**Withdrawal symptoms are not relapse of the disease: A patient’s view on how psychiatry mislabels neurochemical rebound**

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A dangerous misconception, deeply embedded in psychiatry, is that the return of symptoms after discontinuing psychiatric medication is a relapse of the original condition. For many patiens, including me, this belief has led to misdiagnosis, suffering, and unnecessary, prolonged exposure to harmful drugs. What psychiatry labels as "relapse" is almost always a physiological response to the cessation of a substance that has altered brain functions.

This article reflects my personal experiences, bolstered by the research of prominent doctors like Peter Gøtzsche and Joanna Moncrieff. They highlighted the urgent need to rethink how psychiatry interprets symptom recurrence after drug withdrawal. Peter has bluntly stated that drug dependence is often misinterpreted as relapse of the disease. His

books, especially *Deadly Psychiatry and Organised Denial* and *Mental Health Survival Kit and Withdrawal from Psychiatric Drugs*, profoundly changed my view of psychiatry. His courage in challenging mainstream narratives and dedication to telling the truth are truly inspiring.

**The dominant psychiatric dogma**

The standard psychiatric narrative is that psychotropic drugs correct an underlying chemical imbalance. Therefore, when a patient discontinues medication and experiences distress, this is interpreted as evidence that the illness has returned. But no one has ever demonstrated that a psychiatric disorder is caused by a chemical imbalance in the brain, and Joanna recently [rejected this idea](https://www.nature.com/articles/s41380-022-01661-0) for drugs used against depression.

In practice, the false dogma means that patients attempting to taper off medications like lithium, quetiapine, or SSRIs are often told that their condition is "chronic," when in fact they are enduring the neurochemical consequences of withdrawal. Psychiatry, rather than seeing withdrawal as a detox process, frames it as pathological.

**My personal experience**

After being put on quetiapine and lithium, I noticed that any attempt to reduce or pause the medication led to emotional and physiological turmoil - intense anxiety, sleeplessness, hypersensitivity, and mood swings. These symptoms were not present before medication. Yet my doctors interpreted them as signs of relapse.

What happened to me was a textbook example of neurochemical rebound. My brain, having adjusted to the artificial suppression or enhancement of certain neurotransmitters, was attempting to find equilibrium again. This is not disease - it's biology.

The failure to distinguish withdrawal from relapse prolonged my treatment, deepened my distrust, and almost destroyed my sense of autonomy.

**What the science really says**

The scientific literature increasingly supports what patients have been saying for decades. Withdrawal from antipsychotics and mood stabilizers can produce symptoms that mimic or exceed the original condition in severity.

Joanna and Peter have written extensively about how withdrawal symptoms are mistaken for illness recurrence and have pointed out that many "relapse" studies never account for withdrawal effects - a glaring methodological flaw.

**The ethical problem**

Failing to distinguish between withdrawal effects and relapse has devastating consequences. Patients are told they need the drug when in fact they might have healed. They're re-medicated and informed consent is violated.

Doctors often fail to explain the possibility of withdrawal reactions or minimize their impact. I was never told that lithium could cause a glutamate rebound effect or that quetiapine discontinuation could spike dopamine levels. This omission is not just clinical negligence - it is an ethical breach.

**Conclusion: toward an honest psychiatry**

It is time for psychiatry to acknowledge that return of symptoms when the dose is lowered or discontinued is rarely a relapse but the brain recovering from chemical manipulation.

Patients deserve informed consent, not lifelong medication based on a misdiagnosis and false dogma. The future of ethical psychiatry must include a full acknowledgment of withdrawal syndromes, transparent communication, and above all - listening to those who have lived it instead of dismissing their symptoms as disease recurrence.