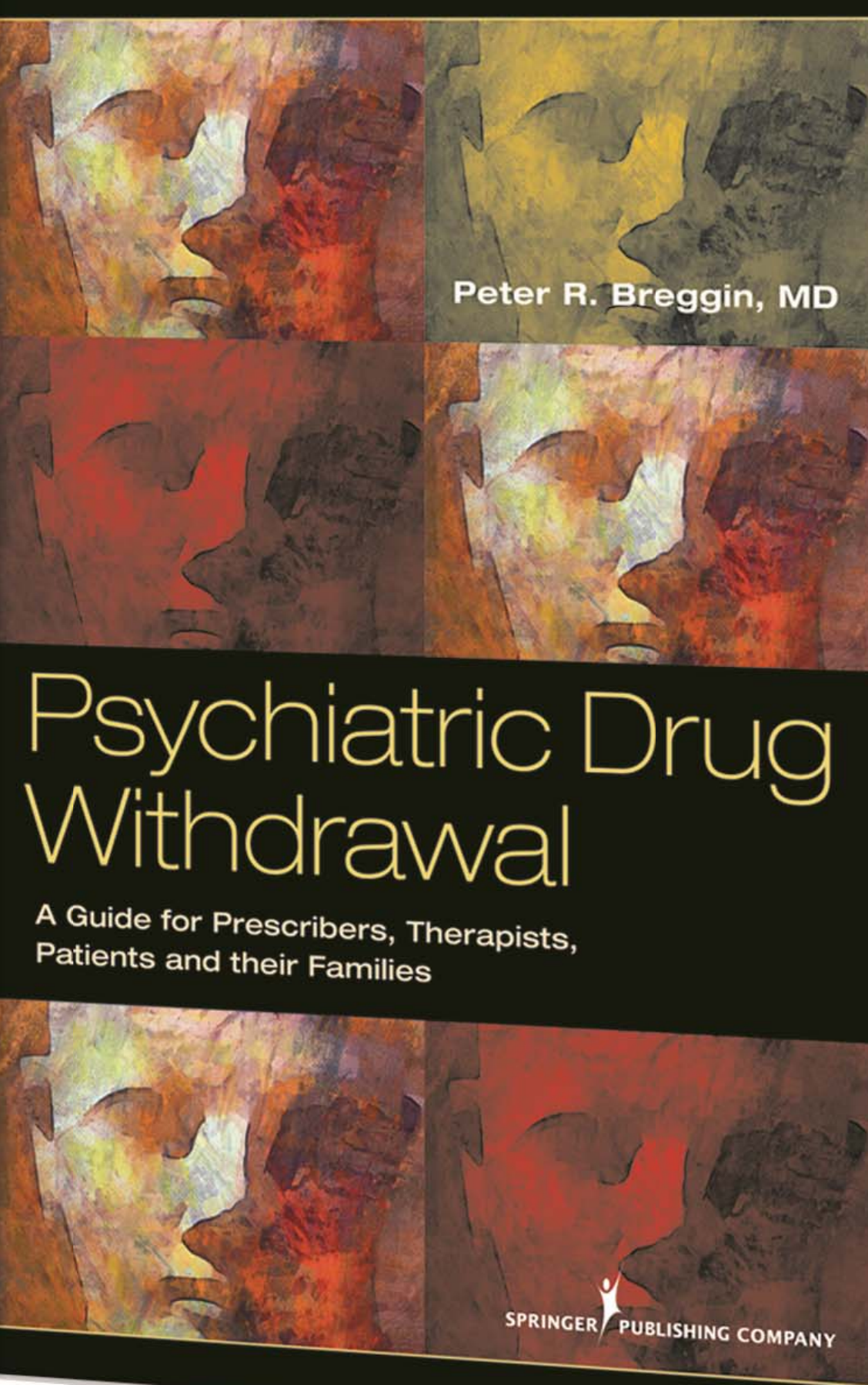
Peter R. Breggin, MD
Psychiatric Drug Withdrawal
A Guide for Prescribers, Therapists, Patients and their Families
SPRINGER PUBLISHING COMPANY

Psychiatric Drug Withdrawal

Peter R. Breggin, MD conducts a private practice of psychiatry in Ithaca, New York, where he treats adults, couples, and families with children. He also offers consultations in the field of clinical psychopharmacology and often acts as a medical expert in criminal, malpractice, and product liability suits. His professional website is www.breggin.com.

A lifelong reformer in the field of mental health, Dr. Breggin has been called "The Conscience of Psychiatry." He and his wife Ginger recently founded the Center for the Study of Empathic Therapy (a nonprofit organization; 501c3), which holds an annual conference of leading figures in the field who critique biological psychiatry and offer empathic psychosocial approaches (http://www.EmpathicTherapy.org).

Dr. Breggin's weekly talk radio show, "The Dr. Peter Breggin Hour," is live and archived on the Progressive Radio Network. He blogs on the Huffington Post. Also follow Dr. Breggin on his public Facebook page and follow him and his wife Ginger on Twitter: @GingerBreggin.

Dr. Breggin is the author of more than 40 peer-reviewed scientific articles and more than 20 mass market and professional books. His two most recent books are *Brain-Disabling Treatments in Psychiatry: Drugs, Electroshock, and the Psychopharmaceutical Complex* (2008) and *Medication Madness: The Role of Psychiatric Drugs in Cases of Violence, Suicide, and Crime* (2008).

Earlier books include *Toxic Psychiatry* (1991), *Talking Back to Prozac* (1994, with Ginger Breggin), *Talking Back to Ritalin* (revised, 2001), the *Antidepressant Fact Book* (2001), and the *Ritalin Fact Book* (2002). *The Heart of Being Helpful* (1997) deals with how to help people through psychotherapy and other human services and *Reclaiming Our Children* (2000) examines the Columbine High School shooting tragedy and addresses the needs of America's school children.

Dr. Breggin's background includes Harvard College, Case Western Reserve Medical School, a 1-year internship and a 3-year residency in psychiatry, including a teaching fellowship at Harvard Medical School. After his training, he accepted a 2-year staff appointment as a full-time consultant at the National Institute of Mental Health (NIMH). He has taught at several universities, including the Johns Hopkins University, Department of Counseling and most recently, State University of New York (SUNY) Oswego in the Department of Counseling and Psychological Services.

He founded a scientific journal, *Ethical Human Psychology and Psychiatry* and is on the board of others, including the *International Journal of Risk and Safety in Medicine*.

He has testified before Congress, addressed numerous federal agencies, acted as a consultant to the Federal Aviation Agency (FAA), and given hundreds of seminars and conferences for professionals. His views have been covered in nearly all of the major media from *Time*, *Newsweek*, *Wall Street Journal*, and *New York Times* to *Oprah*, *20/20*, *Nightline*, *60 Minutes*, and dozens of network and cable news shows.

Dr. Breggin's reform work has brought about significant changes within the profession. In the early 1970s, he conducted a several-year-long successful international campaign to stop the resurgence of lobotomy and newer forms of psychosurgery. His reform efforts and his testimony in the Kaimowitz case in Detroit led to the termination of lobotomy and psychosurgery in the nation's state mental hospitals, National Institutes of Health (NIH), the Veterans Affairs (VA), and most university centers. A public education campaign surrounding his 1983 medical book, *Psychiatric Drugs: Hazards to the Brain*, led the Food and Drug Administration (FDA) to require a new class warning for tardive dyskinesia in 1985. In the 1990s, he was the single scientific expert for more than 100 combined Prozac suits against Eli Lilly and Company. In 1994, his public education campaign led the NIH to reform some of its research policies and to end the Violence Prevention Initiative, a potentially racist program aimed at studying the genetics and biology of inner-city children. His work initiated the reform that led to the FDA's recognition of numerous adverse reactions caused by the newer antidepressants. The FDA warnings in 2004 about suicidality in children and young adults and about a dangerous stimulant profile involving agitation, akathisia, hostility, aggression, and mania, closely followed the language of observations made and publicized by Dr. Breggin over the prior 10 years.

Psychiatric Drug Withdrawal

A Guide for Prescribers, Therapists, Patients, and Their Families

Peter R. Breggin, MD

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For my wife Ginger Breggin,
a partner beyond all expectations and imaginings

Contents

Foreword

I was honored when asked to write the foreword for Dr. Peter Breggin's new book *Psychiatric Drug Withdrawal: A Guide for Prescribers, Therapists, Patients, and Their Families*. Dr. Breggin was an early hero of mine when I read his 1994 book *Toxic Psychiatry* about the significant physiological and emotional dangers of prescribing psychiatric medications and the ethical issues associated with the psycho-pharmaceutical complex particularly for vulnerable populations such as children, women, and the homeless. Breggin's work had a profound impact on my practice and teaching when I began my part-time private practice as a psychoanalyst and prescriber, and a full-time educator and director of a graduate program to prepare advanced practice psychiatric nurses. *Toxic Psychiatry* became required reading for my psychiatric nurse practitioner students.

Since then, Breggin has introduced several new terms into the current lexicon, including medication spellbinding (*intoxication anosognosia*). This term refers to the belief by people taking psychiatric drugs that these neurotoxic substances are actually making them better, when in fact, the false euphoria and artificial sense of relief from anxiety or dysphoria are an iatrogenic medication induced disability. The chronic brain impairment that results from long-term use of psychiatric medication is cited as the most important cause of the current escalating epidemic of psychiatric disability. Intoxication anosognosia literally means the person does not recognize medication intoxication in oneself and may even feel better temporarily. The medications essentially produce a chemical lobotomy and the person does not have true access to his or her feelings and hence does not know what he or she does not know.

Psychiatric Drug Withdrawal provides the answer to *Toxic Psychiatry*. Breggin not only presents compelling evidence about the dangers of long-term use of psychiatric medication, he also provides a solution by outlining a compassionate, detailed plan for helping the patient withdraw from these toxic substances. Breggin's book is a breath of fresh air in the dominant biological paradigm of psychiatry. Monetary incentives from pharmaceutical companies in tandem with

managed care practice guidelines have conspired to value psychiatric medication as *the* solution to mental health problems. Pharmacology textbooks focus on the pharmacokinetics and pharmacodynamics with few suggestions offered about how to stop medication, except to titrate and/or to switch to a new psychiatric medication to accomplish discontinuation. There are few if any resources or protocols that guide the prescriber in withdrawing the patient sanely and safely from psychiatric medication.

Breggin's person-centered collaborative approach is holistic and context-driven in contrast to the current biomedical reductionistic symptom-oriented approach that is based on a descriptive approach of specialized knowledge that treats individuals as members of a diagnostic group. Diagnostic groups tell us little about the person sitting in front of us. Those practicing in the biomedical model might diagnose the person who seeks help as "a 22-year-old male with schizophrenia" while those practicing from a holistic approach would know the same person as "a young man who isolates from his peers, lives with his parents, and is terrorized by voices that call him names." The latter respects the uniqueness and complexity of the person while the former tells us nothing about that individual.

Prescribers who wish to practice holistically and are eager to learn about the patient are often thwarted by the realities of current clinical settings. There is little time to develop a therapeutic relationship, to listen to the person's story as the process unfolds, and to understand the context of the person's life with patients scheduled every 15 minutes. The prescriber is marginalized to the role of manipulator (of neurochemicals at receptor sites) while the therapist, if involved at all, is relegated to the role of enforcer (to ensure patient compliance). This approach leaves both the prescriber and the therapist frustrated and often overrides clinical judgment and common sense. Breggin's new book reaffirms the primacy of relationship and presents an empathic relationship-oriented, person-centered framework for treatment that involves collaboration between the prescriber, the therapist, the patient, and the family or significant other.

Perhaps Breggin's approach heralds a shift toward a new hopeful paradigm for mental health care as it aligns with recent research on the brain. Neuroimaging studies dissolve the dichotomy that psychotherapy is the treatment for psychological–based disorders while medication is prescribed for biological-based disorders. Both psychotherapy and medication have been found to change the function and structure of the brain. These outcome studies in tandem with epigenetic research on the crucial role of experience in determining genetic expression challenge simplistic reductionistic thinking as compelling evidence is presented that it is our subjective experience that affects the brain.

Peter Breggin's *Psychiatric Drug Withdrawal: A Guide for Prescribers, Therapists, Patients, and Their Families* is a timely and extremely important addition to the literature in psychopharmacology. This book is much needed and should be read by all psychiatrists, psychologists, nurses, therapists, patients, and their loved ones. In contrast to the current treatment model where the therapist plays little or no role in medication management, the therapist's role is central to the successful withdrawal of the patient from psychiatric medication. Indeed, a collaborative, relationship-centered approach is key, where power is shifted from what the prescriber wants to honoring the patient's wishes. This is a must read for every prescriber and will change the way you practice forever.

Kathleen Wheeler, PhD, APRN, FAAN
Professor
Fairfield University
School of Nursing
Fairfield, Connecticut

Preface

Psychiatric medications are not only dangerous to take on a regular basis, but they also become especially dangerous during changes in dosage, including dose reduction and withdrawal. *Psychiatric Drug Withdrawal: A Guide for Prescribers, Therapists, Patients, and Their Families* is intended to provide the latest up-to-date clinical and research information regarding when and how to reduce or to withdraw from psychiatric medication.

This book describes a *person-centered collaborative approach* and is intended as a guide for the entire collaborative team. The team includes *prescribers* (psychiatrists and other physicians, physician's assistants, and nurse practitioners) and *therapists* (social workers, psychologists, counselors, marriage and family therapists, occupational and recreational therapists, nonprescribing nurses, and others). It also includes the *patient* and the patient's *family* or significant others.

Although this book focuses on medication reduction and withdrawal, the person-centered collaborative approach is also a model for helping children, dependent adults, adults who are emotionally or cognitively impaired, and the elderly, as well as those going through psychiatric medication withdrawal. It's the soundest approach whenever the individual needs more guidance and help than what is available in one-to-one autonomous psychotherapy.

The guide begins with reviews of adverse drug effects that may require drug reduction or withdrawal. It then discusses withdrawal effects for specific drugs to familiarize clinicians, patients, and families with these problems. However, no book can substitute for informed professional guidance during the withdrawal process. It cannot address the nuances of an individual case or cover all the possible hazards of taking or withdrawing from psychiatric drugs. Health professionals, patients, and their families are urged to inform themselves

from as many sources as possible, and patients are encouraged to seek the best possible professional guidance in deciding whether or not to withdraw from psychiatric medication and how to go about it.

Because it presents a person-centered collaborative approach that involves patients and their families, the information needs to be user friendly to nonprofessionals. Therefore, generic names will sometimes be interchanged with or accompanied by familiar trade names.

I have written this book for the spectrum of prescribers, including those who have a much more favorable view of psychiatric medications than I do. Therefore, at times I make recommendations for dose reduction or the use of minimal medication when in my own practice I would not be using medication at all. I continue to believe and to practice on the principle that psychiatric medications do more harm than good, and in my own practice, I rely upon individual, couples, and family therapy without starting patients on psychiatric drugs (see Breggin, 2008a and 2008b).

Acknowledgments

My wife Ginger Breggin played a central role in my motivation to write this book. She perceived a great need for it through thousands of communications to us, many through our websites and social media. Ginger also drew my attention to and obtained many of the most recent research studies relevant to the book.

In 2010 Ginger and I formed a new 501c3 nonprofit organization, the Center for the Study of Empathic Therapy, and in 2011 we held our first annual conference (www.EmpathicTherapy.org). Her work in making all this happen, and our feedback from Center participants and conference attendees, made us especially aware of the need for a book on psychiatric drug withdrawal aimed not only at prescribers but also therapists, patients, and their families.

One of Ginger's most recent projects was the development of www.ToxicPsychiatry.org as a current news and resource library for cutting-edge issues in the field of mental health. The reader can find many of the articles in this book in the archives of the website.

Our office assistant Melissa McDermott has added immeasurably to our lives, including freeing Ginger up to handle so many areas of our professional work together. I also want to thank Ella Keech for making our lives easier around the office. Both bring spiritual sunshine into the office.

My research assistant Ian Goddard continues to provide original insights along with his careful searches of the scientific literature. He makes my books better.

I published my first book with Springer in 1979—more than three decades ago.

I've now worked on several books with Sheri Sussman, Executive Editor, Springer Publishing Company. She is simply the best! I want to thank her and the entire team at Springer.

A number of friends and colleagues were kind enough to review the manuscript in whole or in part in order to comment or to offer a

prepublication endorsement. It is quite extraordinary that they took time out of their busy personal and professional lives in order to do this. They include Bertram Karon, PhD, Sarton Weinraub, PhD, Frederick Baughman, Jr., MD, Douglas C. Smith, MD, Stuart Shipko, MD, Charles L. Whitfield MD, Piet Westdijk, MD, Terry Lynch, MD, Fred Ernst, PhD, Wendy West Pidkaminy, LCSW-R, Tony Stanton, MD, Melanie Sears, RN, MBA, Gerald Porter, PhD, Kathryn Douthit, PhD, LMHC, Robert Foltz, PsyD, Joanne Cacciatore, PhD, LMSW, FT, Douglas W. Bower, RN, LPC, PhD, Todd DuBose, PhD, and Timothy Evans, PhD. The first eight—Bert, Sarton, Fred, Doug, Stuart, Charles, Piet, and Terry—also gave me helpful feedback on specific aspects of concern that I asked them about.

Thank you, all!

Introduction: Hazards of Psychiatric Drug Withdrawal

Why are psychiatric drug withdrawal problems so common and often so difficult to overcome? Because the brain adapts to all psychoactive substances, the abrupt withdrawal from any psychiatric drug can produce distressing and dangerous withdrawal reactions. Even medications commonly thought to be free of withdrawal problems, such as lithium, can produce potentially dangerous reactions when they are stopped.

By means of a variety of biochemical reactions, the brain attempts to overcome the primary effects of any psychoactive substance. For example, many antidepressant drugs have been tailored in the laboratory to suppress the removal of the neurotransmitter serotonin from the synapse in the brain. This impact was expected to increase the amount of serotonin in the synapse and perhaps in the overall brain. But the brain quickly compensates through several biochemical mechanisms that can dampen and even reverse this intended drug effect (Breggin 2008a). Similarly, many antianxiety drugs enhance the activity of the neurotransmitter gamma-aminobutyric acid (GABA), but once again, the brain reacts by suppressing or even reversing the drug effect.

When these antidepressants or antianxiety drugs are stopped, the brain can be slow to recover from its own biochemical adjustments or compensatory effects. In effect, the brain cannot immediately keep up with the removal of the drug. This can produce distressing and dangerous withdrawal effects.

When a patient has been taking a psychiatric medication for several months or more—or even for a mere few weeks in the case of benzodiazepines—the brain becomes especially slow to react to the withdrawal of the drug, causing potentially more long-lasting, hazardous, and even life-threatening adverse reactions.

Psychiatric drugs also cause directly damaging effects. As several chapters of this book will document, all psychiatric drugs that have been examined have proven to be toxic to neurons or severely disruptive of normal brain function. These harmful effects may be partially masked by the blunting of emotions and judgment and medication spellbinding (see Chapter 9) that is associated with all psychiatric drugs. When the drug dose is reduced or the drug is stopped, the individual becomes more aware of the deficits, and others may notice them as well. At times, it may be difficult to distinguish withdrawal effects from direct toxic effects, even after the medication has been stopped for many months. It becomes difficult to determine if the individual is experiencing a lasting withdrawal effect because of the brain's own compensatory mechanisms or a more direct toxic effect.

UNIQUE PROBLEMS ASSOCIATED WITH DRUG WITHDRAWAL

Withdrawal from psychiatric drugs commonly causes emotionally jarring biochemical changes in the brain. The physical disruption of mental processes during withdrawal can severely impair the patient's judgment and self-control. In the extreme, severe depression, mania, psychosis, violence, and suicidality can occur during drug withdrawal. The withdrawal process can also elicit many psychological fears about managing life with fewer drugs, lower doses of drugs, or no drugs at all. In addition, concerned or fearful friends and relatives may complicate the drug withdrawal process by directly interfering or by the contagion of their anxiety and other negative emotions. Although the person-centered collaborative approach emphasizes the positive involvement of families in helping the patient withdraw, families can also generate many painful emotions and fears that can stymie the patient's withdrawal attempts.

In addition, psychiatric drugs commonly cause chronic brain impairment (CBI) with cognitive dysfunction, emotional instability, apathy or indifference, and anosognosia (the inability to recognize these dysfunctions). As the medication is reduced, and the brain and mind are no longer so impaired, individuals become more aware of their mental deficits, superimposing additional anxiety and despair on the withdrawal process.

These, and other factors that will be discussed, produce a more complex situation than routine medication treatment. In routine treatment, when the brain is exposed to the same dose of a psychoactive substance on a daily basis for a considerable period, the individual tends to stabilize—that is, to settle into a steadier biochemical and emotional state. The prescriber and the client can be lulled into a sense of safety regarding taking the medication. But if doses are skipped or changed, the brain may be unable to adjust in sufficient time to prevent a withdrawal reaction. Drug withdrawal is therefore more complex and more acutely dangerous than the routine prescription and use of psychiatric drugs. More care, more

attention, and more specialized knowledge are required than during the routine administration of the same drug.

These cautionary observations are not intended to discourage withdrawal from psychiatric drugs. The long-term effects of psychiatric drugs on the brain and mind present the most serious hazards of all.

THE RELUCTANCE TO WITHDRAW PATIENTS FROM PSYCHIATRIC DRUGS

Because it is complicated, time consuming, risky, or contrary to their philosophy or training—many healthcare providers do not feel comfortable withdrawing their clients or patients from psychiatric drugs. Very few have the experience to feel confident in how to go about withdrawing from psychoactive medications. As a result, many potential patients have difficulty finding professional supervision and support when they wish or need to reduce the dose or number of their psychiatric medications or to stop them entirely. These individuals may feel compelled to stop their medications on their own without professional help, sometimes with tragic results. Others continue to use their medications despite increasing adverse effects, often with equally or more tragic results.

Because withdrawal from psychiatric drugs can be so difficult, the safest and more effective approach requires a team effort—a person-centered collaborative approach that includes the prescriber, therapist, patient, and the patient's family or support network. This person-centered approach focuses on the client's mental status, needs, feelings, and wishes during the withdrawal process. This person-centered approach is consistent with the practice of contemporary medicine and also provides the safest and most effective approach.

Most prescribers are usually limited in the amount of time they can spend with each patient. These prescribers can provide better services if they work with a therapist who sees the patient more often and can develop more understanding and rapport with the patient and family. Because psychiatric drug withdrawal is so potentially hazardous, the patient's family or social network also needs to be involved to support and to help monitor the patient. The therapist rather than the prescriber will usually be in the best position to coordinate the prescriber, the patient, and the patient's family or friends.

Because it uses a person-centered collaborative approach, *Psychiatric Drug Withdrawal* can and should be read by the entire team. This includes **prescribers**, such as nurse practitioners, primary care physicians, pediatricians, internists, physicians' assistants, and psychiatrists. It includes **therapists**, such as nonprescribing nurses, clinical social workers, clinical psychologists, counselors, marriage and family therapists, and occupational and recreational therapists. And finally, it includes **patients** and

their social network of **family** and **friends**. All these potential members of the collaborative treatment team effort should find this book useful regarding understanding and assessing medication effects, observing and reporting adverse effects during treatment or withdrawal, informing or reminding patients and their families about the risks associated with these drugs and the benefits of withdrawing from them, and providing guidance and support during difficult medication withdrawals.

The Center for the Study of Empathic Therapy

The Center for the Study of Empathic Therapy, Education, and Living is a nonprofit organization (501c3) founded by Peter R. Breggin, MD and Ginger Breggin for professionals and nonprofessionals who want to raise ethical and scientific standards in psychology and psychiatry. It provides a community and network for like-minded people who wish to support empathic, caring approaches to therapy, education, and living.

The center continues Dr. Breggin's 40-year reform efforts as "The Conscience of Psychiatry." Find us at http://www.EmpathicTherapy.org. This new organization carries forward the decades of work launched by Dr. Peter Breggin in his first nonprofit International Center for the Study of Psychiatry and Psychology (ICSPP; http://www.icspp.org) in 1972.

The board of directors and advisory council of the Center include more than 60 professionals in many fields spanning psychology, counseling, social work, nursing, psychiatry and other medical specialties, neuroscience, education, religion, and law, as well as concerned advocates and laypersons. Everyone is welcome to become a general member of this innovative and forward thinking organization.

The Center for the Study of Empathic Therapy provides a free e-newsletter. The latest news, research, and a scientific resources library can be found on the Center's related website, http://www.ToxicPsychiatry.org.

The Center holds annual conferences that are among the most scientifically informed, innovative, and inspiring. For many professionals and advocates, they are life changing. Families, advocates, and the general public are also encouraged to attend. Empathic relationship can be the basis of a wonderful, healing, and thriving life.

Join us at http://www.EmpathicTherapy.org.

Related Books by the Author

College Students in a Mental Hospital (1962; jointly authored by C. Umbarger, J. Dalsimer, A. Morrison, and P. Breggin)

Electroshock: Its Brain-Disabling Effects (1979)

Psychiatric Drugs: Hazards to the Brain (1983)

Toxic Psychiatry (1991)

Beyond Conflict (1992)

Talking Back to Prozac (1994; coauthored by Ginger Breggin)

Psychosocial Approaches to Deeply Disturbed Persons (1996; senior editor)

The Heart of Being Helpful: Empathy and the Creation of a Healing Presence (1997)

The War Against Children of Color: Psychiatry Targets Inner City Children (updated 1998; first published 1994; coauthored by Ginger Breggin)

Reclaiming Our Children (2000)

Talking Back to Ritalin, Revised Edition (2001; first edition 1998)

The Antidepressant Fact Book (2001)

Dimensions of Empathic Therapy (2002; jointly edited by Ginger Breggin and Fred Bemak)

The Ritalin Fact Book (2002)

Your Drug May Be Your Problem, Second Edition (2007; first edition 1997; coauthored by David Cohen)

Brain-Disabling Treatments in Psychiatry, Second Edition (2008; first edition 1997).

Medication Madness: The Role of Psychiatric Drugs in Cases of Violence, Suicide, and Crime (2008)

Endorsements

Today many psychologists, nurses, social workers, and counselors are struggling with how to help adults and the parents of children who are over-medicated or who wish to reduce or stop taking their psychiatric drugs. Dr. Breggin's book shows non-prescribing professionals, as well as prescribers, how to respond to their patients' needs in an informed, ethical, and empowering fashion.

Sarton Weinraub, PhD
Clinical Psychologist
Director, New York Person-Centered
Resource Center
New York, New York

I don't know anywhere else to get this information, at least not compiled in this easy-to-understand way. This book is the culmination of Dr. Breggin's lifetime of work, and it is chock-full of facts, practical recommendations, and wisdom from experience working with children and adults. His person-centered approach is a breath of springtime air for those tens of millions of people who have tried "treatment as usual" and not been helped, and wonder what to do now. Daily, people come to my office after having tried pills, more pills, newer pills, different pills, and pill combinations, with no real relief, or things have gotten worse. Now they are on medicines and they can't get off, or they are afraid to try. Those people need answers. Breggin has answers.

Douglas C. Smith, MD
Psychiatrist
Former Clinic Director
Juneau, Alaska

Peter Breggin has written a unique, brilliant, and comprehensive book that every mental health professional should read and "prescribe" to their patients and families! Dr. Breggin is a true pioneer in identifying the dangers of psychiatric drugs, being the first to warn us decades ago that treatment of the mentally ill would devolve to the shameful status it reveals today. Professional and lay populations everywhere have come to recognize that we are a dangerously over-medicated society, urgently in need of a fix, and Dr. Breggin's new book provides an intelligent way out of this quagmire.

Fred Ernst, PhD
Professor of Psychology
University of Texas–Pan American
Edinburg, Texas

In this exceptional, easy-to-read, highly informative and thought provoking book, Dr. Breggin continues to be the conscious of psychiatry and leading expert in the field of psychiatric drug withdrawal. This groundbreaking work will empower patients, their family members, and mental health professionals. It is a must have for all those wanting the most accurate, up-to-date information regarding collaborative, empathetic, effective, and safe psychiatric drug withdrawal.

W*endy West Pidkaminy, LCSW-R*
Adjunct Professor of Social Work,
Syracuse University
Syracuse, New York

Our culture has increasing need of a new language to counteract and clarify the ascendant role of psychotropic medication in our society. Peter Breggin has provided us with that language. In *Psychiatric Drug Withdrawal* he has created a truly concise and eminently practical guide for evaluating the effects of psychotropic medications and finding ways to withdraw from them. It is a superb summary of the knowledge he has collected over a lifetime. This is invaluable knowledge for those clients of all ages who have ended up addicted to these medications. The guidelines in this book can lead to the recovery of their lives.

Tony Stanton, MD
Adult and Child Psychiatrist
Private Practice, Poulsbo, Washington

This much-needed book and guide to psychiatric medication withdrawal is clearly written and easy to understand. As people become more empowered and able to inform themselves about the effects of pharmaceuticals, practitioners will be called upon to wean their patients off of damaging medications. This book will provide that guidance. Thank you Dr. Breggin for having the courage to oppose conventional psychiatric thinking and the caring to improve the quality of life for individuals who are ready to experience their own innate healing instead of reaching for a pill to mask the symptoms.

Melanie Sears, RN, MBA
Author, *Humanizing Health Care*
and *Choose Your Words*
Albuquerque, New Mexico

Dr. Peter Breggin has written an invaluable reference for mental health professionals and laypersons alike who are seeking a way out of dependency on psychiatric drugs. He describes the many dangers of psychiatric medication in straightforward research-based and contextually nuanced terms. Most helpfully, he articulates a method of empathic, person-centered psychotherapy as an alternative to the prevailing emotionally and system disengaged drug-centered approach. In this book, Dr. Breggin systematically outlines how to safely withdraw a patient from psychiatric medication with rich case examples drawn with the detail and sensitivity to individual and situational differences that reveal not only his extensive clinical experience, but his clear, knowledgeable, and compassionate vision of a more humane form of treatment. In this volume, Dr. Peter Breggin has again demonstrated that he is a model of what psychiatry can and should be. This is an indispensable text for both mental health trainees and experienced practitioners seeking a practical alternative to the dominant drug-centric paradigm.

Gerald Porter, PhD
Vice President for Academic
Affairs School of Professional
Psychology at Forest Institute
Springfield, Missouri

The field of mental health counseling is rooted in principles and practices informed by empathy and client empowerment. Using these core elements of counselor education as guiding principles, Dr. Breggin challenges the status quo of psychiatric practice and provides practitioners

with an alternative vision that raises both controversy and consciousness. This book underscores the counselor's ethical imperative to be informed, critical professionals in regard to psychiatric "evidence-based" treatments. Amidst the swell of public resistance to the growing use of psychotropics, Dr. Breggin's bold work bolsters the ability of counselors to contribute to the professional discourse that surrounds the complex decisions clients make concerning their journey toward healing and wellness.

Kathryn Douthit, PhD, LMHC
Chair & Associate Professor
Counseling & Human
Development
Warner Graduate School of
Education & Human Development
University of Rochester
Rochester, New York

Dr. Breggin has again created an invaluable resource for both treatment providers and treatment recipients. His authoritative knowledge of these issues creates a position of confidence for clinicians, while empowering those individuals and families receiving care. The writing style is great. It offers "chunks" of information—clear, concise, and you don't need to read the whole chapter to get valuable information, making it a handy reference. This important contribution to the field will create a powerful ripple-effect, aimed at ultimately improving the treatment outcomes for those in need of compassionate and effective treatment.

Robert Foltz, PsyD
Assistant Professor, Department of
Clinical Psychology
Chicago School of Professional
Psychology
Chicago, Illinois

A pill is a poor substitute for human connectivity and compassion, and Dr. Breggin's new book is the first step toward understanding the insidious nature of foregoing the call to comfort one another during times of hardship. Some sufferings cannot be fixed with a magic wand, or magic mantra, or magic pill. I urge everyone to read this book, slowly and mindfully.

There is, perhaps, no more important message for those who wish to help heal and those who desperately seek such healing.

Because a pill is a poor substitute for human connectivity and compassion, this book provides insight and guidance to empower therapists who are willing to play a much greater role in helping their patients make decisions about taking, and not taking, psychiatric drugs, without the fear that they have to enforce "medication compliance."

Joanne Cacciatore, PhD, LMSW, FT
Bereavement Trauma Specialist
Assistant Professor, Arizona State University
Clinical Director and Founder
MISS Foundation
Tempe, Arizona

This is a warning. Your psychiatric medicines are dangerous. Further, withdrawal from the medications can trigger horrendous consequences, additional psychiatric symptoms, and even death. In *Psychiatric Drug Withdrawal: A Guide for Prescribers, Therapists, Patients, and Their Families*, Dr. Peter Breggin addresses very important issues regarding the use of psychiatric medicines, and the termination of these medications. Counselors, social workers, psychologists, and psychotherapists will find Dr. Breggin's material helpful for understanding the adverse drug effects, feeling empowered in helping adult patients and the parents of child patients make decisions about medications, for monitoring their patient's drug experience, and in assisting families concerning the issues of patient withdrawal from medications.

Douglas W. Bower, RN, LPC, PhD
Athens, Georgia

The psychodynamic and medical issues critical to stopping psychiatric medications are explained. Dr. Breggin provides a novel and comprehensive blueprint for prescribing doctors, therapists, and patients to join in a collaborative effort to stop taking psychiatric medications. It is a book that patients, therapists, and physicians will all want to read.

Stuart Shipko, MD
Psychiatrist in Private Practice
Pasadena, California

This is such an important book. Describing the problem of withdrawal from psychiatric drugs in detail, and providing clear advice regarding how to deal with this problem, as Peter has done so well in this book, is long overdue. For decades, the belief system that is mainstream psychiatry has denied the existence of withdrawal problems from the substances they prescribe so widely. In reality, withdrawal problems with psychiatric drugs is a common occurrence. Because of psychiatry's reckless denial of this real and common problem, millions of people worldwide have not had the support and care they desperately need when attempting to come off psychiatric drugs, often been erroneously advised that these problems are confirmation of the existence of their supposed original so-called "psychiatric illness." Dr. Breggin's book is therefore both timely and necessary.

Terry Lynch, MD
Physician and Psychotherapist
Limerick, Ireland
Author of *Beyond Prozac: Healing Mental Suffering Without Drugs and Selfhood: A Key to the Recovering of Emotional Well Being, Mental Health and the Prevention of Mental Health Problems*

As a physician who specializes in addiction medicine and drug withdrawal and written widely on them, I recommend Dr. Breggin's book to every health professional who deals with anyone taking psychiatric drugs. He gives highly useful information and reasons for stopping or avoiding them. It's an excellent one-stop source of information about psychiatric drug effects and withdrawal. Prescribers, therapists, patients, and families will benefit from this guidebook.

Charles L. Whitfield MD
Atlanta, Georgia
Best-selling author of *Healing the Child Within*, and recently *Not Crazy* and *Wisdom to the Know the Difference*

This is a needed book. Thoughtful clinicians, including psychiatrists, other prescribing physicians, clinical psychologists, social workers, and other therapists, frequently think their patients should be withdrawn from psychiatric medication, but they are not sure. In addition, they do not know the best way to help the patient to safely withdraw from psychiatric medication.

They are often afraid of the disapproval of their professional colleagues. Nonmedical therapists may feel they have no right to question the judgment of their medical colleagues about medication. Nonpsychiatrist physicians may feel they should not discontinue the medication unless it is requested by the original prescriber, usually a psychiatrist. Psychiatrists may feel that if they withdraw their patients from psychiatric medication they will be resented by colleagues who almost never withdraw their own patients.

Psychiatric medication is sometimes helpful in the short run, but if continued becomes a problem, and eventually a disaster. For a few patients it becomes a disaster right away.

The first part of the book is a careful and relatively complete description of the reasons why one should consider psychiatric drug withdrawal or dose reduction and when. Included are detailed discussions of antipsychotics (neuroleptics), antidepressants, stimulants, benzodiazepines and other sedatives and opiates, and lithium and other mood stabilizers.

The second part of the book is a detailed description of the best way to withdraw from psychiatric drugs, taking into account the specific drug or multiple drugs, the length of usage, and the characteristics of the individual patient. Case histories are presented of simple and of complex cases of withdrawal. This is information not previously available anywhere.

Withdrawal is best handled by the prescriber, therapist, patient, and one or more family members, working together as a team. Prescribers rarely see patients often enough and long enough to have a detailed knowledge of withdrawal effects without information from the others. Therapists are more likely to know about adverse drug effects, including withdrawal effects, especially if they are looking for them. Patients are likely to report symptoms if they think their therapist and their prescriber want to know. However, one common side effect and withdrawal effect of psychiatric medication is a lack of awareness of symptoms ("medication spellbinding" or intoxication anosognosia). That is why a family member can be useful in pointing out and describing obvious symptoms of which the patient seems unaware.

The most heartening chapter is on children and teenagers. Most children and teenagers can be withdrawn with relative ease and safety, if their parents are cooperative. Withdrawal from stimulants is easily accomplished with children and teens diagnosed with ADHD if sensible family

therapy and possible consultation with the child's teachers are provided. Not only will they be off the medication, their troubling symptoms will also be gone. Of course, it would have been better to provide family therapy without medication from the beginning.

Children and teens diagnosed with bipolar disorders also readily respond to family therapy and withdrawal of medication. "Manic" symptoms in children and teens are almost always a side effect of antidepressants or of stimulants. Children diagnosed with autism need help in relating and medication impairs their learning to relate. They are able to respond to efforts by parents and others to relate to them once they are off medication. Children and teens, whatever their diagnosis, even after prolonged exposure to multiple drugs, respond to family therapy and a team approach and usually can be withdrawn easily if they have a stable family.

Peter Breggin has more experience in safely withdrawing psychiatric patients from medication than any other psychiatrist. In this book he shares his lifetime of experience. All of our patients deserve the benefit of our obtaining that knowledge.

Bertram Karon, PhD
Professor of Psychology
Michigan State University
Author, *The Psychotherapy of Schizophrenia*
Former President of the Division of Psychoanalysis of the American Psychological Association
East Lansing, Michigan

In his new book, *Psychiatric Drug Withdrawal: A Guide for Prescribers, Therapists, Patients, and Their Families*, Dr. Breggin takes on a subject and practice that draws both anxiety and hope from all parties: withdrawing from psychiatric medication with the goal of avoiding medication-induced chronic brain impairment. His person-centered principles of respect, concern, empowerment of individual choice, providing as much comfort as possible during withdrawal, encouraging a supportive environment, and careful attunement to clinical monitoring, provide the necessary conditions for the journey of withdrawal to be an experience of personal transformation. At the same time, Dr. Breggin's lifelong career in this field mitigates against a naïve and Pollyannaish romanticism of this process. He explicitly, and regularly, addresses the dangerousness of sudden and unsupervised withdrawal and, instead, encourages a collaborative approach centered on the utmost respect for a patient's choice and pace

in this journey, while very sensitively discerning and weighting the damage that could be done without withdrawal in relation to the discomfort of the withdrawal. Dr. Breggin equalizes the authority of all parties in this process, thus dethroning the dictatorship of the prescriber, but not excluding him or her.

I have been waiting for a text like this one to recommend to numerous families that come to me distressed and vulnerable to authoritative voices that box them into the false dilemma of either taking medications that have severe side effects for themselves or for their children, or being tagged as medically noncompliant and/or neglectful. Dr. Breggin should wear a large "B" on his chest and a cape as this text is a crime-fighting text that will certainly contribute to expanding options for countless individuals seeking liberation from chemically induced violence.

What is also very important here is that Dr. Breggin's person-centered approach is not a militant enforcer of withdrawal, which would merely adjust chairs on the same sinking ship. On the contrary, he emphasizes that attunement to the patient means encouraging autonomy, responsibility, decision making, and pacing are vital to a successful experiences of withdrawal, a stance quite different than what has typically been the case to date. Again, this isn't an argument of polarization of patients against prescribers, but an invitation to a collaboration of *shared* power in mutual dialogue about how to handle suffering in life.

Most importantly, Dr. Breggin notes that "The best way to avoid psychiatric drugs is to forge ahead with creating a wonderful life." We do this through the power of intimacy and love, which can alter more than brain chemistry; it can alter how we are with each other in the world in more communal ways, thus nullifying the need for medications to orchestrate our lives. In Dr. Breggin's book, the possibility of liberation has come.

Todd DuBose, PhD
Associate Professor, Chicago School
of Professional Psychology
Chicago, Illinois

Peter Breggin shows us the wave of the future. The polluting of our mind and souls goes beyond the Gulf Oil Spill. Dr. Breggin gives us the vision to see the damage and the tools to start the cleanup.

Timothy D. Evans, PhD
Private Practice, Tampa, Florida
and Executive Director
Florida Adlerian Society

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."

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.