CHAPTER 1

# *A Person-Centered Collaborative Approach to Psychiatric Drug Withdrawal*[1]

*A person-centered collaborative approach to drug withdrawal requires a trusting relationship between the patient and healthcare providers. Out of respect for the patient and to minimize fear and anxiety, the patient must feel in control of the process or at least an equal partner in it. This requires the clinician to share information and to collaborate with the patient regarding every aspect of the withdrawal process, including what to expect with each dose change up or down. The clinician's empathy for the patient, along with a commitment to honest communication and patient empowerment, lies at the heart of the person-centered approach.*

*The client's mental status and feelings are the most sensitive barometers of how the withdrawal process is progressing. The prescriber must bring an empathic, positive, and encouraging attitude toward the client that places great emphasis on the client's self-evaluation and feelings and encourages the client to voice concerns and to describe the subjective experience of withdrawal.*

*In difficult cases, the patient will need a person-centered collaborative* team effort *involving the prescriber, a therapist or counselor, the patient, and the patient's family or social network. The family or friends not only can provide emotional support; they may also be able to help with monitoring. Patients often fail to recognize when they are*

[1]The term "withdrawal" will be used instead of the more recent term "discontinuation," which is euphemistic and distracts from the seriousness of the problem. Similarly I will often use the term "addiction" rather than the euphemistic "dependence."




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*undergoing a dangerous withdrawal reaction, including violent or suicidal impulses, and so the involvement of significant others can be lifesaving. This book can be used as a collaborative guide for prescribers and therapists, as well as for patients and their support network.*

Twenty percent of adult Americans were taking psychiatric drugs in 2010—15% of men, and 26% of women (Medco, 2011). Antidepressants were by far the most commonly used by both sexes, although antipsychotic drugs were markedly on the rise among men. Prescriptions for psychiatric problems in all adults rose 22% in the decade.

It has become very easy for individuals to find clinicians who will prescribe psychiatric drugs or refer them to other professionals for medication. But it remains very difficult for patients to find help in reducing or withdrawing from psychiatric drugs. Lack of peer support and training are among the reasons why clinicians often feel uncomfortable responding to the patient's desire or need for medication reduction or withdrawal.

Many clinicians, including both prescribers and therapists, have no training and little experience in lowering doses or stopping psychiatric drugs. Some are not aware of the growing number of reasons why patients should avoid staying on these chemical agents for long periods.

To help patients through the sometimes difficult, frightening, and hazardous process of drug reduction or withdrawal, clinicians need to become fully engaged with patients and their families or significant others who can provide support and at times join the treatment team. The process begins with communicating respect and value for the people who seek help from us. It further requires our own personal commitment to offering genuine help based on good science, honesty, the patient's needs and desires, and partnership in decision making. This collaborative relationship is what is meant by the person-centered collaborative approach.

## RELATIONSHIP BETWEEN PRESCRIBERS AND THERAPISTS

In facilities and private practice, many different professionals can prescribe psychiatric medications, including psychiatrists, nurse practitioners, physician assistants, family doctors, internists, neurologists, pediatricians, and even medical specialists such as surgeons, obstetrician/gynecologists, and dermatologists. These prescribers can benefit their patients by working closely with their therapists (see Chapter 12 of this book).

Prescribers and therapists working in facilities and private practice should cooperate to ensure that medicated patients receive proper monitoring and a maximum opportunity for recovery and overall improvement in their quality of life.

Therapists who work with medicated patients are also found in facilities and private practice, including nurses, social workers, clinical psychologists, counselors, family and marriage therapists, occupational therapists, and school psychologists. These therapists can also benefit their patients by working closely with their prescribers.

In the past, prescribers sometimes felt it was sufficient to write psychiatric prescriptions for patients whom they would see briefly and on widely spaced occasions. Therapists in turn were expected to urge their patients to comply with their prescriptions for psychiatric drugs without conducting their own independent evaluations. This situation is changing, with the realization that psychiatric drugs carry considerable hazards and require more serious monitoring than prescribers by themselves can usually provide.

Prescribers and the clinicians with whom they work have begun to realize that the use of prescription drugs is far too hazardous and complex to be monitored by the prescriber alone. Informed and diligent therapists can also contribute to the patient's understanding and decision making concerning medication and provide important feedback or consultations to prescribers.

Suicidality, violence, and other serious short-term hazards have been documented for several classes of psychiatric medication. Long-term exposure to psychiatric drugs has proven to be far more dangerous than originally anticipated, including medication-induced obesity, diabetes, heart disease, irreversible abnormal movements, and an overall deterioration in the patient's clinical condition and quality of life.

As a result, Food and Drug Administration (FDA)-approved labels for psychiatric drugs and good clinical practice now call for a degree and intensity of monitoring that is beyond the capacity of most prescribers regardless of the setting in which they work. Fifteen-minute medication checks conducted at widely spaced intervals are especially insufficient to monitor the patient's condition for any potential adverse drug effects or to maximize the patient's potential for recovery and growth. Prescribers need the help of other clinicians to ensure the safest and most effective use of medications.

Therapists can no longer assume that a prescription, once written, should be continuously taken by the patient and that their professional role is limited to encouraging or monitoring compliance. Nurses on psychiatric wards and in private practice, as well as other clinicians, are commonly in a better position to evaluate the patient's needs, wants, and clinical condition than

Prescribers and therapists, as well as patients and their families, must work closely with each other to ensure the safest and most beneficial use of psychiatric medications.

the prescriber. The informed prescriber will need and want feedback and guidance from key professionals who work more closely with the patient.

Wholehearted collaboration is needed among prescribers, therapists and other clinicians, patients, and their families. Especially when a decision has been made to attempt medication reduction and withdrawal, the team needs to work together to make sure that the patient's needs and desires are being met as safely and effectively as possible.

## THE PERSON-CENTERED COLLABORATIVE APPROACH

Recently, a graduate student in my class on Empathic Therapy and Counseling expressed her personal concerns to the group of fellow students. She felt that she no longer needed her psychiatric medications and worried that they were flattening her emotions and impairing her memory. She then explained in heartfelt tones, "I've been taking benzodiazepines and antidepressants for 10 years—since I was 14 years old. I've grown up on these drugs. I am terrified—terrified!—of ever trying to withdraw from them."

I responded to her, "Many people share your fears. In working with your prescriber, the key for you is to feel in charge of the withdrawal. You must feel empowered to control the rate of drug withdrawal and especially to go as slowly as you need. Then, if you feel you're going too fast, you and your prescriber can stop the withdrawal or even pull back to your previous dose. If the process feels under your control, you won't be so terrified, and your chances of success will be greatly increased."

My attitude—more than my words—will communicate to my students or patients whether or not I am genuinely interested in and truly care about them and their viewpoints. Person-centered drug withdrawal calls on the clinician to express many human qualities, including empathy, honest communication about the dangers of staying on psychiatric drugs and the dangers of withdrawing from them, and a respectful relationship that empowers the patient to make decisions and to manage his or her own life.

Empathic relationship lies at the core of person-centered medication withdrawal, which includes (a) empathy with genuine caring and understanding, (b) honest communication about medication issues, and (c) an empowering respect for the patient's viewpoint, wishes, and needs.

## EXPLORING THE PATIENT'S FEELINGS

When a patient explores or considers the possibility of psychiatric drug withdrawal, the prescriber should explore the patient's fears and anxieties about the withdrawal process. As much as patients may desire to stop

taking psychiatric medications or to reduce the doses, they almost always feel apprehensive about the process. They may fear that they cannot live without the medication—a subject that will be addressed in a separate chapter. Even more commonly they will have fears about withdrawal reactions.

Many individuals have experienced severe withdrawal reactions after temporarily running out of medication or after abruptly trying to stop the medications on their own. Too often, a prescriber has reacted to a request for medication withdrawal by precipitously stopping one or more psychiatric drugs, resulting in a severe withdrawal reaction. Most attempts to reduce or stop medication are initiated by the patient or even the patient's family, and far fewer are initiated by the prescriber. It is hoped that this book will help prescribers and therapists place greater importance on reducing or stopping medications while also providing a safer and more effective person-centered approach to the process.

Fear and anxiety not only prevent many people from asking to be reduced in dose or withdrawn from psychiatric drugs, fear and anxiety also are a major cause of failure during the withdrawal process. These fears should be explored and taken seriously. They must be addressed before making a shared decision to start psychiatric drug withdrawal, and they must be addressed throughout the process.

Terry Lynch, MD, is an experienced psychotherapist in Limerick, Ireland, who often helps individuals to withdraw from psychiatric medication. He observes that "realism" is required in approaching psychiatric drug withdrawal:

> There are times when I am not prepared to enter into a drug reducing process if I feel the person's expectations remain unrealistic despite having been advised of the realities, or if the person is not prepared or ready to embark on this process. This doesn't happen very often, but it does happen. (T. Lynch, personal communication, 2012)

In my experience, lack of a supportive family or social network is the most difficult impediment to proceeding with an especially difficult psychiatric withdrawal. Another is lack of self-determination on the patient's part.

Therapists are increasingly taking responsibility for empowering their patients to take greater control over their psychiatric medication. Sarton Weinraub, PhD, psychologist, and director of a mental health clinic in New York City, finds that subservience to healthcare providers often stymies the individual's desires to reduce or withdraw from psychiatric medication. In what Dr. Weinraub calls "medical disempowerment," he finds that "individuals prescribed psychiatric medication often have not been given

an unbiased assessment of the side effects or the benefits of other options, which can lead to medical disempowerment" (personal communication, 2012). He explains, "Often, medical disempower involves a self-destructive belief in the necessity of involving an authoritarian medical expert in order to recover." Dr. Weinraub has demonstrated that patients can be encouraged and educated to take charge of their own medical treatment and that many prescribers will respond positively when they know the patient has the dedicated support of an informed therapist.

To allay fear and anxiety and to respect their self-determination, individuals withdrawing from psychiatric medications should feel in charge of the decision to withdraw and in charge of the pace of the taper. When needed, this encouragement can come from a therapist, as well as from a prescriber.

Respect for the patient's decision to pursue, or not to pursue, psychiatric drug withdrawal is key to initiating and continuing the process. Monitoring the individual's feelings and emphasizing his or her control over the rate of withdrawal lies at the heart of the person-centered approach to psychiatric drug withdrawal.

The person-centered approach requires the prescriber and/or the therapist to be willing and even eager to remain aware of the patient's needs, to be readily available at all times, and to pay close attention to what the patient or client feels during the withdrawal process.

In emergencies, the prescriber may have to convince the patient that a more rapid withdrawal must be undertaken. Sometimes this will require 24-hour observation by family or friends, or hospitalization. However, even in emergencies, the prescriber and therapist must take the time to enlist the individual's cooperation and to maintain trust.

There will be exceptions to a "go slow" policy when, for example, a psychiatric drug is causing severe or life-threatening adverse effects. However, even in emergencies, the prescriber or the therapist must work closely to enlist the patient's cooperation and to offer emotional support, guidance, and relevant information during a rapid and potentially uncomfortable withdrawal. In some cases, hospitalization will be needed to conduct a very rapid withdrawal.

This very brief introduction to therapeutic aspects of the drug withdrawal process will be elaborated in Part II, Chapters 10–18, of this book. The following Chapters 2–9 examine many of the medical reasons why prescribers, clinicians, patients, and their families need to be alert for adverse drug reactions that require drug reduction or withdrawal.

## AN APPROACH TO HELPING PATIENTS IN NEED OF ADDITIONAL SUPPORT OR GUIDANCE

The person-centered collaborative approach was developed to help individuals who need more guidance, monitoring, or emotional support than most patients in an outpatient practice. Although applied in this book to people undergoing potentially difficult withdrawal from psychiatric drugs, it is also the best approach to helping children, dependent adults, and adults who are emotionally or cognitively impaired, and older adults. Whenever the individual can benefit from more guidance, supervision, or help than available in one-to-one autonomous psychotherapy, the person-centered collaborative approach is ideal.

## KEY POINTS

- Empathy, honest communication, and patient empowerment lie at the heart of the person-centered approach.
- Patient fear and anxiety are a major cause of failure during psychiatric drug withdrawal.
- The individual must feel in charge of the decision to begin the withdrawal and then to continue the process.
- The individual must feel in control of the rate or timing of withdrawal. Unless faced with a very serious adverse reaction, such as tardive dyskinesia or mania, the pace of the withdrawal should stay within the patient's comfort zone. If a faster taper is needed and encouraged, it should be done in a person centered and collaborative manner.
- When prescribers are too busy or otherwise unable to provide sufficient monitoring, psychotherapy, or counseling during the withdrawal process, the prescriber should work closely with an informed therapist or counselor. Therapists and other clinicians should take the opportunity to reach out to prescribers to help them in monitoring and in understanding the patient's needs and desires.
- Even small dose reductions (less than 10%) can sometimes cause serious withdrawal reactions.
- It is important to provide detailed information to the patient about the withdrawal process and then to conduct the process in a collaborative manner that emphasizes the patient's decision making and control over the process. This can help to reverse "medical disempowerment."
- Because individuals undergoing psychiatric drug withdrawal need emotional support and are often unable to recognize when they are experiencing a withdrawal reaction, such as suicidal or violent impulses, a support network of friends and family can be very helpful, and sometimes lifesaving, in the collaborative process. It is preferable, and sometimes necessary, for the patient to permit collaborating

friends or family to contact the prescriber or therapist if they grow concerned. In difficult cases, someone close to the patient should be directly involved in the withdrawal process with office visits and phone contacts.

- In the person-centered approach, the patient's response to each step of drug reduction will determine the rate of reduction. Therefore, it is not possible to predetermine how long a medication taper and withdrawal will take.
- At all times, the prescriber and the therapist must offer hope and encouragement. Few things are more important in successful withdrawals than the positive attitudes of the healthcare providers.
- The person-centered collaborative approach is not exclusively for psychiatric drug withdrawal. It is the best approach whenever the individual needs extra support, monitoring, or guidance, including children, dependent adults, adults who are emotionally and cognitively impaired, and older adults.