



Registered Charity No. 519334

# **COUNCIL FOR INFORMATION ON TRANQUILLISERS, ANTIDEPRESSANTS AND PAINKILLERS**

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## **SSRI WITHDRAWAL PROTOCOL**

### **About these protocols**

Selective serotonin and allied antidepressants can be very effective for moderate to severe depression, however many people do have difficulties in coming off these medications.

With the help of Professor David Healy of Cardiff University School of Medicine, Wales, CITAp has devised protocols for reduction and withdrawal from these drugs.

These protocols may be helpful for withdrawing from: -

Prozac - Fluoxetine  
Seroxat - Paroxetine  
Cipramil - Citalopram  
Lustral - Sertraline  
Efexor - Venlafaxine  
Cymbalta - Duloxetine

If it is mutually agreed that reduction is appropriate, all these drugs may be reduced in several different ways.

### **Standard reduction programme**

It is vital that any reduction process is slow and gradual, probably more gradual than most people would anticipate. Start by reducing only a small part of the dose on one day of the week. For instance from a dose of 20mg, a reduction to a 10mg dose would take place for example on a Monday in each of the first two weeks of the programme, with the usual 20mg being taken through the rest of the two weeks. The following two weeks the reduced dose of 10mg would be taken on two (non-consecutive) days, and the next two weeks on three days and so on, until the 10mg dose is being taken on every day of the week. The next reduction step from 10mg to 5mg then commences and continues in the same way down to seven days at 5mg, and then the final stage goes from 5mg down to zero. If at any point the reduction becomes too painful, rather than increasing the dose again, it is permissible to remain at the current level for several weeks before reducing further.

## Reduction using liquid preparations

Despite the very slow reduction achieved by the above method it can still be difficult for some people to carry out, and especially so with some SSRIs, notably paroxetine (Seroxat). In these cases a liquid preparation can be far more helpful, where one is pharmaceutically available. When a liquid preparation is being taken the same method should be employed as outlined above, in this case reducing 1ml (2mg) on one day of the week then on two days and so on. This clearly means the amount of drug reduced at any one time is much smaller and this may work better for many people. Similar liquid versions are available for most drugs but they are expensive and often need to be ordered specially for individual patients, which may delay their starting their programme. If starting from a high dose of paroxetine, a mixture of tablets and liquid may need to be used at the start.

## Transferring to longer-acting preparations

It has been found that transferring over from their original antidepressant to fluoxetine (Prozac) or citalopram (Effexor) can be very helpful for some people, as the longer acting nature of these drugs makes them easier medications from which to withdraw. There is no need for a gap between the original medication and new one, as these antidepressants can be directly switched to the equivalent level. Although the first few days may be uncomfortable, it is worth persevering as in our experience this is the most effective mode of withdrawing. Fluoxetine and citalopram are best taken early in the day, night time use can reduce sleeping quality and quantity. Sometimes patients experience more feelings of anxiety in the few days after transfer, because the previous antidepressant has been stopped and fluoxetine has not yet started working. But these symptoms of anxiety should settle down and a feeling of well-being established.

Transfer can take place either at the start of the reduction programme, or there can be some reduction time on the original drug before then transferring to the equivalent dose of fluoxetine or citalopram, if and when further reduction on the original drug becomes too difficult or painful. Whenever transfer does take place, a period of four weeks of stabilisation is essential before starting to reduce the fluoxetine. These four weeks can be done with tablets but after this time it is preferable to switch to liquid. It is important to have this period of stabilisation on the new antidepressant in order to begin a smooth reduction process thereafter. Those switching from liquid paroxetine should preferably transfer directly to liquid fluoxetine.

Suitable drug levels at which to transfer over are: -

Paroxetine (Seroxat)	@ 20mgs switch to fluoxetine (Prozac)
Sertraline (Lustral)	@ 50mgs switch to citalopram (Cipramil, <i>but not</i> Cipralelex)
Venlafaxine (Effexor)	@ 75mgs switch to citalopram (Cipramil, <i>but not</i> Cipralelex)

The reduction process with liquid fluoxetine is very similar to that suggested above for tablet reduction. Fluoxetine liquid is marketed at a strength of 20mg per 5ml, and using our above protocol, reduction should proceed by reducing in steps of 1ml (= 4mg) on a one day, two day, three days per week programme as described above.

For those who are too anxious to tolerate the agitation that is occasionally caused by switching from paroxetine to fluoxetine, citalopram (Cipramil - **but not** Cipralelex) can also be used for transfer, and may be a viable alternative antidepressant to use for slow withdrawal. Citalopram is a medium length acting SSRI and although not as easy to use as liquid fluoxetine, does come in tablet sizes down to 10mg allowing for small reduction steps. Whichever antidepressant is being used for reducing on or transferring to, some withdrawal effects are inevitable. These can include anxiety, insomnia, dizziness, electric shock sensations, skin and muscle sensations and cramps and other symptoms, but with suitably slow reduction and pauses when withdrawal symptoms become too severe, these symptoms can usually be bearable and managed.

The formulation of some antidepressants such as Cipralex and Venlafaxine XL makes them difficult to reduce slowly, and advice should be sought from CITAp about reducing these. A set of week by week tables for coming off various antidepressants is available on request from the CITAp office or can be downloaded from the CITAp website.

### **Transferring to St. John's Wort**

It is possible to switch to St. John's Wort towards the end of an antidepressant withdrawal programme, as despite this being an over-the-counter herbal product it is still a highly effective SSRI antidepressant. St. John's Wort is a very safe herbal remedy for depression but can occasionally have side effects such as eye irritation or skin reactions. These are not dangerous and will disappear once you stop taking the tablets, but it does mean that St. John's Wort is not for you.

**St. John's Wort must not be taken whilst still taking another prescription antidepressant as this can be dangerous. The prescription antidepressant must be stopped first and then the St. John's Wort commenced.**

St. John's Wort also interacts with some other prescribed medications which you may be already on including the contraceptive pill, and it is very important that you always discuss your other medication with the pharmacist before starting to take St. John's Wort. If you can take it, St. John's Wort is a very effective way to finish off withdrawal but the changeover from your previous antidepressant may be accompanied by some symptoms of anxiety. These will settle down quite quickly and you will then be able to taper off your final stages of withdrawal in your own time.

St. John's Wort may also be helpful for those who have stopped an SSRI suddenly and are experiencing severe withdrawal symptoms as a result. It may therefore be a way of redeeming the situation and reducing some of these withdrawal symptoms. The dosage of St. John's Wort should be 1000mgs. There may be some symptoms of anxiety, which again will not last and are worth putting up with for a short time, and most people feel better once they settle on the St. John's Wort. It may be necessary to increase the dose of St. John's Wort to 2000mg after three to four weeks as this higher dose seems to be more effective, and is quite safe.

Another over-the-counter preparation that is sometimes used as part of an antidepressant withdrawal programme is 5-HTP (5-hydroxytryptophan). This is a precursor compound which once ingested is converted in the body to serotonin (when taken during the day) and to melatonin, the sleep hormone (when taken at night time). It can be used like St. John's Wort after coming off the last of an SSRI antidepressant, and is useful also as a sleeping aid. You may take up to 3 x 50mg tablets per day but it is wise to start with 50mgs and gradually increase, whilst a 50mg dose of 5HTP taken at bedtime may aid sleep as the serotonin converts to melatonin in the presence of darkness.

**5-HTP must never be taken simultaneously with an antidepressant nor at the same time as taking St. John's Wort, as this can be dangerous.**

## **Depression after SSRI Withdrawal**

Whichever approach is used to reduce and come off an SSRI antidepressant it is likely that some withdrawal symptoms will occur. These will often resemble the original depressive episode which brought about the decision to commence antidepressants, perhaps many years ago. These are not reasons to immediately resume the medication. Rather it is an indication that further time is necessary for the brain and body to get back to normal after the effects of the antidepressant, as it can take several months before SSRI withdrawal symptoms finally disappear. At this stage however it might be appropriate to consider initiating counselling or CBT sessions in the event that the original situation causing the depression was never addressed and resolved.

## **Dealing with Hypoglycaemia**

Whilst taking SSRI antidepressants, and especially when on reduction programmes, the body often has problems in maintaining blood sugar (glucose) levels, and precautions need to be taken to avoid periods of hypoglycaemia when blood glucose falls too abruptly and too low. Many withdrawal symptoms, especially dizziness, weakness and fainting are the result of hypoglycaemia, which most commonly occurs overnight and is frequently apparent on waking in the morning. To avoid such episodes it is preferable to eat frequent small meals through the day and early evening rather than large meals followed by long gaps. Increasing the proportion of pasta, rice, fruit and vegetables in the diet and reducing the intake of refined sugars in sweets and cakes, will also help to stabilise blood glucose, whilst having a half a banana at bedtime with the other half kept for when waking, will further avoid hypoglycaemic episodes during the night and early morning.

## **Life after SSRI Withdrawal**

Anxiety and insomnia are two of the longest lasting of the SSRI withdrawal symptoms to resolve, and the distress that these can cause can undermine the sense of achievement that should come from breaking free of antidepressant dependency. Where a benzodiazepine tranquilliser or hypnotic is being taken alongside the SSRI no attempt must be made to reduce this simultaneously with the SSRI. Rather this should be maintained at its current dose during SSRI reduction as it will help to minimise anxiety or insomnia arising from the antidepressant reduction. Only when the antidepressant withdrawal programme has been completed and full recovery from this been achieved should a start be made on reducing any benzodiazepine or z-drug sleeping tablet. Help and guidance about dealing with anxiety and insomnia is also available from CITAp and its National Helpline, including advice on herbal and other natural remedies, breathing techniques to manage hyperventilation and panic attacks, and the use of therapies such as acupuncture, relaxation, counselling, CBT and Mindfulness.