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Stopping antidepressants safely

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Long-term antidepressant pharmacotherapy is frequently continued beyond guideline-recommended durations. This occurs particularly among women, despite limited evidence of ongoing benefit for many people treated for mild-to-moderate depression and an increasing burden of adverse effects over time. In randomised trials, average symptom improvement over placebo is small (approximately 2 points on the 52-point Hamilton Depression Rating Scale), with an estimated number needed to treat of about 7–10 for a clinically meaningful benefit, underscoring the importance of planning for discontinuation once treatment is initiated. Antidepressant withdrawal is common yet under-recognised: at least half of people experience withdrawal symptoms when stopping, with risk and severity increasing with higher doses, longer duration of use and prior withdrawal experiences. This Therapeutic Letter outlines a practical, patient-centred approach to deprescribing that tailors tapering to individual risk, uses clinical response to guide the pace of reduction and emphasises careful differentiation of withdrawal symptoms from relapse. To minimise harms, abrupt discontinuation should be avoided; higher-risk patients may require very gradual tapering over months or years, often using hyperbolic dose reductions enabled by liquid formulations or dissolving tablets, with close follow-up every 2–4 weeks and the option to pause or reverse tapering if symptoms emerge. The guidance also highlights strategies for challenging presentations, including withdrawal-associated akathisia and protracted withdrawal, alongside patient education, shared decision-making and informed consent to support safer discontinuation and improved outcomes.

Keywords: antidepressant; deprescribing; tapering; withdrawal; shared decision-making.

Case vignette

Your new patient is a 53-year-old woman who started venlafaxine 75 mg/day for post-partum depression 19 years ago. Withdrawal symptoms ended a prior attempt to reduce to 37.5 mg/day, suggesting potential problems if she tries again. She is now determined to stop the antidepressant. You agree to help her plan an approach more likely to succeed. During a 30-min follow-up appointment tomorrow, how will you advise her?

Why stop an antidepressant?

Patients and prescribers have a variety of reasons for wanting to stop an antidepressant. Many people start drug therapy at a stressful period in life but adjust over time to a loss or develop non-drug coping skills. Medication may become superfluous.[1] For up to 30% – 50% of people taking antidepressants, no evidence-based reason is found to continue.[2,3,4,5,6] Without compelling clinical reasons to continue an antidepressant, it may simply be time to attempt a return to life without medication.

Women are especially likely to receive long-term prescriptions. For example, an Australian longitudinal study on younger women's health from mid-2012 to 2019 found a mean duration of drug treatment of 2.4 years in women who refilled an initial prescription (N = 4416 born after 1945).[7] In contrast, most guidelines recommend 6–12 months of treatment for an episode of anxiety or depression, reserving longer-term treatment for severe and recurrent cases. However, most people who are prescribed antidepressants have mild conditions.[8,9]

When patients treated with antidepressant drugs improve, it is natural human psychology – but faulty logic – to attribute this with certainty to a pharmacological effect. Most people improve with time alone.[10] What appears to be obvious clinical logic should be tempered by understanding that in randomised clinical trials (RCTs), the average difference between antidepressants and placebo is about 2 points on the 52-point Hamilton Depression Rating Scale. And the proportion

Note: Additional supporting information may be found in the online version of this article as Online Appendix 1.

of participants in RCTs who achieve clinically meaningful improvement – compared with placebo – varies from a high of about 15% to a low of about 10%.[11]

This translates to a number needed to treat for clinical benefit (NNT) of about 7–10.[12] The large majority would do equally well without an active drug. Even when drug therapy at first seems clearly beneficial, pharmacological tolerance may reduce the effect over time, an inevitable consequence of the brain's adaptation.[13]

For many people, adverse effects of antidepressants outweigh benefits. For example, 50% experience treatment-emergent sexual problems with arousal, erectile dysfunction and orgasm.[14] Emotional numbing, cognitive and memory impairment and sleep disturbance are also common.[15] Evidence of analogous effects in healthy volunteers taking antidepressants indicates that such adverse effects do not arise from a mental illness alone.[16,17]

Other harms are not clinically obvious. Antidepressant RCTs are typically small, brief and enrol relatively healthy participants; longer-term harms in the real world are detectable only from pharmacoepidemiologic studies. While epidemiological associations must account for confounding factors and do not prove causation,[18] antidepressants (including selective serotonin reuptake inhibitors [SSRIs] and venlafaxine) have been associated with increased falls, fractures, osteoporosis, bleeding risk, strokes, dementia, cardiovascular disease, weight gain, cataracts and premature mortality, especially in older people.[19,20,21,22,23] An increased risk of withdrawal after long-term use may be another unanticipated harm.[24]

Is there an optimal way to deprescribe?

Few RCTs have studied how best to stop antidepressants, mostly in people treated for recurrent depression by specialists (total $N = 4995$ people).[25] At least two deprescribing trials are now underway in Australia.[26,27,28] Several cohort studies have compared traditional linear tapers and gradual hyperbolic tapers (described below).[29]

Current recommendations, guidelines and algorithms are also based on the clinical experiences of clinicians and patients – not experimental results. Just as people differ in their tolerance for drugs and dose increases, their experiences of dose reductions vary. This is similar to other drugs that induce pharmacological tolerance and dependence (e.g. nicotine, alcohol, benzodiazepines and opioids). After antidepressant treatment for more than a few weeks or months, many patients may require a relatively cautious approach to deprescribing.

Speed of tapering

Unsurprisingly, the more slowly antidepressants are stopped, the lower the risk of withdrawal effects or apparent relapse of depression.[30] A meta-regression analysis of antidepressant discontinuation RCTs found no increase in depression relapse when doses were tapered over 6 months compared with continuing drug treatment.[31] However, fast tapering over 1 month or 2 months was associated with significantly increased relapse in the largest RCT of deprescribing.[32] The meta-regression authors emphasise that antidepressant withdrawal can easily be mistaken for a relapse of depression.[31]

Tapering pattern

The pattern of tapering is also thought to be important. The relationship between the dose and blood concentration of a drug and its effects on receptors in the brain is believed to be hyperbolic. Drug effects rise steeply at doses near the lower end of the approved dose range. But at higher doses and concentrations, many drug effects plateau.[30] Hyperbolic dose tapering attempts to mimic this relationship inversely. As the daily dose declines, reductions become progressively smaller. This can be approximated by reducing at an arbitrary percentage, such as 10% per month of the most recent daily dose.

Pragmatic alternatives recommended by many guidelines include stepwise dose reductions over a few weeks, a 'slow slide' or substitution of the long half-life SSRI fluoxetine for related antidepressants.[33] However, even the long elimination half-life of the active metabolite norfluoxetine (mean 9 days, range 4–16 days)[34] does not avoid withdrawal in about half of people who take fluoxetine – in whom withdrawal may be delayed for 4–6 weeks after stopping.[35]

Some people need a very gentle approach. In the United Kingdom (UK), a cluster RCT of general practices found that traditional stepwise tapering (e.g. sertraline 200 mg/day, 150 mg/day, 100 mg/day, 50 mg/day, 25 mg/day, stop) was unsuccessful for 58% of patients who had taken at least 9 months of antidepressant therapy for depression or anxiety ($N = 274$ assessable at 6 months).[36]

To reduce withdrawal symptoms markedly, a cautious approach to tapering antidepressants (including hyperbolic dose reductions) is now recommended by the UK National Institute for Health and Care Excellence (NICE) and a number of UK specialty organisations.[37,38]

Safe and effective deprescribing in practice

The rate and pattern of tapering are clinical decisions specific to the circumstances and needs of individual patients. The Canadian Medication Appropriateness and Deprescribing Network provides a convenient, concise and lucid guide for patients, their family or friends and clinicians (also available in French).[33]

As a general rule, people who have taken an antidepressant for more than 4 weeks should preferably not stop abruptly. A practical approach to avoid or minimise withdrawal is a test dose reduction, using the patient's response to determine

further steps. Barring an urgent need to stop the antidepressant, slow decrements are reasonable. One can accelerate the pace as tolerated. A very slow taper may imply a few weeks or months of unnecessary drug exposure (at a very low dose). On the other hand, excessively rapid dose reduction potentially risks akathisia, suicide or possible years of disability. Poor outcomes are not always reversible.[1]

Patients can be risk-stratified based on the duration of use, type of antidepressant, past experience of stopping and dose.[39,40] People who have taken an antidepressant for only several weeks are at low risk of serious withdrawal (but not no risk), compared with those with years of exposure. Past experience of withdrawal and high doses also predict the future risk. But the smallest doses used clinically affect amine transporters and brain receptors almost as much as maximum doses.[30] Therefore, even a 'low' dose of an antidepressant often confers a substantial risk of withdrawal upon discontinuation.

Without direct comparisons between antidepressants after long-term use, withdrawal risk categories are inherently arbitrary. Table 1, adapted from a review of data available in 2022,[35] shows categorical risk estimates for frequent or severe withdrawal and published incidence estimates for antidepressants commonly used in Canada.

Two analyses of the World Health Organization's adverse drug reaction (ADR) database also identified paroxetine, venlafaxine or desvenlafaxine, duloxetine, sertraline and citalopram or escitalopram as the highest risk for withdrawal.[41,42] However, this could reflect ADR reporting biases for newer antidepressants. A 2023 Canadian guideline on the treatment of depression provides different ratings but does not cite sources.[43] And a 2024 systematic review of short RCTs and observational studies also identified imipramine (the original tricyclic antidepressant) as especially problematic.[44]

Starting an antidepressant taper

For low-risk patients (weeks of use, low-risk antidepressant), a rule of thumb is to start with a 25% dose reduction. For patients deemed at moderate risk (months of use, moderate-risk antidepressant), reducing by 10% may be more appropriate. For patients expected to be at high risk for withdrawal (years of use, high-risk antidepressant, significant prior problems with withdrawal), a 5% initial reduction is unlikely to cause serious problems.

After starting a dose taper, experts in deprescribing antidepressants recommend maintaining and monitoring patients clinically for 2–4 weeks per step to assess the response. In 'slow slide' or 'hyperbolic' tapering, milligram reductions in daily dose become smaller and smaller as the dose declines. Table 2 shows a hyperbolic tapering schedule that would last well over 1 year for the *Vignette* patient who took venlafaxine 75 mg/day for 19 years, derived from the Maudsley Deprescribing Guidelines: Antidepressants, Benzodiazepines, Gabapentinoids and Z-drugs.[1]

TABLE 1: Comparative risks for withdrawal after stopping antidepressants.

Drug (alphabetical)	Categorical risk for severe or frequent withdrawal	Reported incidence of withdrawal
Duloxetine	Higher	Not available
Fluvoxamine	Higher	Not available
Levomilnacipran	Higher	Not available
Mirtazapine	Higher	Not available
Paroxetine	Higher	66% – 100%
Venlafaxine/desvenlafaxine	Higher	44%
Citalopram/escitalopram	Moderate	27% – 70%
Fluoxetine	Moderate	14% – 77%
Sertraline	Moderate	59% – 60%
Vortioxetine	Moderate	Not available
Trazodone	Low	Not available
Bupropion	Unknown	Not available

Source: Adapted from Horowitz MA, Framer A, Hengartner MP, et al. Estimating risk of antidepressant withdrawal from a review of published data. CNS Drugs. 2023;37(2): 143–157. https://doi.org/10.1007/s40263-022-00960-y

TABLE 2: Hyperbolic dose tapering: Example of venlafaxine 75 mg/day.

Step	Dose mg/day
1	75.00
2	55.00
3	45.00
4	37.50
5	30.40
6	26.00
7	22.60
8	19.80
9	17.50
10	15.60
11	14.00
12	12.60
13	11.40
14	10.40
15	9.40
16	8.60
17	7.80
18	7.20
19	6.60
20	6.00
21	5.50
22	5.00
23	4.60
24	4.20
25	3.80
26	3.50
27	3.20
28	2.90
29	2.60
30	2.30
31	2.10
32	1.90
33	1.60
34	1.40
35	1.20
36	1.10
37	0.89
38	0.72
39	0.56
40	0.41
41	0.27
42	0.13
43	0.00

Source: Horowitz M, Taylor D. The Maudsley Deprescribing Guidelines in Psychiatry: Antidepressants, Benzodiazepines, Gabapentinoids and Z-drugs. 2024

Schedules recommended by the Canadian Medication Appropriateness and Deprescribing Network are somewhat faster.[33] The ongoing Australian RELEASE deprescribing RCT also provides a series of possible 'slow' and 'slower' schedules for 15 antidepressants.[45]

Expert advice – In the absence of evidence from trials

English and Dutch physicians with substantial deprescribing experience indicate that people at low risk can generally stop in 6–9 months and people at moderate risk in 9–18 months. But high-risk patients may require 2 years or longer. Other experienced clinicians indicate that people treated only briefly with an antidepressant may be able to stop within 2–4 weeks without problematic withdrawal.[33] As with other habituating drugs like nicotine, alcohol and caffeine, some patients may simply prefer to stop 'cold turkey' after short-term use of antidepressants.

Difficult withdrawal symptoms often improve by pausing dose reductions or retreating a step or two in dose reduction and slowing the taper. Profound suffering can necessitate reinstating the original dose. Prescribing other drugs to suppress withdrawal substitutes another potential problem, so it is clinically more sensible to interpret withdrawal symptoms as a useful signal to slow the tapering process.

Practical aspects for clinical practice

1. **Explain the process:** Inform patients about the risks of tapering too rapidly, and that gradual tapering appears to minimise withdrawal problems. Balance the rate of taper against the harms of long-term antidepressant use and adjust to the experience of individual patients. A modifiable *Informed Consent to Taper an Antidepressant* form, adapted from opioid and benzodiazepine treatment agreements recommended by the College of Physicians and Surgeons of British Columbia and adapted by the Therapeutics Initiative at the University of British Columbia, is included as Online Appendix 1. Allowing patients time to review and consider such a form might facilitate true informed consent and mitigate societal pressures associated with antidepressant withdrawal.
2. **Facilitate tapering with appropriate drug formulations, when necessary:** Available tablets and capsules are not suited to very slow tapering. Even fragments of the lowest dose tablets or part of a capsule produce high neuronal receptor occupancy and end-organ effects. Hyperbolic tapering requires the provision of much smaller doses. In South Africa, the fluoxetine dispersible tablet is one option – including for 'cross-tapering' from another antidepressant.[46,47] But, it too should be tapered carefully.

   Some patients use techniques to generate smaller dose units – pharmacists can be a useful source of advice.[48,49] This can include subdividing tablets with a pill splitter, crushing tablets, using the powdered contents of capsules to make suspensions, opening capsules to count or weigh beads or even weighing tablet fragments.[1] Pharmacists can provide guidance on technical issues such as tablet splitting.
3. **Alternate day dosing is often not appropriate:** Because the elimination half-life of many antidepressants is < 1 day, every-second-day dosing can produce wide fluctuations in drug concentrations and precipitate severe withdrawal effects.[50] If inter-dose withdrawal symptoms arise, divided daily doses can be helpful. Fluoxetine is an exception, because both the parent drug and its active metabolite have very long half-lives.[34]
4. **Evidence for switching to fluoxetine is equivocal:** Although its long elimination half-life and availability in a dispersible formulation are obvious advantages for tapering, fluoxetine is not a panacea. Withdrawal is not unusual, even if it is often misdiagnosed because of delayed onset.[35,42] Diverse antidepressant effects on neurotransmission and other brain processes may not be replaced adequately by a substitute drug.[1] This differs from the typical interchangeability of benzodiazepines, opioids or beta-blockers. Tapering the antidepressant already familiar to the patient can simplify clinical assessments.
5. **Managing withdrawal-induced akathisia:** Reinstating or increasing the dose of the antidepressant may improve symptoms, especially soon after symptom onset.[1,51] Akathisia normally resolves spontaneously, but when symptoms persist for months or longer, they can be unbearable. Using other drugs to suppress akathisia yields mixed results; patients can be exquisitely sensitive to psychotropic drugs, sometimes with negative responses.[1] If a short trial of another drug is ineffective, continuing it is irrational.
6. **Managing protracted withdrawal:** Although this affects only a minority of patients, it can be very difficult to treat if it occurs. The term 'protracted withdrawal' is misleading because it implies that resuming the drug will resolve the syndrome, which is not always the case.[1,50,51] A conservative approach is to wait for improvement to occur – generally over months or even years. Non-pharmacological techniques to manage ongoing psychological symptoms are sometimes helpful. Resuming the withdrawn drug, months after stopping it, can have unpredictable effects, including paradoxical worsening of symptoms.[1,50,52] To mitigate these risks, clinicians experienced with antidepressant deprescribing recommend a very small test dose (e.g. 2 mg of venlafaxine or 1 mg of citalopram), with further steps determined by the patient's response.[1] This helps determine whether to increase the tiny dose cautiously or to abandon the approach. As with treating withdrawal-induced akathisia, prescribing other psychotropic drugs as sedatives or to numb symptoms should be a last resort.[1,43,44]

Vignette resolution: *Your new patient has taken venlafaxine 75 mg/day for 19 years. Given her prior experience trying to reduce the dose to 37.5 mg/day, she is at high risk for a withdrawal syndrome if she stops precipitately. But you agree that stopping venlafaxine is reasonable and propose a cautious approach. After a*

thorough discussion, you provide her with written information,[33] *and plan to request preparation of progressively smaller doses with the help of an experienced pharmacist. At the next visit, you and your patient can agree on a supervised taper and a first follow-up in 2 weeks.*

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References

1. Horowitz M, Taylor D. The Maudsley deprescribing guidelines in psychiatry: Antidepressants, benzodiazepines, gabapentinoids and z-drugs [homepage on the Internet]. 2024 [cited 2025 Jul 17]. Available from: https://scholar.google.com/citations?view_op=view_citation&hl=en&citation_for_view=sEcbBuUAAAAJ:abG-DnoFyZgC
2. Cruickshank G, Macgillivray S, Bruce D, et al. Cross-sectional survey of patients in receipt of long-term repeat prescriptions for antidepressant drugs in primary care. Ment Health Fam Med. 2008;5(2):105–109.
3. Piek E, Kollen BJ, Van der Meer K, et al. Maintenance use of antidepressants in Dutch general practice: Non-guideline concordant. PLoS One. 2014;9(5):e97463. https://doi.org/10.1371/journal.pone.0097463
4. Ambresin G, Palmer V, Densley K, et al. What factors influence long-term antidepressant use in primary care? Findings from the Australian diamond cohort study. J Affect Disord. 2015;176:125–132. https://doi.org/10.1016/j.jad.2015.01.055
5. Eveleigh R, Muskens E, Lucassen P, et al. Withdrawal of unnecessary antidepressant medication: A randomised controlled trial in primary care. BJGP Open. 2018;1(4):bjgpopen17X101265. https://doi.org/10.3399/bjgpopen17X101265
6. Davidson SK, Romaniuk H, Chondros P, et al. Antidepressant treatment for primary care patients with depressive symptoms: Data from the diamond longitudinal cohort study. Aust N Z J Psychiatry. 2020;54(4):367–381. https://doi.org/10.1177/0004867419898761
7. Poon E, Donald M, Van Driel M, et al. Patterns and duration of antidepressant use in Australian women: Findings from the Australian longitudinal study on women's health. Asia Pac J Public Health. 2025;37(2–3):272–280. https://doi.org/10.1177/10105395251321316
8. Mojtabai R, Olfson M. National trends in long-term use of antidepressant medications: Results from the U.S. National Health and Nutrition Examination Survey. J Clin Psychiatry. 2014;75(2):169–177. https://doi.org/10.4088/JCP.13m08443
9. Wallis KA, King A, Moncrieff J. Antidepressant prescribing in Australian primary care: Time to reevaluate. Med J Austr. 2025;222(9):430–432. https://doi.org/10.5694/mja2.52645
10. Hengartner MP. Is there a genuine placebo effect in acute depression treatments? A reassessment of regression to the mean and spontaneous remission. BMJ Evid Based Med. 2020;25(2):46–48. https://doi.org/10.1136/bmjebm-2019-111161
11. Munkholm K, Paludan-Muller AS, Boesen K. Considering the methodological limitations in the evidence base of antidepressants for depression: A reanalysis of a network meta-analysis. BMJ Open. 2019;9(6):e024886. https://doi.org/10.1136/bmjopen-2018-024886
12. Arroll B, Elley CR, Fishman T, et al. Antidepressants versus placebo for depression in primary care. Cochr Database Syst Rev. 2009;2009(3):CD007954. https://doi.org/10.1002/14651858.CD007954
13. Kinrys G, Gold AK, Pisano VD, et al. Tachyphylaxis in major depressive disorder: A review of the current state of research. J Affect Disord. 2019;245:488–497. https://doi.org/10.1016/j.jad.2018.10.357
14. Serretti A, Chiesa A. Treatment-emergent sexual dysfunction related to antidepressants: A meta-analysis. J Clin Psychopharmacol. 2009;29(3):259–266. https://doi.org/10.1097/JCP.0b013e3181a5233f
15. Hindmarch I, Alford C, Barwell F, Kerr JS. Measuring the side effects of psychotropics: The behavioural toxicity of antidepressants. J Psychopharmacol. 1992;6(2):198–203. https://doi.org/10.1177/026988119200600
16. Goodwin GM, Price J, De Bodinat C, Laredo J. Emotional blunting with antidepressant treatments: A survey among depressed patients. J Affect Disord. 2017;221:31–35. https://doi.org/10.1016/j.jad.2017.05.048
17. Langley C, Armand S, Luo Q, et al. Chronic escitalopram in healthy volunteers has specific effects on reinforcement sensitivity: A double-blind, placebo-controlled semi-randomised study. Neuropsychopharmacology. 2023;48(4):664–670. https://doi.org/10.1038/s41386-022-01523-x
18. Dragioti E, Solmi M, Favaro A, et al. Association of antidepressant use with adverse health outcomes: A systematic umbrella review. JAMA Psychiatry. 2019;76(12):1241–1255. https://doi.org/10.1001/jamapsychiatry.2019.2859. Anonymous. Data Error in Table: JAMA Psychiatry. 2021;78(5):569. https://doi.org/10.1001/jamapsychiatry.2021.0314
19. Coupland C, Dhiman P, Morriss R, et al. Antidepressant use and risk of adverse outcomes in older people: Population based cohort study. BMJ. 2011;343:d4551. https://doi.org/10.1136/bmj.d4551
20. Gafoor R, Booth HP, Gulliford MC. Antidepressant utilisation and incidence of weight gain during 10 years' follow-up: Population based cohort study. BMJ. 2018;361:k1951 https://doi.org/10.1136/bmj.k1951
21. Coupland CAC, Hill T, Dening T, et al. Anticholinergic drug exposure and the risk of dementia: A nested case-control study. JAMA Intern Med. 2019;179:1084–1093. https://doi.org/10.1001/jamainternmed.2019.0677
22. Prescrire. SSRI antidepressants and venlafaxine: Increased risk of injuries. Prescrire Int. 2025;34(269):105–106.
23. Bansal N, Hudda M, Payne RA, et al. Antidepressant use and risk of adverse outcomes: Population-based cohort study. BJPsych Open. 2022;8(5):e164. https://doi.org/10.1192/bjo.2022.563
24. Horowitz MA, Buckman JEJ, Saunders R, et al. Antidepressants withdrawal effects and duration of use: A survey of patients enrolled in primary care psychotherapy services. Psychiatry Res. 2025;350:116497. https://doi.org/10.1016/j.psychres.2025.116497
25. Van Leeuwen E, Driel ML, Horowitz MA, et al. Approaches for discontinuation versus continuation of long-term antidepressant use for depressive and anxiety disorders in adults. Cochr Database Syst Rev. 2021;4:CD013495. https://doi.org/10.1002/14651858.CD013495.pub2
26. Wallis KA, Donald M, Horowitz M, et al. RELEASE (REdressing Long-tErm Antidepressant uSE): Protocol for a 3-arm pragmatic cluster randomised controlled trial effectiveness-implementation hybrid type-1 in general practice. Trials. 2023;24(1):615. https://doi.org/10.1186/s13063-023-07646-w
27. Coe A, Gunn J, Kaylor-Hughes C. General practice patients' experiences and perceptions of the WiserAD structured web-based support tool for antidepressant deprescribing: Protocol for a mixed methods case study with realist evaluation. JMIR Res Protocols. 2022;11(12):e42526. https://doi.org/10.2196/42526;
28. Melbourne Medical School WiserAD: A randomized trial of a structured online intervention to promote and support antidepressant de-prescribing in primary care [homepage on the Internet]. [cited 2025 Jul 09]. Available from: https://medicine.unimelb.edu.au/research-groups/general-practice-and-primary-care-research/primary-care-mental-health/wiserad-a-randomised-trial-of-a-structured-online-intervention-to-promote-and-support-antidepressant-de-prescribing-in-primary-care
29. Van Os J, Groot PC. Outcomes of hyperbolic tapering of antidepressants. Ther Adv Psychopharmacol. 2023;13:20451253231171520. https://doi.org/10.1177/20451253231171518
30. Horowitz MA, Taylor D. Tapering of SSRI treatment to mitigate withdrawal symptoms. Lancet Psychiatry. 2019;6(6):538–546. https://doi.org/10.1016/S2215-0366(19)30032-X
31. Gøtzsche PC, Demasi M. Interventions to help patients withdraw from depression drugs: A systematic review. Int J Risk Saf Med. 2024;35(2):103–116. https://doi.org/10.3233/JRS-230011

32. Lewis G, Marston L, Duffy L, et al. Maintenance or discontinuation of antidepressants in primary care. N Engl J Med. 2021;385(14):1257–1267. https://doi.org/10.1056/NEJMoa2106356

33. Gardner D. Understanding antidepressant medications part 2: When and how to safely stop them [homepage on the Internet]. [cited 2025 Jul 09]. Available from: https://static1.squarespace.com/static/5836f01fe6f2e1fa62c11f08/t/679d15c7d5442f445e3ee980/1738347977229/article-antidepressants_part2_EN-2025-01-28.pdf

34. Lilly USA LLC. Fluoxetine (Prozac) U.S. label 2016 approved by the FDA [homepage on the Internet]. Reference ID: 4036401. [cited 2025 Jul 09]. Available from: https://www.accessdata.fda.gov/drugsatfda_docs/label/2017/018936s108lbl.pdf

35. Horowitz MA, Framer A, Hengartner MP, et al. Estimating risk of antidepressant withdrawal from a review of published data. CNS Drugs. 2023;37(2):143–157. https://doi.org/10.1007/s40263-022-00960-y

36. Kendrick T, Stuart B, Bowers H, et al. Internet and telephone support for discontinuing long-term antidepressants: The REDUCE cluster randomized trial. JAMA Netw Open. 2024;7(6):e2418383. https://doi.org/10.1001/jamanetworkopen.2024.18383

37. UK NICE. Depression in adults: Treatment and management [homepage on the Internet]. NICE; 2022 [cited 2025 Jul 09]. Available from: https://www.nice.org.uk/guidance/ng222

38. Royal College of Psychiatrists. Stopping antidepressants [homepage on the Internet]. [cited 2025 Jul 09]. Available from: https://www.rcpsych.ac.uk/docs/default-source/mental-health/treatments-and-wellbeing/print-outs/stopping-antidepressants-information-resource-print-version-18-03-24.pdf?sfvrsn=76e4b9a8_3

39. Read J, Moncrieff J, Horowitz MA. Designing withdrawal support services for antidepressant users: Patients' views on existing services and what they really need. J Psychiatr Res. 2023;161:298–306. https://doi.org/10.1016/j.jpsychires.2023.03.013

40. Fava GA, Cosci F. Understanding and managing withdrawal syndromes after discontinuation of antidepressant drugs. J Clin Psychiatry. 2019;80:6. https://doi.org/10.4088/JCP.19com12794

41. Quilichini JB, Revet A, Garcia P, et al. Comparative effects of 15 antidepressants on the risk of withdrawal syndrome: A real-world study using the WHO pharmacovigilance database. J Affect Disord. 2022;297:189–193. https://doi.org/10.1016/j.jad.2021.10.041

42. Gastaldon C, Schoretsanitis G, Arzenton E, et al. Withdrawal syndrome following discontinuation of 28 antidepressants: Pharmacovigilance analysis of 31,688 reports from the WHO Spontaneous Reporting Database. Drug Saf. 2022;45(12):1539–1549. https://doi.org/10.1007/s40264-022-01246-4

43. Lam RW, Kennedy SH, Adams C, et al. Canadian Network for Mood and Anxiety Treatments (CANMAT) 2023 Update on Clinical Guidelines for Management of Major Depressive Disorder in Adults: Réseau canadien pour les traitements de l'humeur et de l'anxiété (CANMAT) 2023 : Mise à jour des lignes directrices cliniques pour la prise en charge du trouble dépressif majeur chez les adultes. Can J Psychiatry. 2024;69(9):641–687. https://doi.org/10.1177/07067437241245384

44. Henssler J, Schmidt Y, Schmidt U, et al. Incidence of antidepressant discontinuation symptoms: A systematic review and meta-analysis. Lancet Psychiatry. 2024;11(7):526–535. https://doi.org/10.1016/S2215-0366(24)00133-0

45. The University of Queensland. RELEASE: REdressing Long-tErm Antidepressant uSE [homepage on the Internet]. [cited 2025 Jul 09]. Available from: https://releaseuq.notion.site/RELEASE-REdressing-Long-tErm-Antidepressant-uSE-c81416ad6f7d41a1bbd274bb248a22c2

46. Odan Laboratories Ltd. Odan-Fluoxetine product monograph [homepage on the Internet]. 2016 [cited 2025 Jul 09]. Available from: https://pdf.hres.ca/dpd_pm/00037306.PDF

47. Apotex Inc. Apo-Fluoxetine product monograph [homepage on the Internet]. 2022 [cited 2025 Jul 09]. Available from: https://pdf.hres.ca/dpd_pm/00066452.PDF

48. Bostwick J, Demehri A. Pills to powder: An updated clinician's reference for crushable psychotropics [homepage on the Internet]. 2017 [cited 2025 Jul 09]. Available from: https://www.mdedge.com/psychiatry/article/130305/bipolar-disorder/pills-powder-updated-clinicians-reference-crushable

49. Anonymous. A range of selective serotonin reuptake inhibitor (SSRI) formulations are suitable for adults with swallowing difficulties [homepage on the Internet]. SPS – Specialist Pharmacy Service; 2024 [cited 2025 Jul 09]. Available from: https://www.sps.nhs.uk/articles/selective-serotonin-reuptake-inhibitor-ssri-formulations-suggested-for-adults-with-swallowing-difficulties/

50. Framer A. What I have learnt from helping thousands of people taper off psychotropic medications. Therapeutic Adv Psychopharmacol. 2021;11:2045125321991274. https://doi.org/10.1177/2045125321991274

51. Akathisia Alliance for education and research. Akathisia: General information [homepage on the Internet]. [cited 2025 Jul 09]. Available from: https://akathisiaalliance.org/about-akathisia/

52. Hengartner MP, Schulthess L, Sorensen A, Framer A. Protracted withdrawal syndrome after stopping antidepressants: A descriptive quantitative analysis of consumer narratives from a large internet forum. Therapeutic Adv Psychopharmacol. 2020;10:2045125320980573. https://doi.org/10.1177/2045125320980573

53. Therapeutics Initiative. How to stop antidepressants; Ther Lett [serial online]. 2025 [cited 2026 Jan 29];157. Available from: https://www.ti.ubc.ca/letter157