

Discontinuation syndromes recognition

Timeline and management across SSRI/SNRI, benzos, stimulants, antipsychotics, and lithium. Reviewed against current guidelines as of June 8, 2026.

Discontinuation is not addiction. The symptoms are real and physiologically predictable, and mostly a function of half-life and how fast you're coming off. Reinstate at a higher dose and taper more slowly and you'll usually turn it around within days. The clinician's job is to distinguish discontinuation from relapse, prevent unnecessary suffering by tapering appropriately, and recognize the few situations (benzo withdrawal seizures, lithium rebound mania) where discontinuation is a real medical event.

SSRI and SNRI discontinuation

FINISH mnemonic: Flu-like, Insomnia (vivid dreams), Nausea, Imbalance (dizziness), Sensory disturbances (brain zaps), Hyperarousal (anxiety, irritability). Onset 1 to 3 days after last dose (later for long-t_{1/2} drugs). Duration 1 to 3 weeks in mild cases, longer for high-risk drugs or prolonged use.

Drug	Risk	Reason
Paroxetine	Highest	Short half-life (21 h), anticholinergic rebound, nonlinear kinetics
Venlafaxine	Very high	Short half-life (5 h IR, 11 h ODV)
Duloxetine	High	Half-life 12 h
Fluvoxamine	High	Half-life 15 h
Sertraline	Moderate	Half-life 26 h
Citalopram, escitalopram	Moderate	Half-life 27 to 33 h
Vortioxetine	Low	Half-life 66 h
Fluoxetine	Very low	Half-life 4 to 6 days, active metabolite 7 to 15 days (self-tapering)
Bupropion	Low	Not serotonergic; mild profile
Mirtazapine	Low to moderate	Some flu-like symptoms, GI
TCAs	Moderate	Cholinergic rebound
MAOIs	Moderate to high	Withdrawal features distinct from SSRIs

Discontinuation vs relapse: onset in days points to discontinuation; weeks points to relapse. Brain zaps, dizziness, GI, flu-like features point to discontinuation. Pure mood or thought symptoms point to relapse. Response to reinstatement in 24 to 72 hours confirms discontinuation. If unsure, reinstate. If it resolves quickly, it was discontinuation.

Benzodiazepine withdrawal

Symptoms: anxiety, insomnia, tremor, sweating, tinnitus, perceptual disturbances, muscle tension, GI upset, depersonalization, seizures. Severe withdrawal produces delirium, hallucinations, seizures. This is the one discontinuation that can be a medical emergency. Short-acting (alprazolam, lorazepam): onset 1 to 2 days, peaks day 2 to 4, acute phase 1 to 4 weeks. Long-acting (clonazepam, diazepam, chlordiazepoxide): onset 3 to 7 days, peaks day 5 to 10, acute phase 2 to 6 weeks. Protracted withdrawal (anxiety, insomnia, cognitive) can last months to years after high-dose or long-duration use.

Management: never stop chronic benzos abruptly (seizure risk). Stabilize on a long-acting equivalent (diazepam or clonazepam) at the current equivalent dose. Taper 5 to 10 percent of current dose every 2 to 4 weeks. High-dose or long-duration users need slower cuts (2 to 5 percent, or hyperbolic). Total 6 to 18 months for high-dose alprazolam.

Stimulants, antipsychotics, lithium

Class	Onset	Common symptoms	Management
Stimulants	1 to 4 days	Rebound fatigue and hypersomnia, low mood, increased appetite, ADHD symptoms unmasked, irritability	Slow taper for long-term high-dose. Drug holidays tolerable in some patients. Supratherapeutic use can produce dysphoria severe enough to raise acute suicide risk.
Antipsychotics: withdrawal dyskinesia	Days to weeks	New orofacial, choreoathetoid, tongue movements	Document with AIMS. Slow taper. If persistent beyond 4 to 6 months post-taper, that's TD by consensus.
Antipsychotics: cholinergic rebound	Days	Nausea, vomiting, diarrhea, sweating, hypersalivation, insomnia, agitation. Most prominent with clozapine.	Taper slowly. If urgent (agranulocytosis), consider benztropine 1 to 2 mg BID cover.
Antipsychotics: rebound psychosis	Days to weeks	Psychotic symptoms worse than baseline. High-D2 blockers (haloperidol, risperidone, olanzapine, paliperidone) most implicated.	Taper slowly. If must stop abruptly, bridge with different antipsychotic or short-term benzos.
Lithium	Weeks (months for relapse)	Manic relapse can exceed pre-treatment baseline. Baldessarini: taper under 2 weeks produces highest relapse rates.	Taper over at least 4 weeks, ideally 8 to 12. Have another mood stabilizer in place first. Warn patient specifically.
Gabapentin, pregabalin	1 to 3 days	Anxiety, insomnia, sweating, GI	Taper 10 to 25 percent every 1 to 2 weeks.
Clonidine	1 to 2 days	Rebound hypertension, anxiety	Taper 1 to 2 weeks.

Hyperbolic tapering

A taper where each reduction is a proportional amount of the current dose, so the absolute cut gets smaller as the dose gets smaller. Mirrors the sigmoidal receptor-occupancy curve, where small absolute changes at low doses correspond to large occupancy changes. Horowitz and Taylor (Lancet Psychiatry 2019) made the mathematical case for SSRIs; it applies conceptually to benzos too. In practice: liquid formulations or compounded low-strength capsules at the tail end.

Not medical advice.

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