Deprescribing in Psychiatry: A Comprehensive Overview

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1. Definition

Deprescribing refers to a supervised and intentional process of reducing or discontinuing medications when, after a careful review of the patient's goals, functioning, life expectancy, and preferences, it is determined that the potential harm of the medication outweighs the benefits. It is not about denying effective treatments, but rather it is a positive intervention eliminating unnecessary medications and represents part of a good prescribing continuum. Modern definitions emphasize thorough review of the entire medication regimen, individualized risk-benefit analysis, gradual tapering, minimizing withdrawal symptoms, monitoring for relapse, and shared decision-making between prescriber and patient.

In psychiatry, the term refers specifically to the planned reduction or elimination of antidepressants, antipsychotics, benzodiazepines, mood stabilizers, stimulants, and sleep agents once they have been deemed to have become unnecessary, ineffective, or whose risks outweigh their benefits.

2. Origins and Rise in Popularity

Early History

The term entered the medical lexicon around 2003, initially in geriatric medicine, where concerns about rising polypharmacy in elderly patients drove the concept into clinical discourse. The practice existed even before that, informally known as the "geriatrician's salute", i.e., the (metaphorical) sweeping of unnecessary medications off the bedside table.

In 2015, a landmark paper by Scott et al. in *JAMA Internal Medicine* (Scott et al., 2015) formalized a 5-step deprescribing protocol, propelling the concept into mainstream medical vocabulary:

- Ascertain all current medications and the reason for each
- Assess the overall risk of drug-induced harm to determine how aggressively to deprescribe
- Evaluate each drug's benefit potential against its harm or burden potential
- Prioritize drugs for discontinuation based on the lowest benefit-harm ratio and lowest risk of withdrawal or rebound
- Implement tapering and monitor the patient

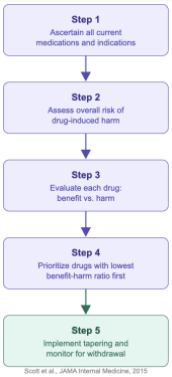

Figure 1. The Scott et al. (2015) 5-step deprescribing protocol.

Rise in Psychiatry

Psychiatry adopted the idea the following year, with Gupta and Cahill's paper in *Psychiatric Services* (Gupta & Cahill, 2016), adapting deprescribing for psychiatric practice. The topic became significantly more prominent in the 2020s, prompted by growing public discussion of antidepressant withdrawal symptoms, concern about long-term benzodiazepine use, the publication of the 2024 Maudsley Deprescribing Guidelines in Psychiatry (Horowitz & Taylor, 2024), and culminating in the 2026 American Society of Clinical Psychopharmacology (ASCP) Task Force Consensus Statement in *JAMA*

Network Open (Goldberg et al., 2026), which convened 45 international experts to develop formal guidance on when and how to deprescribe psychotropic medications.

3. Why It Became Popular

The Polypharmacy Problem

The number of medications prescribed to a single patient at any one time is both the central driver of deprescribing as a field and the single strongest predictor of adverse drug events. Patients frequently accumulate complex multi-drug regimens over time with medications added but rarely removed, and what begins as a short-term prescription often becomes permanent. This happens for several reasons:

- Lack of continuity of care, leaving providers uncertain about the original diagnosis and reluctant to discontinue another clinician's prescription
- Failure to inform patients how long a medication is typically intended to be taken
- Patient resistance to change, particularly when a regimen has been stable for years
- Time pressure in clinical appointments, which makes thorough medication review difficult
- Medicolegal concern about liability if a patient relapses after discontinuation
- Lack of training in tapering protocols and withdrawal management

Long-Term Adverse Effects

There is growing recognition that long-term use of psychiatric medications carries significant risks:

- Atypical antipsychotics are associated with cumulative metabolic effects including weight gain and diabetes, as well as tardive dyskinesia with prolonged use
- Anticholinergic medications contribute to cognitive impairment over time
- Long-term benzodiazepine use leads to dependence and increases fall risk, especially in older adults
- Combinations of QT-prolonging medications raise cardiovascular risk

These concerns have made it increasingly difficult to justify the indefinite continuation of all medications without periodic reassessment; indefinite continuation of all medications is not benign.

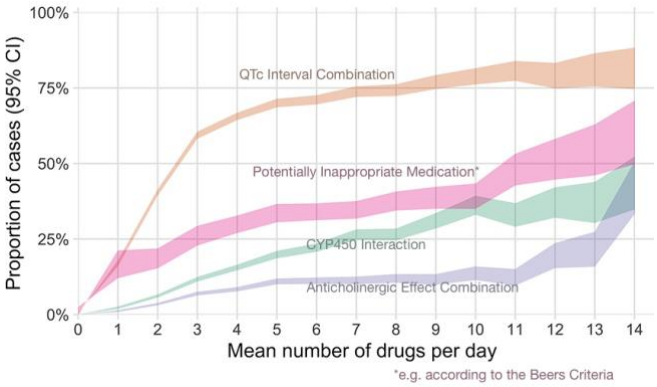

Figure 2. Proportion of specific risk types in patients versus number of drugs prescribed. From: Polypharmacy and the risk of drug-drug interactions and potentially inappropriate medications in hospital psychiatry, Pharmacoepidemiology Drug Saf., 2021. Used under license from Wiley; figure simplified.

Withdrawal Syndromes and Knowledge Gaps

For years, antidepressant discontinuation symptoms were described as mild and brief, and were largely dismissed by the medical community. Yet patients increasingly reported symptoms such as severe anxiety, "brain zaps", insomnia, and depersonalization, which might continue for months or longer. These withdrawal symptoms were difficult to manage and poorly understood. Brain zaps — a distinctive sensation often described as brief electrical jolts or flickering in the head — became one of the most debated withdrawal phenomena, drawing both patient and research attention (Papp & Onton, 2018) (Papp & Onton, 2022). (See also: Brain Zaps: A Patient Guide)

Early clinical work documenting and characterizing these symptoms, including research by Dr. Alexander Papp coauthored with Julie Onton, PhD (Papp & Onton, 2018) (Papp & Onton, 2022), helped establish brain zaps as a legitimate clinical phenomenon rather than a subjective complaint. Accounts of withdrawal symptoms generated patient advocacy groups, online communities, and growing pressure on clinicians and researchers for better tapering methods. The experience of patients often stood in stark contrast to what appeared in the prescribing literature, creating a credibility gap that drew increasing attention to the field. Finally, the ASCP Task Force explicitly identified a critical knowledge gap: despite an extensive literature on how to start medications, remarkably little guidance existed on when and how to stop them (Goldberg et al., 2026).

4. Positive Aspects of Deprescribing

Clinical and Safety Benefits

Reducing medication burden is the core rationale for deprescribing. Eliminating unnecessary agents directly lowers cumulative side effects, CYP450-mediated pharmacokinetic interactions, and pharmacodynamic risks such as QT prolongation and serotonin syndrome. Patients may experience clearer thinking, less sedation, improved energy, better sexual functioning, reduced weight gain, and greater adherence to remaining medications. The ASCP Task Force favored deprescribing antipsychotics that cause significant weight gain or tardive dyskinesia over adding pharmacological antidotes, recognizing that fewer medications can mean better overall functioning. In dementia settings, approximately 70% of patients discontinued antipsychotics without worsening behavioral symptoms, and in one trial there was roughly a 50% lower 12-month mortality risk after discontinuation versus continuation (Ballard et al., 2009).

Deprescribing as a Positive Clinical Intervention

Deprescribing, when done thoughtfully, is not simply about removing medications. It can actively improve the quality of care. Patients are often more receptive than clinicians assume. For example, in one geriatric psychiatry survey, 92% of patients said they would be willing to stop a medication if their physician recommended it. And when deprescribing is approached gradually and paired with psychological support, outcomes are reassuring.

A 2026 network meta-analysis in *The Lancet Psychiatry* (Zaccoletti et al., 2026) found that slow tapering combined with psychological support was as effective as continuing antidepressants in preventing relapse, and clearly better than abrupt discontinuation. The process of reviewing medications together with a patient can strengthen the therapeutic alliance, prompt clinicians to revisit whether original diagnoses and indications are still valid, and they can create an opening to introduce evidence-based psychotherapies that may be more effective than continued polypharmacy for conditions such as borderline personality disorder, PTSD, and OCD. In this sense, deprescribing is best understood not as the absence of treatment, but as a form of active, thoughtful clinical care.

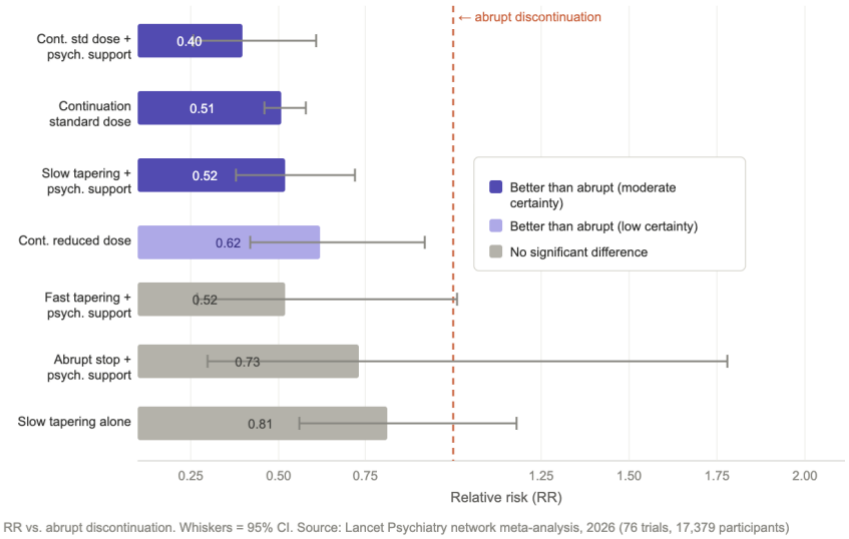

Figure 3. Comparison of antidepressant deprescribing strategies for relapse prevention. Relative risk versus abrupt discontinuation; whiskers = 95% CI. Source: Zaccoletti et al. (Lancet Psychiatry, 2026); 76 trials, 17,379 participants.

5. Negative Aspects and Risks of Deprescribing

Relapse and Withdrawal Risk

The greatest clinical concern is relapse. For chronic recurrent conditions, deprescribing carries inherent risk of decompensation, especially in cases of severe depression, mania, psychosis, or suicidality. The ASCP consensus (Goldberg et al., 2026) opposed deprescribing after three or more lifetime depressive episodes and favored indefinite antidepressant maintenance. Similarly, it considered medication-free status inappropriate in bipolar I disorder (but not necessarily in bipolar II disorder). A further concern is that the symptoms of medication withdrawal, which can include dizziness, nausea, and nervousness may be difficult to distinguish from true psychiatric relapse; clinical guidelines offer little guidance on how to tell the two apart. Benzodiazepines, paroxetine, venlafaxine, and long-term antipsychotics are particularly well known for their destabilizing withdrawal effects.

Evidence Gaps and Ideological Concerns

The evidence base remains incomplete, since most serious psychiatric conditions are highly recurrent, making pharmacological endpoints elusive, and many ASCP recommendations reflect expert consensus rather than clinical trial data (Goldberg et al., 2026).

Some psychiatrists warn that the deprescribing movement has been adopted by antipsychiatry activists and online communities hostile to psychopharmacology, risking conflation of legitimate medication management with anti-medication ideology. This concern takes on new urgency in the current political climate, where high-profile advocacy movements have amplified skepticism about psychiatric medications well beyond the medical mainstream. When deprescribing becomes a rallying point for broader anti-medication ideology, it risks driving patients to discontinue medications abruptly, with potentially serious consequences. Governmental or commercial insurers could further misuse this to restrict treatment access under the guise of responsible prescribing. Clinicians and researchers need to distinguish evidence-based medication review from ideologically motivated campaigns that could discourage patients from seeking or continuing treatments they genuinely need.

Clinical Vignette (illustrative)

A 48-year-old woman with a history of a single major depressive episode presented after 6 years of continuous us of an adequate dose of SSRI, prescribed by her GP; she had never been reassessed to see if the medication could be discontinued. She reported no depressive symptoms but complained of emotional flattening and low libido. Because the patient was experiencing significant side effects with no current depressive symptoms, and because she had had only a single depressive episode, her new psychiatrist initiated a slow taper over 4 months. At week 10, she experienced brain zaps, irritability, poor sleep, and fatigue. Since it was unclear whether these represented a recurrence of depression or discontinuation syndrome, the taper was slowed and monitoring for depressive symptoms was increased. The discontinuation symptoms improved, and the very slow taper continued for six more months. A year later the patient was medication-free and without depressive or withdrawal symptoms.

This case illustrates the need for reassessment of medications after initiation, the feasibility of supervised deprescribing in appropriate candidates, and the clinical challenge of distinguishing withdrawal from relapse.

6. Stakeholder Considerations

Professional Organizations and the Pharmaceutical Industry

Professional organizations such as the ASCP and APA (American Psychiatric Association) generally support thoughtful, individualized medication reassessment while resisting blanket anti-medication narratives. Because there has been little financial incentive to study discontinuation, the pharmaceutical industry has largely neglected this area, a fact noted in a Cochrane review (Van L. et al., 2021) on antidepressant discontinuation. The ASCP Task Force proposed closing this gap through regulatory mandates requiring discontinuation safety data from manufacturers.

Insurers and Patient Advocacy Groups

Insurers have a financial incentive to support deprescribing in principle, since fewer medications means reduced costs. In practice, however, they have been slow to fund the longer appointments, monitoring, and the supportive psychotherapy that responsible medication reduction requires, creating a situation where the cost savings flow to the insurer while the clinical burden falls on the patient and provider. Patient advocacy groups are divided between those championing withdrawal awareness and others warning that fear of medication may discourage treatment, particularly in severe mental illness. The field would benefit from greater pharmaceutical engagement in generating discontinuation data, insurer support for increased clinical monitoring, and expanded prescriber training in this often-overlooked skill.

7. Summary

Current State of the Field

Deprescribing in psychiatry reflects a broader change in thinking: medications are no longer assumed to be indefinite but should instead be regularly reassessed for possible reduction or discontinuation. The 2026 ASCP Consensus Statement (Goldberg et al., 2026) helped formalize this shift in psychiatry, emphasizing that psychiatric medications should be reviewed regularly and that reducing or stopping them should be considered when the risks begin to outweigh the benefits, as long as issues like relapse risk, withdrawal effects, and adequate follow-up care are taken seriously. Research on deprescribing is growing, but it has not yet fully caught up with the enthusiasm surrounding the movement. Slow

tapering combined with psychological support currently appears to be the safest approach, though the best methods are still being worked out.

Key Tensions and Remaining Gaps

At the center of the debate is a difficult balance: reducing unnecessary medication use without destabilizing patients who suffer from chronic or recurring psychiatric illness. The case for deprescribing is strongest when it is individualized, carefully supervised, and grounded in evidence. It becomes far more questionable when it is driven by ideological anti-medication views or used by insurers as a way to limit treatment access. Many experts argue that two major gaps remain: better research on medication discontinuation and better physician training in how to manage it safely.

Working with Dr. Papp and Dr. Myers

For patients who are concerned about their current medications, whether they are managing a complex regimen, experiencing unwanted side effects, or simply wondering whether everything they are taking is still necessary, Dr. Alexander Papp offers an unhurried, evidence-based evaluation that this work requires. As a board-certified psychiatrist with decades of experience in psychopharmacology, Dr. Papp brings particular expertise to medication review, and when appropriate carefully supervised deprescribing. His research interest in antidepressant discontinuation, including the publication of the first peer-reviewed articles on brain zaps (Papp & Onton, 2018) (Papp & Onton, 2022), reflects a longstanding commitment to understanding what happens when patients stop medications, not just when they start them. If you would like to discuss your medications with a psychiatrist who takes these questions seriously, we invite you to reach out.

Dr. Julie Myers brings complementary expertise that is particularly valuable in the context of deprescribing. As a licensed psychologist with a Master of Science in Clinical Psychopharmacology (MSCP), she is qualified to evaluate the role of medications in a patient's overall treatment and work collaboratively with Dr. Papp or other prescribers on medication review. Her training in evidence-based psychotherapy means that patients who are reducing or discontinuing medications can simultaneously engage in therapeutic work that supports the transition, which is an approach the research increasingly identifies as the most effective model for safe, sustainable deprescribing.

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