

Why Antidepressants Aren't Fixing Depression

HIGHLIGHTS

- › In an interview with Tucker Carlson, Dr. Josef Witt-Doerring, a former FDA medical officer and pharma insider, reveals systemic shortcomings in psychiatric drug approval and oversight
- › Selective serotonin reuptake inhibitors (SSRIs), the drug primarily used for depression and anxiety, have surged in use in recent years, especially among adolescents and young adults
- › SSRIs have been linked to emotional blunting, sexual dysfunction, and cognitive dulling, yet these side effects are often misattributed
- › Psychiatric drugs have also been linked to increased suicides and violence, but these outcomes are often untracked, under-investigated, or left unacknowledged by regulatory bodies
- › Government policies and direct-to-consumer platforms are expanding psychiatric drug access, including for children, often without proper evaluation, long-term monitoring, or informed consent

According to the U.S. Centers for Disease Control and Prevention (CDC), up to 11.4% of Americans were taking prescription antidepressants in 2023. The trend has only moved upward, especially among adolescents and young adults. Dispensing rates in these

groups were already increasing before the pandemic, then accelerated by 63.5% in the years that followed, shaping not only how mental health is treated but how it's understood.

In a recent interview with Tucker Carlson, Dr. Josef Witt-Doerring, a practicing psychiatrist who worked within both the pharmaceutical industry and the U.S. Food and Drug Administration (FDA), described what he saw firsthand inside the system responsible for developing, approving, and prescribing these drugs. His account opens the door to questions that deserve to be asked, especially if your well-being is tied to these medications.

The Rise of SSRIs and the Collapse of Psychiatry

Selective serotonin reuptake inhibitors (SSRIs) are a class of psychiatric medications introduced in the late 1980s, starting with fluoxetine, more commonly known as Prozac. They were promoted as a breakthrough for depression, based on the claim that low serotonin caused its symptoms. This theory shaped public understanding and guided prescribing habits for decades, even though it lacked firm biological grounding.

- **SSRIs were built on the idea that boosting serotonin would correct depression** — Early marketing framed depression as a simple serotonin deficit that medication could normalize by blocking the reuptake of serotonin and raising levels at synapses. This explanation was widely embraced by the public and many physicians because it offered a simple and appealing solution — a chemical imbalance that could be fixed with a pill.
- **This theory was never supported by definitive scientific evidence** — Diagnoses are based on patient-reported symptoms and clinical interviews, not lab results or brain scans. The prescribing process became driven by checklists and diagnostic criteria, with little room left for nuance or context. Once a patient met enough criteria, a label was applied, and medication was initiated.

"The chemical imbalance myth was a story that was sold to doctors and patients to make them feel better about taking drugs for their mood ... The idea that these drugs fixed a chemical imbalance simply came from observations that when you give people serotonergic drugs, they can become calmer, they can look less depressed.

And so, rather than the obvious explanation being, 'Okay, this is a drug effect that we're seeing. They are drugged, and that's what we're looking at.' People said, 'Well, maybe they just had low serotonin, and now they're looking better because we've fixed this chemical imbalance.'

That message has just been grabbed by the pharmaceutical industry and psychiatrists to essentially lull people into this state where they feel more comfortable taking them," Witt-Doerring explained in the video.

- **Prozac's launch triggered a fundamental shift in psychiatric practice** — Earlier approaches explored personal history, relationships, stressors, and meaning. After SSRIs became the dominant treatment, depression and anxiety were framed almost exclusively as medical conditions requiring pharmacologic correction.

"No longer was depression and anxiety a complex thing where there could be relationship issues and problems at work and problems in your childhood," Witt-Doerring noted.

"Now it was almost bigoted in a way to talk about depression and anxiety as if they had these intuitive social and societal causes. It was now a medical condition. And if you were going to say that it wasn't a medical condition, you weren't taking it seriously, and you're stigmatizing people."

- **This change aligned with broader institutional incentives** — Drug companies had a clear financial interest in promoting medication as the first and often only treatment option. The push to prescribe was supported by pharmaceutical sales teams, advertising, and continuing medical education courses funded by industry.

- **FDA approval was based on short-term trials despite long-term use in practice** – Most trials submitted for SSRI approval lasted only six to 12 weeks. These brief studies formed the evidence base for judgments about safety and effectiveness, even though patients in the real world take these drugs for far longer, often for many months, years, or decades.
- **Over time, many patients find that the initial effects of SSRIs begin to wear off** – When the brain adapts to the presence of the drug, the benefits that were once felt start to fade. This process, known as tachyphylaxis, is common with SSRIs, and Witt-Doerring noted that patients who experience this often return to their doctors reporting that their symptoms have returned.
- **Escalation becomes the default response, leading to widespread polypharmacy** – Instead of questioning the treatment itself, the usual response is to increase the dose, switch to a different drug, or add another medication. The assumption is that the illness has progressed, rather than the drug having lost its effect or causing a physiological dependency. This escalation leads to polypharmacy, a situation where multiple psychiatric drugs are prescribed at once.

Psychiatry has reshaped itself around these drugs, drifting away from the deeper examination of human emotions that once defined the field. The story of SSRIs reveals how a theory without strong evidence became the foundation for an entire medical model, supported by industry incentives and reinforced through decades of prescribing.

The Emotional Cost of Long-Term SSRI Use

SSRIs often narrow a person's emotional range in ways that go beyond symptom relief. These drugs create a state of emotional constriction that blunts not just sadness and anxiety but also joy, love, and connection. While this effect is frequently misread as therapeutic improvement, it actually only masks distress but prevents meaningful resolution of what caused it.

- **Long-term use often turns numbness into despair** – Patients who remain on SSRIs for years report low energy, cognitive dullness, and difficulty feeling bonded to others. Witt-Doerring described his own patients who feel hollowed out and unable to reconnect with who they were before medication.

"Most people have very clear issues why they're unhappy. They're having problems with drugs. They have relationship issues. They have work issues. They're eating terrible foods. They have massive insulin resistance or diabetes that has completely disrupted the energy system of their body, and their neurons are just starving for energy.

If you're having these legitimate problems, [and] you just throw a drug on top of it to mask that anxiety that is really like the smoke detector saying, 'Problem, problem, problem' – those issues, they just fester. They just sit there, and they just get worse over time."

- **Sexual function is especially vulnerable to these effects** – According to Witt-Doerring, one of the most disturbing yet underrecognized side effects of these medications is post-SSRI sexual dysfunction (PSSD), a state in which patients experience persistent genital numbness, inability to feel pleasure, and persistent loss of sexual sensation even after discontinuing the drug.

"The issue is we tell people that this goes away when they come off the medications. This is just a temporary trade-off. To feel less depressed, you're going to deal with the sexual dysfunction. But what we've been seeing is that these drugs are causing permanent sexual dysfunction in people.

... [T]hose areas down there, they lose erogenous sensation. People will say that when they touch down there, it feels like the back of their hand or the back of their arm. There are sensory changes ... You're essentially castrating people. But it's worse than that because ... it causes cognitive damage as well ...

*People will talk about being completely dissociated from their emotions ...
You have people who are essentially lobotomized with cognitive
impairment who also have severe sexual dysfunction."*

- **PSSD distorts a person's relationship to sexuality and identity** – Witt-Doerring also shared that he sees patients who begin questioning their orientation not because their attractions have changed but because the ability to experience arousal or pleasure has vanished. This is especially confusing for those placed on SSRIs during adolescence when sexual identity is still forming.
- **Despite international recognition, PSSD remains invisible in U.S. medicine** – Regulators such as the European Medicines Agency acknowledge the condition, yet it has no formal recognition in the United States. Witt-Doerring noted that most physicians have never heard of PSSD, and those who have often avoid discussing it. Patients searching for answers are dismissed or misdiagnosed, leaving them without guidance, validation, or support.
- **SSRI exposure during pregnancy carries developmental risks** – According to the interview, about 9% to 10% of pregnant women in the U.S. are taking antidepressants, often without being informed of the impact on their child. Animal and human studies have shown altered sensory processing, changes in social behavior, and disrupted neurodevelopment in children exposed to SSRIs in utero.

Taken together, these effects show how easily SSRI treatment can drift from short-term symptom control into long-term harm that reshapes your emotional life, your relationships, and even your future generations.

When Psychiatric Drugs Trigger Suicide and Violence

While psychiatric medications are prescribed to reduce suffering, they can sometimes cause the very outcomes they're meant to prevent. The interview draws attention to cases where SSRIs contribute to worsening despair, emotional instability, and even violence – outcomes that are rarely acknowledged or properly investigated.

- **"The suicide rates are out of control in this population"** – Witt-Doerring has spoken with families and individuals whose lives were devastated by SSRI-induced harm, including cases of suicide linked to PSSD and emotional blunting. Yet these deaths remain uncounted and unacknowledged, attributed instead to mental illness rather than the medications that contributed to them.

"When you look at the clinical trial data, it's clear evidence that people who are under age 25 [taking SSRIs], they engage in more suicidal activity than people on placebo. Then when reanalysis has been done looking at the adult populations, they also find higher rates of suicide in the clinical trials.

But I want to have some nuance here. They can be experienced as 'life-saving' for some people. If you have a lot of anxiety and you get put on this medication and it blunts it, you will experience that as feeling 'life-saving' in that moment. But in general, on a population level, they're actually contributing to more suicide attempts."

- **The interview also linked antidepressant use with rising mass shootings** – Witt-Doerring explained that SSRIs can trigger paradoxical side effects, in which the drug produces the opposite of its intended effect. Instead of reducing distress or calming the patient, these reactions may induce agitation, mania, aggression, or even suicidal thoughts and behaviors.

"If you look at the side effects of all of these medications, it's already in the label. If you look at stimulants, right there, it says it can cause aggression and hostility. If you look at any psychotics like Abilify, in the label, it says it can cause aggression. If you look at the antidepressants, it also says it can cause mania and aggression and agitation."

- **The system doesn't meaningfully track these outcomes** – Manufacturers submit adverse event reports to the FDA, yet most are never examined. The evidence of drug-induced suicidality or violence often ends up buried in surveillance files or

written off as anecdotal. With no follow-through, red flags go unaddressed, public warnings never materialize, and the same patterns repeat without correction or accountability.

- **Tennessee makes a move to track the link between psychiatric drug use and school shootings** – Tennessee has instituted a new law mandating post-incident reviews of whether the shooter was using antidepressants, stimulants, antipsychotics, or related medications.

These data have historically been withheld or redacted, making it impossible to study drug-related contributions to violence. This approach represents the first attempt to publicly track these links and prevent them from being buried.

The same blind spots that surround SSRIs also apply to other psychiatric drugs. Few illustrate this more clearly than benzodiazepines, where withdrawal alone can become a life-altering ordeal.

Benzodiazepines: From Short-Term Relief to Long-Term Harm

Benzodiazepines, commonly known as benzos, are prescribed for anxiety, sleep problems, and panic attacks. Drugs such as Xanax, Klonopin, Ativan, and Valium work by amplifying the effect of gamma-aminobutyric acid (GABA), a neurotransmitter that slows brain activity and induces calm. While they offer short-term relief, they are highly addictive and difficult to discontinue.

- **Benzo withdrawal often lasts far longer and cuts far deeper than SSRI withdrawal** – Unlike SSRIs, which are usually tapered over weeks or months, benzodiazepine withdrawal can stretch on for years. Witt-Doerring treats patients experiencing protracted withdrawal syndromes marked by burning nerve pain, electric shock sensations, and intense physical discomfort.

Many develop akathisia, an inner restlessness so severe that patients describe it as psychological torture. The longer the exposure, the harder the withdrawal becomes.

- **Benzo withdrawal has directly led to suicides** – As the nervous system becomes profoundly dysregulated, basic functioning breaks down. The ability to return to baseline after stress collapses, leaving patients unable to work, sleep, or interact normally. Many become disabled during this process and require long-term, specialized care that is rarely available.
- **Misdiagnosis during withdrawal deepens the injury** – Most prescribers fail to recognize benzodiazepine withdrawal symptoms and often interpret them as a return of the original anxiety or panic disorder. Instead of supporting a careful taper, they restart the benzo or add new medications. This prolongs the neurological damage, extends dependence, and traps patients in a cycle that becomes harder to escape with each intervention.
- **Even when the taper is successful, full recovery is uncertain** – Witt-Doerring describes cases in which patients experience persistent cognitive deficits, emotional blunting, or physical pain long after the drug has left their system. The nervous system may eventually recalibrate, but for some, the damage appears to linger indefinitely.
- **The severity of benzo-related harm remains largely hidden from public view** – Despite the widespread focus on opioids, the suffering Witt-Doerring sees in patients withdrawing from benzodiazepines is equally severe. These are individuals who followed medical instructions as directed, yet ended up physically and neurologically altered by drugs they believed were safe.

Benzodiazepine withdrawal exposes a major blind spot in modern psychiatric care.

Stimulants Over Solutions – What the ADHD Epidemic Misses

The interview also covered the surge in ADHD diagnoses among children and adolescents, where treatment typically starts with stimulant medications such as Adderall or methylphenidate-based drugs like Ritalin. These medications raise

dopamine and norepinephrine levels, creating short bursts of focus and alertness. While behavior may look improved in the moment, these drugs do not deliver long-term developmental or academic gains.

- **Stimulant use in school-aged children has become normalized and often encouraged** – Many parents feel pressured to medicate their children after teachers report concerns about behavior or performance.

Instead of examining root causes such as sleep quality, nutrition, home environment, or normal neurodevelopmental variability, the system suppresses outward behaviors with medication. The result is short-term compliance in classrooms rather than true understanding or support of a child's needs.

- **Tolerance, side effects, and medication escalation often follow** – Children and adolescents frequently become tolerant to their prescribed dose, prompting dose increases or switches to other stimulants. This pattern is similar to the escalation seen with SSRIs and benzodiazepines, where the initial intervention sets off a cascade of further treatments. Many remain on stimulants for years despite minimal long-term benefit.
- **Attention problems often stem from metabolic and lifestyle factors** – Adults labeled with ADHD frequently show signs of insulin resistance or unstable blood sugar. Diets high in processed carbs can impair glucose delivery to the brain, leading to brain fog, irritability, low energy, and poor focus.

These issues are not typically explored in clinical settings, and patients are placed on amphetamines with no evaluation of metabolic health or nutritional status. For many, improving metabolic function and removing processed foods has a far greater impact on focus and mood, yet these interventions are seldom considered.

The Risk of Cannabis-Induced Psychosis

Cannabis holds therapeutic value for various health conditions, but the way it's promoted, processed, and consumed today has created serious mental health risks, especially for young people. Witt-Doerring described how today's high-potency cannabis products, aggressively marketed by Big Cannabis, have transformed marijuana into what he calls a "massive gateway drug into the psychiatric industry."

- **Modern cannabis contains far higher THC levels than historical varieties** – The cannabis of the past had much lower concentrations of THC, the psychoactive compound responsible for its intoxicating effects. Commercial growers and corporate cannabis interests have now pushed THC concentrations to levels that dramatically increase the risk of psychosis, mania, and paranoia.
- **High-THC products frequently trigger first episodes of psychosis** – Many of the patients Witt-Doerring treats for schizophrenia, bipolar disorder, or severe mood disturbances had their first break immediately after using potent cannabis. These episodes are often misdiagnosed as primary psychiatric illness rather than drug-induced reactions.
- **Misdiagnosis leads to long-term psychiatric labeling and medication** – Once a patient is hospitalized after a cannabis-related psychotic event, the role of cannabis is rarely revisited. Instead, they are placed on antipsychotics and other psychiatric drugs, often for life, based on a diagnosis that never acknowledges the trigger.

As cannabis use rises and its risks are downplayed by commercial interests, a familiar pattern emerges – one where profit overshadows patient safety, and the harms are left for others to manage. This same dynamic runs through every layer of modern psychiatry, including the very institutions tasked with protecting the public.

When Regulators Serve the Industry, Not the Public

In the United States, the agency charged with safeguarding drug safety depends financially on the companies it regulates. Under the Prescription Drug User Fee Act (PDUFA), pharmaceutical manufacturers pay the FDA to review their drug applications, creating a direct financial tie between regulator and industry. This structure reshapes the agency's priorities and weakens its role as an independent safety authority.

- **Financial incentives push the FDA toward rapid drug approval rather than public protection** — Witt-Doerring, who worked inside the FDA's Division of Psychiatry, saw firsthand how this dynamic influenced decision-making.

"What it actually does at the reviewer level is that all of our resources go towards drug development activities. We're reviewing protocols for the drug companies rather than following up on safety issues. There could be something like PSSD ... all these different side effects going on that need reports, and that need attention from medical reviewers.

Those were all just put on the back burner. They were neglected because the way success in our division was measured was that we were just getting these things, these activities done in time. There was much more of an emphasis on drug development activities," he shared.

- **Academic psychiatry has been drawn into the same system of influence** — Leading journals, university researchers, and prominent clinicians often maintain close financial ties to pharmaceutical companies through grants, consulting fees, and speaking honoraria.

As Witt-Doerring noted, industry shapes what gets studied, what gets published, and what messages reach clinicians and the public. When academia adopts industry framing rather than challenging it, it abandons its duty to question assumptions and protect patients from harm.

- **Direct-to-consumer platforms have widened access to SSRIs with minimal oversight** — Companies like Hims and Hers now prescribe psychiatric drugs online after brief questionnaires. These services began as lifestyle brands offering

treatments for issues like erectile dysfunction or hair loss.

However, they now distribute mind-altering medications with no live conversation, no diagnostic evaluation, and no long-term monitoring. The result is an easy-entry pipeline into psychiatric drug use for people who have never received formal mental health care.

- **Government policies are expanding psychiatric labeling and drug access for children** – Illinois recently passed a law requiring statewide mental health screenings beginning in third grade. Witt-Doerring pointed out that such policies accelerate the pathologizing of everyday childhood behaviors.

"Now, why I think this is the dumbest law ever, and it's going to lead to more problems, is [because] our mental health care system is so dysfunctional. Screening is not a bad thing. Knowing that someone is depressed or anxious – that's not inherently bad. We want to help people.

But what is going to happen with a law like this is it's going to end up just scaring parents. 'Oh, your kid has anxiety and depression. You should get that taken care of before they start becoming suicidal.'

They will go into a mental health care system, which is already broken, highly transactional, where doctors will have limited face time and will lean on prescribing medications. I'm all for screening, but not when the mental health care system is dysfunctional, just funneling people into a broken system."

The consequences of this system affect you whether or not you take psychiatric medication. What presents itself as modern mental health care is, in many cases, a commercially driven operation that prioritizes growth and compliance over truth and safety.

Safer, Drug-Free Ways to Improve Your Mental Health

Given the risks linked to psychiatric drugs, it's worth exploring approaches that support mental health without relying on medication. The steps below focus on practical changes that help stabilize mood and energy by giving your body the right inputs:

- 1. Remove linoleic acid (LA) from your diet** – This polyunsaturated fat (PUF) accumulates in your tissues, damages mitochondria, and disrupts mood regulation. It's found in vegetable oils, such as soybean, corn, and sunflower oil, as well as ultraprocessed foods. Swap out these items with real, whole foods, as well as saturated fats like grass fed butter, ghee, or tallow when cooking. Keep your LA intake under 5 grams a day, ideally below 2 grams. To track your intake, I recommend you download my [Mercola Health Coach app](#). It has a feature called the Seed Oil Sleuth, which monitors your LA intake to a tenth of a gram so you can stay in charge of your metabolism.
- 2. Rebuild your gut to support mood and immunity** – Your gut and brain are deeply connected, and when your gut microbes are out of balance, inflammation rises, worsening symptoms of depression. To keep your cells producing energy efficiently, your body needs about 250 grams of carbohydrates each day. If you're active, you need even more. However, loading up on fiber too quickly can overwhelm your gut, trigger endotoxin release, and make things worse. Start with easy-to-digest carbs like fruit and white rice. As your digestion improves, gradually add root vegetables and well-cooked legumes. Once your gut is more stable, you can introduce whole grains that you tolerate well.
- 3. Move regularly, gently, and consistently** – Physical activity helps regulate neurotransmitters and improves energy production. One major review found that exercise is 1.5 times more effective than leading antidepressants for reducing symptoms of depression and anxiety.

Prioritize daily walking and light strength training to support circulation, oxygenation, and lymphatic flow. Even 20 minutes outside makes a difference. Gradually work your way up to one hour daily for best results.

- 4. Get daily sun exposure to power your mitochondria** – Morning [sunlight](#) stimulates your mitochondria to produce adenosine triphosphate (ATP), the energy your body runs on, while reinforcing your [circadian rhythms](#). Expose your skin and eyes to early daylight each day. Avoid midday sun exposure until you've eliminated seed oils for at least six months. This gives your skin time to rebuild its resilience and reduce oxidative stress.
- 5. Support recovery with rest and routine** – Your body handles stress and repairs better when your days are steady. Keep consistent sleep and meal times to stay aligned with your circadian rhythm. In the evening, dim lights after sunset and avoid screens close to bedtime to support [high-quality sleep](#).
- 6. Increase your GABA levels safely** – If you're considering supplements, GABA may be one option to explore. Unlike psychiatric drugs that interfere with complex brain chemistry, GABA works with your body's existing calming pathways. Doses between 500 and 2,000 milligrams have helped ease anxiety and improve sleep, even in those already taking SSRIs.

Lower doses around 100 milligrams have also shown benefits in clinical studies. Combining GABA with L-theanine, an amino acid that acts as a natural GABA agonist, can further enhance these effects. To learn why GABA offers a safer and more effective path than SSRIs, read "[SSRI Drugs Can Cause Chronic Fatigue Syndrome](#)."

Frequently Asked Questions (FAQs) About Psychiatric Drugs

Q: How do I know if SSRIs are causing my symptoms or if it's just my depression getting worse?

A: If you're feeling emotionally numb, detached from others, or struggling with motivation or sexual function, don't assume it's just your depression acting up. These are well-documented effects of SSRIs, especially with long-term use. If your symptoms changed after starting the drug, it's worth questioning whether they're actually being caused or worsened by it.

Q: I've been taking antidepressants for years. Is it too late to stop?

A: No. Even if they helped early on, long-term SSRI use can bring hidden trade-offs. Reassessing doesn't mean you have to quit right away. It means asking whether your current state is really an improvement, and if there's a better path forward.

Q: I was prescribed benzodiazepines for sleep and anxiety. What should I watch out for?

A: Benzos can bring fast relief, but they often lead to tolerance, dependence, and difficult withdrawal, even when taken as prescribed. If you feel worse between doses, more sensitive to stress, or physically unwell when cutting back, your nervous system may already be destabilizing. This isn't anxiety returning – it's a drug effect most doctors overlook.

Q: My child was diagnosed with ADHD. Should I give them stimulant medications like Adderall?

A: You need to ask questions and explore all options. Stimulants can improve behavior in the short term, but they don't address root causes like diet, sleep, screen exposure, or school environment. Many children labeled with ADHD show signs of

blood sugar instability or metabolic imbalance. Before medicating, consider assessing nutritional and lifestyle factors that may be driving your child's attention challenges.

Q: What are safer ways to support my mental health without drugs?

A: You can support your mood, focus, and energy by restoring key physiological foundations. That means cutting linoleic acid from your diet, regulating your circadian rhythm with morning sunlight, improving gut health, and exercising daily. Supplements like GABA may also help without disrupting your brain chemistry.