***Marion Brown** describes the long-term suffering caused by prescribed psychiatric medication, the action that she and others are trying to take – and how therapists can help.*

Why professionals must admit dangers of psychiatric drugs

WHEN I set up my private human givens practice four years ago, I was aware that I would sometimes be working with clients taking prescribed medications for the very conditions that we were going to focus on. As time went on, however, it became apparent that a very high proportion of my clients were already on prescribed psychotropic medications.

With the availability of NHS alternatives, such as individual or group cognitive-behavioural therapy, being scant, people have to wait many weeks or months for free treatment. With prescriptions currently free for patients in Scotland, most just 'take the pills' as prescribed.

After I had been in practice for several months I was contacted by a new client who was trying to come off antidepressants and experiencing terrible problems. It was she who opened my eyes to the true extent of the problems caused by these medications, especially when they have been taken, as prescribed, over many years.

This particular client, Ann, the youngest in a family of seven, had been started on antidepressants at age 14, soon after her father had died. She was 49 when I met her and had been prescribed different and stronger antidepressants throughout the intervening years. She had been functioning, but in a very 'medicated' way – as though she looked out from behind a mask, numbed, insulated and not relating to people with any empathy. Two years previously she had decided that she wanted to come off the medic-ation and get back something of her own self and feelings, so she had taken the proper medi-cal advice of the time and had tapered slowly and carefully down from a high dose of venla-faxine. When I met her she was just at the very end of tapering off. (In hindsight, with greater knowledge, the speed of her tapering was prob-ably much too fast.)

Ann described, and I could see for myself, the awful torment that she had come through and was, indeed, still experiencing. She had been completely debilitated and bed-bound for some time and, when I met her, she still needed a lot of practical help from her brothers and sister. She had dizziness, coordination difficulties, gastric problems, severe agitation and such a terrible 'burning head' that she wrapped ice packs around it. She had done a lot of research and found information and support on the internet and through the Council for Information on Tranquillisers, Antidepressants and Painkillers (CITAP) – see www.citawithdrawal.org.uk – and their Liverpool-based helpline (now closed, as funding was withdrawn). Ann had fought to get a referral to see David Healy, psychiatrist, psychopharmacologist, professor of psychiatry at Bangor University, and author of over 20 books, including most recently *Pharmageddon*, a searing study of how the pharmaceuticalisation of medicine has led to shocking numbers of deaths and disabilities.[1] In 2012, he set up RxISK (www. rxisk.org), a free, independent website where people can research prescription drugs and report a drug side effect (Rx is a symbol often used for 'prescription').

Shockingly, as the site makes clear, "more than 95 per cent of drug side effects go unreported and there are serious gaps and delays in getting relevant feedback on effects of pharmaceuticals once they are released to the market. Regulators do not have reporting systems geared to capturing the data needed for effective post-market monitoring."

The setting up of Recovery & Renewal

Ann asked me to help her set up a local independent peer support group to reach out to others struggling with mood-altering medication. Our group, which we called "Recovery & Renewal", launched in mid 2013 and, as we had no money, the people attending contributed to the basic room-hire and refreshment costs. Our launch coincided with the publication of psychologist James Davies' book *Cracked – why psychiatry is doing more harm than good*.[2] Dr Davies went on the next year to launch the Council for Evidence-Based Psychiatry (cepuk.org) to communicate to those in positions to make a difference the potentially harmful effects of psychiatric drugs, and our group has followed its activities with interest.

Our plan was to meet weekly, to share personal experiences, offer self-help support, invite speakers and local therapists specialising in various non-medical and/or complementary therapies (including the human givens, of course) and to raise wider public awareness. Our local newspapers helpfully provided some free publicity and we had hoped to whet the interest of local GPs, inviting them to attend and perhaps to

share their own input and perspective, but our invitations brought no responses whatsoever.

I heard (both in the group and confidentially in my private practice) more and more stories of the most alarming experiences of individuals and families who found themselves unwittingly caught up in the complex 'trap' of these medications – and of sometimes devastating effects on their lives, careers, marriages, families and others close to them. Antidepressants, benzodiazepines and opiate-based painkillers – mood-altering medications which may indeed sometimes be necessary in emergencies or particularly difficult circumstances – have become very widely prescribed by well-meaning family doctors for common stress-related symptoms, such as anxiety, depression and insomnia. Like Ann, people describe experiencing the most alarming side effects and withdrawal effects and sometimes deeply frightening, disturbed thinking, which they find most upsetting and confusing. If they go back to their doctor, these symptoms tend to be interpreted as a return, or development, of their 'mental illness' and they may be given a further diagnosis, perhaps of personality disorder, and advised that they need additional medication, or even to be 'sectioned' and compulsorily medicated.

Recovery & Renewal had involved our local MSP from the outset, but then moved on to writing to the Scottish Government and NHS Scotland, asking what facilities and/or specialist help or resources were available to people suffering from iatrogenic damage (ie damage caused by taking these medications as prescribed). We were fobbed off and passed from pillar to post. It gradually became clear that there were no services (specialist or otherwise) or even charities in Scotland that could offer the kind of support needed. The medication-related issues experienced by patients were, and still are, not recognised in any of the Scottish mental health 'recovery' initiatives.

By this time members of our group had contributed to the evidence that the Council for Evidence-Based Psychiatry (CEP) was gathering, via survey, for submission to the BMA Board of Science, which had formally called for evidence on involuntary dependence on prescription medications – specifically, benzodiazepines, z-drugs (which have a similar action to benzodiazepines), antidepressants and opiate painkillers. The report was released in October 2015[3] and featured in the last edition of *Human Givens*.[4] This has led to some interesting developments, which I will come to later.

Changing tack

By the end of March last year, having held 70 Recovery & Renewal group meetings, I really wanted to concentrate on developing my human givens practice. It had also become clear that the group meetings were fraught with a level of risk that I (and, indeed, the group) could no longer carry. Several people who attended the meetings had experienced crises in early adulthood, leading on to diagnoses of bipolar disorder and more than 20 years on cocktails of medication. Others had been diagnosed with Asperger's syndrome as teenagers and put on antidepressants, benzodiazepines etc, which had completely ruined their lives. Many people, whether on psychoactive medications, struggling to come off them, or even off them and still struggling years later, go through huge psychological and physical health challenges and terrifying emotional rollercoasters, including periods of feeling deeply suicidal. Even when feeling relatively okay, their empathy and social skills appear severely damaged, and they may be angry, extremely 'needy' and overwhelming. It was really hard to manage the range of often socially inappropriate behaviours of some of the attendees (there were typically up to 12 of us at any one meeting), sometimes resulting in others present becoming upset – including visiting speakers and workshop leaders! Coordinating such a group of people with no support whatsoever from the medical establishment (in fact, a definite distancing), was more than I could continue to do.

To replace our meetings, we set up a Recovery & Renewal closed Facebook group and this has become an extremely active means of sharing resources and offering ongoing member support. In addition, there is a huge self-help community of people that exists on online, such as at www.benzobuddies.org and www.survivingantidepressants.org and many other Facebook and social media groups. We have continued to contact authorities such as Scottish Government and Chief Medical Officer for Scotland, to keep them up to date with developments such as the establishment of the Westminster All Party Parliamentary Group for Prescribed Drug Dependence and the BMA Board of Science work in progress. They tend not to respond.

As an able-bodied member of Recovery & Renewal (many people suffering iatrogenic damage have great difficulties with daily functioning and some are registered 'disabled'), I represented the group at the stakeholder roundtable meeting that the BMA Board of Science held in London in February, to follow up on their report into what needs to be done about prescription drug-dependence (see box, "The injustice of having suffering denied", page 39).

What I have learned

I guess the most worrying aspect of all this is that medical professionals have been hoodwinked for so long by the unscrupulous and aggressive marketing of pharmaceutical companies. I recently came across a statement on the website of a company which produces medicines for 'treatment' of opioid addiction, which encapsulates how easily this can be done:

"Our goal is to medicalise addiction. This starts by partnering with people of influence such as healthcare professionals, policymakers, payers, and the public health community to create an

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environment of education and options. It starts by breaking down the social barriers so patients can be empowered to seek treatment and providing expanded access to treatments for patients all over the world."[5] It sounds kindly, as if recognising the true medical nature of such problems allows stigma to be removed and more people to be helped.

But kindly it is not. We have been so completely brainwashed about 'mental illness' and 'chemical imbalances' (with the media seemingly compliant) that there is a lot of public and professional disbelief about, and resistance to, the notion that these very commonly prescribed mood-altering medicines might actually be causing more harm than good. And all the while that the harms are not recognised, ever more people are being started on these medications every single day.

The drugs may variously affect emotional functioning and reasoning capacities, interfering crudely with the all-important 'fight or flight' sympathetic nervous system – and, in doing so, have all sorts of knock-on effects on people's entire brain/body systems. My discussions with other psychotherapists have confirmed that many of us are seeing these problems frequently – and, while we do what we can, we find that people's capacity for 'recovery' is severely impaired by the medication – and, indeed, our clients may be experiencing bizarre and bewildering effects which they (and we therapists) may not realise are caused by their drugs. These include sexual dysfunctions, impaired senses, the acting out of fantasies, strong compulsions to harm themselves and others, obsessions with knives and weapons, terrifying lucid dreams, belief that they have harmed others, and so on.

The longer that people have been on these medications, the more their individual systems have adapted in order to try to keep functioning, so the longer it takes to 'withdraw' the medication safely (for very many people, this can take years). Stopping any psychiatric medication cold turkey or tapering too fast can be very dangerous indeed, sometimes resulting in seizures and even death.

As they go through withdrawal or, indeed, any change in medication or dosage (up or down), people can experience a wide range of troubling and disabling symptoms, which can continue to manifest even after completely stopping the medication. The drugs can stay in the body tissues for a long time – and even leave permanent brain and other neurological damage.

The physical withdrawal symptoms can be highly debilitating and commonly include dizziness, headache, muscle spasms, hypersensitivity to sounds and light, electric-shock type sensations, nausea, diarrhoea, severe tingling or pain sensations, flu-like symptoms, night sweats, insomnia or drowsiness, feeling hot or cold, shaky, restlessness and food intolerances. The emotional symptoms include depression, extreme anxiety, irritability, confusion, panic, mood-swings, agitation, poor concentration, bizarre thoughts and feeling suicidal.

Of course, not everyone experiences problems coming off antidepressants. A great many people have no difficulty at all. But, for those that do, it helps at least a little if clients can be told that they are not going 'mad' and that their experience has a clear cause. There are some useful guides to medical side effects, withdrawal effects and how to stop taking psychoactive drugs as safely as possible.

Will Hall's "Coming off Meds" is easy to understand and available free online (http://willhall.net/comingoffmeds). Mind also offers, at http://www.mind.org.uk/information-support/drugs-and-treatments some very helpful advice. On the RxISK website, there are helpful guides (http://rxisk.org/tools/guides/) and a lot of information.

RxISK even offers a guide called "Notes on antidepressant withdrawal to take to your therapist", which has some helpful information for those trying to use psychological approaches to help people get their lives back on track. In effect, it warns us to be very, very careful.

"It is not uncommon for people dependent on and having withdrawal problems from antidepressants, mood stabilisers or other drugs to be referred to, seek out, or encounter therapists who will often have the skills to be helpful. However equally, if these therapists take the wrong approach, in practice they may compound rather than relieve the problems.

"Some of the difficulties stem from therapists thinking they understand what's going on — that withdrawal is somehow just linked to too much adrenalin, or what the person now has is a reappearance of some failure to resolve the difficulties that were present when the person was originally put on antidepressants or mood stabilisers.

"But therapists can't understand dependence because no one at present understands what gives rise to dependence on, and withdrawal from, antidepressants, mood-stabilisers or anti-psychotics, and in particular to the enduring symptoms after stopping that can be so distressing, or the instabilities that people can run into on trying to stop that are not mentioned anywhere in any books.

"The challenge is to help the person live with [their] problems and not be defined by them, and to keep their family engaged in supporting them." Although the guide makes clear that there is no simple behavioural approach towards withdrawal that will necessarily ensure the withdrawal succeeds, it emphasises the importance of methods such as validating clients' suffering, offering support, collaborating on problem-solving strategies and enhancing self-management skills.

American psychiatrist Peter Breggin, who has never prescribed a psychoactive medication in all his working life, believes "informed therapists and healthcare providers" have an ethical duty to provide scientific information about the real effects of psychiatric drugs, and consumers, "instead of naively accepting whatever the doctor prescribes to them" also need to take on responsibility for

The injustice of having suffering denied

THE invited stakeholders at the BMA Board of Science meeting that I attended included representatives from the Royal College of Psychiatrists, the Royal College of GPs, the Royal College of Physicians, NICE, Public Health England, the Royal Pharmaceuti-cal Society, the Royal College of Nursing, the General Medical Council, the Council for Evidence-based Psychiatry, and a number of withdrawal charities, including Recovery & Renewal. There were around 30 of us in all. Luke Montagu, co-founder of the Council for Evidence-based Psychiatry, was given four minutes to set the scene, which he used to powerful effect. This is an edited version of what he said.

"Seven years ago I was an entrepreneur running a group of film businesses, which included the UK's largest film school as well as film production and post-production companies. But I was worried by the prescription drugs I was taking – an anti-depressant and a sleeping pill – as I was getting increasingly tired and forgetful.

"In 1990 I had had a bad reaction to a sinus operation. My GP diagnosed me with one of the great falsehoods of modern medicine – 'a chemical imbalance' – and put me on antidepressants and, later, sleeping pills, as the antidepressants made me wired. In 2009 – 19 years and hundreds of prescriptions later – another doctor admitted me to hospital to detox from the sleeping pills.

"Three days after the drug was removed I entered a hell which can only be understood by those who have been there. My brain felt as though it had been torn in two, my ears screeched with tinnitus, sounds blared and colours distorted. I couldn't talk or think or move. After a few weeks, the intensity lessened. But I was forced to resign from the company I had worked so hard to build, as I could no longer function. I spent the next three years mostly sitting at home, unable even to read a book. I then decided to come off the antidepressant and new symptoms appeared, including intense agitation and burning pins and needles. I'm now five years drug free, and it still hurts like hell.

"I sued my doctor and we settled out of court for nearly £1.4 million. The lawyers took almost half of that, and the rest doesn't begin to cover my lost earnings over these lost years. With gritted teeth, I would have accepted my status as an outlier on the bell curve. But I went online and discovered communities of thousands of sufferers from all over the world. If you are among the many in the medical community who continue to deny this issue, then I urge you to visit some of these sites. Go to *benzobuddies.org* or *survivingantidepressants.org*. You cannot fail to be moved by the suffering and loss; the effects on mothers, children and marriages, on good people who have worked hard to build good lives, only to see them implode as they struggle to cope with quite intolerable symptoms. And then listen to them describe the double injustice of having their suffering denied, of doctors refusing to accept that it could possibly be the drugs.

"It can take months or years just to taper off. Once off, it can take several years to recover from the neurological damage leading to the complete devastation of lives. Some don't make it; every other month I come across someone who has taken their life rather than put up with one more day of extreme suffering. And the situation is clearly getting worse. Does anyone in this room really believe that we need almost 60 million prescriptions in England for antidepressants alone, enough for one for every man, woman and child, an increase of 500% since 1992? Why is this number going up? Because, like benzos, people can't get off these addictive drugs; more and more are hooked."

He finished, however, on an upbeat note: "I'll end with a reminder of a quote which has helped me get through these past few years: 'In some ways,' said Victor Frankl, the psychotherapist and Auschwitz survivor, 'suffering ceases to be suffering at the moment it finds a meaning'.[1] I hope that today we have reached a moment of meaning – please let's do our best to seize it."

The meeting was exceptionally skilfully chaired by Baroness Hollins – Sheila Hollins, professor of the psychiatry of learning disability at St George's, University of London – as it seemed that it was not going to be easy to get agreement (the purpose of the meeting) among the highly diverse key stakeholders. However, after breaking into groups to focus on specific key areas for action, we arrived at a clear consensus that:

- NICE should be encouraged to set up a commission into withdrawal, resulting in new guidance for practitioners
- there should be proper training on prescribed drug dependence and withdrawal in medical schools
- more research should be carried out into optimal withdrawal protocols as well as long term harms, particularly with regard to antidepressants
- there should be a national helpline to support patients affected by prescribed drug dependence.

The BMA is writing up the agreed actions from the meeting and proposing next steps. The forceful Baroness Hollins appeared to us determined to make progress before her chairmanship of the Board of Science ended in June, and then perhaps it is up to us interested stakeholders to make sure that what she has started continues and reaches fruition.

1 See Man's Search for Meaning, *page 54*.

educating themselves.[5] In a recent review he focused on what he terms "three principles of rational psychopharmacology":

"The first is the *brain disabling principle*, which states that all psychoactive substances work by causing dysfunctions of the brain and mind. It further observes that no psychiatric drugs work by improving or correcting bio-chemical imbalances or any other presumed biological malfunctions.

"The second principle is *intoxication anosognosia* (medication spellbinding), which states that all psychoactive substances tend to cause a subjective over-estimation of their positive effects while masking their harmful ones, sometimes resulting in extremely harmful behaviors such as mania, violence and suicide.

"The third principle is *chronic brain impairment* – that exposure to psychoactive substances, especially long-term, results in impairments of the brain or mind that can become persistent or permanent, including atrophy (shrinkage) of brain tissue."[6]

Resources, that can't be used well and needs not met

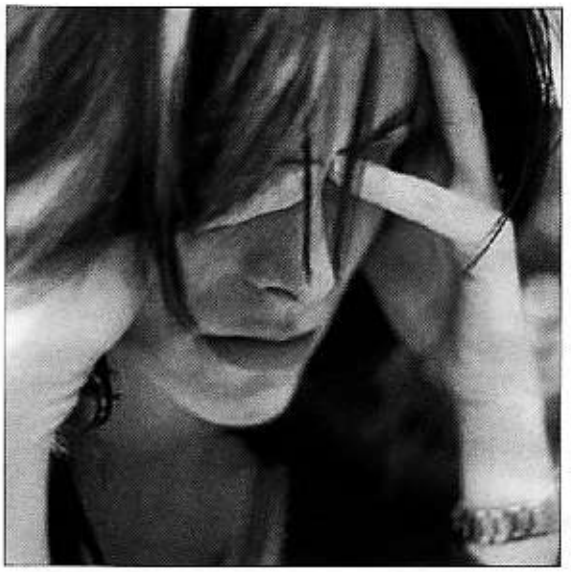
In human givens terms, we can begin to recognise that these medications are affecting access to, skewing and, even worse, damaging the very subtle resources that we work with – emotions/motivation, empathy and rapport (thus all-important abilities to relate to others' suffering), dreaming, imagination, pattern matching, observing self and rational thinking can all become frighteningly distorted. Entire nervous and digestive systems are affected, making recovery a long and complicated process. This doesn't mean that it can't be achieved over time (although I have included others' caveats above), just that we need to recognise that it can be immensely complex and is not going to be the 'brief therapy' that we more usually associate with our approach.

The drugs may have caused people to behave in ways that are completely out of character, leading to their feeling depersonalised and degraded and to lose all self-respect. These clients' emotional needs are normally not at all well met – so, as ever, working towards getting these better met is the overall aim. Peter Breggin encourages 'empathic therapy' – to support and empower people to discover new nourishing ways to live – and our human givens approach fits well with this.

In Recovery & Renewal, our intention has always been to offer a sense of community and understanding, belonging, respect, acknowledgement, encouragement, exploration and sharing of various recovery approaches and therapies – and engender purpose and meaning. We continue to research and seek out effective ways to support people in resurfacing and recovering optimal healthy functioning.

Letter to the BMA

With an eye to the long-overdue medical recognition of these serious medication issues that is beginning to emerge, I have written to the BMA Board of Science since the stakeholder meeting, saying:



"I believe that the setting up of a truly 'national' (ie including England, Scotland, Wales and Northern Ireland) helpline and website, as suggested, would be a most positive and helpful development and would also yield important information on the true scale of the issues in the UK. The Recovery & Renewal group in Scotland is heartened to learn of this outline proposal and hopes that the Scottish professional bodies and public health representatives will collaborate with English and other counterparts to make this come about.

"Until the potential harms of these medications (especially antidepressants, which are widely still seen as 'safe and effective' by GPs) are indeed recognised and 'taken seriously' by the medical profession, there will be no clear evidence-based feedback loop to inform the GP and patient discussions, which all too often lead to that apparently innocuous first prescription, which we now believe can be the beguilingly unlikely start of a life-changing process.

"The perceived shortage of effective and timely non-medical alternatives in primary care is another hurdle – but need not be so. These alternatives are usually most effective when patients have not been exposed to any psychoactive medications and I know, from my own work, that the human givens approach (for one example) can offer immediately available, effective and often brief non-medical therapy for the common presentations of the normal 'mental disorders' of human life, and could lend itself to widespread practical rollout as a realistic option offered within primary care and/or local social services."

To that end, here in West Scotland, I have started running workshops for the public, to introduce human givens concepts. So far, 40 people have attended and the workshops have been well received. They offer, I believe, a highly effective way to start 'spreading the word' more widely. I hope, with fellow practitioners, to develop these workshops further over the coming months and would love to share ideas with others. ■

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