



Antidepressant Withdrawal or Discontinuation Syndrome?

Concern with antidepressant withdrawal or “discontinuation syndrome” seems to be intensifying in the professional literature as more and more evidence accumulates about the risks of taking, and then stopping their use. “Despite its prevalence, the SRI discontinuation syndrome is under-recognized by both clinicians and patients.” (Shelton 2006, 3) In addition, both clinicians and patients may incorrectly attribute discontinuation symptoms to a relapse of the underlying psychiatric illness for which the SSRI was prescribed, or to another psychiatric or medical condition.

Joanna Moncrieff noted that individuals who appear to relapse into recurrent depression after discontinuing long-term maintenance treatment with antidepressants are often seen as strong evidence for the efficacy of antidepressants. She stated that the evidence does not warrant that conclusion. “Studies of maintenance or long-term treatment are effectively discontinuation studies.” (Moncrieff 2007, 97) Maintenance study participants are typically individuals who have improved on antidepressants, but are then randomized into treatment groups (who continue on antidepressants) and placebo groups (where the antidepressant is withdrawn—usually quite rapidly—and replaced by a placebo). Antidepressants are now widely recognized to be associated with a discontinuation syndrome; and the rapid withdrawal/discontinuation method virtually ensures the presence of withdrawal symptoms. These discontinuation symptoms potentially invalidate the maintenance trials not only because they may be mistaken for early signs of relapse, but also because of a “nocebo effect” where negative expectations cause physical illness or psychological distress. Participants who initially “responded” to antidepressants and are likely to believe in their efficacy and have negative expectations about going off of antidepressants.

Peter Breggin (2008a, 418) stated that SSRI withdrawal symptoms can be very severe and long lasting. “These often severe symptoms were ignored for years and even today are too often ignored by a psychiatric community bent on blaming the patient’s suffering on a so-called mental illness.” All of the newer antidepressants (Prozac, Paxil, Lexapro, Zoloft, Celexa, and Effexor) can be extremely difficult to withdraw from. These withdrawal symptoms include a range of emotional reactions from anxiety to depression and mania, as well as physical one like “ringing in the ears, dizziness and feelings of instability.” What follows is a summary of common antidepressant withdrawal symptoms given by Breggin (2008b, 298):

- Psychiatric–mood swings; anxiety and severe panic; depression, mania; suicidal feelings, irritability and excessive anger, insomnia, vivid dreams
- Abnormal neurological sensations–dizziness, spinning or feelings of instability; abnormal skin sensations; abnormal sounds and noise hypersensitivity; shock-like feelings especially in the head
- Abnormal movements–tremor; muscle spasms; impaired balance and drunk-like walking
- Gastrointestinal–anorexia; nausea; vomiting; diarrhea
- Whole body–weakness; extreme tiredness and fatigue; muscle pain; chills; sweating
- Others–visual problems; hair standing on end; flushing (persistent blushing)

Writing from within the ‘psychiatric community,’ Richard Shelton (2006) said the serotonin reuptake inhibitor (SRI) discontinuation syndrome is characterized by the rapid onset of one or more symptoms, such as: crying, dizziness, headache, increased dreaming, insomnia, irritability, myoclonus [brief, involuntary twitching of a muscle or a group of muscles], nausea (with occasional vomiting), paresthesias (including ‘electrical sensations’), and tremor. Maurizio Fava’s (2006) literature review added a few somatic symptoms like fatigue, chills, balance difficulties and diminished appetite; and several psychological symptoms: agitation, anxiety, akathisia [restlessness that manifests itself with an inability to sit still or remain motionless], panic attacks, aggressiveness, worsening of mood, dysphoria [feeling unwell or unhappy], overactivity or hyperactivity, depersonalization, decreased concentration, slowed thinking, confusion, and memory/concentration difficulties.

Fava (2006) said that patients seemed to have a mix of somatic and psychological symptoms. He found that of the patients who were on maintenance therapy with

paroxetine (Paxil), sertraline (Zoloft), or sertraline (Zoloft), Paxil patients had the highest rate of discontinuation symptoms with 8 reported by at least 10% of the participants: dizziness, 29%; nausea, 29%; insomnia, 19%; headache, 17%; abnormal dreams, 16%; nervousness, 16%; asthenia, 11%; and diarrhea, 11%. Zoloft had 4: dizziness, 18%; headache, 18%; nervousness, 18%; and nausea, 11%. Prozac had only 1: headache, 16%. Antidepressants with relatively shorter half-lives like Paxil and Effexor are more likely to have discontinuation reactions than those with longer half-lives like Prozac, Zoloft, Lexapro. Schatzberg et al. (2006) noted three separate studies that also found Paxil to have more frequent and more severe discontinuation symptoms. They theorized it was because of Paxil's high affinity for the serotonin (5-HT) transporter and its shorter half-life.

Shelton (2006) argued there was a distinction between discontinuation and withdrawal, mainly because of the absence of persistent drug craving¹ with antidepressants. "Individuals who discontinue SRIs typically do not consciously crave antidepressants, nor do they exhibit drug-seeking behavior." (Shelton 2006, 4) Further, SRI discontinuation syndrome generally involves the return of some of the symptoms of the underlying disorder, such as anxiety and depressed mood; with non-disease characteristics such as flu-like symptoms and paresthesias [a sensation of tingling, pricking, or numbness of a person's skin]. He also stated that discontinuation was time-limited to no more than 2 or 3 weeks. Anything present 3 weeks after discontinuation or dosage change is not related to discontinuation; but may be related to a relapse or recurrence of the underlying disorder or due to another illness.

Slow tapering and/or drug substitution are recommended to minimize and/or prevent SRI discontinuation syndrome (Rosenbaum and Zajecka 1997; Schatzberg et al. 2006; Shelton 2006) Schatzberg et al. (2006) suggested tapered antidepressant withdrawal with a course of treatment as short as 3 to 4 weeks. Clinicians were told to reassure patients that discontinuation syndrome is easily managed; and to emphasize that "SRI discontinuation does not indicate addiction or dependence." (Schatzberg et al. 2006, 30) Patients should also be reminded frequently during the course of taking antidepressants that discontinuation symptoms can occur if the antidepressant is stopped abruptly.

¹ Persistent drug craving is not characteristic of all alcohol or drug dependent individuals.

The primary reason it seems that Shelton and others want to make this distinction between antidepressant discontinuation syndrome and addictive withdrawal is because of the “negative connotation associated with the term withdrawal.” (Shelton 2006, 4) He cited a source that suggests that as many as 78% of people believe antidepressants are addictive. Using the ‘proper terms’ can alleviate patient concerns about taking antidepressants. In other words, it seems the distinction is a rhetorical device to distance the use of antidepressants from the social stigma of using psychoactive substances like cocaine. The bottom line is that when an individual stops using (discontinues) antidepressants, they can potentially experience a range of physical and psychological symptoms. At times, those symptoms can be rather severe, and a controlled, gradual tapering of the drug is best. The identical strategy, gradual tapering and drug substitution, are often the methods used by individuals attempting a ‘self-detox’ from common drugs of abuse. A drug is a drug, is a drug. Antidepressants and drugs of abuse have many similar symptoms of withdrawal/discontinuation when the mind altering/mood changing chemical has been ingested by an individual regularly over an extended period of time.

In order to illustrate this point, look at the following comparison of ‘withdrawal symptoms’ for the various classes of drugs of abuse listed on a DEA web page.² The symptoms in bold type are identical or very similar to the symptoms described above and those listed on the Discontinuation-Emergent Signs and Symptoms (DESS) Scale developed by Fava (2006) and recommended by Schatzberg et al. (2006) for evaluating discontinuation symptoms. *Opioid narcotics*: **watery eyes, runny nose**, yawning, **loss of appetite, irritability, tremors, panic, cramps, nausea, chills and sweating**. *Depressants (i.e., benzodiazepines)*: **anxiety, insomnia, tremors**, delirium, convulsions, possible death. *Stimulants*: **apathy**, long periods of sleep, **irritability, depression, disorientation**. *Hallucinogens like MDMA*: **Muscle aches, drowsiness, depression**, acne. *Cannabis*: occasional reports of **insomnia, hyperactivity, decreased appetite**. *Anabolic Steroids*: **possible depression**. *Inhalants*: **agitation**. *Alcohol*: **trembling, anxiety, insomnia**, vitamin deficiency, **confusion, hallucinations**, convulsions.

Additionally, the existence of what are referred to as post acute withdrawal (PAW) symptoms in addiction treatment and recovery grow to a peak intensity between three

² See the chart: [“Drugs of Abuse/Uses and Effects”](#) on the U.S. Drug Enforcement Administration web site for more information.

and six months after abstinence begins; and they can be present much longer. “Post acute withdrawal is a bio-psycho-social syndrome. It results from the combination of damage to the nervous system caused by alcohol or drugs and the psycho-social stress of coping with life without drugs or alcohol.” (Gorski and Miller 1986, 58) Typical PAW symptoms include: the inability to think clearly, memory problems, emotional overreactions, sleep disturbances, physical coordination problems (dizziness, trouble with balance, slow reflexes and problems with hand-eye coordination), and problems managing stress. All of these PAW symptoms are replicated on the DESS or are described in the literature on antidepressant discontinuation/withdrawal.

The popular press continues to address the issue as well. An Associated Press article³ by Matt Crenson described the case of a Michigan woman who decided that she no longer needed to use Paxil to treat her anxiety and panic attacks. She followed her doctor’s orders by slowly tapering her dose as directed, but it didn’t work. “I felt so sick that I couldn't get off my couch. . . . I couldn't stop crying.” Overwhelmed by nausea and uncontrollable crying, she felt she had no choice but to start taking Paxil again. More than a year later, the Michigan woman expected to be on it for the rest of her life.

A Kansas woman was switched from Zoloft to Wellbutrin by her doctor, who told her that the new drug would take the place of the old one. These two antidepressants work on different neurochemical systems, “so going straight from one to the other was equivalent to quitting Zoloft cold turkey.” After three days she felt anxious and irritable. “I would shake, not eat much, it felt like little needles in my body and head.”

Critics of the pharmaceutical industry complain that drug companies downplay the severity of drug discontinuation symptoms and the use of terms like “antidepressant discontinuation syndrome” demonstrate the pharmaceutical industry's efforts to downplay the problem, charged an attorney involved in litigation over the phenomenon. “Withdrawal is the word that is used in Europe.” said Karen Menzies.

Making Drug Withdrawal as Safe as Possible

Peter Breggin (2008a; 2008b) has given reasoned, careful guidelines for tapering off of psychiatric drugs. He emphasizes to not attempt a taper or gradual withdrawal on your own. Find and use experienced clinical supervision during drug withdrawal. Take your time. “Don’t let yourself be talked into a rapid withdrawal without good reason

³ [“Antidepressants prove addictive to some.”](#)

and do not push yourself beyond your emotional limits!” (Breggin 2008b, 293) Before trying to withdraw from psychiatric drugs, take four basic steps:

1. Inform Yourself about the Drugs, Including Withdrawal Risks.
2. Ask a Health Professional with Experience in Drug Withdrawal to monitor Your Progress.
3. Inform Friends or Family that You Are Withdrawing from Medication and Ask Them to Keep a Daily Eye on You.
4. Seek Advice and Counsel but Rely on Your Own Judgment about Withdrawing from Medication. (Breggin 2008b, 294-295)

Always use a gradual, slow taper over time. Breggin suggests a month of withdrawal for every year of drug exposure. If you are on more than one medication and want to taper off of them, it is generally better to taper one drug at a time. Thorough medication monitoring is important. “It has sometimes taken more than a year to withdraw patients from a mixture of four or five drugs.” (Breggin 2008b, 295)

Any decision to withdraw from psychiatric drugs needs to be a carefully considered decision. In learning about the drugs, start with the information available in Peter Breggin’s writings. He has a web site (breggin.com) and several books on various psychiatric drugs. The two noted above with guidelines for tapering off of psychiatric drugs are *Medication Madness* and *Brain-Disabling Treatments in Psychiatry*.

Bibliography and Works Cited

Breggin, P. (2008a). *Brain-Disabling Treatments in Psychiatry*, 2nd edition. New York: Springer Publishing Company.

Breggin, P. (2008b). *Medication Madness*. New York: St. Martin's Press.

Fava, M. (2006). "Prospective Studies of Adverse Events Related to Antidepressant Discontinuation." *Journal of Clinical Psychiatry*. vol. 67, suppl. 4, 14-21.

Gorski, T, and M. Miller. (1986). *Staying Sober*. Independence, MO: Independence Press.

Moncrieff, J. (2007). "Are Antidepressants as Effective as Claimed? No, They Are Not Effective at All." *Canadian Journal of Psychiatry*. vol. 52, 96-97. Available online at: [Canadian Journal of Psychiatry](#).

Rosenbaum, J. F. and J. Zajecka. (1997). "Clinical Management of Antidepressant Discontinuation." *Journal of Clinical Psychiatry*. vol. 58, suppl. 7, 37-40.

Schatzberg, A. F., P. Blier, P. L. Delgado, M. Fava, P. Haddad, R. Shelton. (2006). "Antidepressant Discontinuation Syndrome: Consensus Panel Recommendations for Clinical Management and Additional Research." *Journal of Clinical Psychiatry*. vol. 67, suppl. 4, 27-30.

Shelton, R. (2006). "The Nature of the Discontinuation Syndrome Associated With Antidepressant Drugs." *Journal of Clinical Psychiatry*. vol. 67, suppl. 4, 3-7.