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Persistent Postwithdrawal Disorders Induced by Paroxetine, a Selective Serotonin Reuptake Inhibitor, and Treated with Specific Cognitive Behavioral Therapy

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Recently, Scholten et al. [1] described the rationale for cognitive behavioral therapy (CBT) in the treatment of discontinuation and persistent postwithdrawal disorders from antidepressant drugs, particularly selective serotonin reuptake inhibitors [2]. We would like to report 3 cases presenting paroxetine postwithdrawal disorders [2] treated with CBT. One patient had a DSM-IV diagnosis of major depressive disorder and 2 patients a diagnosis of panic disorder with agoraphobia.

The 3 patients were referred to the Affective Disorders Program of the University of Bologna. The same psychiatrist (G.A. Fava) assessed the patients with the Structured Clinical Interview for DSM-IV Axis I Disorder [3], the Clinical Interview for Depression [4], and the Discontinuation-Emergent Signs and Symptoms checklist [5]. An experienced clinical psychologist (C.B.) treated the patients with CBT.

Mr. X is a 45-year-old married man referred for paroxetine-induced pathological gambling. During 12 years, the patient was treated with paroxetine 20 mg at bedtime for major depressive disorder, following his divorce from his first wife and separation from his 2 six-month-old twin babies. During the first year of paroxetine treatment, his mood, energy and sleep improved. However thereafter, his second wife noticed that his mood became elated switching almost to a manic state; he was always right, knew everything, never delegated home or work tasks, slept a few hours, was nervous and became easily aggressive towards others. After he had started taking paroxetine, he began gambling at the casino. The desire to gamble increased over time. He felt as if he was not conscious of his actions. He reported a decreased perception of risk-taking, as if he was 'anesthetized', detached from what he was doing. He reported that paroxetine seemed to alleviate his guilt, which led to gambling and losing large sums of money. Furthermore, he felt he was insensitive and detached from others, including his children, partner and relatives, and that his memory was impaired. The psychiatrist who evaluated him decided to switch paroxetine to fluvoxamine 50 mg at bedtime without tapering paroxetine. Mr. X developed more withdrawal symptoms, characterized by aggressiveness towards his partner, impulsiveness, electric sensations to the face, visual problems, sleep difficulties and severe generalized anxiety. Since these symptoms lasted more than 2 months, the psychiatrist recommended a clinical psychologist to start specific CBT described in table 1, which was based on individualized CBT combined with well-being therapy [6] and explanatory therapy [7] including symptom interpretation according to the oppositional model of tolerance [8]. After 3 months of CBT, gambling stopped with improvement in other withdrawal-induced disorders. The patient started to remember events that had happened during paroxetine treatment. Fluvoxamine was then slowly tapered during 8 weeks and successfully discontinued. CBT lasted 6 months. The patient is now in remission and drug free after 1 year of follow-up.

Mr. Y. is a 32-year-old single man diagnosed as having panic disorder with agoraphobia and treated with paroxetine 20 mg/day for 4 years. During the first 4 weeks of paroxetine, the patient reported severe emerging symptoms, nausea, headaches, panic attacks and increased irritability. After 6 weeks of paroxetine 20 mg/day, the patient experienced a decrease in anxious symptoms, but at the same time, more appetite and a significant weight gain of 20 kg after 2 years. The patient did no longer want to continue paroxetine and self-reduced to 5 mg/day. However, he could not tolerate emerging anxiety symptoms at 5 mg/day and had to increase the dosage back to 10 mg/day. This dosage of 10 mg/day was continued for 4 years during which the patient described himself experiencing generalized anxiety symptoms, nervousness, apprehension and anticipatory anxiety. At that time, he realized that he would need to increase paroxetine back to 20 mg/day and decided to ask for help. After 6 years of paroxetine treatment, the psychiatrist who evaluated him decided to further decrease paroxetine, which was discontinued after 1 month, while giving clonazepam one 0.5-mg tablet 3 times/day.

The first months of paroxetine withdrawal, including tapering and 1 month of complete discontinuation, were characterized by persistent postwithdrawal disorders consisting of continuous agitation, depersonalization, generalized anxiety, physical weakness, mood swings and sleep difficulties. Since postwithdrawal symptoms persisted, CBT, described in table 1, was started in conjunction with clonazepam. Homework exposure focused on agoraphobia. After 5 months of CBT, 1 session every other week, the patient started to feel better, and symptoms, except for occasional anxiety attacks, subsided. The patient is now in remission after 1 year of follow-up, taking half a tablet of 0.5 mg twice a day without CBT.

Mrs. Z is a 43-year-old married woman treated with paroxetine by a neurologist during 4 years for anxious depression and panic

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Table 1. Components of CBT for persistent withdrawal disorders induced by antidepressant drugs (by C. Belaise, G.A. Fava)

The protocol is of 6–16 weekly 1-hour sessions and consists of:
(1) Explanatory therapy, which includes providing accurate information on withdrawal, repeated reassurance and teaching the physiological principles underlying withdrawal phenomena. For example, the patient is told: 'It is quite frequent to have these symptoms after psychotropic drug discontinuation'
(2) Monitoring of emergent symptoms in a diary according to the cognitive behavioral model, followed by cognitive restructuring consisting of alternative interpretations of patient thoughts about his symptoms
(3) Homework exposure for avoidance patterns. For example, 'without the pills, I cannot go to work'
(4) Lifestyle modifications: avoidance of alcohol, increased physical exercise, limited caffeine consumption and no change in cigarette smoking habits
(5) Techniques of decreasing abnormal reactivity to the social environment, consisting in learning ways to cope with stressful situations related to the level of arousal increased by drug withdrawal
(6) Teaching well-being therapy. For example, 'there is life after antidepressants'

disorder with agoraphobia. She took 3 tablets of 20 mg paroxetine/day together with quetiapine 25 mg at bedtime. The first 5 months of treatment were characterized by increased severity of anxiety, muscular stiffening, numbness, depersonalization, lack of concentration particularly when she was driving, stomachaches and gastrointestinal problems. Symptoms, except stomachache, moderately improved. Despite these emergent symptoms, paroxetine was continued for 4 years. After a nocturnal panic attack, Mrs. Z went to emergency, where a gastroscopy found a drug-induced erosive esophagitis. Then, Mrs. Z asked for help in discontinuing paroxetine. The psychiatrist decided first to discontinue quetiapine and then taper slowly and discontinue paroxetine at the rate of 5 mg every other week, while referring the patient to CBT (table 1). Despite slow tapering, once paroxetine was completely discontinued, the patient continued to experience postwithdrawal disorders consisting of agitation, trembling and generalized anxiety. With CBT, the patient said: 'I am starting to have the control over my brain again, even when I am driving the car.' Symptoms persisted for another 3 months, but then slowly disappeared.

These 3 cases illustrate the usefulness of a specific CBT approach to persistent paroxetine postwithdrawal disorders. They should be interpreted with caution since symptoms may have disappeared spontaneously, even though the clinical evolution would suggest unlikeliness of spontaneous remission [9, 10]. It should be noted that all 3 patients received paroxetine during at least 4 years.

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References

1 Scholten W, Batlaan NM, van Oppen P, Smit JH, van Balkom AJ: Discontinuation of antidepressants in remitted anxiety disorder patients: the need for strategies to prevent relapse. Psychother Psychosom 2013; 82:399–400.
2 Belaise C, Gatti A, Chouinard VA, Chouinard G: Patient online report of selective serotonin reuptake inhibitor (SSRI) induced persistent postwithdrawal anxiety and mood disorders. Psychother Psychosom 2012; 81:386–388.
3 First MB, Spitzer RL, Gibbon M, Williams JBW: SCID-1, Structured Clinical Interview for DSM-IV Axis I Disorder (Italian version by Mazzi F, Morosini P, de Girolamo G, Lussetti M, Guaraldi GP). Firenze, Organizzazioni Speciali, 2000.
4 Guidi J, Fava GA, Bech P, Paykel E: The Clinical Interview for Depression: a comprehensive review of studies and clinimetric properties. Psychother Psychosom 2011;80:10–27.
5 Rosenbaum JF, Fava M, Hoog SL, Ascroft RC, Krebs WB: Selective serotonin reuptake inhibitor discontinuation syndrome. Biol Psychiatry 1998;44:77–87.
6 Fava GA, Rafanelli C, Tomba E, Guidi J, Grandi S: The sequential combination of cognitive behavioral treatment and well-being therapy in cyclothymic disorder. Psychother Psychosom 2011;80:136–144.
7 Fava GA, Grandi S, Rafanelli C, Fabbri S, Cazzaro M: Explanatory therapy in hypochondriasis. J Clin Psychiatry 2000;61:317–322.
8 Fava GA, Offidani E: The mechanisms of tolerance in antidepressant action. Progr Neuropsychopharmacol Biol Psychiatry 2011;35:1593–1602.
9 Bhanji NH, Chouinard G, Kolivakis T, Margolese HC: Persistent tardive rebound panic disorder, rebound anxiety and insomnia following paroxetine withdrawal: a review of rebound-withdrawal phenomena. Can J Clin Pharmacol 2006;13:69–74.
10 Chouinard G, Chouinard VA: Atypical antipsychotics: CATIE study, drug-induced movement disorder and resulting iatrogenic psychiatric-like symptoms, supersensitivity rebound psychosis and withdrawal discontinuation syndromes. Psychother Psychosom 2008;77:69–77.