Finding One's Way Through Withdrawal

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By Jennifer Honig January 10, 2021

Prescribers are taught to prescribe psychiatric medication, but they are often not well-educated about the effects on patients of discontinuing these medications. When a patient seeks to stop taking a drug, their prescriber may not be available to assist. The patient risks experiencing withdrawal alone.

Withdrawal, the process of terminating any type of psychiatric medication, may be an uneventful experience or a harrowing one, or somewhere in between. When people experience a cluster of effects from withdrawal, some label their response as "withdrawal syndrome." Like the concept of withdrawal, that term does not have a singular representation but has come to cover a range of experiences.

With prescribers largely absent from the discussion of withdrawal, conversation on this topic has gravitated to online communities. As researchers Peter C. Groot and Jim van Os recently described, this is a world that many participate in and receive aid from, but that remains largely separated from mainstream medicine and psychiatry.

The robust online forums where individuals discuss withdrawal exist parallel to the credentialed psychiatric field, with inadequate influence on it despite its important wealth of experience and information. Meanwhile, prescribers who fail to follow their patients as they withdraw from medication lose the opportunity to learn from their patients' experiences. These actors continue their discrete roles in parallel —one prescribing and one responding—without one informing the other.

The online conversation about withdrawal assistance reveals both the large number of individuals seeking help to discontinue psychiatric medication and the substantial body of information that now exists on how best (or better) to do so.

The overall lack of recognition, beyond the online realm, of that data and practical information prevents the established treatment community from accurately evaluating the value of drug treatment and best assisting patients. Conventional caregivers often do not know how many people are interested in withdrawing, how to assist in withdrawal, or how difficult it may be. Information available online must inform medical practitioners.

That feedback must influence the decision to prescribe in the first place and, as discussed later in this series, the provision of informed consent to patients who are considering medication. Critics of traditional psychiatry have been making these kinds of arguments for years; now they are turning to the problem of withdrawal and seeing the same urgent need for reform.

WITHDRAWAL: A PRESSING PROBLEM

Many of the Americans prescribed psychiatric medication may at some point seek to discontinue this treatment. In 2018, one in five adults in the U.S. were treated with psychiatric medication. And, during the COVID-19 pandemic, both the diagnosis of mental health disorders and the use of prescription psychiatric medication have increased.

We do not know how many people taking psychiatric medication will seek to discontinue such treatment. We also lack aggregated data as to how many people have thought about withdrawal or how many have broached the subject with their prescriber. However, in one study of people with psychosis, for example, researchers observed that people "often want to reduce the dose or stop" their antipsychotics. The large numbers of individuals who seek help online also suggests that there is a pressing need for information about withdrawal.

Moreover, the sheer number of reasons that people have cited as the basis for discontinuation suggest that withdrawal might at some point be a goal of many on psychiatric medication. These include:

- a concern about side effects, including weight gain and sexual dysfunction;
- a concern about taking medication during pregnancy;
- a feeling that one is emotionally flat;
- a worry about long-term effects of medication;
- a desire to stop taking pills;
- lack of access to a specialist;
- the absence of a therapeutic relationship between prescriber and patient;
- a substance use disorder;
- a negative attitude toward medication;
- a belief that one does not have an emotional problem requiring continued treatment with medication.

This range of concerns suggests there is a large and diversely motivated group of people who might have questions about withdrawal.

Many who attempt withdrawal will experience adverse effects

A large percentage of people who attempt withdrawal from psychiatric medication will experience withdrawal symptoms. Data now reveals both the incidence and nature of such symptoms.

James Davies and John Read's 2019 review of studies of anti-depressant withdrawal recorded effects in 27% to 86% of individuals, with a weighted average (i.e., an average that assigns weights in accordance with the relative importance of each data point) of 56%. Likewise, a 2020 meta-analysis of withdrawal from oral antipsychotics found that 49% of individuals experienced symptoms after abrupt discontinuation of the medication compared to 11% in a control group that continued medication.

Withdrawal effects may be pronounced even if discontinuation is gradual. In 2020, **Fiammetta Cosci and Guy Chouinard** documented withdrawal syndrome for multiple classes of drugs, including benzodiazepines, antidepressants, antipsychotics, lithium, and mood stabilizers. Even with slow tapering, each category of drugs could induce both withdrawal syndromes and rebound (a return of primary symptoms, which, while short-lasting and reversible, are usually at a greater intensity than before treatment).

As Adele Framer, the founder of the online forum Surviving Antidepressants, has recently observed, "Every single person who's taking a psychiatric drug for any length of time is at risk for withdrawal syndrome."

The potential tribulations of withdrawal are many and serious

Formal cataloguing of withdrawal symptoms associated with each psychiatric medication is incomplete. Withdrawal effects are under-researched, David Cohen and Alexander Recalt recently observed. "[N]o consensus definition of the physiological and psychological phenomena that may follow dose-reducing or stopping prescribed psychotropics has emerged, excepting those in successive editions of the Diagnostic and Statistical Manual of Mental Disorders."

Nonetheless, a dizzying array of symptoms have been linked to particular drug classes. For example, withdrawal from antidepressants, even with slow tapering, may cause "anxiety, irritability, agitation, dysphoria, insomnia, fatigue, tremor, sweating, shock-like sensations ('brain zaps'), paresthesia ('pins and needles'), vertigo, dizziness, nausea, vomiting, confusion and decreased concentration." Benzodiazepines withdrawal may trigger some of these same symptoms as well as others, such as tinnitus, numbness in extremities, muscle jerking, and irritable bowel syndrome.

The effects can be severe. Davies and Read's 2019 review found that antidepressant withdrawal produced severe effects in 46% of cases, using a weighted average as the measure. **Cosci and Chouinard** recently warned of persistent post-withdrawal disorders — long-lasting, severe, potentially irreversible symptoms – after withdrawal from selective serotonin reuptake inhibitors (SSRIs), serotonin and noradrenaline reuptake inhibitors (SNRIs), and antipsychotics.

These sorts of outcomes can have an almost existential effect. As one person explained: "This withdrawal process has slowly been stripping me of everything I believed about myself and life. One by one, parts of 'me' have been falling away, leaving me completely empty of any sense of being someone."

As Groot and van Os emphasize, patients who try to stop taking psychiatric drugs often fail due to the intense effects of withdrawal. *The New York Times* cites studies in which users of psychiatric drugs faced severe withdrawal symptoms, to the point where, in one study, nearly half who tried to quit could not do so because of these symptoms.

The science behind withdrawal should heighten our concern

The brain's adaptations to various psychiatric medications explains why withdrawal can be such a problem. In *Anatomy of an Epidemic*, Robert Whitaker explains that the brain reacts to the introduction of psychotropic drugs by making "a series of compensatory adaptations." The specific adaptation depends on the drug.

For example, an antipsychotic *blocks* neurotransmitters, whose job it is to send impulses from one nerve cell to another. When a person receives an antipsychotic, the brain adapts by increasing production of and receptivity to neurotransmitters. When a person takes an antidepressant, which *increases* the levels of neurotransmitters, the brain adapts to counter this increase. Similarly, benzodiazepines work by amplifying a type of neurotransmitter (known as GABA) which inhibit brain activity. The brain adapts by decreasing GABA output and the density of GABA receptors. With these types of drugs, and with other categories of drugs as well, the brain changes its functioning to combat the medication's effect.

The trouble arises when the drug is stopped. With its new, abnormal neural functioning now engrained, the brain cannot switch back to its original mechanics in response to the discontinuation. For example, for a person treated with a depressant, when it is withdrawn, the adapted, revved-up brain remains in that heightened state, without a mechanism for control.

"The system is now wildly out of balance… the patient withdrawing from the drugs suffers weird tics, agitation, and other motor abnormalities[,] psychotic relapse or deterioration." Likewise, when SSRIs are withdrawn, imbalance occurs because the brain no longer releases normal amounts of serotonin nor has enough receptors to take in the little that is released. When benzodiazepines are withdrawn, the brain is left in a state of overactivity that it cannot contest. The result, in all these examples, can be withdrawal symptoms.

Despite the growing understanding of the science behind withdrawal effects, these problems are often not acknowledged by the larger medical community.

PRESCRIBERS DON'T HEAR PATIENT VOICES

Patients may not enjoy the support of prescribers when they want to withdraw

For a variety of reasons, individuals may not receive their prescriber's assistance as they contemplate and pursue withdrawal. They may find that their prescribers will not support discontinuation. Prescribers may encourage the patient to trade one medication for another instead of discontinuing. The clinician may believe that the person has a disorder that demands ongoing treatment or that discontinuation of medication would present its own difficulties.

Patients may fear raising the issue with their clinician in the first place. Some may worry that the prescriber might use coercion to compel medication compliance. And, in fact, some prescribers explicitly threaten to civilly commit people if they are not acting as the prescriber wishes.

Despite these barriers, many patients are not dissuaded from the desire to withdraw from medication.

Prescribers lack expertise regarding withdrawal

Even when prescribers are willing to work with their patients who wish to withdraw, many lack the expertise to assist their patients. Most people get their psychiatric medication from their primary care providers. In the U.S., almost four out of five prescriptions for psychotropic medications are written by physicians who are not psychiatrists. This is staggering. These clinicians have neither the expertise regarding psychiatric medications nor the time to devote to the careful oversight of withdrawal.

In *Rethinking Psychiatric Drugs: A Guide for Informed Consent*, psychiatrist Grace E. Jackson cites a 1997 United Kingdom survey of 100 General Practitioners (GPs) which found that only 30% of GPs had a "confident awareness of antidepressant discontinuation syndrome" and only 51% always or usually advised patients about drug withdrawal effects. Additionally, only 42% of GPs had direct experience treating patients for withdrawal associated with SSRIs. Only 6% of GPs had such experience with patients withdrawing from monoamine oxidase inhibitors (MAOI), and only 38% of GPs had such experience regarding tr*icyclic antidepressants (*TCAs).

Even psychiatrists may not be well versed in helping people withdraw from medication. The same U.K. survey also questioned 100 psychiatrists: only 72% had a "confident awareness of antidepressant discontinuation syndrome" and only 52% always or usually advised patients about drug withdrawal effects. Rachel Aviv, reporting in *The New Yorker*, recounts her conversation with Allen Frances, an emeritus professor of psychiatry at Duke, who chaired the task force for the fourth edition of the *DSM*, in 1994:

[He] told me that the field has neglected questions about how to take patients off drugs—a practice known as "de-prescribing." He said that "de-prescribing requires a great deal more skill, time, commitment, and knowledge of the patient than prescribing does.

The practical effect can be dramatic. Adele Framer describes how she visited more than fifty psychiatrists trying to find one who was knowledgeable about antidepressant withdrawal.

Because prescribers are not advising their patients during withdrawal in many cases, they are not gaining empirical knowledge about withdrawal effects and educating themselves through experience. And that contributes to another problem. It is not just that prescribers lack knowledge, but that they don't know what they don't know. As Jackson observed in *Rethinking Psychiatric Drugs: A Guide for Informed Consent*, "Maintained on a steady diet of empty but convenient evidence, many physicians remain oblivious to the signs of their professional malnourishment."

External authorities are not providing a substitute for lack of empirical knowledge

Prescribers have not compensated for their lack of practical experience with some other knowledge base. A psychiatrist may go through their entire formal education and not learn about withdrawal. As psychiatrist Mark Horowitz commented in 2019, "I'd never heard about withdrawal symptoms from antidepressants, not in medical school, not in my psychiatry training." Psychiatrist Vivek Datta, referencing his training, put it even more bluntly, "What we do not learn is how to stop these drugs."

Additionally, neither drug companies nor the U.S. government has a consistent history of providing psychiatrists with accurate information on withdrawal. As *New York Times* reporters have observed, "withdrawal has never been a focus of drug makers or government regulators, who felt antidepressants could not be addictive and did far more good than harm."

The professional literature does not fill the gap in knowledge about withdrawal. Rachel Aviv reported on the discrepancy between the significant information that is available regarding withdrawal experience and the limited published documentation of it. She quotes psychiatrist and researcher David Taylor, saying that if he had not experienced antidepressant withdrawal himself, "'I think I would be sold on the standard texts.' But, he said, 'experience is very different from what's on the page.'"

Aviv offered a reason for the dearth of literature. Describing the experience of Giovanni Fava, a renowned professor of psychiatry who conducts long-term studies of antidepressant withdrawal, she notes that Fava has struggled to publish his research. Groot and van Os sum up the problem: "for a long time, withdrawal problems were not considered a significant issue in academic psychiatry."

Today, to the extent that relevant literature is slowly being disseminated, prescribers just may not be reading it. Framer opined recently, "There are hundreds of papers about antidepressant withdrawal. Most clinicians, most practitioners—and certainly not your GP—don't read those papers." One explanation, suggests professor Christopher Lane, is that withdrawal research may be lost in a sea of other articles, particularly those on drug efficacy.

One mainstream journal recognized this failure to consult the clinical research on psychiatric medication withdrawal. Writing in *Psychiatric Times*, researchers advised prescribers on their patients' growing use of online forums to discuss their medications and withdrawal from them. The message to be gleaned, the researchers counseled, is that physicians are unprepared to deal with withdrawal disorders. Clinicians should look to psychiatric journals for guidance to help "correctly weigh the risks and benefits of using benzodiazepines and antidepressants in the management of depression and anxiety disorders."

Finally, clinician inattention to information about withdrawal may be accentuated by a more systemic dereliction. Recounting their experience in the Netherlands, Groot and van Os found that resistance to exploring the topic of withdrawal extended across multiple parties in the treatment community:

n recent years, it was difficult for us to inform or to discuss these issues with the relevant parties such as our health insurers, the Dutch Psychiatric Association, General Practitioners Association, the patient umbrella organisation MIND, the Dutch National Healthcare Institute and even the Ministry of Health. In our view, we experienced what so many patients had experienced for so many years when they tried to discuss their withdrawal problems. Theory, assumptions and a narrow interpretation of the literature was what counted.

Pharmaceutical companies misinform prescribers

Even more troubling than prescribers' lack of information about withdrawal is pharmaceutical company dissemination of misinformation about it. This is particularly problematic since, as Cohen and Recalt explain, "the pharmaceutical industry dominates the testing of psychiatric drugs by funding it directly and indirectly, while controlling most distribution channels for drug information."

Specifically, pharmaceutical companies have misled prescribers by encouraging them to interpret withdrawal symptoms as signs of relapse—re-emergence of symptoms of the diagnosed mental health condition – rather than as a response to the discontinuance of the medication. As Dr. Jackson has observed:

Through their influence upon the content and dissemination of treatment guidelines, journal supplements, CME (continuing medical education) symposia, and public announcements, pharmaceutical companies have promoted the misinterpretation of withdrawal symptoms as evidence of relapse for which the resumption of pharmacotherapy has been strongly endorsed.

Moreover, witnessing what they are told are relapses, psychiatrists (and patients) are encouraged to believe that the diagnosed illness is chronic, therefore requiring even longer periods of medication. Jackson describes this result, in the case of antidepressants, as an intentional ploy of drug companies:

[T]he existence of antidepressant-withdrawal symptoms have been used by the pharmaceutical industry to construct a mythology of chronic disease, based upon the experience of patients who repeatedly develop depressive (or manic) features whenever their medications are stopped.

Given the chronic nature of depression, Jackson explains, the industry makes a "prophylactic efficiency" argument for pharmacotherapy, where long term treatment is the best means of relapse prevention. In other words, since withdrawal from drug treatment results in a high relapse rate, patients should be maintained on drugs to prevent relapse.

Prescribers are complicit in this system by failing to carefully observe their patients. Rather than differentiate these new withdrawal-induced symptoms, prescribers instead attribute them to the mental health diagnosis itself. Some prescribers do so even when confronted with bizarre symptoms, like brain zaps, which are unrelated to the disorder for which drugs were prescribed. This pattern of attributing such symptoms to relapse led Framer to lament: "You know doctors must not be listening to what their patients are telling them."

In these ways, pharmaceutical companies hide, and prescribers fail to detect, the withdrawal effects of the drugs they prescribe. As Jackson decries: "Whether by ignorance or design, the mental health profession remains largely oblivious to this tragedy of its own making."

Jackson's 2005 grievance holds true today. In 2019, researchers Cohen and Recalt analyzed the conflation of relapse and withdrawal in studies covering multiple drug classes. They found pervasive "withdrawal confounding" (the confusing of withdrawal symptoms with evidence of relapse) in clinical trials focused on relapse prevention and cautioned that "estimating the true magnitude of this confounding is in its infancy."

Part of the reason for this confounding is that, despite extensive study of relapses, there were "few original trials over the last 30 years that investigated whether withdrawal could present as relapse." However, the flaws in relapse studies, which allow for withdrawal to be ignored, are not inevitable and the authors offer a blueprint for redesigning studies to reduce the risk of withdrawal confounding. Unfortunately, they are "not optimistic that [their] broad suggestion will be acted upon soon."

Financial incentives encourage prescribers to maintain patients on medication

There are also economic incentives for prescribers to maintain patients on psychiatric medication. A prescriber who is reimbursed to prescribe has a financial interest in continuing medication and little incentive to take the time to delve into a patient's ordeals. As psychiatrist Steve Balt writes:

It would also help to allow (if not require) more time with psychiatric patients. This is important. If I only have 15-20 minutes with a patient, I don't have time to ask about her persistent back pain, her intrusive brother-in-law, or her cocaine habit. Instead, I must restrict my questions to those that pertain to the drug(s) I prescribed at the last visit. This, of course, creates the perfect opportunity for confirmation bias—where I see what I expect to see.

Focusing on medication administration, and not on problems that might be addressed with other types of treatment responses, becomes the norm.

There is also so much money tied up in the drug industry that its effect on psychiatric treatment is profound. Discussing the dollars generated by SSRIs, Will Self observes, "it can warp the dynamics and the ethics of an entire profession." As an example, prescribing medication is much more lucrative than conducting therapy. As psychiatrists steer towards the former, their income is increasingly tied to prescribing. Psychiatrist Daniel Carlat, quoted in the American Psychological Association's *Monitor on Psychology*, explains:

There is a huge financial incentive for psychiatrists to prescribe instead of doing psychotherapy.... You can make two, three, four times as much money being a prescriber than a therapist. The vicious cycle here is that as psychiatrists limit their practices primarily to prescribing, they lose their therapy skills by attrition and do even less therapy.

An even more obvious example of the influence of money in psychiatry is the practice of drug companies providing cash payments to clinicians to prescribe their products. Finally, a prescriber may perceive a financial risk in not maintaining a patient on

medication; the prescriber may believe that an unmedicated patient's deterioration, resulting in relapse, hospitalization, homelessness, or violence, might subject the clinician to financial penalty or liability.

These economic incentives may influence psychiatrists to maintain their patients on medication.

Reliance on evidence-based medicine insulates prescribers from the withdrawal experiences of patients without offering promised benefits

Psychiatry's embrace of evidence-based practice (aka evidence-based medicine) beginning in the 1990s reinforces the detachment of prescribers from their patients' experiences. Jackson explained that clinicians once learned from the experience of their patients, a methodology she labeled "reality-based medicine." She quoted David Healy who, in *The Creation of Psychopharmacology*, described how "once the psychopharmacology literature was invested with the authority of clinicians who knew at first hand what they were describing."

Gradually, physicians came to rely for their edification more exclusively on evidence-based medicine than on direct observation. Given that there was no alternative source of aggregated patient data, reliance on such trials made some sense. But while proponents of evidence-based practice touted randomized, placebo-controlled clinical trials (RCTs) as the answer, such trials are not free from the problems they were designed to overcome.

RCTs' inability to escape bias is a recurrent theme. A 2018 study of the most frequently cited RCTs in professional journals found that, for a variety of reasons, they produced biased results. Reasons included: "participants' background traits that affect outcomes are often poorly distributed between trial groups, that the trials often neglect alternative factors contributing to their main reported outcome and, among many other issues, that the trials are often only partially blinded or unblinded."

The author found bias despite multiple efforts to control for it:

RCTs face a range of strong assumptions, biases and limitations that have not yet all been thoroughly discussed in the literature. This study assesses the 10 most cited RCTs worldwide and shows that trials inevitably produce bias. Trials involve complex processes – from randomising, blinding and controlling, to implementing treatments, monitoring participants etc. – that require many decisions and steps at different levels that bring their own assumptions and degree of bias to results.

In another 2018 analysis of RCTs, researchers also challenged the reliance on RCTs as a source of unbiased evidence. They concluded that many such trials are "not blinded nor sufficiently controlled for other sources of bias, and indeed many cannot be, and a sufficient defense is rarely offered that unbiasedness is not undermined." They suggest that the medical communities' dramatic shift to RCTs for information about psychiatric medications is imprudent:

Depending on what we want to discover, why we want to discover it, and what we already know, there will often be superior routes of investigation and, for a great many questions where RCTs can help, a great deal of other work—empirical, theoretical, and conceptual—needs to be done to make the results of an RCT serviceable.

This conclusion, by researchers who describe themselves as "not against RCTs, only magical thinking about them," should raise anew Jackson's 2005 warning about dependence on RCTs for psychopharmacological study.

And, in 2020, two sets of researchers have in fact applied Jackson's skepticism to the study of withdrawal. Writing about withdrawal research specifically, Cohen and Recalt provide an extensive list of potential biases of pharmacological RCTs: "[N]early every strategy potentially favoring the tested drug is built into the design of conventional psychopharmacology RCTs." In addition, RCTs inflate the efficacy estimates of drugs through publication or reporting biases.

These researchers applaud recent steps to re-evaluate the use of RCTs. Groot and van Os also challenge the use of RCTs in researching withdrawal. They cite a range of problems including limited data from original studies (as opposed to reviews of studies), lack of attention to polypharmacy, and lack of application of information for vulnerable patient groups.

Thus, Jackson's recommendation to look beyond RCTs to capture and address individual experiences with medication remains trenchant. RCTs may offer some information to assist in that analysis, she wrote, but they do not eliminate the needs to evaluate the specific situation at hand and to consider other methodologies as well. As Jackson put it, the goal of evidence-based practice is to obscure differences between individuals, yet a consideration of patient (and practitioner) individuality is vital to healing.

The current reliance on evidence-based practice has led clinicians to favor treatments that are endorsed by clinical trial over treatments that are not. Doing so, Jackson argued, degrades other forms of knowledge—patient and physician values, theory, and direct observation.

The latest withdrawal research has reflected Jackson's concern with RCTs failure to capture individual patient experience. Cohen and Recalt argue that the muting of the patient's voice in RCTs, and the lack of initiative to redress the problem, bode poorly for addressing withdrawal concerns. "While measures of 'patient reported outcomes' exist, they are not yet prominently incorporated as primary outcomes in psychopharmacology RCTs."

Groot and van Os concur and go further – not only should patient outcomes in the withdrawal process be valued, but their ideas about and ventures regarding that process must be embraced as well: "Patients experiences, ideas and initiatives must be taken much more seriously, also when these are not published in the scientific literature and even when they are considered to contain 'critical' messages."

Finally, the shift we have witnessed from gaining knowledge from empirical experience to learning it from evidence-based studies does even more damage. It weakens the relationship and feedback loop between prescriber and patient that is so necessary for an understanding of the effects of withdrawal. Commenting on this lost information, Jackson starkly observed, "it is the adequacy of medical information which hangs in doubt."

WITHDRAWAL EXPERIENCES IN CONTEXT: THE CRITIQUE OF TRADITIONAL PSYCHIATRY

Psychiatric prescribers must learn about withdrawal, as this knowledge will inform their entire professional practice and, hopefully, cause prescribers to be more cautious when considering chemical treatment. As they do so, prescribers hopefully will recognize that withdrawal stories not only reinforce the existing critique of the medical model of psychiatry, but also raise new questions about the merits of prescribing psychiatric medication in the first place.

In well-documented literature, Grace E. Jackson, Stuart Kirk, Tomi Gomery & David Cohen, Peter Breggin, and Robert Whitaker and others challenge the use of psychiatric medications as treatment for mental health issues. These critics raises questions about virtually all aspects of psychopharmalogical treatment, including the creation of diagnostic categories and their use, the development, testing, and approval of medications, the prescribing and monitoring of such medications, and the lack of attention to effective alternatives.

A critique of traditional psychiatry, in simplified form, reads:

- Diagnostic categories are human creations, masquerading as biological science.
- Medication trials are often conducted by those who stand to profit from their success.
- These trials typically do not track efficacy for periods beyond one to three months.
- Some trial results are spun to suggest that medications are more effective than they actually are.
- Successful trials are published, while unsuccessful ones are not.
- Drug companies have played a large part in this suppression of unfavorable data.
- Drug companies market such medications to professionals.
- While psychoactive medications are promoted as remedies to "chemical imbalances" in the brain, these imbalances cannot be pinpointed.
- In many cases, patients are maintained on medications for much longer than initially intended.
- Medications may be no more effective than placebos and benefits patients feel may derive from a placebo effect.
- Psychotherapy may be more effective than medication.
- Patients receiving an alternative form of treatment to medication may do better than those receiving a combination of that alternative and medication.
- Social supports and activities may be key in promoting recovery.
- Medications may lose any efficacy they do have and, in fact, harm one's mental health over time.

- Medication side effects may be serious and worsen over time.
- These side effects, such as sexual dysfunction, may exacerbate mental health problems.

Activists must now expand this argument for reform to encompass the issue of withdrawal. Focusing on the following wrongs would be a starting point:

- Prescribers lack clear guidelines to evaluate when patients can or should be taken off medications or to assist patients in doing so.
- No rules exist to determine what action should be taken if an adverse effect of a medication occurs in an individual case.
- Most doctors are unlikely to report adverse effects they observe to the Food and Drug Administration (FDA), contributing to the inadequate picture of a medication's impact.
- Lacking guidance and/or incentive, prescribers inappropriately maintain patients on medications without much review or justification for months and years on end.
- Pharmaceutical companies encourage prescribers to believe that withdrawal symptoms are instead signs of relapse and use this theory to encourage long-term maintenance on medication.
- Many patients spend months and years trying to withdraw from psychiatric drugs and some never succeed.
- Psychiatric drugs of all types cause withdrawal symptoms in a large percentage of patients, some of which are serious and long-lasting, even after medications are stopped.
- With a few notable exceptions (e.g., Paxil and benzodiazepines), the FDA has rarely stepped in and required drug companies to warn of the risks of withdrawal from psychiatric medications.

When withdrawal stories are understood in the context of the broader critique of psychiatry, they gain additionally legitimacy. The need for prescribers to acknowledge and learn from these experiences becomes clearer. Prescribers can start this process by looking to the world of online communities, which have filled the void left by traditional psychiatry.

In Part 2 of this series, we will look at online communities and the service they provide.

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