

The Challenge of Going Off Psychiatric Drugs

Millions of Americans have taken antidepressants for many years. What happens when it's time to stop?

[Rachel Aviv](#)

Laura Delano recognized that she was “excellent at everything, but it didn’t mean anything,” her doctor wrote. She grew up in Greenwich, Connecticut, one of the wealthiest communities in the country. Her father is related to Franklin Delano Roosevelt, and her mother was introduced to society at a *débutante* ball at the Waldorf-Astoria. In eighth grade, in 1996, Laura was the class president—she ran on a platform of planting daffodils on the school’s grounds—and among the best squash players in the country. She was one of those rare proportional adolescents with a thriving social life. But she doubted whether she had a “real self underneath.”

The oldest of three sisters, Laura felt as if she were living two separate lives, one onstage and the other in the audience, reacting to an exhausting performance. She snapped at her mother, locked herself in her room, and talked about wanting to die. She had friends at school who cut themselves with razors, and she was intrigued by what seemed to be an act of defiance. She tried it, too. “The pain felt so real and raw and mine,” she said.

Her parents took her to a family therapist, who, after several months, referred her to a psychiatrist. Laura was given a diagnosis of bipolar disorder, and prescribed Depakote, a mood stabilizer that, the previous year, had been approved for treating bipolar patients. She hid the pills in a jewelry box in her closet and then washed them down the sink.

She hoped that she might discover a more authentic version of herself at Harvard, where she arrived as a freshman in 2001. Her roommate, Bree Tse, said, “Laura just blew me away—she was this golden girl, so vibrant and attentive and in tune with people.” On her first day at Harvard, Laura wandered the campus and thought, This is everything I’ve been working for. I’m finally here.

She tried out new identities. Sometimes she fashioned herself as a “fun, down-to-earth girl” who drank until early morning with boys who considered her chill. Other times, she was a postmodern nihilist, deconstructing the arbitrariness of language. “I remember talking with her a lot about surfaces,” a classmate, Patrick Bensen, said. “That was a recurring theme: whether the surface of people can ever harmonize with what’s inside their minds.”

Watch “The Backstory”: Rachel Aviv on the challenges one woman faced while going off psychiatric drugs.

During her winter break, she spent a week in Manhattan preparing for two *débutante* balls, at the Waldorf-Astoria and at the Plaza Hotel. She went to a bridal store and chose a floor-length strapless white gown and white satin gloves that reached above her elbows. Her sister Nina said that, at the Waldorf ball, “I remember thinking Laura was so much a part of it.”

Yet, in pictures before the second ball, Laura is slightly hunched over, as if trying to minimize the breadth of her muscular shoulders. She wears a thin pearl necklace, and her blond hair is coiled in an ornate bun. Her smile is pinched and dutiful. That night, before walking onstage, Laura did cocaine and chugged champagne. By the end of the party, she was sobbing so hard that the escort she’d invited to the ball had to put her in a cab. In the morning, she told her family that she didn’t want to be alive. She took literally the symbolism of the parties, meant to mark her entry into adulthood. “I didn’t know who I was,” she said. “I was trapped in the life of a stranger.”

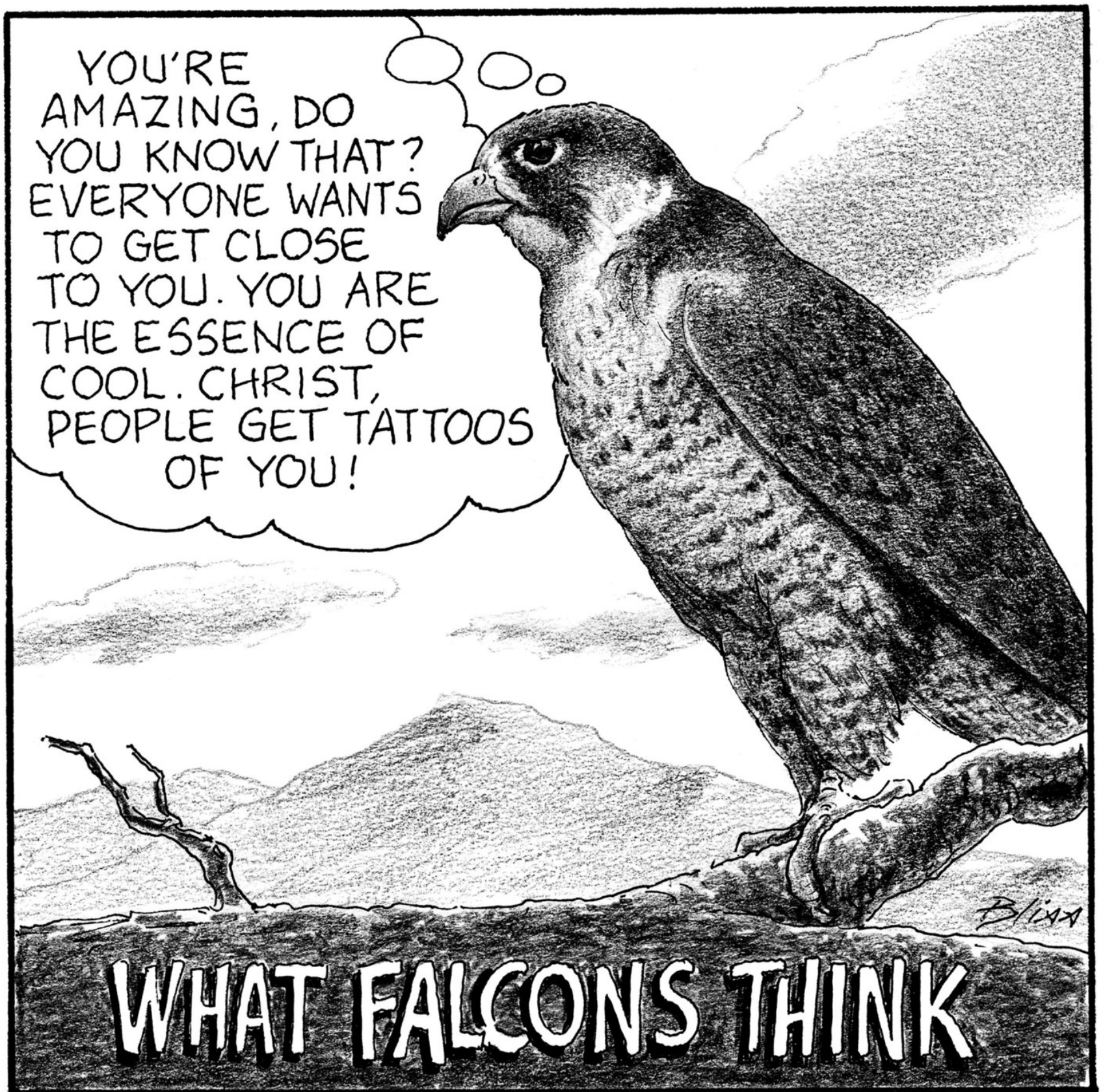
Before Laura returned to Harvard, her doctor in Greenwich referred her to a psychiatrist at McLean Hospital, in Belmont, Massachusetts. One of the

oldest hospitals in New England, McLean has treated a succession of celebrity patients, including [Anne Sexton](#), [Robert Lowell](#), [James Taylor](#), and [Sylvia Plath](#), who described it as “the best mental hospital in the US.” Laura’s psychiatrist had Ivy League degrees, and she felt grateful to have his attention. In his notes, he described her as an “engaging, outgoing, and intelligent young woman,” who “grew up with high expectations for social conformity.” She told him, “I lie in my bed for hours at a time staring at the wall and wishing so much that I could be ‘normal.’ ”

The psychiatrist confirmed her early diagnosis, proposing that she had bipolar II, a less severe form of the disorder. Laura was relieved to hear the doctor say that her distress stemmed from an illness. “It was like being told, It’s not your fault. You are not lazy. You are not irresponsible.” After she left the appointment, she felt joyful. “The psychiatrist told me who I was in a way that felt more concrete than I’d ever conceptualized before,” she said. “It was as though he could read my mind, as though I didn’t need to explain anything to him, because he already knew what I was going to say. I had bipolar disorder. I’d had it all along.” She called her father, crying. “I have good news,” she said. “He’s figured out the problem.”

She began taking twenty milligrams of Prozac, an antidepressant; when she still didn’t feel better, her dose was increased to forty milligrams, and then to sixty. With each raised dose, she felt thankful to have been heard. “It was a way for me to mark to the world: this is how much pain I am in,” she said. Laura wasn’t sure whether Prozac actually lifted her mood—roughly a third of patients who take antidepressants do not respond to them—but her emotions felt less urgent and distracting, and her classwork improved. “I remember her carrying around this plastic pillbox with compartments for all the days of the week,” a friend from high school said. “It was part of this mysterious world of her psychiatric state.”

At parties, she flirted intently, but by the time she and a partner were together in bed, she said, “I’d kind of get hit with this realization that I was



physically disconnected. And then I'd feel taken advantage of, and I would kind of flip out and start crying, and the guy would be, like, 'What the heck is going on?' " Most antidepressants dampen sexuality—up to seventy per cent of people who take the medications report this response—but Laura was ashamed to talk about the problem with her psychiatrist. "I assumed he'd see sexuality as a luxury," she said. "He'd be, like, 'Really? You have this serious illness, and you're worried about *that*?' "

During her junior year, her pharmacologist raised her Prozac prescription to

eighty milligrams, the maximum recommended dose. The Prozac made her drowsy, so he prescribed two hundred milligrams of Provigil, a drug for narcolepsy that is often taken by soldiers and truck drivers to stay awake during overnight shifts. The Provigil gave her so much energy that, she said, “I was just a machine.” She was on the varsity squash team and played the best squash of her life. She was so alert that she felt as if she could “figure people out,” unpacking the details of their identities: she imagined that she could peer into their childhoods and see how their parents had raised them.

The Provigil made it hard for Laura to sleep, so her pharmacologist prescribed Ambien, which she took every night. In the course of a year, her doctors had created what’s known as “a prescription cascade”: the side effects of one medication are diagnosed as symptoms of another condition, leading to a succession of new prescriptions. Her energy levels rose and fell so quickly that she was told she had a version of bipolar disorder called “rapid cycling,” a term that describes people who have four or more manic episodes in a year, but is also applied, more loosely, to people who shift dramatically between moods. Sometimes Laura thought, Women who are happy and socialize like to buy dresses. She’d go to Nordstrom and buy two or three dresses. She recognized that this behavior was “textbook”—she had bought her own copy of the [*Diagnostic and Statistical Manual of Mental Disorders*](#)—but the awareness didn’t prevent the purchases.

Laura felt that the pressures of her junior year were paralyzing, so she did not return for the spring semester. That summer, she kept a journal in which she outlined her personal goals: “overanalysis must go”; “stop molding myself to the ideal person for my surroundings”; “find some faith in something, in anything.” But the idea of returning to Harvard that fall made her so distressed that she thought every day about dying. She took the semester off, and, at her request, her parents drove her to a hospital in Westchester County, New York. A psychiatrist there wrote that she “presents with inability to function academically.” At the hospital, where she stayed for two weeks, she was put on a new combination of pills: Lamictal, a mood stabilizer;

Lexapro, an antidepressant; and Seroquel, an antipsychotic that she was told to use as a sleep aid. Her father, Lyman, said, “I had no conviction that the drugs were helping. Or that they weren’t helping.”

Laura returned to Harvard and managed to graduate, an achievement she chalked up to muscle memory; she was the kind of student who could regurgitate information without absorbing it. Then she held a series of jobs—working as an assistant for a professor and for a state agency that issued building permits—that she didn’t believe would lead to a career. She experienced what John Teasdale, a research psychologist at the University of Oxford, named “depression about depression.” She interpreted each moment of lethargy or disappointment as the start of a black mood that would never end. Psychiatric diagnoses can ensnare people in circular explanations: they are depressed because they are depressed.

Over the next four years, her doctors tripled her antidepressant dosage. Her dosage of Lamictal quadrupled. She also began taking Klonopin, which is a benzodiazepine, a class of drugs that has sedative effects. “What I heard a lot was that I was ‘treatment-resistant,’ ” she said. “Something in me was so strong and so powerful that even these sophisticated medications couldn’t make it better.”

For a brief period, Laura saw a psychiatrist who was also a psychoanalyst, and he questioned the way that she’d framed her illness. He doubted her early bipolar diagnosis, writing that “many depressions are given a ‘medical’ name by a psychiatrist, ascribing the problem to ‘chemistry’ and neglecting the context and specificity of why someone is having those particular life problems at that particular time.” He reminded her, “You described hating becoming a woman.” Laura decided that “he wasn’t legit.” She stopped going to her appointments.

She rarely saw friends from high school or college. “At a certain point, it was just, Oh, my God, Laura Delano—she’s ill,” the friend from high school said. “She seemed really anesthetized.” Laura had gained nearly forty pounds since

freshman year, which she attributes partly to the medications. When she looked in the mirror, she felt little connection to her reflection. “All I ever want to do is lie in my bed, cuddle with my dog, and read books from writers whose minds I can relate to,” she wrote to a psychiatrist. “That’s all I ever want to do.” She identified intensely with Plath, another brilliant, privileged, charismatic young woman who, in her journal, accuses herself of being just another “*SELFISH, EGOCENTRIC, JEALOUS AND UNIMAGINATIVE FEMALE.*” Laura said that, when she read Plath’s work, she “felt known for the first time.”

Laura found a psychiatrist she admired, whom I’ll call Dr. Roth. At appointments, Laura would enter a mode in which she could recount her psychic conflicts in a cool, clinical tone, taking pride in her psychiatric literacy. She saw her drugs as precision instruments that could eliminate her suffering, as soon as she and Dr. Roth found the right combination. “I medicated myself as though I were a finely calibrated machine, the most delicate error potentially throwing me off,” she later wrote. If she had coffee with someone and became too excited and talkative, she thought, Oh, my God, I might be hypomanic right now. If she woke up with racing thoughts, she thought, My symptoms of anxiety are ramping up. I should watch out for this. If they last more than a day or two, Dr. Roth may have to increase my meds.

The day before Thanksgiving, 2008, Laura drove to the southern coast of Maine, to a house owned by her late grandparents. Her extended family was there to celebrate the holiday. She noticed relatives tensing their shoulders when they talked to her. “She seemed muted and tucked away,” her cousin Anna said. When Laura walked through the house and the old wooden floorboards creaked beneath her feet, she felt ashamed to be carrying so much weight.

On her third day there, her parents took her into the living room, closed the doors, and told her that she seemed trapped. They were both crying. Laura

sat on a sofa with a view of the ocean and nodded, but she wasn't listening. "The first thing that came into my mind was: You've put everyone through enough."

She went to her bedroom and poured eighty milligrams of Klonopin, eight hundred milligrams of Lexapro, and six thousand milligrams of Lamictal into a mitten. Then she sneaked into the pantry and grabbed a bottle of Merlot and put the wine, along with her laptop, into a backpack. Her sisters and cousins were getting ready to go to a Bikram-yoga class. Her youngest sister, Chase, asked her to join them, but Laura said she was going outside to write. "She looked so dead in her eyes," Chase said. "There was no expression. There was nothing there, really."

There were two trails to the ocean, one leading to a sandy cove and the other to the rocky coast, where Laura and her sisters used to fish for striped bass. Laura took the path to the rocks, passing a large boulder that her sister Nina, a geology major in college, had written her thesis about. The tide was low, and it was cold and windy. Laura leaned against a rock, took out her laptop, and began typing. "I will not try to make this poetic, for it shouldn't be," she wrote. "It is embarrassingly cliché to assume that one should write a letter to her loved ones upon ending her life."

She swallowed a handful of pills at a time, washing them down with red wine. She found it increasingly hard to sit upright, and her vision began to narrow. As she lost consciousness, she thought, This is the most peaceful experience I've ever had. She felt grateful to be ending her life in such a beautiful place. She fell over and hit her head on a rock. She heard the sound but felt no pain.

When Laura hadn't returned by dusk, her father walked along the shoreline with a flashlight until he saw her open laptop on a rock. Laura was airlifted to Massachusetts General Hospital, but the doctors said they weren't sure that she would ever regain consciousness. She was hypothermic, her body temperature having fallen to nearly ninety-four degrees.

After two days in a medically induced coma, she woke up in the intensive-care unit. Her sisters and parents watched as she opened her eyes. Chase said, “She looked at all of us and processed that we were all there, that she was still alive, and she started sobbing. She said, ‘Why am I still here?’ ”

After a few days, Laura was transported to McLean Hospital, where she’d been elated to arrive seven years earlier. Now she was weak, dizzy, sweating profusely, and anemic. Her body ached from a condition called rhabdomyolysis, which results from the release of skeletal-muscle fibres into the bloodstream. She had a black eye from hitting the rock. Nevertheless, within a few days she returned to the mode she adopted among doctors. “Her eye contact and social comportment were intact,” a doctor wrote. Although she was still disappointed that her suicide hadn’t worked, she felt guilty for worrying her family. She reported having a “need to follow rules,” a doctor wrote. Another doctor noted that she did not seem to meet the criteria for major depression, despite her attempted suicide. The doctor proposed that she had borderline personality disorder, a condition marked by unstable relationships and self-image and a chronic sense of emptiness. According to her medical records, Laura agreed. “Maybe I’m borderline,” she said.

She was started on a new combination of medications: lithium, to stabilize her moods, and Ativan, a benzodiazepine, in addition to the antipsychotic Seroquel, which she had already been taking. Later, a second antipsychotic, Abilify, was added—common practice, though there was limited research justifying the use of antipsychotics in combination. “It is tempting to add a second drug just for the sake of ‘doing something,’ ” a 2004 paper in *Current Medicinal Chemistry* warns.

Shortly before Laura was discharged, she drafted a letter to the staff on her unit. “I truly don’t know where to begin in putting in words the appreciation I feel for what you’ve all done to help me,” she wrote. “It’s been so many years since I’ve felt the positive emotions—hope, mostly—that have flooded over me.” Unpersuaded by her own sentiment, she stopped the letter midsentence

and never sent it.

Laura moved back home to live with her parents in Greenwich and spent her nights drinking with old friends. She told her psychiatrist, “I don’t feel grounded. . . . I am floating.” Her father encouraged her to “try to reach for one little tiny positive thought, so you can get a little bit of relief.” When she couldn’t arrive at one, he urged her, “Just think of Bitsy,” their cairn terrier.

When it was clear that positivity was out of reach, Laura began seeing a new psychiatrist at McLean, who embraced the theory that her underlying problem was borderline personality disorder. “It is unclear whether she has bipolar (as diagnosed in the past),” he wrote.

The concept of a borderline personality emerged in medical literature in the nineteen-thirties, encompassing patients who didn’t fit into established illness categories. Describing a borderline woman, the psychoanalyst Helene Deutsch, a colleague of Freud’s, said, “It is like the performance of an actor who is technically well trained but who lacks the necessary spark to make his impersonations true to life.” In 1980, the diagnosis was added to the *DSM*, which noted that “the disorder is more commonly diagnosed in women.” One of its defining features is a formless, shifting sense of self. [An editorial in *Lancet Psychiatry* this year](#) proposed that “borderline personality disorder is not so much a diagnosis as it is a liminal state.”

In 2010, Laura moved in with her aunt Sara, who lived outside Boston, and attended a day-treatment program for borderline patients. “It was another offering of what could fix me, and I hadn’t tried it,” she said. At her intake interview, she wore stretchy black yoga pants from the Gap, one of the few garments that allowed her to feel invisible. She said that the director of the program told her, “So, you went to Harvard. I bet you didn’t think you’d end up at a place like this.” Laura immediately started crying, though she knew that her response would be interpreted as “emotional lability,” a symptom of the disorder.

Laura had been content to be bipolar. “I fit into the *DSM* criteria perfectly,” she said. But borderline personality disorder didn’t feel blameless to her. Almost all the patients in Laura’s group were women, and many had histories of sexual trauma or were in destructive relationships. Laura said that she interpreted the diagnosis as her doctors saying, “You are a slutty, manipulative, fucked-up person.”

Laura sometimes drank heavily, and, at the suggestion of a friend, she had begun attending Alcoholics Anonymous meetings. Laura was heartened by the stories of broken people who had somehow survived. The meetings lacked the self-absorption, the constant turning inward, that she felt at the clinic, where she attended therapy every day. When Laura’s pharmacologist prescribed her Naltrexone—a drug that is supposed to block the craving for alcohol—Laura was insulted. If she were to quit drinking, she wanted to feel that she had done it on her own. She was already taking Effexor (an antidepressant), Lamictal, Seroquel, Abilify, Ativan, lithium, and Synthroid, a medication to treat hypothyroidism, a side effect of lithium. The medications made her so sedated that she sometimes slept fourteen hours a night. When she slept through a therapy appointment, her therapist called the police to check on her at her aunt’s house. “That really jolted something in me,” Laura said.

In May, 2010, a few months after entering the borderline clinic, she wandered into a bookstore, though she rarely read anymore. On the table of new releases was “[Anatomy of an Epidemic](#),” by Robert Whitaker, whose cover had a drawing of a person’s head labelled with the names of several medications that she’d taken. The book tries to make sense of the fact that, as psychopharmacology has become more sophisticated and accessible, the number of Americans disabled by mental illness has risen. Whitaker argues that psychiatric medications, taken in heavy doses over the course of a lifetime, may be turning some episodic disorders into chronic disabilities. (The book has been praised for presenting a hypothesis of potential importance, and criticized for overstating evidence and adopting a crusading

tone.)

Laura wrote Whitaker an e-mail with the subject line “Psychopharms and Selfhood,” and listed the many drugs she had taken. “I grew up in a suburban town that emphasized the belief that happiness comes from looking perfect to others,” she wrote. Whitaker lived in Boston, and they met for coffee.

Whitaker told me that Laura reminded him of many young people who had contacted him after reading the book. He said, “They’d been prescribed one drug, and then a second, and a third, and they are put on this other trajectory where their self-identity changes from being normal to abnormal—they are told that, basically, there is something wrong with their brain, and it isn’t temporary—and it changes their sense of resilience and the way they present themselves to others.”

At her appointments with her pharmacologist, Laura began to raise the idea of coming off her drugs. She had used nineteen medications in fourteen years, and she wasn’t feeling better. “I never had a baseline sense of myself, of who I am, of what my capacities are,” she said. The doctors at the borderline clinic initially resisted her requests, but they also seemed to recognize that her struggles transcended brain chemistry. A few months earlier, one doctor had written on a prescription pad, “Practice Self-Compassion,” and for the number of refills he’d written, “Infinite.”

Following her pharmacologist’s advice, Laura first stopped Ativan, the benzodiazepine. A few weeks later, she went off Abilify, the antipsychotic. She began sweating so much that she could wear only black. If she turned her head quickly, she felt woozy. Her body ached, and occasionally she was overwhelmed by waves of nausea. Cystic acne broke out on her face and her neck. Her skin pulsed with a strange kind of energy. “I never felt quiet in my body,” she said. “It felt like there was a current of some kind under my skin, and I was trapped inside this encasing that was constantly buzzing.”

A month later, she went off Effexor, the antidepressant. Her fear of people judging her circled her head in permutations that became increasingly

invasive. When a cashier at the grocery store spoke to her, she was convinced that he was only pretending to be cordial—that what he really wanted to say was “You are a repulsive, disgusting, pathetic human.” She was overstimulated by the colors of the cereal boxes in the store and by the grating sounds of people talking and moving. “I felt as if I couldn’t protect myself from all this life lived around me,” she said.

She began to experience emotion that was out of context—it felt simultaneously all-consuming and artificial. “The emotions were occupying me and, on one level, I knew they were not me, but I felt possessed by them,” she said. Later, she found a community of people online who were struggling to withdraw from psychiatric medications. They’d invented a word to describe her experience: “neuro-emotion,” an exaggerated feeling not grounded in reality. The Web forum *Surviving Antidepressants*, which is visited by thousands of people every week, lists the many varieties of neuro-emotion: neuro-fear, neuro-anger, neuro-guilt, neuro-shame, neuro-regret. Another word that members used was “dystalgia,” a wash of despair that one’s life has been futile.

When on the drugs, Laura said, “I never had a baseline sense of myself.”

Photograph by Levi Mandel for *The New Yorker*

For many people on the forum, it was impossible to put the experience into words. “The effects of these drugs come so close to your basic ‘poles of being’ that it’s really hard to describe them in any kind of reliable way,” one person wrote. Another wrote, “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.”

It took Laura five months to withdraw from five drugs, a process that coincided with a burgeoning doubt about a diagnosis that had become a kind of career. When she’d experienced symptoms of depression or hypomania, she had known what to do with them: she’d remember the details and tell her

psychiatrist. Now she didn't have language to mark her experiences. She spent hours alone, watching "South Park" or doing jigsaw puzzles. When her aunt Sara updated the rest of the family about Laura, the news was the same: they joked that she had become part of the couch. Her family, Laura said, learned to vacuum around her. Had she come from a less well-off and generous family, she's not sure she would have been able to go off her medications. Others in her situation might have lost their job and, without income, ended up homeless. It took six months before she felt capable of working part time.

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Laura had always assumed that depression was caused by a precisely defined chemical imbalance, which her medications were designed to recalibrate. She began reading about the history of psychiatry and realized that this theory, promoted heavily by pharmaceutical companies, is not clearly supported by evidence. Genetics plays a role in mental disorder, as do environmental influences, but the drugs do not have the specificity to target the causes of an illness. Wayne Goodman, a former chair of the F.D.A.'s Psychopharmacologic Drugs Advisory Committee, has called the idea that pills fix chemical imbalances a "useful metaphor" that he would never use with his patients. Ronald Pies, a former editor of *Psychiatric Times*, has said, "My impression is that most psychiatrists who use this expression"—that the pills fix chemical imbalances—"feel uncomfortable and a little embarrassed when they do so.

It's kind of a bumper-sticker phrase that saves time.”

Dorian Deshauer, a psychiatrist and historian at the University of Toronto, has written that the chemical-imbalance theory, popularized in the eighties and nineties, “created the perception that the long term, even life-long use of psychiatric drugs made sense as a logical step.” But psychiatric drugs are brought to market in clinical trials that typically last less than twelve weeks. Few studies follow patients who take the medications for more than a year. Allen Frances, an emeritus professor of psychiatry at Duke, who chaired the task force for the fourth edition of the *DSM*, in 1994, 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.” He emphasizes what he called a “cruel paradox: there’s a large population on the severe end of the spectrum who really need the medicine” and either don’t have access to treatment or avoid it because it is stigmatized in their community. At the same time, many others are “being overprescribed and then stay on the medications for years.” There are almost no studies on how or when to go off psychiatric medications, a situation that has created what he calls a “national public-health experiment.”

Roland Kuhn, a Swiss psychiatrist credited with discovering one of the first antidepressants, imipramine, in 1956, later warned that many doctors would be incapable of using antidepressants properly, “because they largely or entirely neglect the patient’s own experiences.” The drugs could only work, he wrote, if a doctor is “fully aware of the fact that he is not dealing with a self-contained, rigid object, but with an individual who is involved in constant movement and change.”

A decade after the invention of antidepressants, randomized clinical studies emerged as the most trusted form of medical knowledge, supplanting the authority of individual case studies. By necessity, clinical studies cannot capture fluctuations in mood that may be meaningful to the patient but do

not fit into the study's categories. This methodology has led to a far more reliable body of evidence, but it also subtly changed our conception of mental health, which has become synonymous with the absence of symptoms, rather than with a return to a patient's baseline of functioning, her mood or personality before and between episodes of illness. "Once you abandon the idea of the personal baseline, it becomes possible to think of emotional suffering as relapse—instead of something to be expected from an individual's way of being in the world," Deshauer told me. For adolescents who go on medications when they are still trying to define themselves, they may never know if they have a baseline, or what it is. "It's not so much a question of Does the technology deliver?" Deshauer said. "It's a question of What are we asking of it?"

Antidepressants are now taken by roughly one in eight adults and adolescents in the U.S., and a quarter of them have been doing so for more than ten years. Industry money often determines the questions posed by pharmacological studies, and research about stopping drugs has never been a priority.

Barbiturates, a class of sedatives that helped hundreds of thousands of people to feel calmer, were among the first popular psychiatric drugs. Although leading medical journals asserted that barbiturate addiction was rare, within a few years it was evident that people withdrawing from barbiturates could become more anxious than they were before they began taking the drugs. (They could also hallucinate, have convulsions, and even die.)

Valium and other benzodiazepines were introduced in the early sixties, as a safer option. By the seventies, one in ten Americans was taking Valium. The chief of clinical pharmacology at Massachusetts General Hospital declared, in 1976, "I have never seen a case of benzodiazepine dependence" and described it as "an astonishingly unusual event." Later, though, the F.D.A. acknowledged that people can become dependent on benzodiazepines, experiencing intense agitation when they stop taking them.

Selective serotonin reuptake inhibitors, or S.S.R.I.s—most prominently

Prozac and Zoloft—were developed in the late eighties and early nineties, filling a gap in the market opened by skepticism toward benzodiazepines. S.S.R.I.s were soon prescribed not just for depression but for the nervous ailments that the benzodiazepines had previously addressed. (There had been other drugs used as antidepressants, but they had often been prescribed cautiously, because of concerns about their side effects.) As Jonathan Metzl writes, in “Prozac on the Couch,” S.S.R.I.s were marketed especially to female consumers, as drugs that would empower them at work while preserving the kind of feminine traits required at home. One advertisement for Zoloft showed a woman in a pants suit, holding the hands of her two children, her wedding ring prominent, next to the phrase “Power That Speaks Softly.” Today, antidepressants are taken by one in five white American women.

Concerns about withdrawal symptoms emerged shortly after S.S.R.I.s came to market, and often involved pregnant women who had been told to discontinue their medications, out of concern that the drugs could affect the fetus. A 2001 article in the *Journal of Psychiatry & Neuroscience* chronicled thirty-six women who were on either antidepressants, benzodiazepines, or a combination of the two, and who stopped taking the drugs when they became pregnant. A third of the patients said they felt suicidal, and four were admitted to a hospital. One had an abortion, because she no longer felt capable of going through with the pregnancy.

Internal records of pharmaceutical manufacturers show that the companies have been aware of the withdrawal problem. At a panel discussion in 1996, Eli Lilly invited seven experts to develop a definition of antidepressant withdrawal. Their findings were published in a supplement of the *Journal of Clinical Psychiatry* that was sponsored by Eli Lilly and was highly favorable to the company’s own product, Prozac, which has the longest half-life of all the S.S.R.I.s; the drug clears slowly from the body. The panelists observed that withdrawing from other antidepressants was more likely to lead to “discontinuation reactions,” such as agitation, detachment, “uncharacteristic crying spells and paralyzing sadness.” “Although generally mild and short-

lived,” one paper in the supplement explained, “discontinuation symptoms can be severe and chronic.” The panel defined “discontinuation syndrome” as a condition that could be “rapidly reversed by the reintroduction of the original medication.”

Shortly after the Eli Lilly panel, SmithKline Beecham, which manufactured Paxil, distributed a memo to its sales team accusing Eli Lilly of “trying to hide” the withdrawal symptoms of its products. “The truth of the matter is that the only discontinuation syndrome Lilly is worried about is the discontinuation of Prozac,” the memo said. In another internal memo, SmithKline Beecham instructed staff to “highlight the benign nature of discontinuation symptoms, rather than quibble about their incidence.”

Guy Chouinard, a retired professor of psychiatry at McGill and at the University of Montreal, who served as a consultant for Eli Lilly for ten years and did one of the first clinical trials of Prozac, told me that when S.S.R.I.s came on the market he was thrilled to see his patients, previously crippled by self-doubt and fear, living tolerable and fulfilling lives. Chouinard is considered one of the founders of psychopharmacology in Canada. In the early two-thousands, he began to see patients who, after taking certain antidepressants for years, had stopped their medications and were experiencing what he described as “crescendo-like” anxiety and panic that went on for weeks and, in some cases, months. When he reinstated their medication, their symptoms began to resolve, usually within two days.

Most people who discontinue antidepressants do not suffer from withdrawal symptoms that last longer than a few days. Some experience none at all. “The medical literature on this is a mess,” Chouinard told me. “Psychiatrists don’t know their patients well—they aren’t following them long-term—so they don’t know whether to believe their patients when they say, ‘I’ve never had this experience in my life.’ ” He thinks that withdrawal symptoms, misdiagnosed and never given time to resolve, create a false sense that patients can’t function unless they go back on their drugs.

Giovanni Fava, a professor of psychiatry at the University of Buffalo, has devoted much of his career to studying withdrawal and has followed patients suffering from withdrawal symptoms a year after stopping antidepressants. A paper published last month in a journal he edits, *Psychotherapy and Psychosomatics*, reviewed eighty studies and found that in nearly two-thirds of them patients were taken off their medications in less than two weeks. Most of the studies did not consider how such an abrupt withdrawal might compromise the studies' findings: withdrawal symptoms can easily be misclassified as relapse. Fava's work is widely cited, yet he said that he has struggled to publish his research on this topic. To some degree, that makes sense: no one wants to deter people from taking drugs that may save their life or lift them out of disability. But to avoid investigating or sharing information on the subject—to assume that people can comprehend the drugs' benefits and not their limits—seems to repeat a pattern of paternalism reminiscent of earlier epochs in the history of psychopharmacology.

David Taylor, the director of pharmacy and pathology at the Maudsley Hospital, in London, and the author of more than three hundred peer-reviewed papers, told me, “It is not as though we haven't been burned by this before.” If he hadn't experienced antidepressant withdrawal himself, Taylor said, “I think I would be sold on the standard texts.” But, he said, “experience is very different from what's on the page.” Taylor described his own symptoms of withdrawal, from the antidepressant Effexor, as a “strange and frightening and torturous” experience that lasted six weeks. In a paper published last month in *Lancet Psychiatry*, he and a co-author reviewed brain imaging and case studies on withdrawal and [argued that patients should taper off antidepressants over the course of months](#), rather than two to four weeks, as current guidelines advise. Such guidelines are based on a faulty assumption that, if a dose is reduced by half, it will simply reduce the effect in the brain by half. The paper asserts that the increasing long-term use of antidepressants “has arisen in part because patients are unwilling to stop due to the aversive nature of the withdrawal syndrome.” But, Taylor told me, his research “wouldn't stop me from recommending an antidepressant for

someone with fully fledged major depression, because the relief of suffering is of a different order of magnitude than the symptoms when you stop taking them.”

In the fifth edition of the *DSM*, published in 2013, the editors added an entry for “antidepressant discontinuation syndrome”—a condition also mentioned on drug labels—but the description is vague and speculative, noting that “longitudinal studies are lacking” and that little is known about the course of the syndrome. “Symptoms appear to abate over time,” the manual explains, while noting that “some individuals may prefer to resume medication indefinitely.”

Three months after Laura stopped all her medications, she was walking down the street in Boston and felt a flicker of sexual desire. “It was so uncomfortable and foreign to me that I didn’t know what to do with it,” she said. The sensation began to occur at random times of day, often in public and in the absence of an object of attraction. “It was as if that whole part of my body was coming online again, and I had no idea how to channel it,” she said. “I felt occupied by this overwhelming power.” She had never masturbated. “I was, like, Why do people like this? It didn’t make sense.”

When she was thirty-one, she began a long-distance relationship with Rob Wipond, a Canadian journalist. Both of them became emotional when talking with me about Laura’s sexuality. Laura told me, “I felt like a newborn. I hadn’t ever figured out what my body was meant to be.” Rob said, “She was open and awake. Everything was new to her. We were, like, ‘Well, gee, what is this sexuality thing—what shall we do?’ ”

For years, Laura had been unable to have stable relationships—a symptom, she’d assumed, of borderline personality disorder. “I honestly thought that, because I was mentally ill, the numbness was just part of me,” she told me. “I looked at beautiful sex scenes in movies, and it never crossed my mind that this was in the cards for me.” Now she wondered about the effects of the many medications she had been taking. “On this very sensory, somatic level, I

couldn't bond with another human being," she said. "It never felt real. It felt synthetic."

Laura bought a book about women's sexuality, and learned how to give herself an orgasm. "It took so long and I finally figured it out, and I just broke down in tears and called Rob, and I was, like, 'I did it! I did it! I did it!'"

She felt fortunate that her sexuality had returned in a way that eluded other people who were withdrawing from drugs. Although it is believed that people return to their sexual baseline, enduring sexual detachment is a recurring theme in online withdrawal forums. Audrey Bahrnick, a psychologist at the University of Iowa Counseling Service, who has published papers on the way that S.S.R.I.s affect sexuality, told me that, a decade ago, after someone close to her lost sexual function on S.S.R.I.s, "I became pretty obsessive about researching the issue, but the actual qualitative experience of patients was never documented. There was this assumption that the symptoms would resolve once you stop the medication. I just kept thinking, Where is the data? Where is the data?" In her role as a counsellor, Bahrnick sees hundreds of college students each year, many of whom have been taking S.S.R.I.s since adolescence. She told me, "I seem to have the expectation that young people would be quite distressed about the sexual side effects, but my observation clinically is that these young people don't yet know what sexuality really means, or why it is such a driving force."

Laura felt as if she were learning the contours of her adult self for the first time. When she felt dread or despair, she tried to accept the sensation without interpreting it as a sign that she was defective and would remain that way forever, until she committed suicide or took a new pill. It felt like a revelation, she said, to realize that "the objective in being alive isn't the absence of pain." She remembered identifying with a sad little bubble pictured in a popular advertisement for Zoloft—the bubble is moping around, crying and groaning, until it takes the medication and starts to bounce while birds sing—and became increasingly aware that her faith in the drugs'

potential had been misplaced. “I never felt helped by the drugs in the sense that I have meaning, I have purpose, I have relationships that matter to me,” she said. Overprescribing isn’t always due to negligence; it may also be that pills are the only form of help that some people are willing to accept. Laura tried to find language to describe her emotions and moods, rather than automatically calling them symptoms. “The word I use for it is ‘unlearn,’ ” she said. “You are peeling off layers that have been imposed.”

Laura still felt fondness for most of her psychiatrists, but, she said, “the loss of my sexuality is the hardest part to make peace with—it feels like a betrayal. I’ve discovered how much of the richness of being human is sexuality.”

She wrote several letters to Dr. Roth, her favorite psychiatrist, requesting her medical records, because she wanted to understand how the doctor had made sense of her numbness and years of deterioration. After a year, Dr. Roth agreed to a meeting. Laura prepared for hours. She intended to begin by saying, “I’m sitting in front of you and I’m off all these drugs, and I’ve never felt more vibrant and alive and capable, and yet we thought I had this serious mental illness for life. How do you make sense of that?” But, in Dr. Roth’s office, Laura was overwhelmed by nostalgia: the familiar hum of the white-noise machine, the sound of the wind sucked inside as Dr. Roth opened the front door. She had always loved Dr. Roth’s presence—the way she would sit in an armchair with her legs folded, cradling a large mug of coffee, her nails neatly polished. By the time Dr. Roth walked into the waiting room, Laura was crying.

They hugged and then took their usual positions in Dr. Roth’s office. But Laura said that Dr. Roth seemed so nervous that she talked for the entire appointment, summarizing the conversations they’d had together. It was only when Laura left that she realized she had never asked her questions.

Laura started a blog, in which she described how, in the course of her illness, she had lost the sense that she had agency. People began contacting her to ask for advice about getting off multiple psychiatric medications. Some had been

trying to withdraw for years. They had developed painstaking methods for tapering their medications, like using grass-seed counters to dole out the beads in the capsules. Laura, who had a part-time job as a research assistant but who still got financial help from her parents, began spending four or five hours a day talking with people on Skype. “People were so desperate that, when they found someone who had gotten off meds, they were just, like, ‘Help me,’ ” she said.

David Cope, a former engineer for the Navy, told me that Laura’s writings “helped keep me alive. I needed to know that someone else had gone through it and survived.” In the process of withdrawing from Paxil, Ativan, and Adderall, he felt detached from emotional reactions that had previously felt habitual. “The way I would explain it to my wife is, I know that I love her,” he told me. “I know that I care for her. I know that I would lay down my life for her. But I don’t *feel* love. There’s no emotional-physical response: the sense of comfort and tingly love when you smell your spouse’s hair—I don’t have that.”

Angela Peacock, a thirty-nine-year-old veteran of the war in Iraq, told me, “I want to be Laura when I grow up.” Peacock had been on medications for thirteen years, including the “P.T.S.D. cocktail,” as it has become known: the antidepressant Effexor, the antipsychotic Seroquel, and Prazosin, a drug used to alleviate nightmares. “I never processed the trauma of being a twenty-three-year-old at war, and how that changed my view of humanity,” she said. “I just pressed Pause for thirteen years.”

Laura realized that she was spending her entire workday on these conversations. Because she needed to become financially self-reliant, she began charging seventy-five dollars an hour (on a sliding scale) to talk to people. Few psychiatrists are deeply engaged with these questions, so a chaotic field of consultants has filled the void. They are immersed in what Laura describes as “the layperson withdrawal community,” a constellation of Web forums and Facebook groups where people who have stopped their psychiatric medications advise one another: Surviving Antidepressants, the

International Antidepressant Withdrawal Project, Benzo Buddies, Cymbalta Hurts Worse. The groups offer instructions for slowly getting off medications—they typically recommend that people reduce their doses by less than ten per cent each month—and a place to communicate about emotional experiences that do not have names. For many people on the forums, it was impossible to separate the biochemical repercussions from the social ones. The medicines worked on their bodies, but they also changed the way people understood their relationships and their social roles and the control they had over elements of their lives. A common theme on the forums is that people felt that at some point, having taken so many medications for so long, they'd become disabled—and they were no longer sure if this was due to their underlying disorder, the effect of withdrawing from their medications, or the way they had internalized the idea of being chronically ill.

Peter Gordon, a Scottish psychiatrist who has worked for the National Health Service for twenty-five years, told me that he has struggled to find doctors to help him with his own process of withdrawal, so he turned to the online communities, which he believes are “changing the very nature of the power balance between patient and doctor.” He went on Paxil twenty-one years ago, for social anxiety, and has tried to go off several times, using a micropipette to measure a small reduction of the liquid form of the medication each month. It has not worked. Each time, he said, “I find my temperament different. I am not an angry person—I am gentle, I am affectionate, I am open—but in withdrawal I found that these qualities were less clear. I was more irritable. I was critical of my wife and focussed on things I wouldn't normally care about.” He continued, “I personally find it really hard to try to capture that experience in words, and, if I'm finding it difficult to translate it into words, how are the studies going to capture it? There's going to be an additional loss from words to quantifiable ratings. We are trained to understand the evidence base as paramount—it is the primary basis for mental-health prescriptions around the world, and I fully subscribe to it—but this evidence base can never be complete without listening to the wider story.”

After consulting with people on the phone for nearly five years, Laura worked with Rob Wipond and a physician's assistant named Nicole Lamberson to create an online guide for people who wanted to taper off their pills. There were few precedents. In the late nineties, Heather Ashton, a British psychopharmacologist who had run a benzodiazepine-withdrawal clinic in Newcastle, had drafted a set of guidelines known as the Ashton Manual, which has circulated widely among patients and includes individual tapering schedules for various benzodiazepines, along with a glossary of disorienting symptoms. "People who have had bad experiences have usually been withdrawn too quickly (often by doctors!) and without any explanation of the symptoms," Ashton wrote.

Laura's Web site, which she called the Withdrawal Project, was published online in early 2018 as part of a nonprofit organization, [Inner Compass Initiative](#), devoted to helping people make more informed choices about psychiatric treatment. She and Rob (whom she was no longer dating) created it with a grant from a small foundation, which gave her enough money to pay herself a salary, to hire others who had consulted with people withdrawing from medications, and to cull relevant insights about tapering strategies. "Anecdotal information is the best we have, because there is almost no clinical research on how to slowly and safely taper," Laura said. The Web site helps people withdrawing from medications find others in the same city; it also offers information on computing the percentage of the dosage to drop, converting a pill into a liquid mixture by using a mortar and pestle, or using a special syringe to measure dosage reductions. Lamberson, who had struggled to withdraw from six psychiatric medications, told me, "You find yourself in this position where you have to become a kitchen chemist."

Swapnil Gupta, an assistant professor at the Yale School of Medicine, told me that she is troubled that doctors have largely left this dilemma to patients to resolve. She and her colleagues have embarked on what she describes as an informal "de-prescribing" initiative. They routinely encounter patients who, like Laura, are on unnecessary combinations of psychiatric medications, but

for different reasons: Laura saw her therapists as gurus who would solve her problems, whereas poor or marginalized patients may be overtreated as they cycle in and out of emergency rooms. Yet, when Gupta, who works at an outpatient clinic, raises the idea of tapering off patients' medications, she said, some of them "worry they will lose their disability payments, because being on lots of meds has become a badge of illness. It is a loss of identity, a different way of living. Suddenly, everything that you are doing is yours—and not necessarily your medication."

Gupta, too, is trying to recalibrate the way she understands her patients' emotional lives. "We tend to see patients as fixed in time—we don't see them as people who have ups and downs like we all do—and it can be really disconcerting when suddenly they are saying, 'See, I'm crying. Put me back on my meds.'" She said, "I have to sit them down and say, 'It's O.K. to cry—normal people cry.' Just today, someone asked me, 'Do you cry?' And I said, 'Yes, I do.'"

In the fall of 2018, a few days after Thanksgiving, Laura's sister Nina texted me: "10 years to the day, Laura has some news for you that may be a great ending to your story." The previous year, Laura had moved to Hartford to live near a new boyfriend, Cooper Davis, and his four-year-old son. Now they had just returned from spending the holiday with her family in Maine. Standing in the kitchen of their second-floor apartment, Laura told Cooper that wood and thin plastic utensils can't go in the dishwasher. He asked if a number of different household items were safe for the dishwasher, before saying he had one last question and pulling an engagement ring out of his pocket. Cooper had been planning to propose for several weeks, and he hadn't realized that the moment he'd chosen was precisely a decade after her suicide attempt.

Laura had met Cooper, who works at an agency that supports people with psychiatric and addiction histories, two years earlier, at a mental-health conference in Connecticut. Cooper had been given Adderall for attention-deficit hyperactivity disorder at seventeen and had become addicted. As an

adolescent, he said, he was made to believe “I am not set up for this world. I need tweaking, I need adjusting.”

His work made him unusually welcoming of the fact that people in various states of emotional crisis often want to be near Laura. A few months after they were engaged, Bianca Gutman, a twenty-three-year-old from Montreal, flew to Hartford to spend the weekend with Laura. Bianca’s mother, Susan, had discovered Laura’s blog two years earlier and had e-mailed her right away. “I feel like I’m reading my daughter’s story,” she wrote. Susan paid Laura for Skype conversations, until Laura told her to stop. Laura had come to think of Bianca, who had been diagnosed as having depression when she was twelve, as a little sister navigating similar dilemmas.

While Bianca was visiting, a friend from out of town who was in the midst of what appeared to be a manic episode was staying at an Airbnb a few houses down the street. Laura was fielding phone calls from the woman’s close friends, who wanted to know what should be done, but the only thing Laura felt comfortable advising was that the woman get some sleep—she had medications to help with that—and avoid significant life decisions. The woman had been traumatized by a hospitalization a few years earlier, and Laura guessed that “she came here because she didn’t want to be alone, and she knows that I would never call the cops on her.”

Laura and Bianca spent the weekend taking walks in the frigid weather and having leisurely conversations in Laura’s small living room. Bianca, who is barely five feet tall, moved and talked more slowly than Laura, as if many more decisions were required before she converted a thought into words. She had been on forty milligrams of Lexapro—double the recommended dose—for nearly nine years. She’d taken Abilify for six years. Now, after talking to Laura, Bianca’s father, an emergency-medicine doctor, had found a pharmacy in Montreal that was able to compound decreasing quantities of her medication, dropping one milligram each month. Bianca, who worked as an assistant at an elementary school, was down to five milligrams of Lexapro.

Her mother said, “I often tell Bianca, ‘I see you coping better,’ and she’s, like, ‘Calm down, Mommy. It’s not like being off medication is going to wipe me clean and you’re going to get the daughter you had before’ ”—the hope she harbored when Bianca first went on medication.

Bianca, who had reddish-blond hair, which she’d put in a messy bun, was wearing a bulky turtleneck sweater. She sat on the couch with her legs curled neatly into a Z—a position that she later joked she had chosen because it made her feel more adult. Like Laura, Bianca had always appreciated when her psychiatrists increased the dosage of her medications. She said, “It was like they were just matching my pain,” which she couldn’t otherwise express. She described her depression as “nonsensical pain. It’s so shapeless and cloudy. It dodges all language.” She said that, in her first conversation with Laura, there was something about the way Laura said “Mm-hmm” that made her feel understood. “I hadn’t felt hopeful in a very long time. Hopeful about what? I don’t know. Just hopeful, I think, because I felt that connection with someone.” She told Laura, “Knowing that you know there’s no words—that’s enough for me.”

At my request, Laura had dug up several albums of childhood photographs, and the three of us sat on the floor going through them. Laura looked radically different from one year to the next. She had had a phase of wearing pastel polo shirts that were too small for her, and in this phase, when Laura was pictured among friends, Bianca and I struggled to tell which girl was her. It wasn’t just that she was fatter or thinner; her face seemed to be structured differently. In her *débutante* photos, she looked as if she were wearing someone else’s features. Bianca kept saying, “I don’t see you.”

Since I’d known Laura, she had always had a certain shine, but on this day she seemed nearly luminous. She had taken a new interest in clothes and was wearing high-waisted trousers from Sweden with a tucked-in T-shirt that accentuated her waist. When Cooper returned to the house, after an afternoon with his family, she exclaimed, “Oh, Cooper is back!” Then she

became self-conscious and laughed at herself.

I told Laura that I was wary of repeating her sister's sentiment that marriage was the end of her story. She agreed. "It's not, like, 'Laura has finally arrived,' " she said. "If anything, these trappings of whatever you want to call it—life?—have made things scarier." She still felt overwhelmed by the tasks of daily life, like too many e-mails accumulating, and she cried about five times a week. She was too sensitive. She let situations escalate. Cooper said that his tendency in moments of tension was to get quiet, which exacerbated Laura's fear that she was not being heard. She did not see a therapist—she felt exhausted from years of analyzing her most private thoughts—but, she said, "If I actually sat in front of a psychiatrist and did an evaluation, I would totally meet the criteria for a number of diagnoses." But the diagnostic framework no longer felt meaningful to her.

Perhaps we all have an ugly version of ourselves that, in our worst moments, we imagine we've become: when Bianca felt hopeless, she thought, mockingly, This is you. How could you possibly think otherwise, you poor thing? Laura's thought was: You are not a legitimate person. You don't deserve to be here. In many of our conversations, Laura said, she was trying to ignore the thought: Who do you think you are, speaking with this journalist? Shut up and go away. She said, "And yet we're also having this conversation and I'm totally present in it."

Bianca said, "It's like your darkness is still there, but it's almost like it's next to you as opposed to your totality of being."

Laura agreed that she was experiencing "the stuff of being alive that I just had no idea was possible for me." But, she said, "it's not like I'm good to go. Literally every day, I am still wondering how to be an adult in this world." ♦

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