**Role of health authorities in denying the withdrawal problem with depression drugs**

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**Summary**

Official guidelines and statements from the authorities and psychiatrists have denied for decades that depression drugs can cause dependence, and this denial is still seen today. They also underestimate substantially the severity and duration of the withdrawal symptoms. They provide dangerous advice about tapering procedures that are far too quick and does not respect the hyperbolic binding curves of the drugs to brain receptors, or they provide no tapering advice at all apart from useless statements about gradually reducing the dose, which is seen in package inserts.

 The massive use of depression drugs is not evidence-based but marketing-driven. These drugs do not have clinically relevant effects on depression; they double the risk of suicide; and have many other important harms. In clinical trials, the patients prefer a placebo for an active drug.

The main focus in the coming years should be on avoiding prescribing depression drugs and on helping those who are on them to come off them as safely as possible.

The use of depression drugs is not evidence-based but marketing based. This is easy to see if one compares sales figures for depression drugs with those for benzodiazepines. In Denmark, the consumption of benzodiazepines, measured as defined daily doses per 1000 inhabitants, peaked in 1987.1 During the next 20 years, the usage dropped by 60% because doctors became aware that the drugs are highly addictive.

This drop was fully compensated by a rise in the use of selective serotonin reuptake inhibitors (SSRIs) and serotonin and norepinephrine reuptake inhibitors (SNRIs).1,2 This was not a rational or evidence-based decision. The new drugs were being used for pretty much the same indications as the benzodiazepines. Much of what was previously called anxiety and treated with benzodiazepines was now conveniently called depression,3 and the new drugs were also used for insomnia even though they were not approved for this indication.

The sales of SSRIs increased from a low level in 1992 almost linearly by a factor of 18, closely related to the number of products on the market that increased by a factor of 16 (r = 0.97, an almost perfect correlation).1 This confirmed that drug usage was primarily determined by marketing. The more companies that sold the drugs, the more salespeople would travel around telling doctors to use them, for a huge variety of approved and non-approved indications.4

A 2019 Public Health England review reported that 17% of adults were prescribed depression drugs in 2017-2018, with even higher rates for women and in deprived areas.5

One reason for the high and rising prescription rates is that the patients stay on the drugs for many years because withdrawal effects are being misinterpreted as relapse of the depression, even in trials that have studied tapering procedures.6

In 2012, I lectured for over 100 Danish psychiatrists who were quite hostile when I told them about withdrawal effects. To my great surprise, a prominent professor who knew a lot about psychopharmacology said that it had never been a problem for him to stop a depression drug. The possible explanations for this misconception are that he never tried to stop but just renewed the prescriptions; that he tried, and the patients developed withdrawal symptoms which he interpreted as relapse; or that he ignored the symptoms he saw because it went against his beliefs. Psychiatrist professors Giovanni Fava from Italy and David Healy from Wales were also invited speakers and they told their colleagues in no uncertain terms that I was right.

 I have studied if two different drug classes, neuroleptics and depression drugs, showed similar patterns in long-term usage. The usage patterns ought to be very different because the main indication for neuroleptics, schizophrenia, has traditionally been perceived as a chronic condition whereas the main indication for depression drugs, depression, has been perceived as episodic. However, they were not different. They were the same (see figure).7

Percentage of current users in Denmark who redeemed a prescription for the same or a similar drug in each of the following years after 2006.

I followed patients who were already on one of these drugs in 2006 for the next ten years. In 2006, 80% of the patients had been on the drug or a similar drug for a while whereas 20% in both drug groups were first-time users. This was a remarkably similar percentage for two groups of drugs used for widely different disorders.

The patients got a new prescription every single year till they stopped or came to 2016, my last observation year, when 35% vs 33% of the patients, respectively, were still on treatment. The similarity of the two curves strongly suggests that drug usage does not reflect the drugs’ efficacy but something else.

That it cannot be the benefits of the drugs that drive their usage is illustrated by the fact that the average effect of both drug groups in placebo-controlled trials is considerably below what psychiatrists have determined is the least clinically relevant effect. For depression, the smallest effect that can be perceived on the Hamilton scale is 5-6,8 but only about 2 was obtained in trials that were biased in favour the drugs.2,9,10 For acutely ill patients with schizophrenia, the least clinically relevant effect corresponds to about 15 points on the Positive and Negative Syndrome Scale (PANSS)11 commonly used in trials, but only 6 was obtained in flawed placebo-controlled trials of recent drugs submitted to the FDA.12,13

These observations support the view that drug usage is not evidence-based but is determined by something else, such as commercial pressures, corruption of doctors and the scientific literature,13,14 and the difficulty of coming off the drugs again.15

**History is repeating itself**

The story about depression pills is a story about history repeating itself throughout the whole 20th century. Like most other people, doctors are poor at learning from history and good at denying uncomfortable facts.13,16,17 It took almost 30 years after it had been demonstrated that benzodiazepines are addictive before this fact became generally accepted.2,17 As this was expected, because their forerunners, the barbiturates, are also highly addictive, it should have been investigated from the beginning. The first barbiturate, barbital, was introduced in 1903, but it took 50 years before it was accepted that barbiturates are addictive.

Benzodiazepine dependence was documented in 1961 and described in the *British Medical Journal* in 1964. Sixteen years later, the UK Committee on the Review of Medicines published a systematic review of benzodiazepines,18 concluding that the addiction potential was low, estimating that only 28 persons had become dependent from 1960 to 1977. The fact was that millions had become dependent.

In 1988, 24 years overdue, the UK Medicines Control Agency finally woke up and wrote to doctors about their concerns.17

Drug companies, clinicians and authorities denied for decades that depression pills make people dependent,17 and many still deny it. This has always been irrational, which we documented in 2012 when we showed in a systematic review that the withdrawal symptoms were described with similar terms for benzodiazepines and SSRIs and were very similar for 37 of 42 identified symptoms.19

In 2020, we published a study of 39 popular websites from 10 countries that found that 22 of 28 websites which warned patients about withdrawal effects stated that SSRIs are not addictive.20 Only one website stated that the pills can be addictive and warned that people “may get abstinence symptoms.”20

Lay people, whose capacity for making observations and conclude logically from what they see has not been clouded by industry largesse or guild interests, view this very differently. Already in 1991, 78% of 2,003 lay people regarded depression pills as addictive.21

**Semantic acrobatics**

The facts about becoming dependent on depression pills have been obscured by semantic acrobatics and foolish definitions of what it means that a drug is addictive or cause dependence.

When we submitted our revised protocol for a systematic review of trials of safe withdrawal of depression drugs to Cochrane in 2019, a peer reviewer referred to the DSM-IV drug dependence criteria and wanted us to remove this sentence: “The patients’ condition is best described as drug dependence.”2,22,23 We replied that, according to these criteria, no one who smokes 20 cigarettes every day is dependent on smoking cigarettes. But we changed the sentence into: “The patients’ condition is best described as drug dependence, not because we, and the patients themselves, see them as addicts, but because the absence of withdrawal symptoms is obtained by continuous drug intake.”23

Whatever academics call it, for patients it’s just the same. It can be very hard for them to stop both benzodiazepines and depression pills15,19 because the drugs have altered their brain chemistry. A survey of 500 Danish patients showed that 57% agreed to the sentence: “When you have taken antidepressants over a long period of time it is difficult to stop taking them.”24 In another survey, 55% of 1,829 patients in New Zealand taking antidepressants mentioned withdrawal effects, which 25% described as severe.25

Imipramine came on the market in 1957, and a paper from 1971 describes dependence with this drug when it was tested in six healthy volunteers.26 The paper’s title is very informative as it says, “Drugs of dependence though not of abuse.” Leading psychiatrists often muddle the waters deliberately by equating the two and then declaring that SSRIs do not cause dependence.

In early 1992, the UK Royal College of Psychiatrists, in association with the Royal College of General Practitioners, launched a five-year “Defeat Depression Campaign.”2,21 Its aim was to provide public education about depression and its treatment in order to encourage earliertreatment-seeking and reduce stigma. Campaign activities included newspaper and magazine articles, television and radio interviews, press conferences, production of leaflets, factsheets in ethnic minority languages, audio cassettes, a self-help video and two books.21,27

When 2,003 lay people were surveyed just before the launch of the campaign, 91% thought that people with depression should be offered counselling; only 16% thought they should be offered depression pills; and only 46% said they were effective.21 As already noted, 78% regarded them as addictive.

The psychiatrists’ view on these responses was that “Doctors have an important role in educating the public about depression and the rationale for antidepressant treatment. In particular, patients should know that dependence is not a problem with antidepressants.”

When challenged about the fact that the two royal colleges had accepted donations from all the major manufacturers of depression pills for the campaign, the president of the Royal College of Psychiatrists, Robert Kendall, acknowledged in a 1997 letter to Charles Medawar from Social Audit Limited that, “I have no doubt that one of their major motives was the hope that an increased recognition of depressive illnesses both by the general public and by general practitioners would result in increased sales for them.”28 In his letter, Kendall acknowledged that benzodiazepines cause dependence but denied that depression drugs cause dependence.

The psychiatrists embarked on their re-education campaign. But people were not easily convinced that they were wrong. A 1998 paper reported that changes were of the order of only 5-10% and that depression pills were still being regarded as addictive and less effective than counselling,27 both of which are correct. Studies with long-term follow-up show that psychotherapy has an enduring effect that outperforms pharmacotherapy.29

In 1996, Eli Lilly organised a “Discontinuation Consensus Panel” of selected psychiatrists who attended a closed symposium on “SSRI Discontinuation Events” to endorse and define “discontinuation syndrome.”30 The meeting was chaired by Alan F. Schatzberg of Stanford University. He was not an impartial observer. Congressional investigators discovered that when he was president-elect of the American Psychiatric Association, he had $4.8 million stock holdings in a drug development company.31

Lilly paid a medical journal to promote the panel’s conclusions in a special supplement, and the abstract of one of the articles claimed that, even though the discontinuation syndrome is referred to as withdrawal symptoms in many anecdotal case reports, it is “distinctly different from the classic withdrawal syndrome associated with alcohol and barbiturates. Anti-depressants are not associated with dependence or drug-seeking behavior.”30

It is of course wrong to say that depression drugs do not cause dependence. Furthermore, the term discontinuation wrongly distances antidepressant withdrawal from withdrawal from other brain active drugs like benzodiazepines, barbiturates and alcohol. The committee reached a consensus, with no supporting evidence, that antidepressant withdrawal was a self-limiting syndrome, typically resolving within 2-3 weeks.

Lilly’s semantic acrobatics worked. The term discontinuation is still being used and abused today, and ever since, withdrawal symptoms from depression drugs have been described by drug companies, national guidelines, and psychiatric associations as being trivial.

As an example, a 2006 article in *American Family Physician* had the title “Antidepressant discontinuation syndrome,” and it claimed that it occurred in approximately 20% of patients after abrupt discontinuation and that the symptoms were usually are mild, lasting 1-2 weeks.32 All of this was wrong.

A 2017 article in the *Canadian Medical Association Journal* also had the title “Antidepressant discontinuation syndrome” and claimed that “symptoms are usually mild.”33

Even Harvard University fell victim to Lilly’s manipulations. In a 2019 Harvard Health Blog with the title “Discontinuation syndrome and antidepressants,” the authors wrote that “As many as one in five people who stop an antidepressant quickly may experience at least a mild version of these symptoms.”34 This misinformation was delivered under Harvard’s prestigious logo:



**The UK NICE guidelines were seriously misleading and contradicted the evidence**

Even though we have known for at least 50 years that people can become dependent on depression pills, and the patients have known it for at least 30 years, the dependence problem is still being trivialized.

A 2019 review undertaken for the All Party Parliamentary Group for Prescribed Drug Dependence to inform an enquiry by Public Health England found a weighted average of 56% for withdrawal incidence and that 46% of those experiencing withdrawal symptoms rated them in the most extreme severity category.15 Seven of the ten studies with duration data found that a significant proportion of people who experience withdrawal do so for far more than two weeks, and that it is not uncommon for people to experience withdrawal for several months or, more rarely, years.

However, 2009 guidelines from the UK’s National Institute for Health and Care Excellence (NICE), which still applied in 2018, stated that antidepressant withdrawal symptoms “are usually mild and self-limiting over about 1 week, but can be severe, particularly if the drug is stopped abruptly.”35 When we sent a freedom of information request to NICE in 2018 asking for the evidence for its 1-week claim, NICE provided two short review articles, neither of which supported the claim, and both cited numerous sources that contradicted it.36

We wrote in *BMJ* in 2019 that the guidelines on antidepressant withdrawal needed to be updated urgently.36 We referred to the systematic review for the All Party Parliamentary Group15 which showed that 55% of patients experience withdrawal symptoms for over two weeks, 40% for at least six weeks, and 25% for at least 12 weeks. A survey of 580 patients reported that the withdrawal symptoms lasted for over 3 years in 16%.15

Our criticism caused NICE to decide to update its guidelines, but even though this took three years,37 the 2022 guidelines continued to downplay the problems by avoiding presenting any numerical data and by splitting the symptoms into three categories:

* withdrawal symptoms can be mild, may appear within a few days of reducing or stopping antidepressant medication, and usually go away within 1 to 2 weeks
* withdrawal can sometimes be more difficult, with symptoms lasting longer (in some cases several weeks, and occasionally several months)
* withdrawal symptoms can sometimes be severe, particularly if the antidepressant medication is stopped suddenly

It is not transparent to use terms such as “usually” and “sometimes” about serious harms when there are data on the incidence and severity, but it was the first time any national clinical guideline acknowledged that severe and protracted antidepressant withdrawal symptoms exist.38
 The updated guidelines were first published in 2021 but they were so heavily criticised that they are no longer available on NICE’s website. I wrote to NICE and got hold of them.

The term “discontinuation symptoms” occurred six times while it was gone in the 2022 version.

The patients should be advised to use depression drugs for at least 2 years and they should be informed that continuing the medication “greatly reduces the risk of relapse” and that “antidepressants are not associated with addiction.”

In the 2022 version, doctors are told that continuation of treatment “may reduce their risk of relapse and may help them stay well.” The word “addiction” does not appear in the 2022 version, but “dependence” appears:

“For further advice on safe prescribing of antidepressants, see the [NICE guideline on medicines associated with dependence or withdrawal symptoms: safe prescribing and withdrawal management for adults](https://www.nice.org.uk/guidance/ng215).”

**The UK Royal College of Psychiatrists didn’t care about patient safety**

I first published this story about professional misconduct in my book about psychiatric drug withdrawal.2

In February 2018, Wendy Burn, president of the Royal College of Psychiatrists and David Baldwin, chair of its Psychopharmacology Committee, wrote in *The Times* that, “We know that in the vast majority of patients, any unpleasant symptoms experienced on discontinuing antidepressants have resolved within two weeks of stopping treatment.”

 Headed by psychologist professor John Read, we were nine clinicians and academics that wrote to Burn and Baldwin that their statement was incorrect and had misled the public on an important matter of public safety. We noted that the College’s own survey of over 800 antidepressant users (*Coming Off Antidepressants*) found that withdrawal symptoms were experienced by 63% and that a quarter reported anxiety lasting more than 12 weeks. But within 48 hours of publishing their misleading statement in *The Times*, the College removed the *Coming Off Antidepressants* document from its website.

We asked Burn and Baldwin to retract their statement or provide supporting research. Baldwin sent two company funded papers with himself as first author, none of which provided data about how long withdrawal symptoms last.

Next, we sent a formal complaint to the College, signed by 30 people, including ten who had experienced withdrawal effects for one to ten years, and ten psychiatrists and eight professors. We noted:

“People may be misled by the false statement into thinking that it is easy to withdraw and may therefore try to do so too quickly or without support from the prescriber, other professionals or loved ones. Other people, when weighing up the pros and cons of starting antidepressants may make their decision based partly on this wrong information. Of secondary concern is the fact that such irresponsible statements bring the College, the profession of psychiatry (to which some of us belong), and – vicariously - all mental health professionals, into disrepute.”

We provided numerous studies and reviews showing the Baldwin-Burn statement to be untrue and asked them to publicly retract, explain and apologize for their misleading statement; provide guidance or training for all the College’s spokespersons, including the current president, on the importance of ensuring that public statements are evidence-based and on the limitations of relying on colleagues who are in receipt of payments from the pharmaceutical industry (e.g. Baldwin); and to reinstate, on the College’s website, the document *Coming Off Antidepressants*.

The College’s registrar, Adrian James, replied that there was “no evidence that the statement in *The Times* was misleading.” They dismissed the complaint and James gave four reasons, three of which were either irrelevant or disingenuous. He repeated an earlier claim by Burn that the removal of the survey from their website happened because it was out of date (which it wasn’t; it was only six years old). Even when we pointed out that the removal was done within hours after we had shown it includes data contradicting the Baldwin-Burn statement, and that over 50 other items on their website were out of date, but not removed, James adhered to his explanation.

The only relevant comment was that the Baldwin-Burn statement was consistent with NICE recommendations that stated that doctors should advise patients that discontinuation symptoms are “usually mild and self-limiting over about 1 week.”

However, James misrepresented the NICE statement by leaving out the next sentence: “but can be severe, particularly if the drug is stopped abruptly.”

Four months after *The Times* letter, the CEO of the College, Paul Rees, sent a lengthy reply that merely echoed James. We responded that Rees’ emphatic statement, that “it is no part of the College’s function to ‘police’ such debate,” implied that even his most senior officials can say anything they like, however false or damaging, and the College would stand by them - as, indeed, it had in this case.

We explained that we were now certain that the Royal College of Psychiatrists:

* prioritizes the interests of the College and the profession it represents over the wellbeing of patients;
* does not value empirical research studies as the appropriate basis for making public statements and for resolving disputes, and has thereby positioned itself outside the domain of evidence-based medicine;
* has a complaints process which results in substantive, carefully documented, complaints on serious matters of public safety not being investigated, but rather dismissed out of hand by one individual;
* has no interest in engaging in meaningful discussion with professional and patient groups who question the College’s position on an issue;
* is prepared to use blatantly disingenuous tactics to try to discredit reasonable complaints, and has thereby positioned itself outside the domain of ethical, professional bodies;
* is unaware of, or unconcerned about, the distorting influence of the pharmaceutical industry, and the need to maintain a strong, ethical boundary between itself and profit-based organizations.

Even though the College is not accountable to Parliament, or it seems to anyone, we wrote to the Secretary of Health and Social Care and informed the government that:

“The Royal College of Psychiatrists is currently operating outside the ethical, professional and scientific standards expected of a body representing medical professionals … We believe [the College’s] responses show a trail of obfuscation, dishonesty and inability or unwillingness to engage with a concerned group of professionals, scientists and patients.

If a group of scientists and psychiatrists together cannot challenge [the College] in a way that leads to an appropriate, considered response and to productive engagement with the complainants, what hope is there for individual patients to have a complaint taken seriously?”

We were not alone. We were helped by the Earl of Sandwich whose son Luke Montagu has struggled with withdrawal symptoms from antidepressants for years.39,40 In April 2018, he said in the House of Lords:41

“Another important issue is the degree of public understanding of the effects of overprescription. On 24 February, the president of the Royal College of Psychiatrists and a colleague wrote in the *Times* that for, ‘the vast majority of patients, any unpleasant symptoms experienced on discontinuing antidepressants have resolved within two weeks of stopping treatment.’

This statement has appalled a large number of psychiatrists and patients who have lodged a complaint with the RCP, including some who have experienced withdrawal effects for between 11 months and 10 years ... If even one of our leading institutions can mislead *Times* readers on a matter of public safety, what hope do the Government have of explaining these things to the general public?”

Burn and Baldwin never retracted their false statement, provided research to support it, or apologized for misleading the public. Neither did James nor Rees ever address our concerns about the complaint procedure.

We made our complaint public, and the BBC’s Radio 4 program, *Today*, covered it on 3 October 2018. The College refused to provide a spokesperson to debate with John Read. Instead, Clare Gerada, exchair of the Royal College of General Practitioners, represented their perspective. She denigrated the complaint as an “anti-antidepressant story” and vehemently defended the College’s official position saying that, “the vast majority of patients that come off antidepressants have no problems whatsoever.”

Later, the Royal Society of Medicine launched a podcast series, “RSM Health Matters.” The opening topic was about depression pills and withdrawal. One of the two interviewees was Sir Simon Wessely, president of the Royal Society of Medicine (and recent president of the College). The other one was Gerada. None of them disclosed they are married, and both stressed that depression pills enable people to “lead normal lives.”

This has never been documented and is highly unlikely to be true. According to the American Psychiatric Association‘s disease manual, DSM-5, major depression is present when the patient exhibits 5 or more of 9 symptoms that “cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.” Given how the disorder is defined, it makes no sense that ordinary placebo-controlled trials have never included outcomes of social functioning.

A trial with such outcomes was inappropriate, as it was a withdrawal trial that only told us that the cold turkey harms the psychiatrists inflicted on their patients were bigger for some drugs than for others.42 Unsurprisingly, patients on fluoxetine (Prozac, the sponsor’s, Eli Lilly’s product) could endure a short treatment interruption where the patients got placebo because this drug has an active metabolite that remains in the body for a long time. In contrast, a statistically significant increase in harms occurred after missing just one dose of paroxetine (Paxil or Seroxat).

Wessely rejected any link between depression pills and suicide, despite it having been sufficiently well demonstrated for the drugs to carry a Black Box Warning. He also stated, categorically, that depression pills are “not addictive.”2

Gerada complained that, “Once a year when the prescribing figures come out, we have this soul-searching - why are we prescribing too much of this medication.” She said that she personally even prescribes them for people she knows “are going to get depressed” in the future and encouraged “psychiatrists to move away from the fear, which has been propagated I think by the media and certain people, to actually say, is there a space for antidepressants in preventing depression?”

Regarding withdrawal, Gerada stated: “As a GP [general practitioner] of 26 years… probably 50% of the tens of thousands of patients I have seen have been there with a mental health issue and I can count on one hand the number who have gone on to have long term problems withdrawing from antidepressants or problems coming off antidepressants.”

If we interpret “tens of thousands” to mean 30,000, Gerada was talking about roughly 15,000 people with mental health issues. Given her enthusiasm for depression pills, which she uses even “prophylactically,” we assumed she prescribed them to 25% of these patients, about 3,750 people. Even if only half of them have ever tried to come off the drugs, then she is claiming an incidence of withdrawal effects of five out of 1,875 or 0.3%. The review by James Davies and John Read estimated a rate of 56%,15 210 times larger than Gerada‘s clinical experience.

On 27 November 2018, the BBC Radio programme, *All in the Mind*,invited John Read and psychiatrist Sameer Jauhar to discuss the Davies and Read review. Jauhar explained that, “My hope is that people don’t get scared about antidepressants ... by thinking that the numbers that have been given out apply to them.” When the interviewer asked if patients were warned about withdrawal effects in advance when they started antidepressants, Jauhar replied: “Yes. Like with any other medicine in general medicine you warn patients about any side effects.” Read said: “The two largest surveys that we’ve done, of 1800 and 1400 people, when asked were they ever told anything about withdrawal effects, less than 2% in both surveys said that.”

In April 2019, the *Journal of Psychopharmacology* published a critique of the Davies and Read review, which was dismissed as “a partisan narrative.” The lead author was Jauhar, accompanied, amongst others, by Baldwin and psychiatrist David Nutt, the journal editor. Three of the six authors, Nutt, Baldwin, and Oxford University psychiatrist Guy Goodwin, disclosed payments from 26 different drug companies, but Jauhar failed to disclose his research funding from Alkermes or his paid lectures for Lundbeck.

The *Journal of Psychopharmacology* is owned by the British Association of Psychopharmacology, which accepts money from the industry in the form of sponsored satellite symposia that are not controlled by the Association. Both the current president, Allan Young, and past presidents, including Nutt, have received money from the drug industry.

The seriously misleading critiques of the Davies and Read review were not confined to the UK. On 1 Dec 2018, the *American Journal of Psychiatry*, the official journal for the American Psychiatric Association, published a particularly derisory effort to preserve the myth that “discontinuation symptoms” (as they called them) are very brief.43 Michael Hengartner, Davies and Read responded that,

“Not only did Jha and colleagues select only three studies, representing a total of just 24 patients, but the three studies they present to readers as evidence for their 2–3 weeks claim do not actually support their claim at all ... Based on this evidence, the conclusion that withdrawal reactions ‘typically resolve spontaneously over 2–3 weeks’ is fallacious and arbitrary. Moreover, two references were merely case reports, which have very little external validity.”44

All three authors received drug company money. The corresponding author, Dr Mudhukar Tivedi, had “served as a consultant or on advisory boards” for more than 20 companies.43

Read’s tenacity paid out. In May 2019, the College published a statement where they noted that, “To ensure informed consent and shared decision-making, the use of antidepressants should always be underpinned by a discussion with the patient, and family/carer (as appropriate), about the potential level of benefits and harms, including withdrawal … Discontinuation of antidepressants should involve the dosage being tapered or slowly decreased to reduce the risk of distressing symptoms, which may occur over several months, and at a reduction rate that is tolerable for the patient. Whilst the withdrawal symptoms which arise on and after stopping antidepressants are often mild and self-limiting, there can be substantial variation in people’s experience, with symptoms lasting much longer and being more severe for some patients.”45,46

Within hours, however, Allan Young, tried to undermine this U-turn by the College. He repeated his drug company line: “So called withdrawal reactions are usually mild to moderate and respond well to simple management. Anxiety about this should not obscure the real benefits of this type of treatment.”47

In September 2019, Public Health England published a historic 152-page evidence review making important recommendations, including for services to assist people coming off depression pills and other psychiatric drugs, and about better research and more accurate national guidelines.5

The following month, NICE updated its guideline in line with the Davies and Read review.38 But there was a long way home. For example, the guideline talked about “discontinuation symptoms.”46 It was criticised, and when I used the link to the 2019 guideline,48 it was gone. It took more consultations and three more years before it re-appeared and then, the term “discontinuation symptoms” had been removed.

What this illustrates is: We already knew that drug companies don’t care about patient safety if it could harm sales.13,16 We now know that psychiatric leaders also don’t care about patient safety if it could threaten their own reputation, the guild they represent, or the flow of money they receive from drug companies. This corruption of a whole medical specialty also permeates our authorities, which rely heavily on specialists and their studies when issuing guidelines.

I have described the events in the UK in some detail because they show how difficult it is to accomplish any change even when authorities have issued statements that are dangerous for the patients. This happens all the time in psychiatry but those who can document that what is being claimed is untrue rarely engage in a public fight, as they know how exhausting it will be; how unlikely it is that it will lead to any changes or apologies; and how likely it is that it will harm their careers.

**Danish psychiatrists did not want to learn about safe withdrawal**

In November 2017, psychiatrist Jan Vestergaard tried to get a two-hour symposium on the programme about benzodiazepine dependence and withdrawal for the annual meeting of the Danish Psychiatric Association four months later.2 Even though the meeting lasted four days, with parallel sessions, the board declared there wasn’t room for the symposium.

I was scheduled to talk about withdrawal in general, not limited to benzodiazepines. I found out there a free room and held a two-hour symposium for the psychiatrists in the morning, which I repeated in the afternoon, together with one of my PhD students, a psychologist with experience in helping patients withdraw.

Another bump in the road came after we had advertised our symposium in the *Journal of the Danish Medical Association*. Professor of clinical microbiology, Niels Høiby, elected for a conservative political party in the Capital Region, felt compelled to interfere with our altruistic initiative (we took no entrance fee), even though bacteria do not have much to do with psychiatric drug withdrawal. He mentioned that I had written a book on the use of psychiatric drugs and conducted courses to help patients reduce their use of psychiatric drugs, and he asked if my hospital’s Executive Board and the Capital Region, possibly in collaboration with the Health Council for Psychiatry, had informed the region’s psychiatrists, psychiatrists in specialist practice and family physicians whether they supported or distanced themselves from the activities of the Cochrane Centre’s director regarding the use of psychiatric drugs.

Quite a mouthful. My activities threatened a profession that turned a blind eye to the obvious problems they caused with their drugs. Psychiatry in the Capital Region declared that they had informed all their centres about the activities Høiby mentioned; were critical of my offer; and had requested that attention be given to patients that might accept the offer. Moreover, they noted that several department heads and professors had publicly expressed their disagreement with me and my activities, e.g. at the event “The art of discontinuing a drug” organised by the Capital Region and at a public debate about psychiatric drugs organised by Psychiatry in the Capital Region. “At both events, Peter Gøtzsche himself participated.”

Oh dear. Gøtzsche himself showed up at our precious events and even dared ask questions! Apparently, it is wrong to ask questions. Socrates was killed because he asked questions, which is why I have chosen a logo with Socrates for my Institute for Scientific Freedom. It was unacceptable for the establishment that I tried to meet the needs of the patients when the psychiatrists didn’t want to, even though the establishment constantly talks about putting the patient at the centre of their activities.

When we strolled around in the corridors after the symposia, we learned that the young psychiatrists had been scared away from attending because their bosses would see them as heretics and might retaliate. This explained why most of the 60 participants were nurses, social workers, patients, and relatives. Only seven identified themselves as psychiatrists, but there were likely eight more who did not give their background despite being asked to do so when they entered the room.

On other occasions, psychologists, social workers, and nurses wishing to attend my lectures or courses have told me similar stories about receiving dire warnings from their superiors that their attendance would not be well received at their department.

This is frightening and diagnostic for a sick specialty. It tells a story of a guild that behaves more like a religious sect than a scientific discipline. In science, we are keen to listen to new research results and other points of view, which make us all wiser.

**Dangerous official advice about withdrawal in Denmark**

In November 2019, the Institute for Rational Pharmacotherapy at the National Board of Health in Denmark wrote a guideline about depression drugs for family doctors, which was enclosed in the *Journal of the Danish Medical Association*. This ensured that all Danish doctors would see it.

 The guideline was far from being rational, but there was little I could do to rectify it. National Boards of Health are the modern day variants of high priests. You don’t criticise them, and if you do, they won’t admit they are wrong even when you provide indisputable evidence that this is the case. I have written a whole book about the many egregious errors health authorities and other institutions have committed when issuing their rosy messages about mammography screening where they exaggerate non-existing benefits and downplay or omit the harms and my many failed attempts at rectifying them.49

So, instead of banging my head against a closed door, I decided to publish my criticism of the guideline in a long article in *Politiken*, a national newspaper, with the telling title: “The dangerous advice by the National Board of Health about depression pills.”50 I considered this to be the most effective way of warning patients, citizens, and my medical colleagues against the dangerous guidance.

The guideline recommended doctors to assess if the drug has helped and to change to another depression pill if this is not the case. In a quote of uncertain origin, the definition of insanity is doing the same thing over and over and expecting a different result. When drugs don’t work, more of the same won’t work either. As the difference between drug and placebo is so small that it lacks clinical relevance,8-10 it is impossible for doctors to assess in the individual case if a drug has helped or not.

Worst of all, the guideline did not mention with one word that depression pills increase the risk of suicide,13 the most severe outcome of a depression, or that psychotherapy halves the risk of suicide.51

According to the guideline, withdrawal symptoms are usually temporary and disappear within two weeks. I explained that this is highly misleading information and that the recommended tapering, halving the dose every two weeks, is risky. I wrote:

“Even though the authors included a psychiatrist and a clinical pharmacologist, they apparently didn’t know what a binding curve for depression pills to brain receptors looks like. As with other drugs, it is hyperbolic. It is very steep in the beginning when the dose is low, then flattens out, so that it becomes almost horizontal at the top.

This is important to know. With usual dosing, the vast majority of receptors are occupied because you are at the top of the binding curve, where it is flat. It therefore usually goes well the first time you halve the dose. The vast majority of patients are overdosed and are therefore still high up on the binding curve and don’t get any withdrawal symptoms. But already next time, when you go from 50% of the starting dose to 25%, it can go horribly wrong. If there are no withdrawal symptoms this time, they will usually come when you take the next step and comes down to 12.5%. It is also way too fast for many patients to change the dose every two weeks.

The physical dependence on the pills is often so pronounced that it takes many months, in some cases years, to fully recover from them. It is dangerous that the National Board of Health recommends such a drastic tapering. One of the worst withdrawal symptoms is extreme restlessness (akathisia), which predisposes to both suicide and violence, and in rare cases homicide. A tapering must of course respect the shape of the binding curve, and it must therefore be smaller and smaller, the lower the dose is. This can be obtained by removing a certain percentage of the previous dose. If you start by removing 10%, you come down of 90%, and if you are down to 50%, you should not reduce to 25% but only to 45%. These principles have been known for many years and were meticulously described in *Lancet Psychiatry* on 5 March 2019 by Horowitz and Taylor.[52]

Some of my colleagues who have withdrawn many patients and I wrote about the principles in *Politiken* 8 September 2019, and they can also be found on my website, [www.deadlymedicines.dk](http://www.deadlymedicines.dk), where there is a link to them on the front page. That's why there is no excuse for people at the National Board of Health not to know about them.

About half of the patients have difficulty stopping with the pills because they have become physically dependent on them, just as we know it from sleeping pills. It is therefore strange that the Board does not do more about this very large problem created by doctors.”

Already in 2017, we wrote about removing 10% of the previous dose – hyperbolic tapering - in a journal for family doctors53 and also in a major Danish newspaper.54 This makes the ignorance and dangerous advice from the National Board of Health even more embarrassing.

This is what a binding curve for citalopram to the brain receptor looks like:2



Hyperbolic relationship between receptor occupancy and dose of citalopram in mg(Courtesy of Mark Horowitz)

**Advice from other authorities**

When I searched on *"american psychiatric association" withdrawal of drugs* on Google, there were no meaningful records on the first pages. I then tried *"american psychiatric association" antidepressant guidelines*. Curiously, despite my use of inverted commas, the first record was to a 2019 guideline of 80 pages from the American Psychological Association.55

 Since the guideline is written for psychologists, it is not surprising that it doesn’t say anything about withdrawal effects or tapering schemes. It mentions that direct comparisons between psychotherapies and antidepressants suggest that the effects of psychotherapies may be better in the longer term and that there is clear evidence that psychotherapy has an enduring effect, in contrast to antidepressants. Since suicide is the worst outcome of a depression, it is curious that the guideline does not mention that depression pills increase the risk of suicide,13 or that psychotherapy halves the risk of suicide in people at the highest risk, those admitted acutely after a suicide attempt.51

 The clinical practice guidelines from the American Psychiatric Association do not have one about depression up front but under the heading “Legacy Practice Guidelines,” where there is one about Major Depressive Disorder of 152 pages from 2010.56

 The term Major Depressive Disorder has an interesting history. Allen Frances, chair of the DSM-IV Task Force, has explained that the reason that all different types of depressions were lumped into just one category was because the US insurance companies refused to reimburse treatment if the diagnosis was not major depression. So, to get covered by an insurance company, the problem could not be an understandable reaction to difficult life circumstances, which almost all cases of depression are, but something more akin to a physical illness. The big winner was the drug industry and the big loser was virtually everyone, as most of us know one or more people who were harmed by depression drugs.

The conflicts of interest for the guideline authors was daunting, e.g. “Dr. Thase reports that he provided scientific consultation to AstraZeneca, Bristol-Myers Squibb, Eli Lilly & Company, Forest Pharmaceuticals, Inc., Gerson Lehman Group, GlaxoSmithKline, Guidepoint Global, H. Lundbeck A/S, MedAvante, Inc., Neuronetics, Inc., Novartis, Otsuka, Ortho-McNeil Pharmaceuticals, PamLab, L.L.C., Pfizer (formerly Wyeth-Ayerst Laboratories), Schering-Plough (formerly Organon), Shire U.S., Inc., Supernus Pharmaceuticals, Takeda (Lundbeck), and Transcept Pharmaceuticals. He was a member of the speakers bureaus for AstraZeneca, Bristol-Myers Squibb, Eli Lilly and Company, GlaxoSmithKline, Pfizer (formerly Wyeth-Ayerst Laboratories), and Schering-Plough (formerly Organon). He received grant funding from Eli Lilly and Company, GlaxoSmithKline, the National Institute of Mental Health, the Agency for Healthcare Research and Quality, and Sepracor, Inc. He had equity holdings in MedAvante, Inc., and received royalty income from American Psychiatric Publishing, Inc., Guilford Publications, Herald House, Oxford University Press, and W.W. Norton and Company. His wife was employed as the group scientific director for Embryon (formerly Advogent), which does business with Bristol-Myers Squibb and Pfizer/Wyeth.”

Being so well looked after by the drug industry, it is not surprising that the guideline authors don’t speak about withdrawal symptoms but a “discontinuation syndrome.” Under the heading, “Discontinuation of treatment,” they recommend a slow taper over the course of at least several weeks, which - despite all the authors’ financial conflicts of interest - is far better advice than the one from NICE from 2009.

However, like NICE, they got the facts about duration of the withdrawal symptoms wrong: “Discontinuation-emergent symptoms include both flu-like experiences such as nausea, headache, light-headedness, chills, and bodyaches, and neurological symptoms such as paresthesias, insomnia, and ‘electric shock-like’ phenomena. These symptoms typically resolve without specific treatment over 1–2 weeks.”

There is no guidance about tapering schemes, and the worst withdrawal effect, akathisia, is not mentioned under discontinuation symptoms but only as something that can occur during ongoing treatment, in which case it is not recommended to lower the dose but to add a betablocker or a benzodiazepine.

This is dangerous advice because akathisia increases the risk of suicide, violence and homicide.13 Unfortunately, psychiatrists commonly recommend adding another psychiatric drug when patients experience harms on the first one, which often leads to polypharmacy and an aggravation of the initial problem.13

On 11 August 2023, the top of the Norwegian Psychiatric Association claimed in a newspaper article written in defense of psychiatric drugs that “There is no biological basis for saying that commonly used psychiatric drugs such as antidepressants, mood stabilizers and antipsychotics cause dependence.”57 It is very sad that many leaders of the psychiatric profession still deny that the drugs they use can cause dependence. Their article was full of other false or seriously misleading statements.58

**Package inserts**

One might have expected the package inserts for the drugs to be reliable sources of information, but this is not at all the case. I looked up the package insert for paroxetine because missing just one dose of this drug can cause withdrawal symptoms.42 The FDA is far too close to industry13,16 and its package insert for paroxetine illustrates this. It does not talk about withdrawal symptoms when stopping the drug or lowering the dose but uses Lilly’s euphemism, discontinuation:59

“Discontinuation of Treatment With PAXIL: Symptoms associated with discontinuation of PAXIL have been reported (see PRECAUTIONS: Discontinuation of Treatment With PAXIL). Patients should be monitored for these symptoms when discontinuing treatment, regardless of the

indication for which PAXIL is being prescribed. A gradual reduction in the dose rather than

abrupt cessation is recommended whenever possible. If intolerable symptoms occur following a

decrease in the dose or upon discontinuation of treatment, then resuming the previously

prescribed dose may be considered. Subsequently, the physician may continue decreasing the

dose but at a more gradual rate ...

Discontinuation of Treatment With PAXIL: Recent clinical trials supporting the various approved indications for PAXIL employed a taper-phase regimen, rather than an abrupt discontinuation of treatment. The taper-phase regimen used in GAD [Generalised Anxiety Disorder] and PTSD [Post-Traumatic Stress Disorder] clinical trials involved an incremental decrease in the daily dose by 10 mg/day at weekly intervals. When a daily dose of 20 mg/day was reached, patients were continued on this dose for 1 week before treatment was stopped. With this regimen in those studies, the following adverse events were reported at an incidence of 2% or greater for PAXIL and were at least twice that reported for placebo: Abnormal dreams, paresthesia, and dizziness. In the majority of patients, these events were mild to moderate and were self-limiting and did not require medical intervention.”

This advice is highly dangerous and misleading. Receptor occupancy with a 20 mg daily dose is about 75%.60 This means that many patients will experience serious withdrawal symptoms if they go from 20 mg to nothing, in stark contrast to the information from GlaxoSmithKline that the FDA uncritically propagated. It also means that the placebo-controlled randomised trials must have been seriously flawed. The symptoms caused by abrupt cessation of therapy are not “mild to moderate” in the majority of patients and they are not “self-limiting.”

It is misleading to mention only adverse events with an incidence of at least 2%. Serious adverse events should always be mentioned, but akathisia is not mentioned at all under discontinuation symptoms, only during ongoing treatment:

“Akathisia: The use of paroxetine or other SSRIs has been associated with the development of akathisia, which is characterized by an inner sense of restlessness and psychomotor agitation such as an inability to sit or stand still usually associated with subjective distress. This is most likely to occur within the first few weeks of treatment.”

The term *associated with* downgrades the problem. We use this term about correlations in observational studies, but the randomised placebo-controlled trials have *proven* that these drugs *cause* akathisia. It is also misleading to say that akathisia most likely occurs within the first few weeks of treatment. A major cause of akathisia is a lowering of the dose, which the FDA does not want doctors about.

FDA’s package inserts for other depression drugs are not any better. For sertraline, for example, there is only this text:61

“2.6 Discontinuation of Treatment with ZOLOFT. Adverse reactions may occur upon discontinuation of ZOLOFT [See Warnings and Precautions (5.5)]. Gradually reduce the dosage rather than stopping ZOLOFT abruptly whenever possible.”

**The number needed to treat to benefit one patient does not exist**

One of the big illusions in psychiatry is that the number needed to treat (NNT) with a drug to benefit one patient is low. Psychiatrists constantly tell the world how effective their drugs are by referring to NNTs. But for virtually all psychiatric drugs and clinical situations, more patients are harmed than those who benefit. Therefore, NNT does not exist.62

 Harms and benefits are rarely measured on the same scale, but when patients in a placebo-controlled trial decide whether it is worthwhile to continue in the trial, they make a judgement about if the benefits they perceive exceed the harms. We did such an analysis based on clinical study reports we had obtained from drug regulators and found out that 12% more patients dropped out on a depression pill than on placebo (P < 0.00001).63 Thus, the patients consider placebo more useful than a depression drug.

This means that there cannot be an NNT for depression pills, only a number needed to harm (NNH), and our meta-analysis showed that this number is about 25. It would have been impossible to show this harm based on published trial reports that tell a very different story to the one in clinical study reports.

Technically, NNT is calculated as the inverse of the benefit difference. If, for example, 60% have improved on drug and 50% on placebo, NNT = 1/(0.6-0.5) = 10. But that is just the mathematics. The data such NNTs are derived from are highly flawed, and here are the main problems:

1) NNT is virtually always derived from trials where the patients were already in treatment before they were randomised to drug or placebo. This means that many of those switched from a previous drug to placebo will experience withdrawal symptoms, which the psychiatrists interpret erroneously as disease symptoms.

When the top among UK psychiatrists in 2014 tried to convince their readers that depression pills are highly effective, they claimed that they have an impressive effect on recurrence, with an NNT of around three to prevent one recurrence.64 But the trials do not assess recurrence; they estimate the degree to which patients in the placebo group are harmed by withdrawal symptoms. As only two patients are needed to get one with withdrawal symptoms when a drug is stopped,15 there cannot exist an NNT to prevent recurrence, only an NNH, which is two.

2) As psychiatric drugs have conspicuous adverse effects, the blinding in placebo-controlled trials is inadequate, which tends to exaggerate the measured benefit, as this judgment is highly subjective.

3) By far most trials are industry-sponsored, and fraud and other manipulations with the data are very common.13,16 We therefore cannot trust published trial reports. This became abundantly clear after one of my PhD students and I in 2010 opened up the archives at the European Drug Agency after we had complained to the European Ombudsman.65 Based on the regulators’ clinical study reports, we recently showed that fluoxetine in minors is unsafe and ineffective, in marked contrast to the claims in published trial reports.66

4) The NNT only takes those patients into account that have improved by a certain amount. If a similar number of patients have deteriorated, there can be no NNT, as there is no benefit. Thus, a totally useless drug, which only makes the condition after treatment more variable, so that more patients improve and more patients deteriorate than in the placebo group, will seem effective based on NNT. Reporting how many patients that have improved by at least 50% on the Hamilton Depression Scale is therefore also misleading, as all those who are not improved are not accounted for.

5) The NNT opens the door to additional bias. If the chosen cut-off for improvement does not yield the desired result, other cut-offs can be tried till the data confess. Such manipulations with the data during the statistical analysis, where the prespecified outcomes and the statistical methods are changed after company employees have seen the data, are very common.67

In psychiatry, NNT is so misleading that it should be abandoned altogether. We might instead use NNH. Since depression pills harm the sex life in about half the patients,68 the NNH is only two. Thus, by not using depression pills, we will preserve the normal sex life in one out of every two patients we do not treat.

**Conclusions**

The main focus in the coming years should be on avoiding prescribing depression drugs and on helping those who are on them to come off them as safely as possible. These drugs double the risk of suicide and completed suicides, also in adults.69,70

**References**

1 Nielsen M, Gøtzsche P. An analysis of psychotropic drug sales. Increasing sales of selective serotonin reuptake inhibitors are closely related to number of products. Int J Risk Saf Med 2011;23:125-32.

2 Gøtzsche PC. Mental health survival kit and withdrawal from psychiatric drugs. Ann Arbor: L H Press; 2022.

3 Medawar C. The antidepressant web - marketing depression and making medicines work. Int J Risk & Saf Med 1997;10:75-126.

4 Gøtzsche PC, Dinnage O. What have antidepressants been tested for? A systematic review. Int J Risk Saf Med 2020;31:157-163.

5 Taylor S, Annand F, Burkinshaw P, et al. [Dependence and withdrawal associated with](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/940255/PHE_PMR_report_Dec2020.pdf)

[some prescribed medicines: an evidence review](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/940255/PHE_PMR_report_Dec2020.pdf). London: Public Health England; 2019.

6 Gøtzsche PC, Demasi M. Interventions to help patients withdraw from depression drugs: systematic review. MedRxriv 2023 ([preprint](https://www.medrxiv.org/content/10.1101/2023.03.13.23287182v1)) and Int J Risk & Saf Med (in press).

7 Gøtzsche PC. Long-term use of antipsychotics and antidepressants is not evidence-based. Int J Risk Saf Med 2020;31:37-42.

8 Leucht S, Fennema H, Engel R, et al. What does the HAMD mean? J Affect Disord 2013;148:243-8.

9 Jakobsen JC, Katakam KK, Schou A, et al. Selective serotonin reuptake inhibitors versus placebo in patients with major depressive disorder. A systematic review with meta-analysis and Trial Sequential Analysis. BMC Psychiatry 2017;17:58.

10 Cipriani A, Zhou X, Del Giovane C, et al. Comparative efficacy and tolerability of antidepressants for major depressive disorder in children and adolescents: a network metaanalysis. Lancet 2016;388:881-90.

11 Leucht S, Kane JM, Etschel E, et al. Linking the PANSS, BPRS, and CGI: clinical implications. Neuropsychopharmacology 2006;31:2318-25.

12 Khin NA, Chen YF, Yang Y, et al. Exploratory analyses of efficacy data from schizophrenia trials in support of new drug applications submitted to the US Food and Drug Administration. J Clin Psychiatry 2012;73:856–64.

13 Gøtzsche PC. Deadly psychiatry and organised denial. Copenhagen: People’s Press; 2015.

14 Whitaker R, Gøtzsche PC. [The pervasive financial and scientific corruption of psychiatric drug trials](https://www.scientificfreedom.dk/2022/03/23/the-pervasive-financial-and-scientific-corruption-of-psychiatric-drug-trials/). Institute for Scientific Freedom 2022; March 23.

15 Davies J, Read J. A systematic review into the incidence, severity and duration of antidepressant withdrawal effects: Are guidelines evidence-based? Addict Behav 2019;97:111-21.

16 Gøtzsche PC. Deadly medicines and organised crime: How big pharma has corrupted health care. London: Radcliffe Publishing; 2013.

17 Nielsen M, Hansen EH, Gøtzsche PC. Dependence and withdrawal reactions to benzodiazepines and selective serotonin reuptake inhibitors. How did the health authorities react? Int J Risk Saf Med 2013;25:155-68.

18 Committee on the Review of Medicines. Systematic review of the benzodiazepines. Guidelines for data sheets on diazepam, chlordiazepoxide, medazepam, clorazepate, lorazepam, oxazepam, temazepam, triazolam, nitrazepam, and flurazepam. Br Med J 1980;280:910-2.

19 Nielsen M, Hansen EH, Gøtzsche PC. What is the difference between dependence and withdrawal reactions? A comparison of benzodiazepines and selective serotonin re-uptake inhibitors. Addict 2012;107:900-8.

20 Demasi M, Gøtzsche PC. Presentation of benefits and harms of antidepressants on websites: cross sectional study. Int J Risk Saf Med 2020;31:53-65.

21 Priest RG, Vize C, Roberts A, et al. Lay people’s attitudes to treatment of depression: results of opinion poll for Defeat Depression Campaign just before its launch. BMJ 1996;313:858-9.

22 Gøtzsche PC. [The review on antidepressant withdrawal that Cochrane won’t publish](https://www.madinamerica.com/2020/02/review-cochrane-wont-publish/). Mad in America 2020; Feb 11.

23 Gøtzsche PC. [Cochrane reviews of psychiatric drugs are untrustworthy](https://www.madinamerica.com/2023/09/cochrane-reviews-of-psychiatric-drugs-are-untrustworthy/). Mad in America 2023; Sept 14.

24 Kessing L, Hansen HV, Demyttenaere K, et al. Depressive and bipolar disorders: patients’ attitudes and beliefs towards depression and antidepressants. Psychol Med 2005;35:1205-13.

25 Read J, Cartwright C, Gibson K. Adverse emotional and interpersonal effects reported by 1829 New Zealanders while taking antidepressants. Psychiatry Res 2014;216:67-73.

26 Oswald I, Lewis SA, Dunleavy DL, et al. Drugs of dependence though not of abuse: fenfluramine and imipramine. Br Med J 1971;3:70-3.

27 Paykel ES, Hart D, Priest RG. Changes in public attitudes to depression during the Defeat Depression Campaign. Br J Psychiatry 1998;173:519-22.

28 Kendall R. [Letter to Mr Medawar](https://www.socialaudit.org.uk/4401RCP.htm#Dear%20Mr). Social Audit 1997; Nov 28.

29 Gøtzsche PC. [Critical psychiatry textbook](https://www.scientificfreedom.dk/books/). Copenhagen: Institute for Scientific Freedom; 2022 (freely available).

30 Schatzberg AF, Haddad P, Kaplan EM, et al. Serotonin reuptake inhibitor discontinuation syndrome: a hypothetical definition. Discontinuation Consensus panel. J Clin Psychiatry 1997;58 Suppl 7:5-10.

31 Levine B. [Too corrupt, insane & ridiculous to be reformed? Even establishment psychiatrists distance themselves from their own profession](https://www.madinamerica.com/2014/04/corrupt-insane-ridiculous-reformed-even-establishment-psychiatrists-now-distancing-profession/). Mad in America 2014; April 17.

32 Warner CH, Bobo W, Warner C, et al. Antidepressant discontinuation syndrome. Am Fam Physician 2006;74:449-56.

33 Gabriel M, Sharma V. Antidepressant discontinuation syndrome. CMAJ 2017;189:E747.

34 Bullock C, Bernstein CA. [Discontinuation syndrome and antidepressants](https://www.health.harvard.edu/blog/discontinuation-syndrome-and-antidepressants-2019040416361). Harvard Health Blog 2019; April 11.

35 [Depression in adults: recognition and management](https://www.nice.org.uk/guidance/cg90/resources/depression-in-adults-recognition-and-management-pdf-975742638037). National Institute for Health and Care Excellence (NICE) 2009; Oct 28.

36 Davies J, Read J, Hengartner MP, et al. Clinical guidelines on antidepressant withdrawal urgently need updating. BMJ 2019;365:l2238.

37 [Depression in adults: treatment and management](https://www.nice.org.uk/guidance/ng222). NICE guideline [NG222] 2022; June 29.

38 Iacobucci, G. NICE updates antidepressant guidelines to reflect severity and length of withdrawal symptoms. BMJ 2019;367:l6103.

39 Smith JL. [Julia Llewellyn Smith meets Luke Montagu](http://cepuk.org/wp-content/uploads/2015/07/Times-Magazine-18-July-2015-pdf.pdf). The Times Magazine 2015; July 18:22-6.

40 Montagu L. ['Doctors gave me depression pills I DIDN'T need for 20 years': Coming off his antidepressants drove Viscount Hinchingbrooke to the brink - but his story is alarmingly common](https://www.dailymail.co.uk/health/article-4173468/My-GP-gave-antidepressants-didn-t-need-20-years.html). Daily Mail 2017; Jan 30.

41 Earl of Sandwich. [The long-term sustainability of the NHS and adult social care](https://hansard.parliament.uk/Lords/2018-04-26/debates/F523BB19-90B8-4AA9-BCC0-7B8AA92AD6DE/TheLong-TermSustainabilityOfTheNHSAndAdultSocialCare#contribution-2C578EC2-8B18-462C-8181-91FE31C2F977). Hansard 2018; April 26.

42 Michelson D, Fava M, Amsterdam J, et al. Interruption of selective serotonin reuptake inhibitor treatment. Double-blind, placebo-controlled trial. Br J Psychiatry 2000;176:363-8.

43 Jha, M, Rush, A, Trivedi, M. When discontinuing SSRI antidepressants is a challenge: management tips. Am J Psychiat 2018;175:1176-84.

44 Hengartner, M, Davies, J, Read, J. How long does antidepressant withdrawal typically last? Am J Psychiat 2019;176:487.

45 [Position statement on antidepressants and depression](https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/position-statements/ps04_19---antidepressants-and-depression.pdf?sfvrsn=ddea9473_5), PS04/19. Royal College of Psychiatrists 2019; May.

46 Read J, Renton J, Harrop C, et al. [A survey of UK general practitioners about depression, antidepressants and withdrawal: implementing the 2019 Public Health England report](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7457636/). Ther Adv Psychopharmacol 2020;10:2045125320950124.

47 [Expert reaction to Royal College of Psychiatrists’ position statement on antidepressants](https://www.sciencemediacentre.org/expert-reaction-to-royal-college-of-psychiatrists-position-statement-on-antidepressants/). Science Media Centre 2019; May 30.

48 [Antidepressant treatment in adults](http://pathways.nice.org.uk/pathways/depression). NICE 2019; October (the link does not lead to the document, which was likely deleted due to criticism).

49 Gøtzsche PC. Mammography screening: truth, lies and controversy. London: Radcliffe Publishing; 2012.

50 Gøtzsche PC. Sundhedsstyrelsens farlige råd om depressionspiller. Politiken 2020; Feb 6.

51 Gøtzsche PC, Gøtzsche PK. Cognitive behavioural therapy halves the risk of repeated suicide attempts: systematic review. J R Soc Med 2017;110:404-10.

52 Horowitz M, Taylor D. Tapering of SSRI treatment to mitigate withdrawal symptoms. Lancet Psychiat 2019;6:538-46.

53 Gøtzsche PC, Toft B, Rüdinger B, et al. Udtrapning af psykofarmaka: En opfordring til de praktiserende læger. Practicus 2017; Dec 17:48-50.

54 Gøtzsche PC, Toft B, Rüdinger B, et al. Hvordan skal man trappe ud af psykofarmaka? Jyllands-Postens kronik 2017; Oct 10.

55 [APA clinical practice guideline for the treatment of depression across three age cohorts](https://www.apa.org/depression-guideline). American Psychological Association 2019; Feb.

56 [Practice guideline for the treatment of patients with major depressive disorder](https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/mdd.pdf). American Psychiatric Association 2010; Oct.

57 Lien L, Reitan SK, Nilsson MJ, et al. ”Pilleskam” i psykiatrien er et alvorlig samfunnsproblem. Aftenposten 2023; Aug 11; p38.

58 Gøtzsche PC. [The media’s false narrative about depression pills, suicides, and saving lives](https://www.madinamerica.com/2023/08/media-false-narrative-depression-pills/). Mad in America 2023; Aug 23.

59 [Prescribing information for Paxil](https://www.accessdata.fda.gov/drugsatfda_docs/label/2012/020031s067%2C020710s031.pdf). FDA 2012; Dec (accessed 25 Aug 2023).

60 Sørensen A, Ruhé HG, Munkholm K. The relationship between dose and serotonin transporter occupancy of antidepressants-a systematic review. Mol Psychiatry 2022;27:192-201.

61 [Prescribing information for Zoloft](https://www.accessdata.fda.gov/drugsatfda_docs/label/2016/019839s74s86s87_20990s35s44s45lbl.pdf). FDA 2016; Dec (accessed 27 Aug 2023).

62 Gøtzsche PC. [Number needed to treat with a psychiatric drug to benefit one patient is an illusion.](https://www.madinamerica.com/2022/12/nnt-psychiatric-illusion/) Mad in America 2022; Dec 13.

63 Sharma T, Guski LS, Freund N, et al. Drop-out rates in placebo-controlled trials of antidepressant drugs: A systematic review and meta-analysis based on clinical study reports. Int J Risk Saf Med 2019;30:217-32.

64 Nutt DJ, Goodwin GM, Bhugra D, et al. Attacks on antidepressants: signs of deep-seated stigma? Lancet Psychiatry 2014;1:103–4.

65 Gøtzsche PC, Jørgensen AW. Opening up data at the European Medicines Agency. BMJ 2011;342:d2686.

66 Gøtzsche PC, Healy D. Restoring the two pivotal fluoxetine trials in children and adolescents with depression. Int J Risk Saf Med 2022;33:385-408.

67 Chan A-W, Hróbjartsson A, Haahr MT, et al. Empirical evidence for selective reporting of outcomes in randomized trials: comparison of protocols to published articles. JAMA 2004;291:2457-65.

68 Montejo A, Llorca G, Izquierdo J, et al. Incidence of sexual dysfunction associated with antidepressant agents: a prospective multicenter study of 1022 outpatients. Spanish Working Group for the study of psychotropic-related sexual dysfunction. J Clin Psychiatry 2001;62 (suppl 3):10–21.

69 Hengartner MP, Plöderl M. Newer-generation antidepressants and suicide risk in randomized controlled trials: a re-analysis of the FDA database. Psychother Psychosom 2019;88:247-8.

70 Hengartner MP, Plöderl M. Reply to the Letter to the Editor: “Newer-Generation Antidepressants and Suicide Risk: Thoughts on Hengartner and Plöderl’s ReAnalysis.” Psychother Psychosom 2019;88:373-4.