MALISSA PISTILLO

Dear Doctor

ANTIDEPRESSANTS

Dear Doctor,

My name is Malissa Pistillo, and I am writing as a psychotropic-drug harm awareness advocate and survivor. I'm sharing current, evidence-based guidance on antidepressant withdrawal—including protracted withdrawal—and the fact that these medications can cause physical dependence, with emphasis on patient-centered tapering to support safer prescribing and deprescribing.

What We Are *Asking*

Shared decision-making — Please include patients and caregivers in the choice to continue or taper, with informed consent about withdrawal risks (including protracted courses) and practical taper options.[2] [3]

Gradual, hyperbolic tapering — Please individualize reductions and slow further at lower doses (a hyperbolic pattern). Experts generally suggest starting with 5–10% reductions, but some patients will require going as low as 2% every few weeks or longer, particularly at the lowest doses. Expert guidance also recommends tapering to well below minimum therapeutic doses to mitigate withdrawal.[8] (See also Horowitz & Taylor, Maudsley Deprescribing Guidelines, 2024.[4])

Accurate recognition of withdrawal vs. relapse — Many withdrawal syndromes, including protracted cases, are often misdiagnosed as relapse. The DAWSS clinical features proposed by Moncrieff, Read & Horowitz (2024) can help distinguish withdrawal from recurrence.[2]

Access to safe formulations — Please enable very small dose steps options (e.g., liquids or compounded preparations, scored tablets, bead-counting when appropriate) so the taper can match patient tolerance.[3]

Recognition of akathisia — a high-risk withdrawal phenomenon that is frequently misdiagnosed. It is not merely a movement disorder but an intense inner agitation and distress strongly associated with suicidality; it warrants prompt recognition and an urgent, appropriate clinical response, with alignment to the patient's experience and supportive measures.[9] In some cases, the safest course is to provide reassurance, careful monitoring, and space for the nervous system to heal.

Physical Dependence on Antidepressants

Antidepressants are now recognized as drugs capable of causing **physical dependence**, meaning the body adapts to their presence and compensatory changes occur in the central nervous system. Dependence is distinct from addiction: it does not necessarily involve craving or compulsive use, but it does mean that when the medication is reduced or stopped, withdrawal symptoms emerge because the body has come to rely on the drug's continued effects.

NICE NG222 explicitly classifies antidepressants among "medicines associated with dependence or withdrawal symptoms," advising clinicians to provide informed consent about these risks and to manage withdrawal carefully.[3] The FDA-approved labels for sertraline, venlafaxine, and duloxetine similarly acknowledge the risk of discontinuation symptoms and recommend gradual tapering to mitigate withdrawal.[5–7]

Neuroadaptations underlying dependence are thought to include receptor downregulation, altered neurotransmitter sensitivity, and changes in neuroplasticity. When medication is stopped abruptly, these adaptations are suddenly unmasked, producing acute and sometimes protracted withdrawal syndromes.[2 4] Recognition of antidepressant-induced physical dependence underscores the need for shared decision-making and very gradual, individualized tapers.

Protracted Antidepressant Withdrawal

Protracted Withdrawal Syndrome (PWS)

is the persistence or late emergence of characteristic antidepressant withdrawal symptoms well beyond the acute period (often weeks), sometimes lasting months or even years after dose reduction or cessation. Importantly, PWS can also begin months after the antidepressant has been stopped, rather than appearing immediately. Symptoms typically wax and wane ("waves and windows") and are distinct from relapse of the original condition.

Patients frequently describe a **"waves and windows"** course, with fluctuating symptom intensity—periods of relative improvement (windows) alternating with recurrences (waves). However, research and patient reports also show that **not all individuals follow this trajectory**. Some experience **persistent, unremitting symptoms without windows of relief**, which should gradually lessen in intensity over time but still cause substantial impairment.[4]

Recognizing these variations helps avoid dismissing persistent or non-fluctuating courses as "relapse" or unrelated conditions.

Common symptoms include:

- **Neurological/sensory:** paresthesias, "brain zaps," visual disturbances, tinnitus, dizziness.
- **Sleep/autonomic:** prolonged insomnia, sweating, temperature dysregulation, palpitations, gastrointestinal disturbance
- **Affective/cognitive:** marked anxiety, panic, dysphoria, intrusive or ruminative thoughts, irritability, cognitive fog, impaired concentration or memory
- **Motor/behavioral:** akathisia, agitation, tremors.

Recognizing PWS prevents mislabeling iatrogenic symptoms as recurrence and supports patient-centered, flexible tapering.[2] [3] [4]

What Recent Evidence Shows

Incidence & risk

A 35-study meta-analysis (2025) estimated a pooled incidence ≈43% of antidepressant withdrawal symptoms overall (≈44% in RCTs). Risk increased with longer treatment duration (~35% at 6–12 weeks → ~51% after >24 weeks).

Severity & impact

A 2024 study (Moncrieff, Read & Horowitz) characterized withdrawal as often “severe and protracted,” with substantial life impacts among discontinuers: impaired work functioning (56%), job loss (20%), sick leave (27%), and relationship breakdown (25%); it proposed DAWSS to help clinicians differentiate withdrawal from relapse..

Duration

NICE NG222 advises clinicians to inform patients that withdrawal may be severe and can last weeks or months, especially if stopped suddenly.[3] Consistent descriptive analyses show months-long (sometimes year-long) symptoms for a subset of patients.[4]

Protracted withdrawal

An international survey of 1,430 antidepressant users (Davies & Read, 2020) reported that nearly half (47%) experienced withdrawal symptoms lasting longer than one year, with some describing persistence for several years.

What Authoritative Sources Say About Tapering

FDA-approved labeling for several SSRIs/SNRIs instructs gradual dose reduction rather than abrupt discontinuation:

Sertraline (Zoloft):

"A gradual reduction in the dose rather than abrupt cessation is recommended whenever possible... If intolerable symptoms occur... consider resuming the previously prescribed dose."[5]

Venlafaxine (Effexor XR):

"A gradual reduction in the dose, rather than abrupt cessation, is recommended."[6]

Duloxetine (Cymbalta):

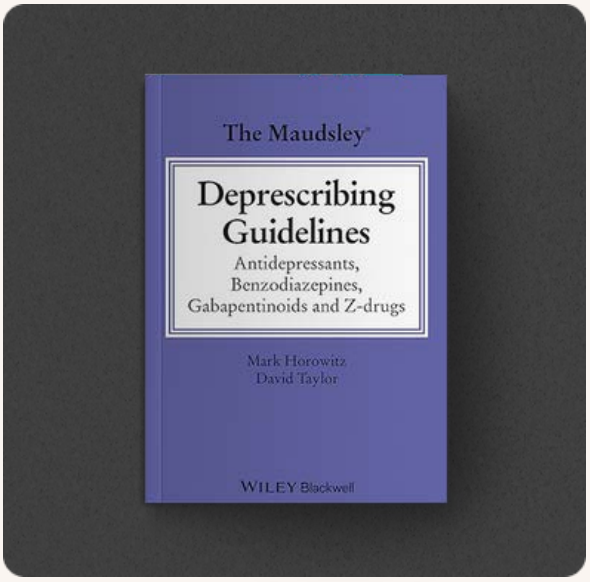
labeling warns of discontinuation symptoms and instructs clinicians to gradually reduce dosage to avoid them.[7]

In addition, Lancet Psychiatry guidance recommends slow, hyperbolic tapers to doses well below minimum therapeutic levels to mitigate withdrawal.[8]

Taken together, these sources confirm that all antidepressants require slow, individualized tapering. The FDA has already updated several antidepressant labels to reflect this, and more drug inserts are expected to be revised as recognition of withdrawal and protracted risks continues to grow.

Gold-Standard Tapering Guidance

A highly regarded resource forms the foundation of safe deprescribing.



The Maudsley Deprescribing Guidelines (Horowitz & Taylor, 2024) [4]

which emphasize hyperbolic tapering, patient-led pacing, and the risk of misdiagnosing withdrawal as relapse. The authors state: *"Go slowly… and proceed even more cautiously for the last few milligrams."*

The guideline emphasizes hyperbolic, individualized tapers—sometimes as small as 2% every few weeks or longer, especially at the lowest doses.

Practical Requests

1. **Shared decision-making** about continuation vs. taper, with informed consent addressing withdrawal and possible protracted courses.[2] [3]
2. **Individualized, gradual (often hyperbolic) tapers**, slowing further at low doses; avoid abrupt stops.[5–8]
3. **Careful monitoring** to distinguish withdrawal (including PWS and akathisia) from relapse; consider DAWSS features to support clinical judgment.[2]
4. **Access to liquid/compounded formulations** to enable very small decrements consistent with slow tapering.[3]

Closing

Too often, physicians mistake these withdrawal symptoms for relapse of the underlying condition. This misunderstanding can lead to misdiagnosis, stigmatization, and the inappropriate continuation of medications. Thank you for considering this patient-safety perspective grounded in current evidence. I respectfully ask that you work in partnership with your patient to develop an individualized, symptom-paced taper plan that prioritizes function, informed consent, and minimizes iatrogenic harm.

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ACCESS LIVE TEXT OF LETTER

References

1. **Zhang M-M, Tan X, Zheng Y-B, et al.** Incidence and risk factors of antidepressant withdrawal symptoms: a meta-analysis and systematic review. **Molecular Psychiatry.** 2025.

2. **Moncrieff J, Read J, Horowitz M A**. *The nature and impact of antidepressant withdrawal symptoms and proposal of the Discriminatory Antidepressant Withdrawal Symptoms Scale (DAWSS).* **Journal of Affective Disorders Reports.** 2024;16:100765.
(Open-access institutional version)

3. **National Institute for Health and Care Excellence (NICE).** *Medicines associated with dependence or withdrawal symptoms: safe prescribing and withdrawal management for adults (NG222).* 2022.

4. **Hengartner M P, Schulthess L, Sørensen A, Framer A.** *Protracted withdrawal syndrome after stopping antidepressants: a descriptive quantitative analysis of consumer narratives from a large internet forum*. **Ther Adv Psychopharmacol.** 2020;10:2045125320932455.

5. **Sertraline (Zoloft) — Full Prescribing Information.** DailyMed/FDA labeling (discontinuation guidance to taper gradually).

6. **Venlafaxine (Effexor XR) — Full Prescribing Information.** DailyMed/FDA labeling (discontinuation guidance to taper gradually).

7. **Duloxetine (Cymbalta) — Full Prescribing Information.** DailyMed/FDA labeling (discontinuation guidance to taper gradually).

8. **Horowitz M A, Taylor D.** Tapering of SSRI treatment to mitigate withdrawal symptoms. The Lancet Psychiatry.2019;6(6):538–546.

9. **Akagi H, Kumar T.** Akathisia: overlooked at a cost. **BMJ.** 2002;324(7352):1506–1507.