

Two Points. Eight Weeks. Millions of Prescriptions. A Gentle but Urgent Plea to Rethink How We Use Antidepressants.



Rethinking Medication: Listening to an Insider Who Stepped Outside

Recently I listened to psychiatrist Dr. Josef Witt-Doerring, a former FDA medical officer who worked within pharmaceutical and regulatory systems before stepping away from conventional pathways. After leaving the FDA, he entered a higher-paying role within the pharmaceutical industry itself, an experience that, by his own account, eventually left him disillusioned with aspects of how psychiatric medications were evaluated and promoted. Over time, he became increasingly troubled by how these medications are studied, prescribed, and discontinued, particularly the gap between short-term research and long-term real-world use. Today his work focuses on

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deprescribing and safe withdrawal, inviting clinicians and patients alike to reconsider assumptions that have quietly shaped modern mental health care.

Whether one agrees with every conclusion he draws or not, his journey raises an important question: Are we examining the full story behind the medications we prescribe, or only the parts that fit within familiar frameworks?

His reflections do not demand rejection of medication. Rather, they call for deeper curiosity, a willingness to rethink how, when, and why we intervene pharmacologically in the first place.

And that question led me to look inward, at my own profession.

A Confession from My Own Profession

Before I challenge psychiatry, I need to begin closer to home, with psychology itself.

My profession is not innocent in this conversation. Too often, psychologists and allied mental health professionals refer patients for medication management without fully understanding the research frameworks and assumptions guiding those prescriptions. We reassure ourselves that we are helping, that we are “staying in our lane,” yet sometimes we are quietly reinforcing a system we have not examined deeply enough.

This is not written as blame. It is written as confession, and as concern.

Because when referrals become reflexive rather than thoughtful, we risk sending vulnerable people into treatment pathways shaped more by habit than by holistic understanding. And that realization is what prompted this reflection.

Short-Term Science, Long-Term Prescribing

Across many antidepressant trials, the average difference between medication and placebo often amounts to only a few points on standardized depression scales such as the Hamilton Depression Scale (HDRS). Statistically meaningful? Yes. But whether that difference translates into genuine and observable transformation in a person’s life remains an open question, one that deserves humility rather than certainty.

The larger concern is not only the size of the effect, but the duration of the science behind it. Many studies last only weeks, while prescriptions continue for years. We are building long-term treatment cultures on short-term data, and that mismatch should invite curiosity rather than defensiveness. Estimates suggest that roughly 15% of adults and about 5% of children in the United States are currently taking antidepressant medications, with adults remaining on them on average for five years or longer, a reality that makes the absence of robust long-term research even more consequential.

This is no longer solely a psychiatric issue. Family physicians, nurse practitioners, physician assistants, interns on overnight rotations, many frontline prescribers now write a significant share of antidepressant prescriptions. That reality is not an indictment of primary care; it is simply the landscape we live in. Yet it means the responsibility for thoughtful prescribing belongs to all of us.

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Psychiatry must examine itself.
Primary care must examine itself.
Psychology must examine itself.

Not in accusation — but in awakening.

Another area that deserves deeper reflection is the interpretation of relapse-prevention studies. When individuals stabilized on medication are rapidly discontinued and compared to those who remain on treatment, the line between relapse and withdrawal can become blurred. Are we observing the return of illness, or the nervous system responding to abrupt neurochemical change? The answer is rarely simple, and it deserves more careful conversation than our current discourse often allows.

Critics of long-term prescribing also point to the relative scarcity of extended-duration human trials. Some of the longer observational insights come from primate research, where investigators have explored prolonged exposure to antidepressant medications. Interpretations of these findings remain debated, but certain studies have suggested possible changes in dendritic complexity in frontal brain regions, alterations in sleep patterns, and behavioral flattening in some primate models after extended use. While animal data cannot be directly generalized to humans, the absence of robust multi-year randomized human studies leaves clinicians grappling with more questions than answers, and that uncertainty alone should invite deeper scientific investment.

A Wake-Up Call — For Clinicians and for the Public

Perhaps the most important question lies beyond pharmacology altogether. Why are we, as a culture, so quick to reach for medication before exploring deeper layers of human suffering? Trauma histories, nervous system dysregulation, loneliness, spiritual disconnection, sleep deprivation, nutritional imbalance, these are not secondary considerations. They are often the ground from which symptoms grow.

Integrity in care means seeing the person beneath the diagnosis, the history, the nervous system, the relationships, the spiritual questions, and the deeper wounds such as trauma that often drive such painful states of unhappiness. Healing is rarely linear and almost never rushed. Quick is not always better; sometimes quick simply means we have not listened long enough. When we slow down, truly slow down, we begin to notice the more complex stories that medication alone cannot resolve, and it is there, in that deeper seeing, that real change often begins.

Medication can be a valuable tool. For some, it is lifesaving. That truth must be honored. Yet when medication becomes the first and only response, we risk narrowing the very definition of healing.

This essay is not written in anger. It is a plea, to clinicians and to the public alike, to slow down, to ask harder questions, and to approach mental health care with greater depth and humility. Patients deserve more than polarized narratives. They deserve thoughtful medicine that addresses root causes as much as symptom relief.

If this sounds like a challenge, it is meant to be. Not a shout, but a wake-up, for psychiatry, for primary care, for psychology, and for all of us who influence the direction of healing.

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Because the deeper question is no longer simply whether antidepressants help.

It is whether we are willing to practice medicine that is curious enough, courageous enough, honest enough, and compassionate enough to look beyond the prescription and truly see the person.

— Dr. Jeffrey E. Hansen, Ph.D.
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