Practitioner Perspective

We need to Talk about Anti-Depressants

By Mari Gallagher.

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Introduction

A strong movement questioning the efficacy and aptness of long-term[1] prescription of anti-depressant medication has been present in the psychiatric and medical profession for some time now. In this article I will reflect on the role of the therapist when a client expresses a wish to discontinue anti-depressant medication. In order to place my reflections in context of the current debate, I will cite statistics outlining the extent of anti-depressant prescription in Ireland, a summary of the side effects of anti-depressants and also reference literature from both psychiatric and medical circles questioning the efficacy of the long term taking of anti-depressant medication. I will include observations on this topic from my client work and conclude by reflecting on the role of the psychotherapist in the face of an increasing movement towards questioning the value of long term anti-depressant medication.

I realise that to write about client work in the context of medication veers towards stepping outside the boundary of my training – I am not medically qualified, therefore am not equipped to make diagnosis or prescribe. However, significant numbers of clients are, in my experience, on long-term anti-depressant medication and frequently include living life "anti-depressant-free", as one of the goals of therapy. To try to separate client anti-depressant medication from the process of therapy is to ignore a salient aspect of the healing process: therapeutic work is as much a constituent of the recovery process as is the taking of medication - in fact, the citations in this article would suggest that talk therapy contributes to recovery in a far greater way. Therefore it is essential that therapists are aware of the potential impact of anti-depression medication on the mood and disposition of the client. This is not stepping outside the boundary of training but rather a responsible noting of all aspects of the client's world while endeavouring to assist that client towards recovery. Also, it is important to note that questioning the potential negative impact of long term use of anti-depressants is not in any way a dismissal or minimizing of the potency and debilitation of the suffering

[1] Long-term prescription of anti-depressants has been defined as > 1 year – Oxford Handbook of General Practice (2014).

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experienced during depression or an ignoring of the apparent benefits of short term doses of such medication.

This article, therefore, seeks to explore the psychotherapist's role in a situation where the client speaks during therapy of side effects of his/her long term medication and expresses a desire to become anti-depressant-free.

Statistics

Much has been made in media reporting in recent years of Ireland as the "Medication Nation." Shanahan (2015) reports that an analysis of figures based on publicly-prescribed drugs under the GMS Scheme (which covers medical card holders), shows two million plus prescriptions were written for the top five anti-depressants in 2012 for the benefit of 331,368 patients. When prescriptions for the same medication written under the Drug Payment Scheme (DPS) and the Long Term Illness Scheme as well as private patients whose bills do not reach the monthly threshold to qualify for the DPS are included, the numbers on anti-depressant medication in Ireland is estimated as being close to half a million, a significant 10% of the population (Shanahan, 2015).

Side effects of anti depressants

Information on the side effects of anti-depressants is widely available. Side effects are also outlined on the information leaflet accompanying medications. Brogan (2016) cites a 2014 review in the Journal of Affective Disorders: "Side effects include headache, nausea, insomnia, sexual dysfunction, agitation, sedation, stroke, cardiac conduction defects and increased risk of mortality." Brogan (2016) also notes that the long-term use of anti-depressants has also been associated with an increased acute risk of suicide in younger patients and that there is growing body of research suggesting that when anti-depressants are used in the long term as a maintenance treatment, they can lose efficacy, and may even result in chronic and treatment resistant depression.

It is important that therapeutic work is done within the context of awareness that aspects of a client's presenting issues may be potentially related to the side effects of the long-term taking of anti-depression medication.

Depression: A Chemical Imbalance or not?

Doubts have been raised by neuroscientists, general medical practitioners and psychiatrists alike on the claim that depression is caused by chemical imbalance. Lynch (2015) refers to the lack of evidence on chemical imbalance as a contributory factor in depression. Lynch states there was never good scientific reason to believe that anti-depressants healed a chemical imbalance in the brain and supports his statement with exhaustive coverage of expression of doubts from a wide variety of psychiatrists, general practitioners and neuroscientists. Lynch concludes that "existence, experience and life itself is at the heart of the human distress that doctors reframe as psychiatric diagnoses such as depression" (2015, p.340).

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Renowned psychiatrist Professor Ivor Browne has consistently been a critic of the long term use of anti-depressants and writes:

> It was experiences like this which taught me how bogus is the concept of "clinical depression". The idea that there is a chemically mediated form of depression which is an "illness", quite separate from the sadness and depression which are part of the slings and arrows of ordinary life, is manifest nonsense (2008, p.125).

Davies (2013) writes of the tendency to turn to anaesthetics as a first response when there is often value in working through our suffering productively. Davies asks: "What if psychiatry, by progressively lowering the bar for what counts as mental disorder, has recast many natural responses to the problems of living as mental disorders requiring psychiatric treatment?" (2013, p. 40).

Davies (2013) also cites Dr Joanna Moncrieff, a psychiatrist and senior researcher specialising in anti-depressant research:

> The idea that there is a brain disease, or a chemical imbalance or a faulty neural network that anti-depressants correct is completely false

and unsupported. You cannot therefore say that these drugs are having curative or remedial effect if the evidence doesn't support that point of view (p.111).

Brogan (2016) writes: "antidepressants have repeatedly been shown in long-term scientific studies to *worsen* the course of mental illness". Brogan posits that the true cause of depression is not simply a chemical imbalance, but a lifestyle crisis that demands change which can be achieved not through medication but through talk therapy and dietary interventions (2016).

In the therapy room

The therapy room provides clients with a safe and confidential space for expression of innermost thoughts. Frequently, these thoughts include reservations with being on long term anti-depressant medication. The client often does not wish to question the opinion of their general practitioner or be seen, as one client put it, "to be telling the doctor how to do his job". If a system for coming off anti-depressants has not been put in place for the client, and significantly in my experience this seems to be the case, medicating can continue for several years. In one instance, a client reported being on anti-depressants for fifteen years.

Clients have spoken about the side effects of anti-depressants: dry mouth, dizziness, slurring of speech, insomnia, drowsiness and in the case of long term medication, no ongoing improvement in their feelings of low mood. Brogan (2016) writes that it is not easy to get off psychiatric medications once started and not easy to get information on how to wean oneself safely from them. For the client who expresses a wish to live life without anti-depressants and who is in therapy in the first place to address issues of low self esteem, the prospect of approaching a medical professional and requesting to come off medication, can be daunting. Where the client does not have the confidence or self-belief to address the situation, medicating continues. The purpose of therapy is the empowering of the client to make the changes necessary to improve his life. Therapy work will encompass the development of strategies for accomplishing goals, including the building of the self-esteem necessary to adopt a firm approach with regard to the prescription of anti-depressant medication when dealing with medical professionals.

The therapist who encounters a client who expresses a desire to come off anti-depressants may arbitrate that the inclusion of such a goal in the therapeutic work is to step outside the boundary of their training.

Conclusion

Carl Rogers (1961) has reiterated that the client is the person best equipped to know how to heal himself. The therapist who encounters a client who expresses a desire to come off anti-depressants may arbitrate that the inclusion of such a goal in the therapeutic work is to step outside the boundary of their training. However, reservations are held by medical experts on the efficacy of long term prescription of anti-depressants. By helping the client develop the tools to take the necessary steps to make changes in his life, one of which is maybe anti-depressant free, the therapist is fulfilling his role in a congruent, responsible way.

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