

HELPING COUNSELEES COME SAFELY OFF ANTIDEPRESSANTS

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I. Introduction

A. The goals of this workshop are as follows:

1. Give a brief history of psychiatric drug use.
2. Present a brief, clear explanation of the various categories of psychiatric drugs.
3. List the nine most commonly used drugs today.
4. Explain the most common side effects as well as the much more serious side effects.
5. Give practical advice on how to help a counselee come off of their medication.

II. History of Psychiatric Drugs

- It has always been a challenge to try to control the behavior of someone who is acting crazy.
- One hundred years ago the psychiatric drug “of the day” was cocaine. Obviously cocaine would perk a depressed patient up, but it had the unfortunately side effect of being addictive.
- Not long before I was in nursing school (in the mid- 1960’s), psychiatrists experimented with giving violent or depressed patients insulin to place them in insulin shock.
- In the 1960’s, the main treatments for psychiatric problems were Thorazine, Librium, Phenobarbital, and shock treatments.
- Over the past 40 years psychiatric drugs have come and gone.
- There is a pattern that has emerged: at first the drug is touted by the drug company that it is safe and non-addictive. Time has told otherwise.
- In the last twenty years, we have seen the emergence of the anti-depressants. It has never been established *how* these drugs lift someone’s mood. However, for some they *will* do that (at least for a while). The thought is that a chemical imbalance is causing the depression and since the anti-depressants change the levels of the neurotransmitters (dopamine, serotonin, and norepinephrine) in the brain, hence the patient’s problem is a chemical imbalance.
- The problem with this is it is *simply not true* that depression or anxiety is caused by a chemical imbalance (if there is a true imbalance, the person would have observable neurological symptoms such as the patient with

Parkinson's disease), but the medical and lay communities have bought into this much like the world has embraced the theory of evolution. To make matters worse, all specialties of doctors are prescribing these drugs often misdiagnosing someone with depression whose problem is really anxiety.

- Psychiatrists in general are prescribing multiple drug therapies.
- The problem with helping people get off their medications is not going away. It is getting worse and more complicated.
- Even though we are not doctors, we need to know a few basic things about these drugs and how to counsel our counselees about them.

III. Categories and Most Commonly Used Drugs

1. Antidepressants:

- SSRI's (selective serotonin reuptake inhibitor). These drugs cause an increase in the level of serotonin in the spaces in the brain.) Some of the most common ones used today are Zoloft and Paxil. Others are celexa, lexapro, and luvox.
- SNRI's (serotonin and norepinephrine reuptake inhibitor). Two of the commonly used ones today are Effexor and cymbalta.
- Atypical (like a methamphetamine, an "upper"). The most commonly used one today is Wellbutrin.

2. Mood Stabilizers:

- Primarily used for counselees diagnosed with bipolar (formerly manic-depressive) disorder.
- The most common drugs used are Depakote and Lithium, and Lamictil.

3. Antipsychotics:

- Primarily used for counselees diagnosed with schizophrenia or someone having hallucinations.
- The most common drugs used today is Zyprexa and Abilify.

4. Stimulants:

- The primary use is for those (it used to be only children but now more and more adults) diagnosed with ADHD (attention deficit hyperactivity disorder).
- Most common ones used today is Ritalin and Concerta and Adderall.

5. Tranquilizers:

- The primary use is for anxiety, typically for a limited amount of time due to the risk of addiction.
- The most commonly used one today is Xanax.

IV. Side Effects

- Anxiety, panic attacks, paranoia
- Sleeplessness, abnormal dreams
- severe restlessness, agitation (Akathasia), suicidality
- Tiredness, weakness, tremors
- dizziness, light headed, difficulty concentrating
- dry mouth, upset stomach, decreased appetite, nausea, vomiting
- decreased sex drive, impotence
- weight loss at first, then weight gain
- Physical symptoms: sweating, blurred vision, hair loss, acne, dry skin, chest pain, runny nose, abnormal heart rhythms, bleeding, blood pressure changes, bone pain bursitis, breast pain, anemia, swelling, low blood sugar, low thyroid activity
- Uncontrollable neurologic symptoms: tics and tardive dyskinesia.

V. When the Counselee is at Greatest Risk

1. **The first month** – when counselee starts on one of the mood altering drugs, they will likely begin to experience side effects. The most dangerous side effects to watch for are akathasia, anxiety, and insomnia. It would not take long for someone already emotionally upset to feel overwhelmed and suicidal.
2. **When withdrawing.** The most common withdrawal effects from antidepressants are “anxiety, crying spells, fatigue, insomnia, irritability, dizziness, flu-like aches and pains, nausea, vomiting, headaches, tremors, and sensory abnormalities such as burning, tingling, or electric shock-like symptoms.”ⁱ Counselees may become suicidal while withdrawing and some of the medications are very slow to be metabolized out of the body. For instance, the onset of withdrawal symptoms from prozac could take up to 25 days after stopping the drug and last up to 56 days.ⁱⁱ If a counselee did not know this, they might think their psychiatric “disease” had returned. On the other hand, “paxil and Zoloft are the worst offenders in terms of the sheer numbers of people affected by withdrawal reactions, because they are short acting and have been widely prescribed. Effexor is the worst offender in terms of the lightning speed with which it can cause withdrawal reaction, within hours of just one missed dose.”ⁱⁱⁱ

VI. How to Help the Counselor come off the Medications

1. Read Joseph Glenmullen's book, *The Antidepressant Solution* (New York: Free Press, 2005). This will help you to have some knowledge of how a counselor may come off of their medications safely. Also it will help you to be able to talk to the counselor and their doctor, if necessary, in an informed way.
2. Gather data: the name, dose, and how long the counselor has been on each medication.
3. Look up each medication to learn about what it is typically used for and the side effects. One good and easy to read resource is the book, *The Pill Book* (Harold Silverman, editor-in-chief. New York: Bantam Books, 2004).
4. Give the counselor hope that for the Christian they *can* be controlled by the Holy Spirit and not by their medications.
5. Continue with biblical counseling so that, by God's grace, their thoughts and emotions will stabilize and they can have joy in giving God glory.
6. Teach them a right view of sanctification and where their feelings come from. For example: THOUGHTS –(then)- FEELINGS –(then)- ACTIONS. As biblical counselors we help them with their thoughts (renewing their mind) and hold them accountable for their actions (loving God and loving others). They must be told that they can honor God and show love to others in spite of how they feel. Ultimately as they obey God and honor Him, their feelings will improve and be replaced with the peace of God.
7. If the counselor is confused or uncertain about the "chemical imbalance disease" that her doctor has *insisted* she has, give her Martha Peace's paper on "Chemical Imbalance" for homework. Be prepared to answer questions the counselor may have.
8. The counselor will need to talk with their doctor about tapering off the medicines. Suggest that they tell their doctor, "I have been receiving biblical (or faith-based) counseling and my counselor and I both think I am ready to begin tapering off the medication. Would you be willing to help me slowly taper off?"
9. If the doctor refuses, then the counselor has the option of finding another doctor. It might be helpful if you know some Christian doctors in your area that would be willing to help.
10. Teach your counselor the possible side effects he or she may experience while tapering off and for him not to be panicked if he experiences agitation or anxiety or feels down. It may be that, on occasion, his doctor will need to slow the taper or increase the dosage to the last dose before he began to experience withdrawal. Then the next decrease in dosage should likely be smaller. If the counselor's symptoms improve when the medication is increased, that is proof that the symptoms were from withdrawal.

11. If your counselee wants to take himself off the medicines, caution him against it. Document what you told her/him in your notes. If he insists, have him read Glenmullen's book, *The Antidepressant Solution*, before he begins.
12. During the time the counselee is tapering off, you probably need to see him/her more often than usual.

VII. Conclusion

- A. We have the good news of the gospel and we are persuaded of the sufficiency of the Word of God.
- B. The psychiatric drugs come and go. They are loudly heralded by the drug companies to be safe when they first come out. Later they are found out to be dangerous and the drug companies quietly place warning label in the drug literature.
- C. The preeminent psychiatrists are admitting there is no chemical imbalance. We need to have the same assurance especially because we have the *sure* Word of God "restoring the soul" (Psalm 19:7).

ⁱ Glenmullen, Joseph. *The Antidepressant Solution*. (New York: Free Press, 2005), p.120.

ⁱⁱ Glenmullen, p.85

ⁱⁱⁱ Glenmullen, p.88-89