CASE REPORT

Successful Discontinuation of Chronic Polypsychotropic Regimen and Resolution of Withdrawal Syndrome Through Nutrition and Lifestyle Interventions: A Case Report

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ABSTRACT

Background • A 38-year-old, female with a history of GAD, MDD, AN, and PTSD wanted to taper her multiple medications in preparation for pregnancy. Benzodiazepine medications, such as Klonopin and Restoril; antidepressants, such as Effexor; and anticonvulsant medications, such as Lamictal, can be habit-forming, and withdrawal symptoms can occur upon discontinuation of use. Polypharmacy can be implicated in poor clinical outcomes, and a strategic and supported medication taper may improve those outcomes.

Summary • After the primary MD unsuccessfully attempted to taper off the patient's psychotropic medications without lifestyle interventions, she was stabilized on a minimal regimen by an outside reproductive psychiatrist throughout her pregnancy. A second tapering was implemented by the primary MD after the patient had given birth and had established changes to her lifestyle. These lifestyle interventions included dietary changes, use of detoxification protocols, contemplative practices, and strategic supplement support in the setting of a powerful mindset shift. The patient experienced remarkable symptom remission after strategic discontinuation of medications through the addition of the lifestyle interventions. She also was able to heal the root-cause drivers of her psychiatric diagnoses. Currently she is symptom-free and medication-free after nearly 21 years.

Conclusions • This case demonstrates the effectiveness of lifestyle interventions and psychospiritual support to enable dramatic clinical change without withdrawal syndrome after cessation of medication. More important, the initial failed tapering underpins the notion that a diligent meditation practice may be necessary to heal root-cause drivers of psychiatric symptoms and withdrawal syndrome. The results may serve to inform practitioners assisting patients who wish to discontinue benzodiazepine and other psychotropic medications or patients who would like to try a nonpharmaceutical approach as a first-line therapy. (*Adv Mind Body Med.* 2019;33(3):22-30.)

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INTRODUCTION

Benzodiazepine medications, such as Klonopin and Restoril; antidepressants, such as Effexor; and anticonvulsant medications, such as Lamictal, can be habit-forming, and withdrawal symptoms can occur upon discontinuation of use. Polypharmacy can be implicated in poor clinical outcomes.

Additionally, a 2017 randomized controlled trial (RCT) found that only 6% of psychiatric patients who wish to discontinue antidepressant medications were able to successfully taper off the drugs. This study further suggested that patients who engaged longer-term antidepressant use—over 9 years—were less successful in discontinuing medication than those who had been on medications for less time. Finally, the study found no association between medication discontinuation and symptomatic relapse, underpinning the notion that many psychiatric symptoms aren't sufficiently managed by antidepressant medications.[1]

Furthermore, the medications have long-term effects, especially given that single doses of selective serotonin reuptake inhibitor (SSRI) medications can change the functional architecture of the human brain.[2] A recent meta-analysis of 15 RCTs, 4 open trials, 4 retrospective investigations, and 38 case reports has shown debilitating symptoms of withdrawal from these medications.[3] That analysis reported that antidepressant withdrawal symptoms can occur within a few days or after several weeks, and that gradual tapering does not eliminate the risk of withdrawal reactions. Symptoms can include gastrointestinal distress, agitation, insomnia, myoclonus, and suicidality.

Similarly, a 2015 editorial in *Psychotherapy and Pyschosomatics* called for a new classification of symptoms from withdrawal from SSRIs and other central-nervous-system drugs, because those symptoms are related to the withdrawal itself and are differentiated from the symptoms of the original diagnoses.[4] The authors recommended using a nuanced diagnostic criteria for withdrawal-syndrome subtypes and a gradual tapering over a long period of time.

Importantly, Jonathan E. Prousky described the psychotropic drug tapers of 14 patients from 2011 to 2013 and suggested that nutraceutical support can aid the withdrawal process.[5]

The burgeoning field of psychoneuroimmunology, which is supported by approximately 2 decades of medical literature demonstrating gut-brain bidirectionality,[11-14] has helped inform lifestyle interventions that can impact the nervous and immune systems, such as meditation and dietary changes that can positively influence mood and behavior. Within this framework of psychoneuroimmunology, medical practitioners can consider mental illness as a nonspecific indicator of bodily imbalance and inflammatory signaling. As such, lifestyle interventions represent a low-risk and potentially high-yield synergistic strategy to send a safety signal to the nervous and immune systems; measurable positive clinical outcomes can emerge within days.[15] A recent publication implied that 90 weeks is required for most patients to successfully complete a taper.[16]

Lifestyle interventions may take many forms, including dietary changes. For example, the dairy protein casein and the wheat protein gliadin[6] have been linked causally to a range of symptoms.[7] Notably, immunoreactivity to dairy and gluten is possible outside of a diagnosis of lactose intolerance or celiac disease.[8,9] Dairy products contain not only the inflammatory protein casein but also hormones and other signaling molecules such as exosomes that can induce Th_{17} T-cell differentiation.[10]

Additionally, one of the most scientifically validated forms of meditation,[17-19] Kundalini yoga, including right-nostril breathing and Breath of Fire, has been shown to decrease perceived stress,[23] improve pulmonary function[24] and potentially increase oxidation processes.[25] Right-nostril breathing stimulates unilateral effects on the heart[26] and the autonomic nervous system[27] and can modify cognitive processes.[28] Sat Kriya and Sudarshan Kriya have been shown to reduce PTSD symptoms in military veterans[29] and to reduce stress as measured by EEG and ECG,[30] and kriyas can help improve digestion and immunity.[31] Additionally, the Kirtan Kriya sequence,[20] a combination of focused breath visualization, movement, and chanting, has a growing literature that supports its effects on cognitive capacity and many subjective parameters of wellness.[21] Moreover, researchers theorize that predawn practice amplifies the effects of this meditation. The basis perhaps resides in the ancestral biorhythms embedded in human evolutionary history, wherein waking approximately 40 minutes before dawn at the coldest point of the night enables the healthiest and most resilient stress response.[22]

Given the evidence for lifestyle interventions, including dietary modifications and meditation, the primary MD theorized that a strategic and supported medication taper could improve outcomes for the patient in the current case study. They intended to determine if a gradually implemented, multimodal, lifestyle-based approach could achieve remission of generalized anxiety disorder (GAD), major depressive disorder, (MDD) anorexia nervosa (AN), and posttraumatic stress disorder (PTSD) as well as successful tapering of multiple classes of psychotropic drugs.

PATIENT INFORMATION

The patient was a 38-year old, married, female Caucasian, who was employed as a television producer. She had a history of generalized anxiety disorder (GAD), major depressive disorder (MDD), anorexia nervosa (AN), and posttraumatic stress disorder (PTSD) as an incest survivor. She had made an appointment for a prepregnancy consultation with the primary MD in her NYC-based practice with an expressed preference for tapering off her medications. Her initial appointment was on December 19, 2012. The patient has reviewed the case study and consented to discussion of all of the included information.

The patient reported that she had experienced a period of relative stability over the 10 years prior to her appointment, with some restrictive eating in response to stressors. She denied body-image motivation or preoccupation and indicated she had a chronic low appetite.

For 12 years after the year 2000, she had taken 250 mg of Lamictal at bedtime; 25 mg of Seroquel at bedtime, used for sleep; 75 mg of Effexor for depressed mood; 1 mg of Klonopin, at lunchtime and bedtime; 2 tablets of Tylenol with codeine at lunchtime and dinnertime, as prescribed by her previous psychopharmacologist, and she participated in weekly psychotherapy. She also and took Enbrel injections, 50 mg twice a week for psoriasis.

One year prior to her appointment, the patient had tapered her use of 25 mg of Seroquel over a 6-week period and had begun to taper her use of Effexor from 75 mg over a 3-month period after the tapering of the Seroquel on her own. She had experienced notable withdrawal symptoms over the course of this process. In October 2012, she had begun to taper Klonopin by 1 mg over several months and had discontinued her 2 mg dosage in the month prior to her appointment. She indicated that her withdrawal symptoms included nausea, headache, hot and cold flashes, diarrhea, word-finding difficulty, agitation, sedation, and insomnia. She had resumed Seroquel without effect in an effort to help with sleep.

Social and family history. The patient was born and raised outside of Boston, with an older sister and younger brother. Her mother suffered from depression, and her maternal grandfather had committed suicide. Her brother suffered from addiction and bipolar disorder (BD), and her father from BD and pedophilia.

Timeline.

born	8/19/74	
developed symptoms consisstent with depression, disordered eating, GAD, OCD	1997	trialed on Prozac
		titrated Prozac with no effect
		hospitalized at Renfrew for medical stabilization
	1999	hospitalized at Four Winds; treated with Neurontin, Remeron
		trialed on Prozac, Celexa, Zoloft, Temazapam
	2000	hospitalized at The Center; treated with Nerontin, Remeron
	2000	Lamictal (250 mg at bedtime), Seroquel (25 mg at bedtime)
		Klonopin (1 mg at lunch, 1 mg at bedtime), Tylenol with codeine (4 tabs)
		Effexor HR (75 mg)
Osteopenia	2008	
tapered off of Effexor XR	2012	
initial visit to Dr. Brogan with intent to taper Klonopin and Tylenol with codeine prepregnancy	Dec-12	initiated Klonopin and Tylenol tapers
	Jan-13	successfully tapered Tylenol with codeine
began Lamictal taper	Feb-13	
cross-tapered Klonopin to Valium	May-13	Last dose of Klonopin
initiated Seroquel taper	Jun-13	Last dose of Lamictal
	Jul-13	Last dose of Seroquel
	Aug-13	Last dose of Valium
eliminated caffeine, alcohol, nuts, grains, legumes, nightshades	Sep-13	
autonomic nervous system destabilization from withdrwal from 5 psychotropics.	Sep-13	Required medical disability leave due to withdrawal symptoms; Lamictal
		Resumed Lamictal and Klonopin
Severe BMDD to the point of hitting herself	Oct-13	initiated Restoril for sleep aid
gave birth to her daughter naturally	Apr-15	
began meditation practice	Jul-15	
began tapering Klonopin	Jul-16	
	Nov-16	last dose of Klonopin
began tapering Lamictal	Nov-16	
	Jun-16	Last dose of Lamictal
began tapering Restoril	Jan-18	
	Apr-18	last dose of medication

Diagnosis
Life Event
Treatment
Treatment Outcome

She was a victim of incest and was physically, emotionally, and sexually abused by her father and multiple colleagues and friends of her father's and by neighbors for her entire upbringing. Her parents divorced when she was a teenager, and she began smoking, drinking, and engaging in promiscuous relations at age 12. She was in a car accident her senior year of high school. She has few memories of that time. She briefly attended a military school and completed 2 years of college in Minneapolis prior to moving to New York City. Her sister is a present source of support, encouraging the patient into treatment at this time. The patient has worked at odd jobs and became a TV producer 8 years ago. She is married, and her husband manages a bar. She states that they have a great relationship. She has no contact with her father, who has remarried.

CLINICAL FINDINGS

Medical history. The patient had a jaw replacement in 1995, which was idiopathic and suspected to be secondary to abuse. Chronic psoriasis throughout her body but primarily localized to her joints beginning at age 13. During the taper process, her symptoms migrated to include her scalp, face, and vulva/perineum. She was diagnosed with osteopenia in 2008.

Psychiatric history. In 1997, the patient first developed symptoms consistent with depression, disordered eating, features of obsessive-Compulsive Disorder (OCD), and generalized anxiety with anxiety attacks. Her initial symptoms happened in the context of her father's announcement that he was remarrying. While she didn't have full recall of all of her history of incest and rape, the event triggered severe anxiety, panic, and insomnia. She began to experience weight loss, social withdrawal from friends and family, poor sleep, and lack of sociability.

The lack of support led her to seek clinical care as an outpatient. She was referred for psychopharmacology after a single visit with a psychotherapist, largely based on her family history of paternal BD and maternal MDD, according to the patient. She was given Prozac because her mother had a history of tolerating the medication.

Her restrictive eating continued, and she lost 30 pounds in 1 month; she was 5 feet, 7 inches tall and initially weighed 95 lbs. Despite attendance at Overeaters Anonymous (OA) meetings as a source of support for dysfunctional relationship to food and treatment with Prozac, she was hospitalized for medical stabilization. During this hospitalization, Prozac administration was continued and titrated with no effect. She recalls the community as the most positive aspect of this treatment.

During this time of intense destabilization, she experienced panic, hopelessness, fear, fits of crying, and an uncontrollable urge to hurt herself, in addition to her food restriction. She would hurl herself into walls, bang her head repeatedly on the floor, or punch herself in the stomach, but she never disclosed these actions to her practitioner. She would also scavenge for opiate painkillers as she had learned during jaw-reconstruction surgery that opiates allowed her some moments of relief and calm.

After her initial hospitalization, when her weight stabilized a bit, she was flooded with vivid memories of sexual abuse. She then began to regularly see a therapist to process these memories in addition to behavioral management of her disordered eating, initially 2 to 3 times per week.

She saw different psychiatrists during this time who tried a number of medications with limited efficacy including: (1) Prozac, Celexa, and Zoloft, reported as ineffective; (2) Temazapam, reported as ineffective; and (3) Neurontin and Remeron during hospital stays. She also had chronic exposure to oral contraceptives, antibiotics, and steroids.

It was this lack of relief, more traumatic memories, and another phase of isolation that led to her hospitalization in 1999 and 2000. She recalls her hospitalization in the psychiatric unit of a hospital in 1999 as being very pharmaceutically aggressive, with significant attendant side effects. She returned to outpatient treatment a couple of months after hospitalization in an attempt to find a patient population that was more reflective of her experience of abuse and assault. Her medications were modified due to sedative and cognitive-blunting side effects, and she was then referred to a prominent psychopharmacologist in New York City, who established her chronic regimen of Effexor, Codeine, Klonopin, Lamictal, and Seroquel, as mentioned above. She had no personal history of substance abuse.

Diagnostic Assessment

Initially, the primary MD had the patient describe her typical daily diet and list her medications and supplements. A mental status examination was also performed.

Dietary habits. At the time of her appointment, the patient's daily diet typically included cereal or a protein bar and a vanilla whole-milk latte for breakfast; a muffin or a peanut-butter-and-jelly sandwich for lunch; graham crackers as a snack; chicken with quinoa and broccoli for dinner; and pink lemonade and chocolate-and-peanut-butter fudge squares as a snack or dessert.

Medications and supplements. The patient was taking 50 mg of Enbrel by injection twice weekly, Flonase daily, 250 mg of Lamictal, 25 mg of Seroquel nightly, 1 mg of Klonopin nightly, and Tylenol with codeine twice daily.

Mental status examination. The patient was dressed in casual attire and was tall and thin with prominent skeletal features, dark shoulder-length hair with bangs, and light eyes. She was cooperative and friendly throughout the session. She showed no visible gait abnormalities or psychomotor retardation or agitation, and her speech was within normal limits. Her mood was not great, but her affect was reactive and stable. Her thought process was logical and goal-directed. Her thought content contained no suicidal, homicidal, or paranoid ideation or auditory or visual hallucinations. She expressed no ruminations or preoccupations beyond withdrawal discomfort. She displayed

good insight and judgment and was oriented to person, place, and time.

Laboratory testing. The patient's laboratory results all were within normal limits.

Tapering off psychotropic medications. The first taper focused solely on reduction of medication (as well as taking many supplements, detailed below). The patient was also cross-tapered from Klonopin to Xanax, which was deemed very ineffective. The patient did not make any dietary or lifestyle changes in the first taper. The second taper occurred after the patient made significant dietary changes, took targeted supplements, began a meditation practice (Kundalini yoga), and began exercising regularly, and the patient reports that her starting points were quite different between the two tapers. She became pregnant after her first taper, and she began the second taper after childbirth, while nursing.

INTERVENTIONS

At the patient's initial consultation, the risks, benefits, and types of treatment alternatives were reviewed, and alternative treatments were initiated, including acupuncture, craniosacral therapy, and homeopathy. The patient also was provided with resources for self-education and support, and an anti-inflammatory traditional diet was discussed.

The patient was initially tapered off medications by following a commonly-accepted practice of supporting minimal dosage decrements with corresponding supplementation (please see Detoxification Protocol) and avoiding the tapering of multiple drugs simultaneously. This first tapering attempt was unsuccessful, and the second taper was implemented after the patient had given birth and had established changes to her lifestyle. These lifestyle interventions included dietary changes, meditation, dietary supplements, and use of detoxification protocols. The treatment also included recruitment of psychospiritual support.

Dietary protocol. The dietary protocol prescribed and gradually adopted by the patient was based on scientific literature implicating food-based proteins in psychiatric symptomatology. For example strict avoidance of gluten and dairy was recommended as a low-risk and potentially high-yield clinical intervention because of the link of the dairy protein casein and of the wheat protein gliadin[6] to a range of symptoms.[7] As such, the patient was prescribed a diet that excluded antigenic foods such as gluten and dairy and included a high proportion of nutrient-rich and high-fat foods.

Detoxification Protocol. The primary MD recommended the following supplements:

Supplements Prescribed During the First Taper:

PharmaNAC. The patient took 900 mg daily of PharmaNAC for antioxidant support and anxiolytic effect (Bioadvantex, Mississauga, Canada).

Inositol. The patient took 6 g three times daily of Inositol for anxiety (Pure Encapsulations, Sudbury, MA, USA).

Total Amino Solutions. The patient took 6 capsules three times daily of Total Amino Solutions for general support (Genesa Brentwood, CA, USA).

B_{12} hydroxycobalamin. The patient took 5 mg intramuscularly weekly of B_{12} hydroxycobalamin for cognition, mood, energy (Johnson Compounding Pharmacy, Waltham, MA, USA).

Best Rest. The patient took 2 capsules nightly of Best Rest for sleep support (Pure Encapsulations, Sudbury, MA, USA).

Ultra B Complex with PQQ. The patient took 2 capsules daily of Ultra B Complex for cognition, mood, energy (Pure Encapsulations, Sudbury, MA, USA).

Empower Plus. The patient took 3-5 capsules three times daily of Empower Plus for general support as a multimin/vit (TrueHope, Raymond, AB Canada).

Taurine. The patient took 1g of taurine as needed for anxiety (Pure Encapsulations, Sudbury, MA, USA) 1g as needed.

Neurocalm. The patient took 2 capsules three times daily of Neurocalm for anxiety and SNRI withdrawal support (Pure Encapsulations, Sudbury, MA, USA).

Femmenessence. The patient took 4 capsules daily of Femmenessence for hormonal support (Natural Health International, Lima, Peru).

Daily Essentials. The patient took 3-5 capsules twice daily of Daily Essentials for general support as a multimin/vit (Hardy Nutritionals, Alberta, CA).

Stress Calm. The patient took 2 capsules of Stress Calm as needed for anxiety (Restorative Formulations, Montpelier, VT, USA).

Lavela. The patient took 2 capsules nightly of Lavela for anxiety (Integrative Therapeutics, Green Bay, WI, USA).

Seriphos phosphorylated serine. The patient took one capsule nightly of Seriphos for sleep support (Interplexus, Kent, WA, USA).

L-Tryptophan. The patient took 500-1500 mg nightly of L-tryptophan for SNRI withdrawal support (Pure Encapsulations, Sudbury, MA, USA).

Grounded. The patient took one scoop nightly of Grounded for sleep support (Pacific BioLogic, Concord, CA, USA).

De-Stress. The patient took 2-4 capsules of De-Stress as needed for acute anxiety (Biotics Research, Rosenberg, TX, USA).

Niacinamide. The patient took 500 mg of niacinamide as needed for anxiety (Pure Encapsulations, Sudbury, MA, USA).

Glycine. The patient took 1 g nightly of glycine for sleep support (Pure Encapsulations, Sudbury, MA, USA).

Calm PRT. The patient took 2 capsules nightly of Calm PRT for sleep support (Neuroscience, Osceola, WI, USA).

RelaxMax. The patient took 1 scoop twice daily of RelaxMax for anxiety (Xymogen, Orlando, FL, USA).

Melatonin. The patient took 10 mg of melatonin as needed for anti-oxidant support (Pure Encapsulations, Sudbury, MA, USA).

Same-e. The patient took 1200 mg daily of Same-e for mood support (Jarrow, Los Angeles, CA, USA).

Pregnenolone. The patient took 8 drops daily of Pregnenolone for hormonal support (Biomatrix, Weston, FL, USA).

Adrenal capsules. The patient took 4 adrenal caps (Allergy Research Group, Alameda, CA, USA) after lunch.

Meriva. The patient took 500 mg of Meriva for mood and anti-inflammatory effects (Thorne, Berkeley County, SC, USA) before bed.

LDN. The patient took 4.5 mg nightly of LDN for immune modulation and mood support (Johnson Compounding Pharmacy, Waltham, MA, USA).

Cytozyme-AD. The patient took one tablet daily of Cytozyme-AD for stress response support (Biotics Research, Rosenberg, TX, USA).

DL-phenylalanine. The patient took 500-1000 mg daily of DL-phenylalanine for SNRI withdrawal support (Pure Encapsulations, Sudbury, MA, USA).

L-tyrosine. The patient took 500-1000 mg daily of L-tyrosine for SNRI withdrawal support (Pure Encapsulations, Sudbury, MA, USA).

Acetyl glutathione. The patient took 2 capsules daily of acetyl glutathione for anti-oxidant/anti-inflammatory effects (Allergy Research Group, Alameda, CA, USA).

Thyrocalm. The patient took 2 capsules daily of Thyrocalm (Restorative Formulations, Montpelier, VT, USA).

Supplements Prescribed During the First and Second Tapers

PharmaGABA. The patient took 500 mg of PharmaGABA as needed for anxiety and 500 mg of PharmaGABA as needed before bed (Designs for Health, Palm Coast, FL, USA).

Vitamin D Supreme. The patient took one capsule daily of Vitamin D Supreme for immune, mood, and hormonal support (Designs for Health, Palm Coast, FL, USA).

Oxytocin. The patient took 40 IU intranasally of Oxytocin for mood support (Johnson Compounding Pharmacy, Waltham, MA, USA)

Ultimate Omega Fish Oil. The patient took 2 g daily of fish oil for anti-inflammatory effects and mood support (Nordic Naturals, Watsonville, CA, USA).

Hypothalamus glandular. The patient took 2-4 nightly and as needed for anxiety (Allergy Research Group, Alameda, CA, USA).

Licorice root. The patient took 1/4 teaspoon of licorice root for adrenal support/fatigue (Wise Woman Herbals, Creswell, OR, USA) before breakfast and before lunch.

Magnesium citrate. The patient took 250 mg of magnesium citrate for calming effect (Integrative Therapeutics, Green Bay, WI, USA) after breakfast after lunch after dinner and before bed.

Prenatal pro. The patient took 2 capsules after breakfast one capsule after lunch and 2 capsules after dinner for general multivit/min support (Designs for Health, Palm Coast, FL, USA).

Therbiotic complete. The patient took one capsule of Therbiotic complete for digestive support (Klaire Labs, Reno, NV, USA) after breakfast.

Vitamin D supreme. The patient took Vitamin D supreme (Designs for Health, Palm Coast, FL, USA)—5000 IU vitamin D 500 mcg vitamin K_1 and 50 mcg vitamin K_2—after breakfast.

Cod liver oil. The patient took one teaspoon of cod liver oil for general support (Carlson, Arlington Heights, IL, USA) after dinner.

Progesterone cream. The patient used 10 mg nightly of progesterone cream for hormonal support (Emerita, California, USA) before bed.

Supplements Prescribed During the Second Taper:

Flower remedies. The patient took 3 drops of each of the following remedies for emotional support (Bach, California, USA): olive, crab apple, larch, pine, rock rose, rock water, cherry plum, and clematis.

Interventions Employed During the Tapers:

Meditation. Kundalini yoga meditation[17-19] was employed. Specifically, the patient was prescribed the Kirtan Kriya sequence,[20] a combination of focused breath, visualization, movement, and chanting. The patient performed 11 minutes of Kirtan Kriya meditation daily, beginning in early 2016. She tried a number of Kundalini meditations, including right-nostril breathing and Breath of Fire. She also employed Sat Kriya and Sudarshan Kriya.

Psychospiritual Support. The patient worked one-on-one with two counselor/energy healers during the second taper (Swaranpal, a Kundalini yoga teacher, and a counselor who used Emotion Code and Soul Detective). Additionally, the patient sought psychospiritual support through acupuncture and engagement with the Kundalini community.

Cranial Electrical Stimulation. The process used a cranial electrical stimulator from Fisher Wallace (NY, NY, USA), a self-administered device that delivers a bipolar wave form to stimulate neurochemical balance. This technique was employed was during the first taper, and the patient self-administered this treatment at home.

Emotional Freedom Techniques (EFTs).

The patient started engaging EFT in late 2017 during the successful (second) taper, a self-administered acupressure and affirmation-based technique for anxiety. The patient employed these techniques at home by herself.

Exercise. The patient began to gradually introduce regular cardiovascular exercise, beginning with long daily walks, extended periods of rebound jumping, and then cycling classes and vinyasa yoga.

Acupuncture. The patient began to receive regular weekly to biweekly acupuncture.

OUTCOMES

Unsuccessful Taper

In her initial appointment on December 19, 2012, the patient wished to begin a gradual taper of Klonopin and Tylenol with codeine. The Klonopin taper was initiated at 0.125 mg per week. She successfully tapered Tylenol with

codeine within 1 month and experienced limited side effects from this change.

At a follow-up appointment on February 19, 2013, the patient had reduced her Klonopin dosage to 0.25 mg in the morning and 0.875 mg in the evening. She maintained her Lamictal dosage at 150 mg and her Seroquel dosage at 50 mg. She agreed to initiate a Lamictal taper at 25 mg per week while keeping Klonopin steady.

Approximately 1 month later, the patient's Lamictal dosage was down to 125 mg in divided doses, and Klonopin was down to 0.75 mg at night in contrast to 2 mg. The primary MD recommended that the patient continue to taper Lamictal by 12.5 mg weekly while keeping Klonopin stable.

Klonopin was tapered to 0.625 mg and remained stable while Lamictal was tapered to 50 mg in May 2013. At this point, the patient cross-tapered Klonopin to 5 mg of Valium, with the intent of tapering Valium at 1mg/week. The last dose of Klonopin was on May 4, 2013.

In June 2013, the patient had tapered Lamictal from 250 mg to 12.5 mg at bedtime and had initiated a taper of Seroquel, which had been dosed at 25 to 50 mg for sleep. Her last dose of Lamictal was on June 25, which she followed by eliminating dairy, gluten, eggs, and yeast on June 27. Note that the timing of this dietary intervention was near the end of the taper process, 8 months after the taper began. Her last dose of Seroquel was on July 19. Her last dose of Valium was on August 31.

She continued to implement dietary interventions, eliminating caffeine and alcohol on September 6 and nuts, grains, legumes, and nightshades on September 10.

On September 15, the patient wrote in her journal that she had become very angry, overwhelmed, aggressive, and unable to cope with anything, and she punched the wall. She reported via phone message on September 17 that she had resumed Lamictal to manage these symptoms.

In an appointment on September 17, the patient required a medical disability leave. She received 0.5 mg Klonopin and restarted Lamictal at 25 mg.

At a follow-up appointment on September 24, the patient reported medication dosages of 0.125 mg of Klonopin and 6.25 mg of Lamictal. She increased Lamictal to 100 mg and began Restoril on October 16, reporting that these medications provided some symptom relief.

From October 2013 to July 2016 the patient remained on 250 mg of Lamictal, 1 mg of Klonopin, and 15 mg of Restoril at night. In an appointment on October 29, the patient indicated she had severe body dysmorphic disorder (BMDD) to the point of hitting herself. She was treated throughout her pregnancy by a reproductive psychiatrist.

The patient gave birth to her daughter naturally on April 2, 2015 and initiated breastfeeding. She reported feelings of well-being with her daughter that she had never felt previously.

Successful Tapering

On July 13, 2015, the patient began a meditation practice that she had been unable to do previously. In early 2016, the patient returned to work at what she described as a dream job, and in July 2016, she began tapering Klonopin with dietary, meditative, and environmental/personal detox practices, including rebounding, dry skin brushing, and a period of coffee enemas.

In an appointment on August 10, 2015 the patient described withdrawal symptoms related to coming down from 0.8 mg to 0.5 mg of Klonopin, including nausea, headache, diarrhea, racing heart, extreme sweating, flushing, chills, interrupted sleep, insomnia, dizziness, vertigo, and frequent illnesses, including pneumonia twice. She completely discontinued Klonopin in November 2016 and began to taper Lamictal by 12.5 mg every 2 weeks. In March 2017, the patient revised her taper of Lamictal to 6.25 mg every 2 weeks, and she successfully completed the Lamictal taper on June 1 (Figure 1). In January 2018, the patient had tapered down to 10 mg of Restoril, by 1 mg every 1-3 weeks (Figure 2).

Figure 1. Lamictal and Klonopin dosages during taper period.

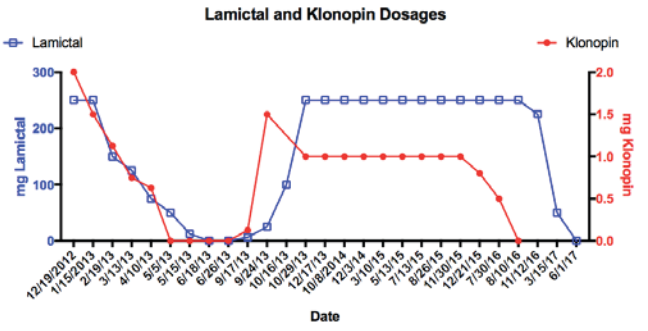
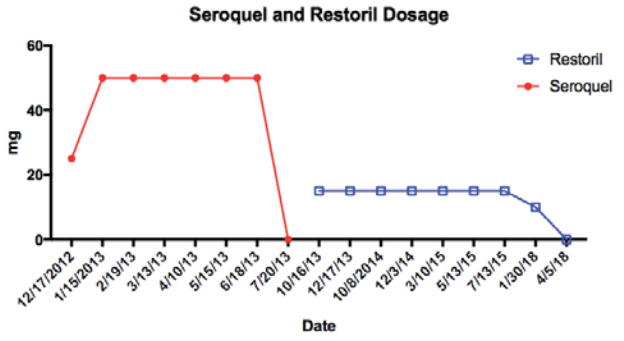


Figure 2. Seroquil and Restoril dosages during taper period



PATIENT PERSPECTIVE

The patient sent an email to the primary MD indicating that she had taken her last medication on April 5, 2018. She said it was a relief to not need to rely on a doctor, pharmacy, and pill. She thanked the primary MD for introducing her to practices, healers, modalities, science, and ideas that had been incredibly crucial to her healing and learning journey. Notably the patient has remained psychiatrically and physically symptom-free for 20 months.

In summarizing her experience for the authors, the patient wrote:

> There were two primary differences between the two tapers that contributed to their outcomes. Before initiating the second (successful) taper, I (1) developed a meditative practice, and (2) my mindset regarding my situation, and medications, had shifted as I did healing preparation.
>
> Before I began the second taper, I adopted a steadfast, daily meditative practice. I believe that it was this practice, coupled with my mindset shift, that allowed me to complete the taper. This was a crucial piece— that this daily practice be established, routine, and effective before I began to taper.
>
> My mindset going into the first taper was very desperate, as I urgently wanted to be off of all medications and felt trapped as I was 'stuck' on them. There were really no interventions that offered any significant relief during this taper (supplements, dietary changes, acupuncture, craniosacral work, homeopathy, etc) because of this persistent desperation.
>
> However, my mindset going into the second taper was different. I had made some peace about being on medications and therefore I had no expectations about restarting the taper process, or the outcome. Releasing expectations opened up the space I needed in order to successfully stop taking medications.
>
> Additionally, while I appreciate the apparent need for some medications in an acute setting, I nonetheless believe the doctors that treated me over the years did me a disservice by never discussing or considering any sort of timeline or plan for stopping these medications, particularly those that have very straightforward negative health effects with long-term use."

DISCUSSION

This case illustrates the habit-forming potential and associated withdrawal symptoms of benzodiazepine medications. The patient experienced alarming withdrawal symptoms when tapering down medications at milligram levels, and successful discontinuation required an ever-evolving suite of dietary and lifestyle interventions. Furthermore, sustained support from a diverse group of highly-trained practitioners was necessary.

These current findings are consistent with the 2017 RCT that found that only 6% of psychiatric patients who wish to discontinue antidepressant medications were able to successfully taper off the drugs.[1] Furthermore, this case provides an invitation to examine the long-term effects of medications. The debilitating withdrawal symptoms illustrated in this case report are consistent with the findings of the recent meta-analysis mentioned previously,[3] with antidepressant withdrawal symptoms occurring within a few days and with gradual tapering not eliminating the risk of withdrawal reactions.

The current case study of severe withdrawal syndrome joins the compiled reports of Jonathan E. Prousky, who suggested that nutraceutical support can aid the withdrawal process.[5] In this case the notable shift in capacity to taper successfully, however, was marked by a comprehensive approach to self-care, including a daily meditation practice and a mindset shift.

This case contributed notably to the authors' clinical observations that pre-emptive lifestyle interventions prior to tapering medications can lead to successful discontinuation. This first taper didn't succeed, as evidenced by the patient's destabilization and subsequent disability assignment in September 2013, approximately 9 months after initiation of tapering Klonopin and Lamictal. This failure indicated that the current clinical protocols for psychotropic drug tapering can be insufficient, and the authors' clinical experience with the patient in the current case study and with dozens of more recent patients have shown that additional autonomic, emotional, and spiritual support is required to complement the conventional dietary and supplementation changes. The patient in the current case study attests that a steady meditation practice was key to her successful taper.

CONCLUSION

Based on the outcome of this case, medication tapering combined with dietary and lifestyle interventions focused on meditation as the first-line therapy should be considered when symptoms are not managed by medication alone. The current case, which exemplified dramatic clinical remission of withdrawal syndrome after cessation of medications and engagement of lifestyle interventions, demonstrated the potential effectiveness of dietary changes, meditation, and detoxification protocols. This case complements other reports showing the utility of mind-body techniques in the setting of anxiety and agitation. The results may serve to inform practitioners assisting patients who wish to discontinue benzodiazepine and other psychotropic medications or patients who would like to try a nonpharmaceutical approach as a first-line therapy.

AUTHORS' DISCLOSURE STATEMENT

No conflicts of interest to declare.

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