiety, chronic pain e.g. Lyrica, Neurontin	■ Sedative ■ Significant risk of dependence ■ Drowsiness and impaired cognitive ability	■ Sweating, nausea, dizziness, abdominal cramps ■ Anxiety, agitation, insomnia, muscle stiffness ■ Tingling, electric shock type feelings. Risk of epilepsy ■ Panic attacks, poor memory ■ Hallucinations, delusions ■ Nightmares
Antidepressants Used for: depression and anxiety e.g. Fluoxetine, Paroxetine	■ Sedative ■ SSRIs/SNRIs: nausea, drowsiness, insomnia ■ Sexual dysfunction ■ Anxiety and agitation ■ Emotional blunting ■ Suicidality	■ Anxiety ■ Nausea, dizziness, insomnia. ■ Mood changes ■ Hallucinations ■ Vivid dreams ■ Confusion
Stimulants Used for: Attention deficit hyperactivity disorder e.g. Ritalin	■ Insomnia ■ Growth suppression in children	■ Rebound effects, including tearfulness, irritability, emotional lability
'Mood stabilisers' Used for: Bipolar affective disorder e.g. Lithium, Tegretol	■ Sedative ■ Drowsiness, tremor, lethargy, decreased ability to learn new information, prolonged reaction time, poor memory, reduced spontaneity ■ Weight gain ■ Reduced emotional responses ■ Toxic state: levels have to be regularly monitored	■ No physical withdrawal effects ■ Relapse or rebound of mania
Anti-psychotics Used for: Psychotic disorders (including schizophrenia), acute mania, sedation e.g. Chlorpromazine, Haloperidol, Olanzapine, Risperidone	■ Sedative ■ Dampened emotional responses and motivation ■ Dizziness, sexual dysfunction, weight gain ■ Cardiovascular effects ■ Akathisia and extra-pyramidal effects ■ Tardive dyskinesia ■ Anticholinergic effects: dry mouth, blurred vision, constipation ■ Restlessness ■ Suicidality	■ Nausea, headache, tremor ■ Sleep disturbance, irritability, aggression, depression. ■ Possibility of 'supersensitivity psychosis', particularly when withdrawing from clozapine. ■ Rebound psychosis.

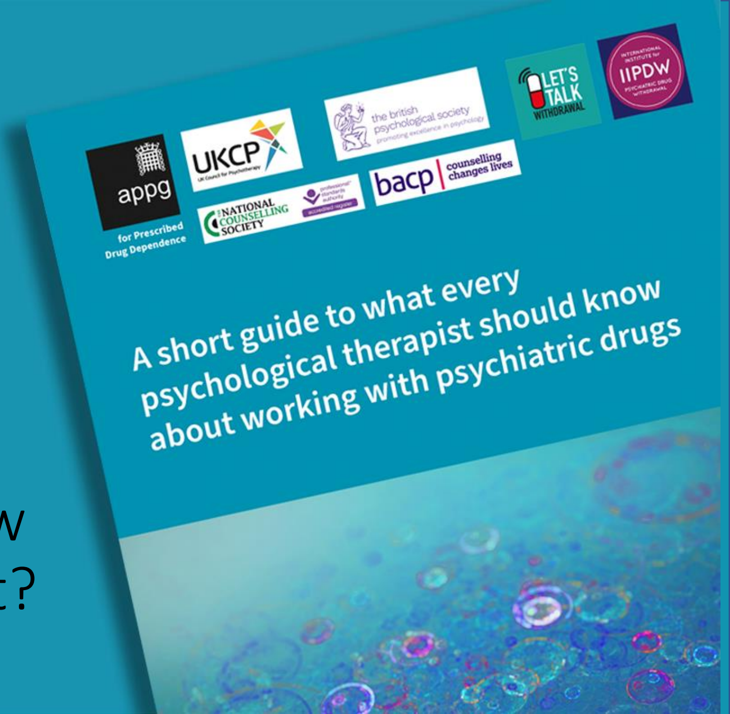
How well is it understood?

- Withdrawal reactions are caused by the removal of a drug from the body
- But they can be mistaken as signs of:
  - The return of an original problem (physical or emotional) – also known as relapse
  - A new problem[3]
- When someone is going through withdrawal the first assumption should be that any new reaction is related to that process
- It is vital to locate the cause of the problems with the *drug* and not with the *person*



What can a therapist do? The 3 stages of support

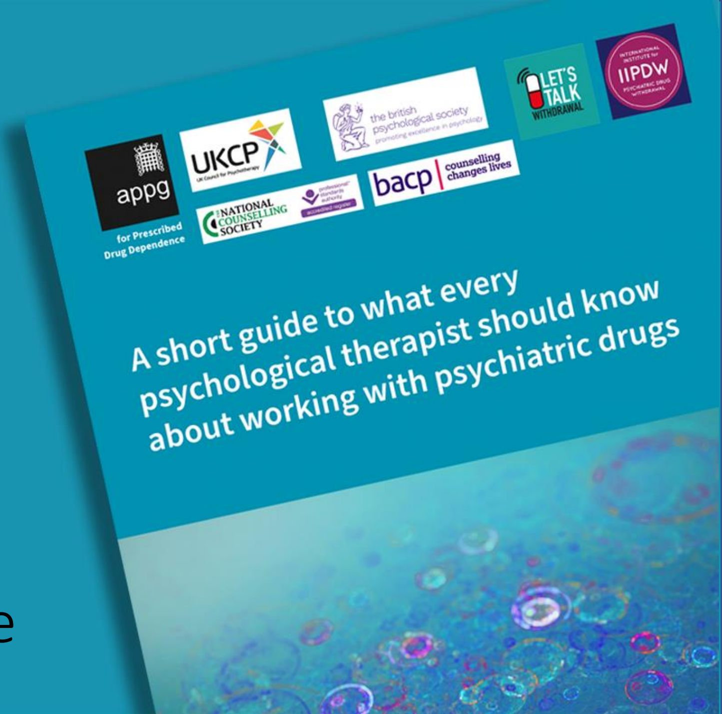
1. Preparation
   - Exploring readiness to begin, talk through fears
   - Signposting relevant information (e.g. importance of slow tapering), who is going to support tapering management?
   - Discussing possibility and nature of withdrawal effects
   - Discussing difference to relapse, agree approach
   - Identifying support networks
   - Discuss idea of using a diary or log to track reductions & reactions
   - Availability of extra sessions or other contact if needed – being clear about the limits



What can a therapist do? The 3 stages of support

2. During withdrawal

- Helping to identify withdrawal reactions, normalising
- Supporting agency, encouraging the client to go at their own pace whilst they continue to draw on medical advice
- Suspend work on deeper psychological material during periods when withdrawal reactions are strong, shifting to providing support
- Help the client identify useful practices to manage experiences
- Continuing to provide a warm and attentive therapeutic relationship



What can a therapist do? The 3 stages of support

3. After withdrawal is complete

- If the client has experienced any cognitive problems as a part of their withdrawal experience it may take a while for confidence in decision making to rebuild
- Ensure the clients' aims and assessment of progress are realistic given their experience of withdrawal
- If the clients' withdrawal was experienced as traumatic this might need to be considered in any further therapeutic work
- Post-withdrawal reactions can occur for sometime after stopping taking prescribed psychiatric drugs

In practice

- Any intervention is always subject to the frame of therapy and the best interests of the client
- You need to decide what's right for you and your practice
- However, we are often in a unique position to hear possible signs of dependence and withdrawal
- Just being alert to its possibility, and being willing to flag it, could prevent or reduce suffering

In practice

Withdrawal in the midst of normal therapeutic work

Client: “My boyfriend says I must really need the pills – he can tell if I’ve forgotten to take them”

Therapist: “What is it he notices? (explore)

I wonder if you’d considered the possibility that what you experience is the effect of not taking the medication, a mini withdrawal, rather than an underlying problem showing through?

The effects of missing a dose or stopping taking these drugs is only now being more commonly recognised…”

In practice

Withdrawal in the midst of normal therapeutic work

Client: “ I’m feeling so much better, I’ve decided to stop taking my medication”

Therapist (after normal exploration): “What’s your plan for coming off? Sometimes people aren’t aware that it needs to be done very slowly to avoid experiencing withdrawal reactions – have you had a chance to discuss it with your prescriber? “

Client: “Yes, they’ve suggested I take one every other day”

In practice

Therapist: “As you know, I’m not a medic and so can’t give you medical advice, but I can highlight relevant information. There is evidence that doing that can lead to triggering withdrawal reactions, and that a slow, smooth reduction can be more successful – I can let you have some links to some information if you’d like to look into that.

e.g. The Royal College of Psychiatrists has issued a new leaflet[4] about coming off antidepressants which covers this. How might it feel to go back to your prescriber to discuss it again?”

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Stopping antidepressants

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This information is for anyone who wants to know more about stopping antidepressants.

It describes:

- symptoms that you may get when stopping an antidepressant
- some ways to reduce or avoid these symptoms

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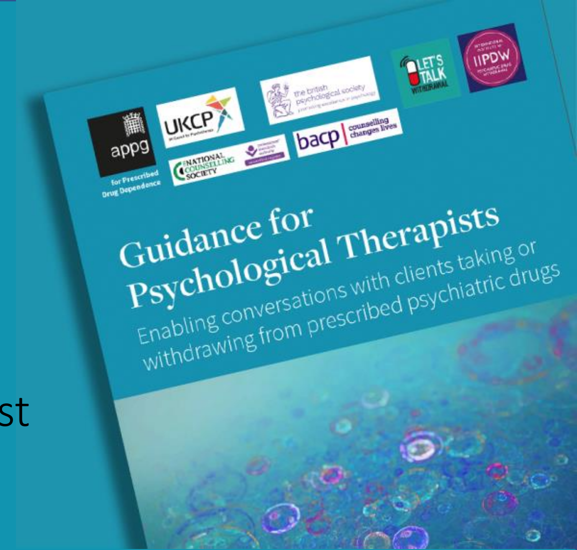
How might you reflect this in your practice?

- Decide what kind of interventions you might make taking into account your way of working and your setting. Any are always subject to the frame of therapy and the needs of your client.
- Think through your client list – where are each of them in relation to prescribed psychiatric drugs? Might there be any issues to take to supervision to explore?
- Consider any areas for further reading you might like to do
- Update your client facing information to reflect your awareness of issues of prescribed drug dependence and withdrawal

Reference and sources for further reading



1. Rizq, R., Guy, A. with Stainsby, K. (2020) A short guide to what every psychological therapist should know about working with psychiatric drugs. London: APPG for Prescribed Drug Dependence.

2. Davies, J. & Read, J. (2018). A systematic review into the incidence, severity and duration of antidepressant withdrawal effects: Are guidelines evidence based? *Addictive Behaviors*. pii: S0306-4603(18)30834-7. doi: 10.1016/j.addbeh.2018.08.027.

3. Guy, A., Brown, M., Lewis, S., & Horowitz, M., (2020) The ‘patient voice’: patients who experience antidepressant withdrawal symptoms are often dismissed, or misdiagnosed with relapse, or a new medical condition, Therapeutic Advances in Psychopharmacology Sage Publications, 2020, Vol. 10: 1–15

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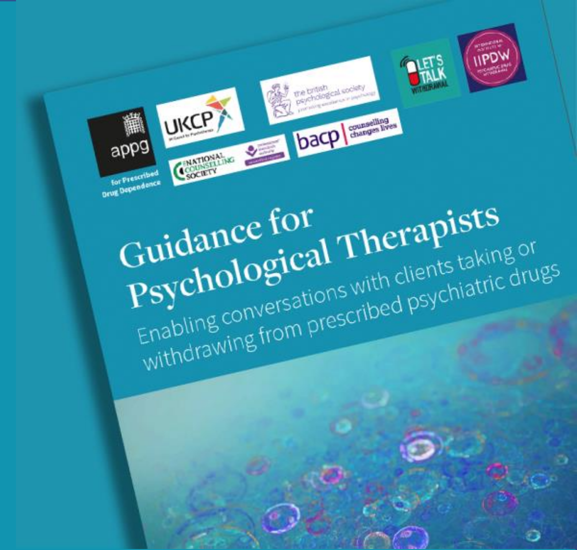
Sources for further reading



Guidance for Psychological Therapists is available either to read online or download for free at www.prescribeddrug.info

PCCS Books are also now taking orders for a hard copy of the full version at cost price of £6.90

Other Books / articles

- Ashton, C. H. (2007). *Benzodiazepines: How they work and how to withdraw*. Newcastle upon Tyne: School of Neurosciences.
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