Antidepressant Dependence & Withdrawal

The first antidepressants were released in 1958. By 1961, peer reviewed publications in leading journals linked them to dependence and withdrawal.

In general, however, older antidepressants were used sparingly, largely restricted to patients with melancholia, a severe condition with a high risk of suicide. The severity of the condition warranted a trade-off between benefits and hazards.

There was a continuing recognition of antidepressant withdrawal through to the launch of the selective serotonin reuptake inhibiting (SSRI) antidepressants. This was viewed as a lesser problem than benzodiazepine dependence, which in the 1980s appeared to be a significant public health hazard, in part because of extraordinarily widespread use. At one point, Valium was the best-selling drug in the world.

Many people can stop benzodiazepines without difficulty, while others have severe problems. Regulatory bodies worldwide have seen fit to recommend these drugs should not be used for longer than 4 weeks at a stretch.

SSRI Dependence and Withdrawal

There was evidence from healthy volunteer studies conducted in the mid-1980s that SSRIs could cause dependence and withdrawal.

The original intention was to pitch these drugs as non-dependence producing tranquilizers (anxiolytics) but marketing feedback suggested this would not work. The drugs were recast as antidepressants. These anxiolytics are weaker antidepressants than the earlier drugs but, for companies, primary care nervous problems were the big market. Rebranding SSRIs as antidepressants meant they would not be linked in either the medical or the public mind with dependence and could be pitched where the money was – in primary care.

Although within 3 years there were more reports to the British regulator of dependence on one SSRI paroxetine than there had been in the previous 20 years of reports from all benzodiazepines combined, a vigorous rear-guard action by companies minimised these problems and spun them as transient and mild and discontinuation rather than withdrawal.

Close to 15% of the population of many Western countries is now on one or other of these drugs. This number is growing not because more people are put on them but primarily because those on them can’t get off.

Many view these drugs as life-saving because if they miss a few doses the relief on getting back on treatment is undeniable. These drugs may save lives by treating dependence but not because they treat an original condition. Clinical trials show that people put on these drugs for the first time are more likely to die on treatment than on placebo.

People who stay on treatment can often continue working, although some treatment effects might mean they do not do as good a job in sensitive areas such as the safety of others as they might otherwise do – pilots and doctors for instance.

Others have been persuaded that the extreme debilitation they are now suffering is Treatment Resistant Depression (TRD). TRD did not exist a decade ago. In many instances it is likely a consequence of prior treatment with antidepressants. In Belgium and the Netherlands recently and in other countries soon, TRD has led young women to seek Medical Assistance in Dying.

In between, there is a large group of people who recognise their difficulties in stopping treatment stem from a dependence. Some can stop SSRI and related drugs by tapering. Others can't. Some opioid addicts characterize stopping an SSRI as worse than getting off Heroin or Oxycontin. We don't know what proportion of people fall into either group.

Many women, for instance, no longer try to get off venlafaxine, desvenlafaxine or paroxetine, which they have often been put on for menopausal flushing. These are normal women with no mental health problems, often functioning as professionals, who opt to continue treatment as to do otherwise would end their career.

For those trying to get off treatment, tapering over several years can work. Tapering makes some sense but doesn't work for all and can cause severe problems for some. Some of those who do get off may be unable to function sufficiently to work, despite recognising that work is likely to be the best therapy for them. This is commonly referred to as protracted withdrawal syndrome, which can be explored further on googling.

Some will opt to continue with their work rather than stop, despite increased risks of stroke, dementia and other problems. Others are equally keen to work but prefer to get off treatment if possible. Ongoing treatment that is ineffective because of dependence or difficulties in withdrawal will leave some incapacitated in a manner that warrants disability support.

This certificate stating that antidepressants can cause problems that might warrant disability support does not mean that anyone producing it to their doctor, or any agency involved in assessing disability, actually has a disability that should be compensated.

A doctor who has known the person over time, has access to all their records, and has a chance to assess these issues is best placed to complete any application in respect of this.

Many doctors however may underestimate the degree of problems that dependence on and withdrawal from antidepressants can cause. There are eloquent testimonies on RxISK.org to the impairments of function many who look relatively well can be suffering.

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