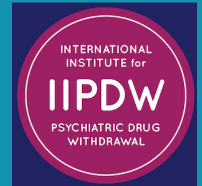
for Prescribed
Drug Dependence



A short guide to what every psychological therapist should know about working with psychiatric drugs

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1. Introduction

Although psychiatric drugs have traditionally been regarded as the mainstay of psychiatric treatment, evidence now suggests they are over-prescribed and that a large proportion of people struggle to reduce or withdraw from them. With prescriptions doubling over the last 10 years, most psychological therapists are now working with clients who have either taken or are currently taking psychiatric drugs. However, a recent survey of over 1,200 BACP, BPS and UKCP therapists found that most felt a need for support when working with issues of prescribed drug dependence. Only 7% of those surveyed felt that their training equipped them 'very well' to work in this area, and 93% reported they would find it either 'useful' or 'very useful' to have professional guidance to help them work with clients who are taking or withdrawing from psychiatric drugs.

In response to this need for support, during the 2017–2019 parliament the All-Party Parliamentary Group for Prescribed Drug Dependence facilitated the creation of the *Guidance for Psychological Therapists: Enabling conversations with clients taking or withdrawing from psychiatric drugs*[1]. This provides up-to-date evidence and information about the main effects of psychiatric drugs and the possible withdrawal reactions associated with them. It also invites therapists to consider and work with a wide range of issues associated with prescribed psychiatric drugs where they arise in therapeutic work. The full guidance is extensive, so this short-read version has been created to summarise some of the main issues and implications for practice in a more convenient and accessible format. For further information, you are advised to consult the full version of the guidance here.

Given the diversity of therapeutic backgrounds, professional trainings and practice settings, neither the full guidance nor this short-read summary aims to be prescriptive. No formal 'competences' or guidelines are suggested. Instead, you will be encouraged to consider whether and how you might begin to integrate issues of prescribed drugs into your therapeutic practice. The following guidance will support you by:

- Providing information about the main effects, adverse consequences and possible withdrawal reactions for each of the main classes of psychiatric drug.
- Helping you to understand how and when prescribed psychiatric drugs might impact the therapeutic relationship and process.
- Supporting and empowering you to talk about prescribed drugs with clients and, where appropriate, with prescribers.
- Enabling you to support clients in whatever decisions they reach with prescribers about taking or withdrawing from psychiatric drugs.
- Encouraging you to reflect on your own attitudes and beliefs about the use of prescribed psychiatric drugs.

This guidance aims to empower and support conversations that may already be taking place between you and your clients. You will need to decide for yourself whether, and to what extent, you wish to use it in the context of your therapeutic work. This decision will depend on your modality, setting, and the individual needs of your clients. The client's agency, as always, should be supported and respected at all times. Clients should be encouraged to discuss withdrawal from prescribed psychiatric drugs with a knowledgeable prescriber who can give medical advice, oversee and manage any withdrawal process appropriately. While this guidance advocates the importance of informed client choice based on full information about potential benefits and risks, *it does not advocate telling your clients to take, not take, stay on or withdraw from psychiatric drugs. These matters should be left to the prescriber and your client to decide.*

2. How do psychiatric drugs work? The ‘disease-centred model’ vs. the ‘drug-centred model’ *(see the full guidance section 2)*.

Despite decades of intensive research into various neurotransmitters, genetics and neural networks, a definitive cause of any form of mental distress has yet to be determined. In the light of this uncertainty, two main models for drug action have been proposed. The ‘disease-centred’ model of drug action assumes that psychiatric drugs reverse (or partially reverse) an underlying abnormality or disease process that is presumed to give rise to the symptoms of a disorder. This is closely related to theories that some mental health conditions arise from ‘chemical imbalances’ in neurotransmitters in the brain. Consequently, many people have been told that there is a biological reason for their depression (such as a biochemical change in the brain or a genetic factor).The powerful psychological ‘message’ that they have little control is inconsistent with the thinking that therapy helps people gain more control over their feelings and how they behave.

As there is little dependable evidence to support the above model, the ‘drug-centred’ model has more recently been proposed. This highlights that psychiatric drugs produce an altered global state that involves physiological, psychological and behavioural changes. These changes are superimposed on, and interact with, symptoms of mental ‘disorders’ in ways a person may experience as either helpful or unhelpful. An example of this is the effects of a benzodiazepine on anxiety. Benzodiazepines reduce arousal and induce a state of calmness and relaxation. This may be experienced as a relief for someone suffering from anxiety, but it does not mean that the person returns to their ‘normal’ or pre-symptomatic state. Moreover, it is accompanied by sedation and mental clouding which may be problematic. Because they alter normal bodily functions, all drugs have adverse effects and may do more harm than good especially if prescribed long term. Psychiatric drugs are likely (to varying degrees) to impair and suppress aspects of a person’s mental and emotional functioning. Individuals have to decide and periodically re-evaluate whether the overall effects of a drug are preferable to the original distress or difficulties they experienced.

Understandably, some clients do not wish to experience strong feelings of distress and might assume that drugs will quickly and with little effort bring them relief. Therapists will need to consider not only the implicit and explicit messages received by clients regarding psychiatric drugs, but the beliefs and meanings associated with these, as they could prevent them from accepting an alternative view of what could help.

The British Psychological Society (BPS) takes the view that *‘clients and the general public are negatively affected by the continued and continuous medicalisation of their natural and normal responses to their experiences; responses … which do not reflect illnesses so much as normal individual variation … This misses the relational context of problems and the undeniable social causation of many such problems.’*[2]

2.1 The main psychiatric drugs: possible adverse effects and withdrawal reactions

For more information see section 4 in the full guidance.

You may wish to familiarise yourself with some of the main psychiatric drugs, their common uses, adverse effects and withdrawal reactions. Table 1 offers a summary of this information.

N.B. More than one psychiatric drug can be prescribed at any one time. For example, an antidepressant may be prescribed at the same time as a benzodiazepine. Also, some drugs classed primarily as 'psychiatric' may be used to treat physical health conditions. For example, Tegretol can be prescribed to help with migraine.

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.

3. What do therapists believe about psychiatric drugs?

As previously mentioned, the disease-centred model of drug action is closely linked to the biomedical approach in healthcare. The continued dominance of this approach means it is likely to shape the attitudes, beliefs and values of therapists from all psychotherapeutic backgrounds and to influence their practice in a variety of different ways. Before thinking about how to work with clients who have issues of prescribed drug dependence, it may be useful to think about your relationship to the biomedical or 'medical model' and its place in your therapeutic practice. This will help you to consider whether and to what extent it contributes to any beliefs you may have about prescribed psychiatric drugs.

Of course, beliefs and attitudes are not only shaped by the medical model; they will be influenced by your professional background, training and work, as well as by any personal experiences you may have had with prescription drugs. Your beliefs will also be influenced by the setting in which you work. Some therapists work within settings that privilege a biomedical framework, requiring them to use the language of psychiatric classification, standardised assessments and manualised 'clinical' techniques. This sits more closely with the 'disease-centred' model that emphasises notions of deficiency, symptomatology and medicalisation (sometimes referred to as the 'what's wrong with you' approach). Other therapists work in settings that privilege theoretical frameworks emphasising the psychological, systemic and psychosocial aspects of experience thought to underpin emotional distress (which is more akin to a 'what happened to you' approach). You may find it useful to reflect on the professional framework and language used in your particular practice setting, and how it may affect your beliefs and attitudes about prescribed drugs.

Therapeutic modalities are also important. Within the humanistic and psychodynamic traditions, distress is regarded as having potential value and purpose. Rather than being seen as 'pathological' (and of little use), it can be regarded as an opportunity for change and transformation. By contrast, cognitive behavioural approaches focus mainly on removing symptoms of distress by altering patterns of cognition, emotion and behaviour that may be maintaining emotional suffering. Again, you may wish to consider how your own theoretical position shapes your understanding of psychological distress and how, in turn, it influences your perspective on the use of prescription drugs.

Questions to help you reflect on your position as a therapist, to be used on your own or in supervision:

- What do I understand by the term 'medical model'?
- What position do I take up in relation to the medical model? Where do I locate myself?
- How does my professional training and practice setting influence the way I understand and work with issues relating to taking or withdrawing from prescribed psychiatric drugs?
- Do I have any experience of taking prescribed psychiatric drugs myself? Am I aware of any family members or friends who have taken prescribed drugs?
- If so, what do I think and/or feel about these drugs, based on my own knowledge and experience, both personal and professional?

3.1 Ethical implications to consider: medical advice vs. medical information

The rapid growth of scientific and medical knowledge can make it difficult for any professional guidance to keep up with the speed of change. This means there is scope for differences of opinion amongst those providing care for the client. Unfortunately, there is no specific guidance available on how therapists should respond to ethical issues relating to taking or withdrawing from psychiatric drugs. However, the general ethical principles provided by all main professional accrediting bodies remain important touchstones. These include:

- 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.

Working in therapy with issues of prescribed psychiatric drugs raises particular ethical questions that relate to boundaries of professional competence, modality and role. For example, clients may ask you for medical advice and information and you can quickly find yourself drawn into discussions about drug choice, dosage and frequency. It is important here to distinguish between providing medical *advice* and providing medical *information*. Discussing scientific evidence, sharing information from a reputable source, or offering a different perspective where appropriate with clients differs substantially from offering a diagnosis, prescribing drugs or advising withdrawal. It is important to be clear about this distinction with clients and it can bear repeating. Clients requiring advice on psychiatric drugs should *always* be referred to their medical practitioner or a knowledgeable prescriber. But helping a client to understand the potential advantages and disadvantages of taking prescribed psychiatric drugs during therapy can be thought of as part of your responsibility to ensure your client's informed consent for the work you do together. This is different from the prescriber's responsibility to inform the client about the physiological and psychological effects of their prescribed drugs. It can, of course, be helpful for you to support this process where appropriate, for example by directing clients to relevant sources of information.

3.2 How do psychiatric drugs affect the therapeutic relationship and process?

Clients come to therapy with many beliefs and assumptions about psychiatric drugs. Many people believe, or have been told, that depression, anxiety and other psychological problems are caused by biochemical changes to the brain, while others believe there are genetic factors underlying their emotional distress. In these cases, psychiatric drugs carry a strong psychological 'message' that the individual has an 'illness' and requires medical 'treatment' in order to cope. Clients may also believe that it is not good for them to experience strong feelings of distress, and that psychiatric drugs will quickly and effortlessly get rid of feelings of sadness or anger. In these and many other situations, you will need to sensitively explore the beliefs and meanings held by the client, taking into account their particular experiences as well as any unrealistic expectations they may have about psychiatric drugs.

As we have seen, prescription psychiatric drugs act on the brain to alter mood and consciousness sometimes helping to control reactions to emotional distress by numbing, sedating or tranquilising a person. While some clients will find the effects of psychiatric drugs helpful, they can

result in a range of adverse effects, which may significantly impact the therapeutic relationship and process. Some of the possible effects on thinking, feeling and behaviour are listed below:

Adverse effects on thinking may include:

- memory impairment
- 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.

Adverse effects on feeling may include:

- emotional withdrawal, being less able or willing to connect with a therapist
- being uninvolved, distanced or 'not really there'
- inability to reconnect with feelings relating to past experience
- suppressed anger, sadness or fear
- lack of emotional congruence.

Adverse effects on behaviour may include:

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

You will need to bear in mind that many of the effects listed here can also be part of the experience of emotional distress. You may therefore wish to consider exploring with your client whether any perceived effects on thinking, feeling and behaviour could have been evident before they took the prescribed drug.

4. Implications for therapeutic practice

When starting work with clients who are taking, or thinking of taking, a prescribed psychiatric drug, you may wish to:

- Explore sensitively and with care how your client understands their psychological difficulties and whether they are ready to discuss taking prescription drugs.
- Enquire whether your client's prescriber has discussed with them all the possible effects of, and potential for dependence on, any proposed drug. It is important to encourage your client to discuss this with their prescriber if they have not already done so.
- Think about whether and to what extent taking prescribed psychiatric drugs is likely to affect your client's experience of therapy. If this is a first appointment, you may decide that it is not in your client's best interests to start therapy. You may choose instead to refer them to alternative sources of help and support to either manage distress or withdraw from such drugs. However, given the lack of currently available services, you should remain cautious about assuming other professionals are better able to offer emotional or psychological care. Therapists are generally well placed to offer support to withdraw (ideally with a prescriber advising on a reduction plan), though it may be necessary to adjust therapeutic expectations of what kind of work will be possible whilst it is taking place.

You will also need to take care not to offer any personalised suggestions about the advisability or otherwise of taking prescription psychiatric drugs. Any specific questions about the type, dosage or frequency of psychiatric drugs should be referred back to the prescriber who can give medical advice. As this is an emerging area of knowledge, however, not all prescribers will necessarily be aware of the need for, and how to plan, a slow reduction. Clients may need signposting to relevant information that will give them the confidence to ask for a prescriber's support with this.

Questions to help you reflect on your practice, either on your own or in supervision:

- What does my client think and feel about taking prescribed psychiatric drugs?
- Why does my client wish, or feel they need, to accept (or not) a prescription?
- What is my client's relationship with their GP or prescriber? How can I best support my client's choice either to start taking prescribed drugs or to revisit the GP/prescriber to consider alternatives to drugs?
- Is my client directly requesting advice about drugs? If so, can I support their agency in relation to the prescription? Do they need more information?
- Have I been clear about the distinction between medical information and advice?
- What is the likely impact of the proposed drug on my client's ability to engage in psychological therapy?

5. Withdrawing from prescribed psychiatric drugs: the 'combined wisdom' approach

Despite limited evidence for the benefits of prolonged treatment, some people are advised to continue taking psychiatric drugs long after their problem has subsided. Some will want to stop taking their prescribed drugs, either because they are stable or because they are concerned about possible harmful effects. Others may feel their drugs have not helped them. When a person takes a psychiatric drug, their body views it as foreign and tries to counteract its effects by adapting to it. This means that over time, higher doses may be needed to achieve the same effect ('tolerance'). It also means that when a drug that has been taken for some time is stopped, the body's adaptations are no longer opposed by the drug's presence. This can lead to the unpleasant sensations and experiences that are called 'withdrawal'.

During the course of therapeutic work, clients may consider withdrawing from their psychiatric drugs. They might think about moving to therapy alone or even ending all interventions if they are feeling better. However, the process of withdrawal may not be an easy one (*see section 5 of the full guidance*). It requires planning and preparation and may take some time. The process of withdrawal itself can take months or years, not days or weeks. A rushed or unplanned withdrawal process is unlikely to succeed. It is usually achieved by 'tapering', i.e. the slow reduction over time of a drug that is managed by a prescriber likely to be following a proven, recommended protocol. Whilst it is important to remind clients of the risks of any abrupt discontinuation or reduction of a psychiatric drug, you will also need to bear in mind that a knowledgeable prescriber should offer specific tapering advice.

Although there is a lack of formal research into which therapeutic strategies best support withdrawal, a 'combined wisdom' approach can be adopted. (Additional information about this, including references, can be found in section 6 of the full guidance). It includes three stages:

Stage 1: Before withdrawal begins

You can help your client to prepare for withdrawal by:

- **Maintaining** an attitude of non-judgemental acceptance.
- **Exploring** whether your client is 'ready'. Why now? Is there any plan? Who is going to provide medical support?
- **Discussing** the advantages, disadvantages of withdrawal. What are your client's motivations, goals and fears? What is the likelihood and nature of withdrawal effects? What about the availability of future extra sessions or 'between-session' contact if necessary?
- **Signposting**. This involves providing relevant information on withdrawal and useful coping strategies and/or supportive lifestyle changes that may be appropriate. For some however, withdrawal effects can be severe and these clients may need therapeutic support to select strategies that are appropriate to need, and are realistic and achievable given their current capacities.
- **Clarifying**. It is important that both the client and you clearly understand the high-level definitions of relapse, rebound, recurrence and withdrawal that might be mistaken for relapse (*see section 5.4.2 of the full guidance*).
- **Identifying** any fears, including how attempts at withdrawal could be sabotaged, either by the self or others. It is also helpful to identify support networks and the potential impact of any withdrawal effects on the client's family and other social networks (particularly relevant for older adults and those with learning disabilities or communication problems).

It is important to discuss with your clients that withdrawal should be planned, not abrupt, and is best carried out under the supervision of a knowledgeable prescriber. Drugs may need to be tapered very slowly over a period of months or more, particularly if the person has been taking the drug for a long time. In these cases, liquid prescriptions that enable accuracy in small reductions can be helpful.

Stage 2: During the withdrawal process

You can help the client through the withdrawal process by:

- **Maintaining** an empathic attitude of non-judgemental acceptance.
- **Identifying and normalising** withdrawal reactions (e.g. intense anxiety) and offering reassurance that these reactions will pass.
- **Helping** your client to manage withdrawal reactions that can come and go over time.
- **Encouraging** your client to use a diary or log to keep track of reactions and experiences.
- **Suspending** any attempt to understand deeper psychological material if withdrawal reactions are strong, shifting instead to supportive work.
- **Helping** your client to identify supportive practices such as mindfulness, positive self-support and self-talk, breathing exercises, emotional freedom techniques, meditation, self-compassion work, keeping a diary, visualisation and de-catastrophising (*see section 6.1.2 and appendix A of the full guidance for a longer list of strategies*).

During this stage, withdrawal reactions, especially those that continue for some time, are often assumed by clients and prescribers to mean the return of psychological problems (relapse) and to require further prescription drugs. **In these cases, you may need to help your client understand that these are physiological reactions to withdrawal rather than the reappearance of psychological problems.** It is also important to recognise that some withdrawal reactions such as akathisia (extreme restlessness) can be severe and may lead to suicidal thinking and actions.

As clients reduce their drug levels, very powerful feelings may also return. Initially, it may not be possible to tell which feelings are related to withdrawal and which to any returning emotional connection. Your client may need help in managing this uncertainty and in coping with their feelings for the first time without drugs. As a result, it will be important to agree with your client what is realistic to work on in terms of therapeutic aims.

Stage 3: After withdrawal is completed

You can help your client following withdrawal by:

- **Continuing** to maintain an empathic attitude of non-judgemental acceptance.
- **Discussing** your client's withdrawal experience and any further therapeutic needs.
- **Exploring** any issues around traumatic withdrawal and how this might be considered in future therapeutic work.
- **Identifying** and working with any post-withdrawal reactions (which can continue to occur for some time).
- **Identifying** any need for further support and how this might be put in place.

6. Further practice implications to consider

Working with partners, families or carers
Taking (and withdrawing from) psychiatric drugs can have significant implications for partners, family, carers and other people involved with the client. For example, in the case of some older adults, or those with learning disabilities or communication difficulties, carers, partners and families are likely to be involved in supporting the client. It is important to consider, from the perspective of your own setting and preferred therapeutic framework, the range of issues associated with contacting and working with carers and/or family members (*see the full guidance, Note 1, 3.3*).

Working with the client's prescriber
If you are concerned about a client taking or withdrawing from psychiatric drugs, you may also wish to consider contacting the client's prescriber. This decision will depend on many complex and overlapping factors: whether contact is at the request of and in the best interests of the client; whether the client has given consent; your preferred therapeutic model and rationale for communicating – or not – with the prescriber concerned; your work context; and your previous experience of initiating contact with prescribers and other medical professionals. Where contact is made, it is important not to undermine your client's relationship with their prescriber. However, you may need to be prepared respectfully to support your client's right to make informed choices.

You may also wish to bear in mind the extensive debates in the field about the overprescribing of psychiatric drugs in marginalised groups, including those from black and ethnic minority backgrounds[3]. It is also important to be aware of the implications of adverse drug effects for particular groups of clients such as those who are either planning a pregnancy or are pregnant, and older adults with diminished physical capacities who may be more prone to falls.

The impact of legal frameworks
There are complex issues to be considered when working with clients who are required to take drugs because they are detained under the Mental Health Act or being treated under a Community Treatment Order (CTO). In these circumstances, you will need to be alert to the way in which pharmacological treatments are likely to impact on the therapeutic relationship, working with clients to support them within the limitations imposed by the relevant legal frameworks. Difficulties are also likely to arise where clients rely on prescription psychiatric drugs to demonstrate eligibility for benefits such as Employment and Support Allowance (ESA). In these situations, you will need to explore sensitively and with care the extent to which anxiety about any possible loss of benefits underpins your client's understanding of the causes of their emotional distress and drives any decision about withdrawing from prescribed psychiatric drugs. These are complex scenarios, and you will need to remain respectful of your client's perspective and to value the choices they are able to make at all times.

7. Conclusion and possible next steps

With around a quarter of the UK adult population being prescribed a psychiatric drug,[4] it has never been more important for us as psychological therapists to understand and actively engage with the impact these drugs can have on our work with clients. Learning about their effects and becoming aware of what might happen during withdrawal allows us to help our clients better. If you want to include what you have learned within your practice, you could start by:

- Updating your client-facing information to say you are aware of/work with issues related to prescribed psychiatric drug dependence and withdrawal.
- Suggesting this short read as a discussion topic for your supervision or reading group.
- Deepening your understanding by doing some further reading or training – go to www.prescribeddrug.info where you can access the full guidance (which includes an additional resource list in Appendix A) and find news about planned events.

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