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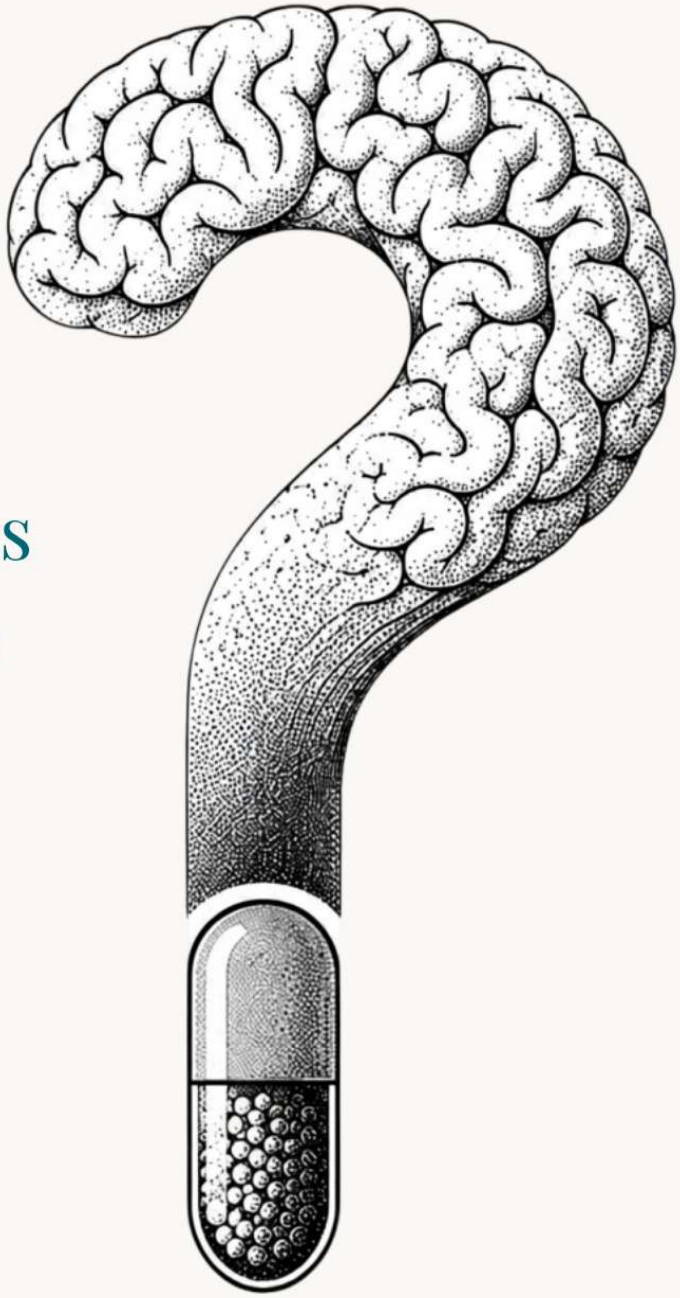
RESEARCH REPORT

Are You Adequately Informed?



A Survey of Patient Recall and Preferences Concerning SSRI Side Effect Information

How do people report their recall of informed consent and how does that compare to their preferences?

INNER COMPASS INITIATIVE

Research Institute Report July 2026

Are You Adequately Informed?:
A Survey of Patient Recall and Preferences Concerning SSRI Side Effect Information

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A research report from Inner Compass Research Institute
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About This Report

This report presents findings from a national online survey of 1,260 U.S. adults with a history of SSRI prescription. The study examines what side effect information respondents recalled receiving from prescribers, what information they would have preferred to receive, and the size of the gap between recalled education and patient preference.

The report focuses on informed consent as an ethical and practical issue in SSRI prescribing. It does not evaluate individual prescribing decisions, determine whether any specific provider met or failed to meet legal standards, or offer individualized medical advice. Instead, it contributes empirical data to a broader question: whether current prescribing conversations provide patients with the information they consider meaningful before starting SSRI prescriptions.

This report has been peer-reviewed according to the organization's tiered peer-review system. For questions regarding this process, please contact ICRI@theinnercompass.org.

About Inner Compass Research Institute

Inner Compass Research Institute supports independent research, analysis, and public education on psychiatric drugs, psychiatric diagnosis, informed consent, withdrawal, and mental health systems. The Institute works to expand access to clear, rigorous, and publicly available information so that individuals, families, clinicians, advocates, researchers, and policymakers can better understand the evidence and ethical questions shaping mental health care.

The Research Institute is part of Inner Compass Initiative, a 501(c)(3) nonprofit organization uniting people with firsthand experience of psychiatric diagnoses and drugs to chart new paths beyond the current limits of today's mental health industry.

The findings, interpretations, and conclusions expressed in this report are those of the authors and do not necessarily represent the views of all Inner Compass Initiative staff, fellows, advisors, or community members.

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Are You Adequately Informed?

A Survey of Patient Recall and Preferences Concerning SSRI Side Effect Information

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Abstract

Background: Informed consent, a cornerstone of ethical medical practice, remains understudied in the prescription of selective serotonin reuptake inhibitors (SSRIs). With expanding SSRI use and monoamine deficiency models undermined, this study assessed the extent of side effect education U.S. patients receive from prescribers, focusing on gaps that respondents perceived between the information they received and the information they would have preferred to receive.

Methods: We analyzed results from an online poll of 1,260 U.S. adults with a history of SSRI prescription, asked which of 11 common and less common biological side effects their prescriber had reviewed with them, and whether they would have preferred additional education. The effects and their prevalence ranges were drawn from a clinical psychiatric textbook and a literature review.

Results: A significant gap was identified between the education patients recalled receiving and the education they would have preferred ($p < 0.0001$). The largest gaps were for bleeding risk and difficulty discontinuing antidepressants. Only 0.6% ± 0.2% (SE) of respondents recalled being informed of all the 11 side effects, and only 11.2% ± 0.9% recalled being informed of all the side effects they wished to know about. Overall, 40.4% ± 1.4% of respondents disagreed or were neutral that they were appropriately informed, and 43.9% ± 1.4% agreed that more comprehensive education would have made them less likely to take the medication.

Conclusion: The findings show a notable gap between the information patients recalled receiving and the information they wish they had. This suggests that clinical practices fall short of the patient standard requiring disclosure of "all perils bearing significance," which would limit genuine risk-benefit analysis and autonomy. A lack of a baseline measure of information received when starting SSRIs prevents ruling out a recall bias and thus calls for a study of what happens in the consulting room when antidepressants are prescribed.

Keywords: SSRIs, Informed consent, Side effects, Patient education, Antidepressants, Medical ethics, Shared decision-making

Highlights:

- Significant gaps were found between recalled SSRI side effect education and current patient preference.
- Fewer than 1% of patients recalled being informed of all 11 side effects surveyed.
- 44% of patients believed they would have been less likely to take SSRIs if informed of the 11 risks presented to them in the poll.
- Withdrawal and bleeding risks represent the largest information gaps for patients, between recall and preference.
- Patient-centered prescribing is needed to meet ethical informed consent standards.

Introduction

This study examines American adults' assessments of the side-effect education they recalled receiving when prescribed selective serotonin reuptake inhibitors (SSRIs), as a component of informed consent. The rate of use of antidepressants and diagnoses of depression have both increased over past decades, while biological rationales for prescribing antidepressants, such as the chemical imbalance notion, have been seriously questioned. These confluences, in addition to a long-lasting debate over the genuine efficacy of SSRIs, suggested a need to check how ordinary patients view the information they recalled receiving from their prescriber concerning biological adverse or side effects of SSRIs.

From 1988-94, 2.4% of Americans were prescribed antidepressants (National Center for Health Statistics, 2011), increasing to 13.2% by 2015-18 (Brody et al., 2020). Concurrently, the rate of depression in Americans increased from 3.3% in 1991–1992 (Kessler et al., 2003) to 13.1% in 2021–2023 (Brody et al., 2025). SSRIs are prescribed to treat conditions purportedly beyond depression (Watson, 2005), including generalized anxiety, social anxiety, panic, obsessive-compulsive disorder, PTSD, eating disorders, and premenstrual dysphoric disorder. In 2023, an extensive review, finding no evidence of measurable serotonin defects in individuals with depression, dealt a serious blow to the validity of the chemical imbalance theory (Moncrieff et al., 2023).

The effectiveness of antidepressants has remained in question despite rising depression diagnoses and use of antidepressants. Most antidepressant trials are short, small, or sponsored by their manufacturers. The STAR*D (Sequenced Treatment Alternatives to Relieve Depression) trial remains a highly cited reference for antidepressant efficacy (Rush et al., 2006). Using creative statistical analysis, its authors reported a 67% "theoretical" cumulative remission rate, one established as 35% in a re-analysis 16 years later by Pigott et al. (2023), similar to the expected remission rate without intervention (Posternak et al., 2006). Kirsch et al. (2008) also highlighted the limited efficacy of widely prescribed antidepressants, reviewing all their 35 trials (including unpublished, with 5,133 patients), submitted to the FDA. The mean improvement on the Hamilton Rating Scale of Depression (HRSD) was 9.6 points for antidepressant users and 7.8 points for placebo users, a difference smaller than the 3-point threshold for clinical significance. That significance was reached only in patients with the highest baseline HRSD scores, those most depressed at the start of trials. This would suggest that most benefits seen in clinical trials of SSRIs

reflect non-specific helping factors shared across both drug and placebo arms. In 2018, a meta-analysis by Cipriani et al. found that antidepressants were all "more efficacious than placebo" in adults with depression but combined effect size was small at 0.3.

Informed consent

Informed consent, a cornerstone of ethical medical practice, embodies a patient's right to make decisions about their body and health. Shaped by evolving social values and key legal rulings, it requires a patient's permission before providing treatment. Valid consent mainly rests on disclosure by the provider and voluntary choice by the patient. Disclosure means sharing all information needed for a patient to make an informed choice, including the treatment's purpose, a clear description of the procedure, its risks, benefits, uncertainties, reasonable alternatives, and consequences of refusing care. However, providers need not list every possible side or adverse effect. The goal is to provide clear information for a reasonable health decision.

Among the legal cases that shaped current standards of informed consent, three deserve mention. Salgo v. Stanford (1957) established a physician's duty to disclose after a patient, paralyzed post-treatment, successfully argued he was not informed of risks. The court ruled that withholding facts necessary for "intelligent consent" makes a physician liable for ensuing risks. Natanson v. Kline (1960) required physicians to disclose what a typical practitioner would disclose under similar circumstances, including a treatment's risks, benefits, and alternatives (the "Reasonable Medical Practitioner Standard"). Canterbury v. Spence (1972), shifting to what a prudent person in the patient's position needs to know for informed choice, requires physicians to ensure patients are suitably informed of "all perils bearing significance" (the "Objective Patient Standard"). The last two standards are most common in the United States (Slobogin et al., 2020).

In this study we focus on information about adverse effects of antidepressants as a key component of "all perils bearing significance," i.e., what a prescriber ought to communicate to their patient before initiating the prescription, to obtain the patient's informed consent to be medicated. First, we review these adverse effects and summarize their observed incidence or prevalences as found in two main sources: (1) the American Psychiatric Association Textbook of Psychopharmacology (2024), and (2) peer-reviewed articles.

Adverse effects of antidepressants

"Adverse" and "side" effect are used interchangeably in this article. For example, some may view sedation as a beneficial effect in some instances, not uniformly negative. However, others can see the generic term "side" effect as minimizing adverse consequences of frequently occurring effects. Using a primary clinical textbook and numerous peer-reviewed articles known to the authors, we reviewed the prevalence of often-noted SSRI biological side effects. Challenges to present this information concisely include categorizing the effects by specific symptoms, describing their severity and duration, and consolidating their varying prevalence reports. To simplify, we distinguished between *common* (present in ≥ 10% cases) and *less common* (present in ≤ 1% cases) antidepressant side effects, following the literature review. Table 1 presents the information concisely.

APA Textbook of Psychopharmacology

The 2024 *American Psychiatric Association Publishing Textbook of Psychopharmacology* (Schatzberg et al., 2024) lists fluoxetine side effects, including agitation, anxiety, sleep disturbance, tremor, sexual dysfunction, headache, gastrointestinal issues, dry mouth, sweating, and weight changes. Specific prevalence rates are omitted. Arthralgia, lymphadenopathy, syndrome of inappropriate antidiuretic hormone secretion, agranulocytosis, and hypoglycemia are noted as "very rare." Bleeding risk is mentioned but considered a likely confounder due to pre-existing factors in patients rather than medication related. Agitation, anxiety, and insomnia are described as typically transient. SSRI discontinuation syndrome, including anxiety, irritability, and crying spells, is acknowledged, with tapering recommended.

Dopamine-induced hyperprolactinemia, extrapyramidal symptoms, sexual and cognitive dysfunction, galactorrhea, mammary hypertrophy, and gynecomastia are noted as "unlikely" related to the medication. Serotonin syndrome is described as a life-threatening condition, with symptoms like abdominal pain, fever, tachycardia, high blood pressure, altered mental state, and myoclonus. Recommendations are to avoid combining SSRIs with MAOIs.

Regarding suicidality, a subsection states that serotonin depletion is linked to suicide and violence, and antidepressants significantly improve or eliminate suicidal ideation and impulses for most patients. It claims that no evidence suggests SSRIs trigger emergent suicidal ideation beyond baseline rates observed in depression but later notes a risk of increased suicidal thoughts or behaviors under

antidepressants. Discussing the FDA's 2004 black box warning, the textbook mentions increased suicide attempts in children and adolescents due to the warning but labels the supporting study as weak.

Peer-reviewed literature - common side effects

Sexual dysfunction. A prospective study of 1,022 patients on different antidepressants reported rates of effects such as decreased libido, delayed orgasm, anorgasmia, erectile dysfunction, and reduced vaginal lubrication ranging from 58% for fluoxetine to 73% for citalopram, compared to 24% for mirtazapine and 8% for nefazodone, non-SSRI antidepressants (Montejo et al., 2001). Authors noted that sexual side effects are often underestimated. A survey of 401 individuals prescribed SSRIs reported a rate of 34% (Hu et al., 2004).

Emotional blunting. Some dismiss it as an irrelevant effect, often unnoted in studies (Hu et al., 2004), others see it as part of antidepressants' mechanisms of action (Moncrieff et al., 2006). Goodwin et al. (2017), surveying 669 depressed patients on antidepressants, found nearly half of them reported feeling emotionally numb, lacking emotions, or detached. Prevalence was consistent across SSRIs (e.g., 47% on fluoxetine, 43% on escitalopram).

Difficulty coming off SSRIs. Antidepressant withdrawal or discontinuation syndrome is debated, some seeing it as a re-emergence of depression symptoms. Health and Human Services Secretary Robert F. Kennedy, Jr. recently suggested that some find discontinuing SSRIs more challenging than discontinuing heroin (Mann & Riddle, 2025). A systematic review of 24 studies found that 56% of people attempting to stop antidepressants experience withdrawal, with 46% reporting severe symptoms (Davies et al., 2019). A later review of 79 studies estimated a 15% withdrawal incidence after accounting for placebo/nocebo effects, though without this adjustment, the prevalence would be 31% (Henssler et al., 2024). A more recent systematic review of 35 studies reported the incidence at 45.6% for SSRIs; the length of treatment showed a dose-response relation to the incidence (Zhang et al., 2025).

Digestive issues. Many studies report individual gastrointestinal side effect rates, making a combined incidence rate unclear. Hu et al. (2004) note nausea at 17.5%, weight gain at 17.2%, diarrhea at 15%, constipation at 12.5%, weight loss at 11.2%, and upset stomach at 11.0%; some overlap in

individuals is likely. Trindade et al.'s (1998) meta-analysis of 84 trials compared adverse effects of SSRIs and TCAs: SSRIs caused significantly more gastrointestinal issues, including diarrhea and anorexia; nausea occurred in 26% of SSRI and 12% of TCA cases.

Sleep disturbance. Trindade et al. (1998) also reported a 12% prevalence of insomnia and 10% of fatigue and drowsiness with SSRIs. A survey of 401 patients in their first three months of SSRI treatment noted frequent sleep-related side effects (Hu et al., 2004), most commonly drowsiness (38.4%) and insomnia (22.4%). Most side effects began within two weeks but persisted; many patients still experienced drowsiness and insomnia at three months.

Other. Trindade et al. (1998) and Hu et al. (2004) also noted headaches in 18-23% of patients, dizziness in 14-23%, and dry mouth 22-34%.

Peer-reviewed literature - less common but serious effects

Sodium imbalance. De Picker et al.'s (2014) literature review noted that hyponatremia is most common with SSRIs relative to TCAs and mirtazapine. Severe hyponatremia can extend hospital stays, and large sodium drops may cause metabolic encephalopathy or death. Incidence varies widely (0.06%–40%) due to study design and population, with higher risk in older adults and those on diuretics. Studies using a stricter threshold for blood level of sodium (<130 mmol/L) reported rates of 0.06%–2.6%.

Suicidal thinking and behavior. As noted in the *Textbook of Psychopharmacology,* the link between SSRIs and suicidal behavior remains debated despite an FDA boxed warning on the drug label. Some argue that increased risk is a confounder from mental disorders in those prescribed SSRIs. Others suggest that SSRIs may heighten suicide risk by boosting energy and activation in depressed individuals. Rates of SSRIs contribution to suicidal thinking and behavior vary based on definitions and the age of the population studied.

In the early 2000s the FDA commissioned an external, blinded review of adverse event reports from 23 randomized controlled trials (RCTs) of antidepressants in youth. Of note, participants with suicidal risk are typically excluded from RCTs of psychotropics. The review found a statistically significant increased risk of suicidality (70% higher) for those taking antidepressants compared to

placebo. Based on these findings, the FDA issued a boxed warning in October 2004, stating that antidepressants increased the risk of suicidality in children, adolescents, and young adults in short-term studies, updated in 2006 to more explicitly include young adult patients (Spielmans et al., 2020).

A meta-analysis about antidepressants by Hengartner et al's (2021) found that adults taking these medications had a 75% higher risk for suicide than the placebo group, even after adjusting for publication bias. A separate study (Hengartner et al., 2019) clarified the absolute risk: compared to the placebo group's risk of 0.04% for suicide and 0.3% for suicide attempts, the antidepressant group's suicide risk was triple (0.12%), and the risk of suicide attempts more than double (0.7%).

Concerns increase for adolescents and young adults. A reanalysis of the Treatment for Adolescents with Depression Study (Aboustate et al., 2025) found that the SSRI fluoxetine was not superior to placebo for adolescent depression on most measures. More common in the fluoxetine group than in other treatment arms combined were suicide attempts (4.2% vs 0.4%) and suicidal ideation (3.7% vs 1.8%).

Increased risk of bleeding. A meta-analysis of 42 observational studies involving over 1 million surgical patients found that SSRIs were linked to a significantly higher risk of this effect (Laporte et al., 2017). SSRI users' 41% increased bleeding risk raised the baseline rate from 2.5% to 3.5% in surgical patients, who are more prone to bleeding. The increased risk primarily involves gastrointestinal bleeding but also includes intracerebral hemorrhage. While most research has focused on surgical patients, seemingly narrowing its relevance, the average American undergoes 9.2 surgical procedures in their lifetime (Lee et al., 2008).

Sexual dysfunction after stopping SSRIs. Ben Sheetrit et al. (2023) analyzed 19 years of data on males aged 21-49. They estimated that persistent erectile dysfunction after discontinuation of serotonergic antidepressants occurred in 1 of every 216 male patients (a 0.46% risk). They conclude that this risk of irreversible sexual dysfunction should be disclosed to patients during informed consent before starting therapy. Tarchi et al. (2023)'s systematic review of studies of post-treatment sexual dysfunction suggests such dysfunction is reported to occur but estimates are not reliable at this time.

Serotonin syndrome or toxicity. This is a potentially serious drug reaction due to elevated serotonin levels in the nervous system. Ellahi (2015) estimated its incidence in SSRIs users at 0.5–0.9 cases per 1000 patient-months, suggesting an annual rate of 0.6–1.1%. Their review expands the concept of serotonin syndrome to include milder presentations often misdiagnosed, which may involve anxiety, confusion, restlessness, and agitation. Severe cases may involve life-threatening hyperthermia, rigidity, and multi-organ failure.

Table 1a lists the prevalence of adverse effects discussed in the *APA Textbook of Psychopharmacology* and Table 1b the prevalence of adverse effects reviewed in our literature review as well as the ranges derived from them that were used in this study's poll. Three months after the poll was conducted, we identified an independent review (Chan, 2026) of SSRI adverse effects and provide in Table 1b, for purposes of comparison, the prevalence ranges or other indications of frequency that it estimated for the adverse effects queried in the poll.

Table 1. Adverse effects prevalence in our review of the literature

a. *American Psychiatric Association Publishing Textbook of Psychopharmacology*

Effect mentioned without prevalence rates		
Mentioned	**Mentioned as "rare"**	**Mentioned as possibly due to confounders**
Agitation	Serotonin syndrome	Bleeding
Anxiety	**Mentioned as "very rare"**	Dopamine-related
Sleep disturbance	Arthralgia	Suicidality
Tremor	Lymphadenopathy	**Mentioned as "transient"**
Sexual dysfunction	Sodium imbalance	Agitation
Other (dry mouth, headache, sweating)	Agranulocytosis	Anxiety
SSRI discontinuation syndrome	Hypoglycemia	Insomnia

b. Peer-reviewed literature

Effect	**Prevalence range in studies reviewed**	**Prevalence range as stated in poll+**	**Prevalence in Chan (2026)^**
Common			
Sexual dysfunction	34-73%	40-70%	30-70%
Emotional blunting	43-47%	40-70%	46%
Withdrawal	31-56%	30-50%	15-56%
Gastrointestinal*	18-26%	20-25 %	up to 64%
Sleep disturbance*	12-23%	10-25 %	up to 59%
Other	14-35%	15-25%	
Less common			
Sodium imbalance	0.1-2.6%	<1-2%	0.9%
Suicidal thinking/behavior	0.1-0.7%	<1-1%	2%↑^

Bleeding#	1%	<1-1%	*40–70%*↑^
PSSD	0.5%	0.5%	0.5-5%
Serotonin syndrome	0.6-1.1%	<1-1%	"rare but severe"

*Those adverse effects were separated in individual symptoms in studies underestimating their overall prevalence
#Based on surgical patients
+Based on clinical experience, training, approximation, and review of the literature
^The publication also mentioned (1) cognitive slowing in up to 50-51%, (2) akathisia in up to 25%, (3) QTc prolongation as a cardiac side effect, but specifically in the context of citalopram and, to a lesser extent, escitalopram, (4) sodium imbalance in up to 10% of the elderly, (5) suicidal thinking as 2% higher than placebo specifically in youth, (6) bleeding as 40 to 70% higher than baseline risk.

Prior studies of the informed consent process and antidepressants

Despite the widespread use of antidepressants, research directly assessing the exchange of information between prescriber and patient remains sparse. Prior studies highlight general deficits in communication but have largely focused on patients' "understanding" of side effects or satisfaction with the information provided, rather than measuring a discrepancy between disclosures and patient preferences. To our knowledge, the "information gap," defined here as the difference between the risks a patient recall being told and the risks they retrospectively state they would have preferred to know, has not been previously quantified in a general population sample. The following studies represent the literature on which this investigation builds.

Bahrick and Harris (2009) previously pointed to an "informed consent accountability gap" regarding sexual dysfunction, highlighting the discrepancy between the high rate of sexual side effects (up to 73%) reported in prospective studies versus the lower rates (2–16%) mentioned in drug inserts. However, their theoretical review did not examine the quality of information provided to patients by their providers, nor did it quantify the patients' preference to be informed about such side effects.

Among 424 Japanese outpatients, Kudo et al. (2015) found that psychoeducation regarding depression was insufficient, particularly concerning antidepressant side effects. They used a questionnaire to assess patient understanding of symptoms, treatment duration, and side effects. Half (50.6%) of the participants reported receiving an explanation from their doctor about the side effects of their antidepressants. Self-rated understanding of side effects was significantly higher among those who had received an explanation compared to those who had not. Those questionnaires were further analyzed by Tomita et al. (2018), showing lower understanding of side effects in older adults.

Cartwright et al. (2016) analyzed data from 180 long-term (3-15 years) users of antidepressants extracted from a larger anonymous online survey in New Zealand. Participants completed rating scales regarding their levels of depression before and during antidepressant treatment, perceived effectiveness, impact on quality of life, and perceived adverse effects. In an analysis of two open-ended questions, authors report that 11.1% of respondents spontaneously expressed a need for more accurate or comprehensive information regarding long-term risks and withdrawal.

Surveying 1,008 UK antidepressant users, Read et al. (2017) found that less than half (48.4%) of those taking only antidepressants felt they had been given enough information about their medication, including side effects and withdrawal symptoms, whereas 40.4% stated they did not receive enough information. Older patients were significantly less likely to report being adequately informed than younger patients. Some testimonials recounted prescribers dismissing patients' concerns; one participant recalled a doctor stating that their medication had "no known side effects." The authors concluded that to ensure informed consent, prescribers must provide all patients with comprehensive information about the full range of potential adverse effects.

Methods

Administration of poll and data integrity precautions

The Inner Compass Initiative enlisted Centiment, a company that matches customers' specific sample eligibility criteria to population characteristics, to conduct this online poll of U.S. adult SSRI users about potential side effects they were informed of by their prescriber. Centiment shares polls with registered partners and social media platforms, using targeted ads to recruit voluntary participants, who receive modest monetary compensation. The poll was distributed by Centiment in October 2025. Data were obtained by the authors free of any respondent identifiers.

Centiment provided a description of the safeguards it commonly uses to ensure the quality of the data it collects in polls. including IP verification, to confirm that a respondent's location matches their profile geography; proxy detection, to identify users attempting to misrepresent their location; and visible and invisible ReCaptcha to ensure respondents are not bots. To prevent users from manipulating links to seek a reward without completing the poll, Centiment employs a cryptographic hash function. Furthermore, it builds a "fraud score" for every respondent by evaluating signs of disengagement, such as speeding or straightening, which bars certain respondents. Finally, the

company utilizes duplication prevention by keeping detailed records on which surveys a respondent has entered.

Description of poll

The poll contained 15 questions, four of them allowing multiple responses. It first asked participants if they were ever prescribed SSRIs, with named examples; an affirmative answer was required to proceed. It then collected data on gender, age, location, and household income. Next, in two questions, it inquired about whether each of six "common" and five "less common but serious" SSRI side effects "were reviewed with you by your prescriber." Then, providing the prevalence rate for each, asked, "Which of these side effects would you have wanted to be informed about by your prescriber?" Then, participants were asked if they agreed that they were "appropriately educated on the risk of side effects of SSRIs, and if having "been informed about all listed SSRI side effects before starting would have affected your decision to take them." Finally, the poll asked about the duration of their SSRI use, the specialty of the prescriber (psychiatrist, general practitioner, nurse practitioner), and number of meetings with that provider. To ensure attentiveness to the poll, one test question was added.

Analysis

The primary goal of the analysis was to identify and determine the statistical significance of any "gap" between reported patient SSRI education (i.e., whether a side effect was reviewed) and preference (i.e., whether they preferred that such an effect be reviewed). A series of McNemar's tests were conducted, appropriate for comparing paired, dichotomous data. For each of the 11 side effects, the test compared the proportion of patients who reported it as reviewed versus the proportion who preferred that it be reviewed. A Bonferroni correction was applied to account for multiple comparisons, establishing a statistical significance threshold of $p < 0.0045$.

To convey the precision of sample estimates, statistics for survey responses are reported as percentages alongside their standard errors (± SE). Smaller SEs mean the estimate is more precise. As a rule of thumb, the "true" percentage is likely to fall within about 2 SEs above or below the reported value. For example, if 11.2% ± 0.9% reported a particular experience, a realistic percentage in the broader population is likely to be between about 9.4% and 13.0%.

Results

Respondents

Of 1,982 individuals who started the poll, 1,275 (64.3%) indicated that they had been prescribed SSRIs, of whom 15 did not complete the poll, leaving 1,260 completers included in the final analysis. Table 2 shows a nearly even gender split between male (48.3% ± 1.4%) and female (51.3% ± 1.4%) respondents, with 0.4% ± 0.2% identifying as nonbinary.

Table 2. Demographics and respondent characteristics (n = 1,260)

Gender	Age	US Region	Household income
Male: 48.3%	18-34: 26.2%	Northeast: 25.1%	<$50k: 29.5%
Female: 51.3%	35-54: 48.4%	Midwest: 26.3%	$50k-$100k: 42.5%
Non-binary: 0.4%	55+: 25.5%	South: 29.2%	>$100k: 27.4%
		West: 19.4%	Prefer not to say: 0.6%

SSRI use

Among the 1,260 respondents, 47.2% ± 1.4% were prescribed SSRIs by a primary care practitioner, 40.9% ± 1.4% by a psychiatrist, 11.1% ± 0.9% by a nurse practitioner, and 0.8% ± 0.3% other. Of the respondents, 4.6% ± 0.6% reported having met with their provider once, 40.5% ± 1.4% 2 to 5 times, 22.8% ± 1.2% 6 to 10 times, and 32.1% ± 1.3% more than 10 times. Concerning duration of treatment, 15.6% ± 1.0% reported having been prescribed for less than 6 months, 27.0% ± 1.3% between 6 months and 1 year, 31.3% ± 1.6% for 1 to 5 years, and 26.2% ± 1.2% more than 5 years. These durations are consistent with data suggesting that antidepressants are prescribed for much longer periods than they were tested for in clinical trials (Ward et al., 2025).

SSRI side effect information

Biological side effects of SSRIs recalled as reviewed in prior patient encounters are shown in Table 3. The most recalled common effect reviewed was sleep, the least was SSRI withdrawal; 13.6% ± 1.0% of respondents answered that no common effects were reviewed with them, and 4.0% ± 0.6% that all had been reviewed. Among less common side effects of SSRIs, the most recalled reviewed was suicidal thinking and behavior, the least was sodium imbalance; 30.1% ± 1.3% of respondents answered that none were reviewed with them and 2.4% ± 0.4% that all had been reviewed.

Only 7 individuals, (0.6% ± 0.2% of completers), indicated that all 11 listed effects had been reviewed; 11.3% ± 0.9% reported having none of them reviewed.

Table 3. Respondents' reports of SSRI side effects information

Common side effects	Recalled as reviewed	Preferred had been reviewed	Gap
Sleep	49.0%	67.9%	18.9%
Emotional blunting	46.3%	69.2%	22.9%
Digestive	44.8%	65.2%	20.4%
Sexual dysfunction	40.7%	69.0%	28.3%
Other	32.4%	58.3%	25.9%
Difficulty coming off	29.8%	62.9%	33.1%
No common side effect	13.6%	3.8%	
All common side effects	4.0%	41.7%	
Less common side effects			
Suicidal thinking and behavior	47.8%	73.4%	25.6%
Serotonin syndrome	25.3%	67.0%	41.7%
Sexual dysfunction after cessation	25.1%	67.1%	42.0%
Bleeding	17.5%	63.7%	46.1%
Sodium imbalance	15.6%	59.4%	43.8%
No less common side effect	30.1%	8.3%	
All less common side effects	2.4%	47.1%	
No listed side effect	11.3%	2.1%	
All listed side effects	0.6%	38.2%	

*Note: Standard errors for all percentages range from ± 0.2% to ± 1.4%.

SSRIs education vs. preference

Common side effects of SSRIs reported as preferred they had been reviewed are shown in Table 3, highlighting the gap between preferred and recalled reviewed. Overall, 74.4% ± 1.2% of participants had indicated one or more preferred common side effects not recalled reviewed, averaging 2.1 unreviewed side effects. The largest observed gap was for difficulty coming off SSRIs (withdrawal), with 62.9% ± 1.4% preferring it had been reviewed but only 29.8% ± 1.3% recalling it reviewed. Table 3 also shows responses concerning less common effects: overall, 75.6% ± 1.2% of participants had one or more less common side effects not reviewed with them, averaging 2.3 effects not reviewed with them. The largest gap was for bleeding, with 63.7% ± 1.4% preferring it had been reviewed but only 17.5% ± 1.1% recalling it so. A total of 141 respondents (11.2% ± 0.9%) felt they had been informed about all the side effects they wanted to know about. On average, respondents

indicated a preference for being informed about 4.3 (SD 3.27) additional side effects beyond those recalled being reviewed: 2.1 (SD 1.9) common and 2.3 (SD 1.83) less common.

In summary, for each of the 11 common and less common side effects presented in this poll of SSRI users, McNemar's tests identified a statistically significant gap ($p < 0.0001$) between reported preference for information and information retrospectively recalled received.

Appropriateness of SSRI education and effect on decision to use

Nearly 60% respondents either somewhat (36.6% ± 1.4%) or strongly agreed (23.0% ± 1.2%) that they had been appropriately educated; while the remaining 40% did not agree (combining 16.3% ± 1.0% somewhat and 10.2% ± 0.9% strongly not agreeing, and 13.9% ± 1.0% neither agreeing nor disagreeing). When asked how education on side effects would have affected their decision to take SSRIs, 43.9% ± 1.4% of respondents indicated it would have made them less likely to take SSRIs, 40.6% ± 1.4% stated that it would have had no impact on their decision, and 15.5% ± 1.0% reported they would have been more likely to take SSRIs.

Discussion

Limitations

This study has several limitations to consider when interpreting the results. First, assessing the completeness of informed consent by comparing the information respondents report receiving with the information they retrospectively state they would have preferred to receive is a methodologically challenging approach. Without a verifiable baseline measure of information received, the "gap" between "received" and "wished had been received" is less certain. Respondents' current attitudes, experiences, and satisfaction with their antidepressant treatment may have distorted their rating of original events (hindsight bias) or, more generally, respondents may not have clearly remembered the details of conversations with their prescribers or what they had preferred to know about their medication (recall bias), particularly if the prescription was initiated years before. As such, the data doesn't prove that inadequate informed consent occurred but that patients report significant gaps between what they remember being told and what they now wish they had been told. Alternatively, many respondents have had multiple opportunities to receive such information over years of treatment, expanding their knowledge over individuals provided informed consent at their first visit.

Second, participants who voluntarily register for such online platforms may differ systematically and in unknown ways from the general patient population (selection bias): for example, they might be more tech-savvy or hold sharper opinions about healthcare experiences. In this sample, the near-even gender ratio in this sample differs with that observed in nationally representative samples of US adults that aim to estimate the prevalence of antidepressant use, where twice as many women than men typically report such use (Oguntuase et al., 2025). Also, most patients in this sample frequently visited their providers and were prescribed SSRIs for over a year, likely representing more knowledgeable respondents than people newly prescribed SSRIs. Third, the side effect prevalence rates provided to respondents varied widely across studies and incorporated our judgments of the studies and our clinical experiences. These rates could have influenced how respondents answered questions about their preference for information about an effect. Fourth, the list of side effects presented was not comprehensive. For example, it did not include a common effect such as weight gain or a less common effect such as akathisia (Chan, 2026). A different list might have elicited somewhat different responses. Finally, this study did not measure variables that might explain why information might not be provided in typical prescriber-patient encounters, such as clinical time constraints, the severity of a patient's condition, or the addition of written educational materials.

Findings

The findings of this national poll, the first of its kind to our knowledge, suggest a disconnect between the principles of informed consent and the lived experience of U.S. patients prescribed SSRIs. In this survey, close to 45% of respondents did not agree that they were appropriately educated about 11 common and less common but serious biological side effects. The average patient would have preferred to be informed of 4.3 more effects than they say were reviewed with them. The widest information gaps were for the less common but serious potential non-psychiatric risks like bleeding (18% recalled reviewed vs 64% preferred) and sodium imbalance (16% recalled reviewed vs 60% preferred), and the common difficulty of coming off antidepressants (30% recalled reviewed vs. 63% preferred).

These results challenge the adequacy of contemporary prescribing practices in meeting the objective patient standard established in Canterbury v. Spence (1972) and considered most conventional in the U.S., which stipulates informing patients of "all perils bearing significance." The present findings suggest that the standard patient prefers comprehensive information that they are not receiving.

Fewer than 1% of respondents reporting they were educated on all 11 effects listed in the survey. The process of informed consent for SSRIs appears to be more of a procedural formality than a dialogue enabling informed choice. Ultimately, the requirement of revealing side effects is based on whether that disclosure would have changed the opinion of the patient; as stated in Cobbs v. Grant (1972) "the test for determining whether a potential peril must be divulged is its materiality to the patient's decision."

The recalled information gap highlighted by the present snapshot of SSRI user views matters, given the evolving understanding of SSRIs. As the "chemical imbalance" theory has been sharply undermined (if not laid to rest) and the long-term efficacy of the drugs shown to be half that promoted in landmark trials like STAR*D, the rising prescription of SSRIs over the past decades has rested on shaky foundations. Thorough and transparent discussions of risks with prospective patients seem paramount today. That 44% of patients state that a more comprehensive understanding of side effects would have made them less likely to take the medication points to a prescriber-patient communication that may fail to uphold patient autonomy. On the other hand, only slightly fewer respondents (41%) expressed that more education than they received would not have affected their decision, which could be taken as an indirect measure of satisfaction with the decision to use SSRIs in this sample.

Over half of respondents (57.5%) reported using SSRIs for more than a year, a duration far exceeding that of the typical clinical trials designed to test their safety and efficacy. This disconnect between trial duration and real-world use underscores the ethical imperative for prescribers to discuss the potential for long-term complications and dependency, a topic our findings suggest is frequently neglected.

Conclusion

This survey indicates that approximately 40% of U.S. adults prescribed SSRIs do not feel they were appropriately educated by their prescriber on the potential side effects of these drugs. The gaps in recalled information on common issues like sleep disturbance and difficulty coming off SSRIs, to less common but severe outcomes like PSSD and serotonin syndrome, would prevent patients from engaging in a genuine risk-benefit analysis. This would undermine the ethical foundation of informed consent and shared decision-making. To better align clinical practice with ethical

standards, a shift toward a more transparent, patient-centered approach to antidepressant prescribing appears needed. Future studies drawing samples from more precisely mapped patient populations, expanding the queries around SSRI education, and adding prescribers or prescriber-patient dyads as respondents, as well as recordings of encounters in the consulting room, would help to test the validity of the present findings and better describe the practice of informed consent. Researchers, professional organizations, and funding agencies can address this important gap in knowledge and should prioritize rigorous investigation on the practice of informed consent with respect to the prescription of SSRIs.

Ethical Considerations and Informed Consent

The data used in this study were collected by Centiment from a sample of willing respondents on behalf of the Inner Compass Initiative. Data were delivered to the researchers in a fully de-identified format, ensuring the privacy and anonymity of all participants. This analysis of de-identified data was conducted to evaluate patient education standards.

Declaration of competing interests

N.B. and D.C. are senior fellows at the Inner Compass Research Institute, which is affiliated with the Inner Compass Initiative, the organization that commissioned and administered the poll analyzed in this study. They have not received any remuneration for this project. None of the authors receive any money from pharmaceutical companies.

The Inner Compass Initiative is a 501(c)(3) nonprofit organization uniting people with firsthand experience of psychiatric diagnoses and drugs to chart new paths beyond the current limits of today's mental health industry.

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