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FORUM: PHARMACOLOGICAL ALIENATION, PHENOMENOLOGICAL SELF AND PHENOMENOLOGICAL PSYCHIATRY

Pharmacological alienation and the phenomenological self: SSRI use, bodily attunement, and phenomenological psychiatry

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Summary

Background: *Phenomenological psychiatry, drawing on Heidegger, Merleau-Ponty, and Thomas Fuchs, particularly the concepts of Stimmung, leibliche Resonanz, and being-in-the-world, initially engaged selective serotonin reuptake inhibitors (SSRIs) with cautious optimism. Accumulating evidence now suggests their characteristic effects constitute a distinct form of ontological disturbance not yet fully addressed in psychiatric practice or the philosophy of psychopharmacology.*

Subjects and methods: *This paper proceeds through textual and conceptual analysis rather than primary empirical research. It draws on the empirical phenomenological studies of Teal (2009) and Bornäs and Sandell (2017), documenting first-person patient accounts of SSRI treatment, alongside the philosophical analyses of Svenaeus (2006, 2007) on illness and homelikeness. These are read against the biochemical critique of the serotonin hypothesis advanced by Moncrieff et al. (2022). The method is structural comparison: identifying convergences between phenomenological accounts of disrupted bodily resonance and empirical findings undermining the biochemical rationale for SSRIs, to determine whether both critiques support a shared conclusion.*

Results: *SSRIs appear to produce pharmacological alienation: a state in which the lived body loses resonant responsiveness to the world without restoring the deep temporal and relational engagement constitutive of authentic being-in-the-world. Rather than repairing disrupted attunement, SSRIs substitute a flattened mode of bodily experience for the responsiveness they were meant to restore. This phenomenological finding is structurally convergent with Moncrieff et al.'s biochemical critique. Both lines of evidence independently undermine confidence in SSRIs as agents that restore, rather than further disrupt, engagement with the world.*

Conclusion: *Phenomenological psychiatry, having extended initial charity to the SSRI paradigm, now has a principled basis for rejecting it. The convergence of biochemical and phenomenological critique points to a deeper mismatch between pharmacological mechanism and the ontological structure of depressive experience, not merely insufficient efficacy. A genuinely phenomenological psychiatry would restore bodily resonance through metabolic, relational, and environmental means rather than pharmacological suppression of attunement.*

Keywords: *SSRIs, phenomenological psychiatry, attunement, bodily resonance, pharmacological alienation*

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INTRODUCTION: PROZAC AND THE PHILOSOPHICAL EAR

This forum accompanies the announcement of a forthcoming monograph by Toma Gruica, titled *Depression, Serotonin, and Embodiment: A Phenomenological and Critical Examination of SSRI Pharmacotherapy*, which will be published next year by *Psychiatria Danubina*. The forum is organized around the article "Pharmacological Alienation and the Phenomenological Self" and brings together a series of commentaries addressed to it. The monograph characterizes life under SSRI treatment as a distinct configuration of bodily attunement and selfhood with phenomena of its own, a characterization that places the notion of restored normality under critical scrutiny. The monograph situates this within the wider debate on depression, serotonin, and the lived body. The contributions gathered here are intended to open that debate to the readers of the journal in advance of the publication of the book.

In 1993, Peter Kramer famously proposed that psychiatrists should "listen to Prozac", that the behavioral and affective changes induced by fluoxetine might teach us something important about the biological underpinnings of personality and mood (Kramer, 1993). Kramer's

metaphor of listening was chosen deliberately, and it has a certain ironic resonance. Listening implies receptivity, attunement, an orientation toward meaning. Whether Prozac itself can be listened to, whether it discloses something about the structures of human selfhood or only papers over them, is the question that phenomenological philosophy has been attempting to answer for the past three decades. The question has become considerably more urgent. SSRIs are now among the most widely prescribed drugs in the Western world, with estimates suggesting that one in eight adults in Europe and the United States has taken such medication in the past year. The rate has more than doubled among adolescents since 2006. Yet over this same period, rates of depression have risen sharply rather than declining, and the conceptual foundations of SSRI pharmacology, the so-called "chemical imbalance" or serotonin deficiency hypothesis, have been subjected to a systematic and, by now, largely decisive empirical critique. A landmark umbrella review published in Molecular Psychiatry in 2022, examining seventeen prior studies and numerous meta-analyses, found no consistent evidence linking low serotonin to depression across any of the major lines of inquiry that had been proposed.

This paper approaches the SSRI question from a different angle than the biochemical critique, though one that ultimately converges with it. It asks: What does taking an SSRI feel like from the inside? And what does phenomenological philosophy, the tradition most rigorously concerned with the structure of lived experience, make of those feelings? These are not merely descriptive questions, instead, they bear directly on whether SSRIs constitute a genuine therapeutic intervention in the life of a depressed person, or whether they replace one form of ontological disturbance with another.

DEPRESSION AND THE PHENOMENOLOGICAL BODY

Any phenomenological approach to depression must begin with Heidegger's analysis of Stimmung in Being and Time. For Heidegger, moods are not secondary additions to an already-constituted subject who then "has" feelings about a world she encounters. They are, rather, the primary mode through which the world is disclosed as meaningful at all (Heidegger, 1986). The concept of Befindlichkeit, usually translated as "state-of-mind" or "attunement", captures the way in which the human being always already finds itself disposed toward the world in some particular way before any explicit act of cognition or will. One does not first perceive a situation as neutral and then decide to feel anxious about it; anxiety is already there, coloring the entire field of disclosure, making certain possibilities appear threatening and others invisible. This means that to be depressed, in the Heideggerian sense, is not simply to have a bad feeling overlaid on an otherwise intact engagement with the world. Depression fundamentally alters the structure of world-disclosure: possibilities shrink, things lose their Zuhandenheit (readiness-to-hand), the future appears closed, and the weight of facticity, one's thrownness, becomes overwhelming. The depressed person is not simply unhappy; their temporal horizon is contracted, their being-with-others is severed, and their most basic capacity for projection, for understanding themselves as having a future toward which they can comport themselves, is impaired.

Two of Heidegger's analyses of specific moods are particularly germane here. In Being and Time, anxiety (Angst) is described as a mood in which the worldly Bewandtnis, the network of meaningful significance, becomes radically uncanny: things lose their familiar, "at home" quality, and the subject is thrown back upon its naked thrownness (Heidegger, 1986, p. 184-191). In The Fundamental Concepts of Metaphysics, deep boredom is analyzed as a state in which entities cease to offer any call whatsoever: the world is there, but it no longer engages (Heidegger, 1983). Both moods, Heidegger argues, can be philosophically productive by forcing confrontation with the bare structure of existence. But both, in their pathological forms, constitute forms of ontological imprisonment (Heidegger, 1983, 1986).

Heidegger's account of attunement, while indispensable, risks remaining too abstract, it articulates the formal structure of world-disclosure without attending sufficiently to the body that enacts it. It is Merleau-Ponty who supplies this bodily dimension, arguing in the Phenomenology of Perception that the subject of experience is not a pure consciousness but a corps propre, a lived body, that is the original site of intentionality, perception, and world-engagement (Merleau-Ponty, 2012). The lived body is not an object among objects but the zero-point of orientation, the moving ground from which the world is perceived and engaged. Crucially for the analysis of depression, Merleau-Ponty's account implies that disorders of bodily being are not merely somatic events but disruptions of the entire structure of world-engagement. If the lived body is the organ of world-disclosure, then any pathology that stiffens, alienates, or narrows the body's responsiveness will have immediate consequences for the subject's capacity to inhabit a meaningful world. The phenomenologically depressed body is not simply a body that feels heavy or fatigued; it is a body that can no longer

serve as a transparent medium of engagement with the world, that has become opaque, reified, thematic, what Fuchs will later call korporifiziert.

Thomas Fuchs (2000): Bodily Resonance and Its Loss

The most influential synthesis of the Heideggerian and Merleau-Pontian frameworks for phenomenological psychiatry is found in the work of Thomas Fuchs, particularly his Psychopathologie von Leib und Raum (2000) and his subsequent papers on depression and embodiment (Fuchs, 2000, 96-110). Fuchs introduces the notion of leibliche Resonanz, bodily resonance, to describe the lived body's capacity to "pick up" moods from the environment, to vibrate in response to the affective qualities of situations, persons, and places. The body, on this account, functions as a resonance box for meaning: it does not passively receive the world but actively amplifies and modulates its affective address. In his programmatic chapter on phenomenology and psychopathology, Fuchs (2010, p. 546) describes phenomenology as the systematic investigation of the structures of subjective experience and therefore as the foundational science of psychopathology, which methodically suspends assumptions about causal explanation while furnishing a framework for analyzing subjectivity and its disturbances in mental disorders.

Depression, for Fuchs, is paradigmatically a loss of this resonance (Fuchs, 2000; Fuchs, 2010). The body becomes korporifiziert, objectified, heavified, stiffened, and can no longer vibrate in response to the world's call. The depressed person does not simply feel sad; the entire relational fabric of the world becomes unresponsive. Others' emotional expressions no longer reach them. Music does not move them. Pleasures do not attract. The body, instead of being a transparent medium through which the world is inhabited, becomes a heavy, alien thing that must be dragged through the day. Fuchs later develops this account in terms of what he calls "intercorporeality" and "interaffectivity", the ways in which human bodies resonate with one another in shared moods, co-regulated through face, posture, gaze, and touch (Fuchs, 2013, p. 219-238). Depression disrupts this intercorporeal resonance: the depressed person becomes, as Fuchs puts it, isolated within an "affective glass wall" that prevents the reciprocal communication of feeling that constitutes normal social life. This image will recur, with uncanny precision, in the phenomenological accounts given by SSRI users.

Svenaeus (2007) extends Fuchs's framework by proposing a "spectrum of bodily resonance" stretching from normal attuned responsiveness, through personal idiosyncrasies and sensitivities, to full pathological disconnection. On this spectrum, depression occupies an extreme in which the body is "severely out of tune, or even devoid of tune and thus useless as a tool of resonance." The concept of unhomelikeness (Unheimlichkeit), drawn from Heidegger's analysis of anxiety, provides the existential counterpart to this bodily loss: the depressed person is no longer at home in the world, no longer able to settle into the familiarity and meaning-density of shared practical life (Heidegger, 1986; Svenaeus, 2001).

THE INITIAL PHENOMENOLOGICAL ENGAGEMENT WITH SSRIS: "PHENOMENOLOGY LISTENS TO PROZAC" (2006).

When Fredrik Svenaeus turned the phenomenological apparatus toward the SSRI question in his 2006 essay "Phenomenology Listens to Prozac," his position was notably measured (Svenaeus, 2006, p. 164-183). Writing at a moment when the serotonin hypothesis had not yet been subjected to decisive empirical scrutiny and when the long-term consequences of widespread SSRI use were still poorly understood, Svenaeus approached the drugs as a philosophical puzzle rather than a medical scandal. His central question was Kramer's: do SSRIs alter the self, and if so, in what sense?

Svenaeus's framework, developed through Heidegger's concepts of attunement and world-disclosure, and Fuchs's concept of bodily resonance, allowed him to articulate a philosophically coherent account of how SSRIs might work. If depression is a loss of bodily resonance, a stiffening of the body-as-resonance-box, then a drug that modulates serotonergic transmission might plausibly restore some of that resonance by altering the physiological substrate of attunement. Svenaeus grants this possibility: "The phenomenological notion of 'bodily resonance' explains well why serotonin levels could be relevant for feelings and being-in-the-world" (Svenaeus, 2006, p. 178-179). However, Svenaeus's 2006 essay is far from a simple endorsement of SSRIs. He raises three concerns that, in retrospect, anticipate the more critical positions that would develop over the following decade. First, he notes the underdetermination of the biological by the phenomenological: serotonin levels might be causally relevant to depression, but so are the life-world conditions, relational, cultural, political, that generate states

of unhomelikeness. To treat the symptom biochemically while ignoring the existential situation is, at best, to manage a fire without addressing its fuel. Second, he raises the question of pharmacological enhancement: do SSRIs alter the personality, and if so, is the result an authentic self or a pharmaceutical artifact? Third, and most presciently, he points to the cultural dimension: the "popularity of the SSRIs can be explained not only by defects of our biological makeup that we are now able to treat, but also by the presence of cultural norms of self-styling, which pharmaceutical companies have been quick to exploit."

In the 2006 essay, Svenaeus stops short of condemnation: "I am convinced that SSRIs have helped millions of people who, for medical, psychological, or political reasons, had no other realistic option." This sentence deserves careful reading. It is not an endorsement of SSRIs as a treatment of choice, but an acknowledgment of constraint: for people trapped in situations offering no other means of relief, pharmacological management of suffering may be the only livable option. This is a concession to structural necessity, not an affirmation of therapeutic adequacy (Svenaeus, 2006, p. 179).

Svenaeus (2007): The Question of Self-Change

In his 2007 article "Do Antidepressants Affect the Self?," Svenaeus deepens the phenomenological analysis, focusing specifically on the question of identity (Svenaeus, 2007, p. 153-166). If the self is constituted through its attuned being-in-the-world, if, as Heidegger insists, Dasein is its disposedness, then any pharmacological alteration of attunement is ipso facto an alteration of the self. The question is not whether SSRIs change the person but what kind of change they produce and whether that change is to be welcomed. Svenaeus draws a philosophically important distinction between two kinds of bodily change. The first is restoration: a return to a prior range of bodily resonance that has been pathologically narrowed or distorted. The second is modification: an alteration that produces a new attunement style not previously characteristic of the person. Depression, on the first model, involves a pathological contraction of resonance; recovery involves returning to a broader range. But SSRIs may do neither: they may produce a specific kind of attunement, a calm, disengaged, emotionally flattened mode of being, that is not a return to the pre-depression self but the installation of a novel one.

Svenaeus acknowledges the philosophical difficulty here: "The dividing line between personality and pathology is necessarily vague, since different cultures and societies favor differently attuned self-styles as paradigmatic of the normal and good life." (Svenaeus, 2007, p. 163). This observation opens onto a critical sociology of psychiatric norms: the "normal" attunement that SSRIs tend to produce, functional, emotionally even-keeled, productive, unreactive, maps suspiciously well onto the demands of contemporary neoliberal work culture. What phenomenological psychiatry risks, if it is insufficiently critical, is naturalizing a pharmacologically induced attunement that serves economic rather than existential needs.

Writing in 2007, Svenaeus did not press this critique to its conclusion. But the materials for a more radical analysis were already present in his framework. The concept of bodily resonance implies that there is an authentic range of attunement, not a single correct mood, but a span of responsiveness to the world's affective address, and that anything that systematically narrows this span, whether by pathological process or pharmacological intervention, represents a diminishment of being-in-the-world rather than its restoration.

Teal (2009): The A-Motional World

The most rigorous empirical phenomenological investigation of SSRI experience is Jay Teal's 2009 study, "Nothing Personal," published in the Journal of Phenomenological Psychology (Teal, 2009). Drawing on interviews with seven participants across three distinct stages of SSRI use, initial distress, relief, and functional establishment, Teal identified what he calls the "essential lived characteristic" of being-on-an-SSRI: an "increased distance or disconnection between takers and their worlds." What makes Teal's study philosophically significant is its fidelity to the phenomenological framework. Rather than simply cataloguing symptoms, sexual dysfunction, emotional blunting, weight gain, it attends to the structural transformation of the participants' world-relation. The core finding is not that SSRI users feel less bad but that the very mode by which the world addresses them undergoes a fundamental change. In Teal's resonant formulation, the drug creates an "a-motional" acceptance of what occurs: a state in which the world is present to the person, cognitive understanding is intact, but the world no longer reaches them, it no longer solicits a personal response.

Participants describe this structure with remarkable consistency. Jenny reports: "I could 'hear' the anxiety yelling somewhere inside me, but it was muffled, as if someone had put up soundproofing glass." Tom speaks of "a sort of invisible barrier that was just bouncing me off."

These are not simply metaphors of relief; they are phenomenological descriptions of a fundamental alteration in the relationship between selfhood and world-disclosure. The world is no longer for them in the sense Heidegger intends: it no longer calls them, no longer holds possibilities that matter (Teal, 2009, p. 29).

Crucially, this structural change extends beyond the amelioration of suffering. Participants find themselves unable to be moved by things that should move them: they cannot reach the joy that a film among friends once offered; they find their temper gone and, unexpectedly, miss it; they know intellectually that a situation is significant but cannot feel its weight. The world presents itself as cognitively legible but affectively neutral, what Teal calls "a-motional" (Teal, 2009, p. 31). In Heideggerian terms, the drug does not restore lost possibilities; it installs a mode of being in which possibilities no longer have existential urgency. The future is not reopened; it is simply made irrelevant.

Teal's structural analysis converges with Fuchs's account of bodily resonance. If depression involves the loss of resonance, the body becoming unable to vibrate in response to the world's address, then the SSRI-induced state involves something subtly different but equally troubling: a kind of muted resonance, in which the body still registers the world's address but no longer amplifies it to the point of personal significance. The soundproofing glass does not stop sound; it attenuates it below the threshold of engagement. This is not the restoration of authentic resonance but its pharmacological management.

Bornäs & Sandell (2017): Emotional Numbness and Mechanical Corporealization

Bornäs and Sandell's 2017 study, published in NORA: Nordic Journal of Feminist and Gender Research, employs a feminist phenomenological approach to analyze young Swedish adults' lived experiences of depression and antidepressant use (Bornäs and Sandell, 2016, p. 251-266). Their findings largely corroborate Teal's, while adding important dimensions relating to gender, self-image, and the temporal trajectory of medication use.

Like Teal's participants, Bornäs and Sandell's interviewees report an initial phase of relief, a lifting of the corporeal weight of depression, an abatement of intrusive thoughts and anxiety. Christian describes depression as "lying in bed with 15 arms holding him down"; with medication, "all the arms let go." This relief is real, and the study does not minimize it. However, as participants continued on medication, the relief was progressively replaced by a new kind of disturbance that the authors characterize as "emotional numbness" and "mechanical corporealization" (Bornäs and Sandell, 2016, p. 259).

Samira's account is the most philosophically interesting: she describes a transition from an initial period of stability, "like floating on pink clouds, I had never felt as stable", to "some sort of empty vacuum, a pretty monotonous echo of nothing." She felt "almost like a rag doll," her character disappeared, and her body became "a Sertralin-marinated piece of meat I couldn't relate to." Christian spoke of feeling "glazed over" and having a "fuck-off attitude" toward the world, not being "really there." In phenomenological terms, these are descriptions of a radical disruption of the lived body's transparency, its capacity to serve as a vehicle of world-engagement rather than an object of alienated attention.

Bornäs and Sandell identify what they call "disquieting similarities" between the experience of depression and the experience of being on antidepressants (Bornäs and Sandell, 2016, p. 262; Fuchs, 2005, p. 100). In both states, participants describe isolation, distance from the world, an inability to be moved by others, a "feeling of not feeling", exactly the phrase Fuchs uses to characterize depression in his 2005 paper (Fuchs, 2005, p. 95-107). The critical difference is that the medicated state preserves functional capacity: participants can work and study. But this functional preservation comes at the cost of the very emotional engagement that makes working and studying meaningful, that makes relationships intimate rather than merely adjacent.

Eli's description of stopping his SNRI is also revealing: "It's like taking away the damper. All of a sudden the impressions are much stronger, I feel more in all directions. I feel much more engaged." For Eli, it is the cessation of medication, not its initiation, that constitutes recovery: the return of spontaneous emotional responsiveness, the capacity to be irritated, moved, delighted. The two and a half years on medication sound, in his retrospective account, like "a functional but colourless corridor of just existing" (Bornäs and Sandell, 2016, p. 260).

Several participants underwent a retrospective revaluation of anxiety itself. Once the medication had removed it, they came to recognize that anxiety had served an orienting function, a "compass needle," as one participant put it, that signaled what to approach and what to avoid. Christian described anxiety as "your psychological punishment," the affective corrective that prevents morally wrong actions; without it, he found himself able to do things he knew to be wrong but felt no corresponding emotion. This is a valuable phenomenological finding: the pharmacological removal of anxiety does not simply bring relief but dismantles a structure of moral attunement.

PHARMACOLOGICAL ALIENATION: A CONCEPTUAL PROPOSAL

The convergent findings of Teal (2009) and Bornäs & Sandell (2017), read through the framework of Fuchs and Svenaeus, allow us to articulate a concept that these authors do not quite name but that their evidence supports: pharmacological alienation.

The concept of alienation, in its Marxian and Hegelian registers, refers to the disruption of the relationship between a subject and its productive capacities: the worker who labors but does not recognize her labor as her own, the product that stands over against the producer as a foreign object. In phenomenological psychiatry, alienation names a broader structure: the condition in which the most basic dimensions of self-being, attunement, bodily resonance, world-disclosure, are experienced as no longer one's own, as imposed, mechanical, foreign.

Pharmacological alienation, as I am proposing the concept, designates a specific form of this disruption: one in which the alteration of lived experience is not the result of pathological process, psychological conflict, or environmental assault, but of pharmacological intervention. The SSRI user who reports feeling "like a robot," "a machine," "a little inhuman," or who finds that their body has become "a Sertralin-marinated piece of meat" is not describing a side effect in the sense of an unintended complication; they are describing the constitutive structure of what it is to have one's attunement pharmacologically managed.

What distinguishes pharmacological alienation from the alienation of depression is precisely the element of normality it preserves. The depressed person knows they are suffering and typically seeks relief. The pharmacologically alienated person often does not initially register their condition as pathological; they are "fine," functional, "on an even keel." It is only in retrospect, often through comparison with their pre-medication or post-medication selves, that they recognize what has been lost. This retroactive recognition, "I can feel more in all directions now that I've stopped", is itself a phenomenological datum of great importance: it suggests that the attunement style installed by SSRIs is sufficiently different from authentic resonance that the transition back to resonance is experienced as a kind of recovery even when the cessation of medication was undertaken reluctantly.

Pharmacological alienation has three structural features that distinguish it from both depression and ordinary emotional blunting.

First, it involves what we might call attenuation without restoration. Depression involves a loss of bodily resonance, the body can no longer vibrate. Pharmacological alienation does not restore vibration; it installs a new, flattened mode of attunement in which the body registers the world's address but no longer amplifies it to personally significant intensity. The world is present but not for the subject in the full Heideggerian sense: it does not call, claim, or concern.

Second, it involves functional preservation coupled with relational evacuation. The SSRI-induced state preserves cognitive function and work capacity, indeed, this is typically experienced as the drug's primary benefit. But it does so by severing the motivational and emotional threads that make work, relationships, and projects genuinely meaningful rather than merely executable. The person can get out of bed, go to class, complete tasks, but the world in which they do so is affectively thin, drained of the caring engagement that, for Heidegger, constitutes the very being of Dasein as Sorge (care).

Third, pharmacological alienation involves a distinctive form of self-estrangement. Unlike depression, in which the body becomes alien through its heaviness and unresponsiveness, pharmacological alienation involves the experience of one's emotional responses as foreign or absent. Nathalie reports that the medication "changed my temperament, and I think a big part of who I am is my temperament. It didn't change my way of thinking, I still got angry thoughts if I was angry or sad thoughts if I was sad, or happy thoughts if I was happy, it was just that I didn't feel them in the same way" (Bornäs and Sandell, 2016, p. 261). This dissociation between cognitive and emotional self-experience is not depressive withdrawal but something philosophically distinct: a pharmacological sundering of thought from feeling, of intentional content from affective coloring, that leaves the self in a peculiar state of cognitively intact self-alienation.

THE CONVERGENCE OF PHENOMENOLOGICAL AND BIOCHEMICAL CRITIQUES

The phenomenological critique of SSRIs has developed largely independently of the empirical-scientific critique of the serotonin hypothesis. Yet the two lines of argument are structurally convergent in ways that deserve careful attention.

That such a convergence is possible at all follows from the methodological position of phenomenological psychopathology, which brackets causal explanation without renouncing testable hypotheses about the

underlying neurobiological mechanisms (Fuchs, 2010, p. 546). A phenomenological finding and a biochemical finding may therefore meet at the same structure without either having been derived from the other.

The serotonin deficiency hypothesis, the claim that depression results from insufficient serotonergic activity, and that SSRIs correct this deficit, was never rigorously established. As Moncrieff and colleagues documented in their 2022 umbrella review, no consistent association between serotonin levels, serotonin metabolite concentrations, serotonin transporter density, or serotonin-related gene expression and depression has been found across decades of research and tens of thousands of participants (Moncrieff et al., 2022, p. 3249). The hypothesis, which entered public discourse as settled fact via pharmaceutical advertising and simplified clinical communication, was, in the words of the review, "not supported by current evidence" (Moncrieff et al., 2022, p. 3243-3244).

Importantly, the serotonin hypothesis was always a post-hoc rationalization rather than a genuine theoretical basis for SSRI development. SSRIs were not designed because serotonin deficiency in depression was established; they were prescribed because they had been observed to have some antidepressant effect in clinical trials, and the serotonin hypothesis was then constructed to explain this effect. The hypothesis preceded the explanation of evidence, not the other way around. This order of reasoning, from apparent clinical benefit to hypothesized mechanism, has shaped psychiatric epistemology in ways that philosophers of science have consistently criticized: it treats the fact that a drug has some effect as evidence for a specific causal model, ignoring the many other pathways through which a drug might produce its observed effects (Moncrieff, 2008).

Meta-analyses of SSRI efficacy have consistently found that the drug's benefit over placebo is statistically significant but clinically modest, the mean difference on depression rating scales falling substantially below the threshold for clinically meaningful improvement, with benefit concentrated among patients with severe depression (Kirsch et al., 2008). These findings do not establish that SSRIs are ineffective; they establish that their effectiveness is considerably more limited and more mechanistically obscure than the disease-centered model implies. The observed clinical benefits may arise through several pathways unrelated to serotonin reuptake inhibition: neurosteroid effects (particularly increases in allopregnanolone, which modulates GABA-A receptors), anti-inflammatory properties, modifications of neuroplasticity signaling, or simply the emotional blunting that reduces the intensity of suffering without addressing its source.

Serotonin as Metabolic Brake and Psychosomatic and Phenomenological Implications

A more theoretically developed account of serotonin's biological function challenges the serotonin hypothesis at a deeper level. Converging evidence from physiology, comparative biology, and metabolic research suggests that serotonin's primary role is not as a "happiness signal" but as a metabolic modulator, a brake on oxidative phosphorylation and a regulator of energy allocation across tissues. In hibernating mammals, brain serotonin levels peak during entry into torpor and fall during arousal. Elevated serotonin is associated with states of metabolic stress, inflammation, hypoxia, endotoxemia, chronic stress, suggesting that it functions as an adaptive signal of constraint rather than a reward signal.

This metabolic account of serotonin has both psychosomatic and phenomenological implications. If serotonin is primarily a brake on metabolic activity, a signal that narrows the organism's responsiveness to its environment in conditions of stress or resource limitation, then chronically elevated extracellular serotonin, as produced by SSRIs, should be expected to produce exactly the phenomenological signature documented by Teal and Bornäs & Sandell: a generalized dampening of responsiveness, a flattening of the organism's engagement with its environment, a reduction in the intensity and urgency of the world's affective address.

The convergence here is not coincidental. Both the phenomenological and the physiological descriptions point to the same structure: SSRIs do not restore the organism's capacity for full-range engagement with the world; they reduce the intensity of that engagement across the board. The "soundproofing glass" that Teal's participant Jenny describes is not a metaphor of healing, it is a metaphor of pharmacologically imposed containment. The lived body that can no longer hear the world's call has not been restored to resonance; it has been muffled.

A Twenty-Year Retrospective: How the Discourse Has Shifted

Reading the phenomenological literature on SSRIs chronologically reveals a clear directional movement. Svenaeus (2006) writes at a moment of relative confidence in the SSRI paradigm: the serotonin hypothesis is contested but not yet definitively refuted; the long-term phenomenological consequences of widespread SSRI use are not yet well documented; the cultural and economic dynamics of pharmaceutical promotion are noted but

not yet analyzed as systematically distorting as they have since proven to be. His engagement is philosophical but moderate.

By 2009, when Teal publishes his empirical phenomenological study, the tone has shifted. Teal is not merely exploring a philosophical question; he is documenting a lived structure, the a-motional world of being-on-an-SSRI, that challenges the therapeutic framing of the drugs. His findings do not support the disease-centered model; they suggest that SSRIs install a new kind of ontological disturbance rather than correcting a prior one.

By 2017, Bornäs and Sandell find the phenomenological literature sufficiently developed to cite Fuchs's concept of "a feeling of not feeling" as characterizing both depression and the medicated state, a convergence that would have been philosophically scandalous to assert in 2006. Their conclusion, that "the medicated state has strong similarities with the depressed state from which it was originally an effort to escape", represents a significant departure from the cautious optimism of the early phenomenological literature.

This shift coincides with, and is supported by, the broader collapse of the serotonin hypothesis. The 2022 Moncrieff umbrella review was not an isolated finding but the culmination of a sustained critique that had been building for decades, from Irving Kirsch's placebo-controlled meta-analyses to David Healy's (1997) historical and pharmacological work. As the scientific basis for the disease-centered model of SSRI action eroded, the phenomenological evidence of pharmacological alienation, which the disease model had previously allowed to be dismissed as "side effects", could no longer be set aside. The "side effects" were, in many cases, the primary effects: the actual lived consequences of having one's attunement pharmacologically managed.

It is also worth noting the shift in Thomas Fuchs's own trajectory. His mature work, particularly Ecology of the Brain (2018), develops an explicitly anti-reductionist, ecological account of the brain that is fundamentally incompatible with the chemical imbalance model (Fuchs, 2018). On Fuchs's mature account, depression is not a brain disease but a disruption of the organism's coupling with its environment, a failure of the embodied organism to maintain its active, resonant engagement with the world of persons and practices that sustains it. This ecological account implies that genuine recovery from depression requires a restoration of environmental engagement, not merely a pharmacological alteration of neurotransmitter concentrations. In this respect, the phenomenological tradition has moved, over twenty years, from cautious engagement with the SSRI paradigm to a principled basis for questioning it.

TOWARD A PHENOMENOLOGICAL PSYCHIATRY BEYOND SEROTONIN

If the phenomenological critique of SSRIs is as cogent as the foregoing analysis suggests, what are its positive implications for psychiatric theory and practice? Three directions present themselves.

First, phenomenological psychiatry requires a more rigorous account of therapeutic goals. The dominant metric of SSRI efficacy, reduction of scores on depression rating scales, captures only a limited aspect of what it means to recover from depression. Recovery, phenomenologically understood, is not the absence of depressive symptoms; it is the restoration of authentic bodily resonance, temporal openness, relational engagement, and the capacity for genuine caring (Sorge). A person whose depression scores have decreased but who experiences themselves as pharmacologically alienated, as "fine" in the sense of functional but emotionally evacuated, has not recovered in the phenomenological sense. This distinction should inform both clinical assessment and research methodology.

Second, the phenomenological framework suggests that depression should be approached as a disruption of the organism-environment relationship rather than as a brain-internal deficit. On Fuchs's ecological account, the appropriate therapeutic response to depression is not primarily pharmacological but relational, environmental, and metabolic: the restoration of the conditions under which bodily resonance can be naturally re-established. This is consistent with empirical evidence that exercise, social engagement, exposure to natural environments, and behavioral activation produce clinical outcomes comparable to SSRIs in moderate depression, without the phenomenological costs of pharmacological alienation.

Third, phenomenological psychiatry has a distinctive contribution to make to the ethics of informed consent. The studies of Teal and Bornäs & Sandell document a widespread failure of prescribers to communicate the phenomenological consequences of SSRI use: the attenuation of emotional range, the disruption of relational attunement, the possibility of prolonged discontinuation effects. Patients deserve to know not merely the symptomatic side-effect profile of a drug but its likely effects on their capacity to be affected by the world, to be moved, engaged, claimed by what matters. The phenomenological tradition has the conceptual resources to articulate these effects in terms that are both philosophically precise and clinically relevant.

The question of hyperbolic tapering, developed in the clinical work of Horowitz and Taylor, (Horowitz and Taylor, 2019, p. 538-546) illustrates how phenomenological insight can translate into therapeutic practice. The recognition that SSRI discontinuation involves a neurochemical "cliff", that the receptor occupancy curve means small dose reductions at low doses produce disproportionately large changes in brain pharmacology, reflects an understanding of why abrupt or linear tapering fails: the nervous system has adapted to chronic pharmacological modulation of attunement, and rapid removal disrupts even the managed equilibrium that has been established. This is not merely a pharmacokinetic observation; it is a description of what happens when a pharmacologically stabilized mode of being-in-the-world is abruptly withdrawn.

CONCLUSION

Phenomenological philosophy entered the SSRI debate in the early years of the twenty-first century with a characteristically nuanced posture, attending carefully to the structure of lived experience, resisting both uncritical enthusiasm for pharmacological solutions and moralizing rejection of them, and insisting that the question of what it is like to be on an SSRI cannot be answered by biochemistry alone. The work of Svenaeus (2006, 2007) represents this posture at its most careful, philosophically acute, empirically informed, and genuinely open to the possibility that SSRIs might constitute a legitimate therapeutic intervention for a biochemically-grounded disruption of bodily resonance.

Over the subsequent two decades, however, the evidence has accumulated in ways that press phenomenological psychiatry toward a more critical position. Teal's (2009) empirical phenomenology documents the a-motional, distanced, barrier-mediated world of the SSRI user with sufficient precision to challenge any reading of the drugs as straightforwardly restorative. Bornäs and Sandell's (2017) findings of "disquieting similarities" between the depressed and medicated states converge with Fuchs's own description of depression as "a feeling of not feeling", a convergence that the disease-centered model cannot easily explain away. And the collapse of the serotonin hypothesis removes the theoretical rationale that had allowed the phenomenological costs of SSRI use to be classified as acceptable side effects of a biochemically necessary intervention.

The concept of pharmacological alienation, developed here, attempts to name the specific ontological structure that the empirical phenomenological literature reveals: a state in which the lived body's resonant responsiveness to the world is pharmacologically managed rather than restored, in which functional preservation is purchased at the cost of relational and emotional depth, and in which the very structures of caring, attunement, and temporal engagement that constitute authentic being-in-the-world are systematically attenuated. This is not the same as depression, it lacks depression's acute suffering, its temporal implosion, its paralysis. But it is not health either.

What phenomenological psychiatry is in a position to offer, at this juncture, is not a simple condemnation of SSRIs but a philosophical framework within which their limitations can be precisely articulated and their alternatives seriously developed. If depression is a disruption of the organism's resonant coupling with its environment, of the lived body's capacity to vibrate in response to the world's affective address, then recovery is not the pharmacological management of this disruption but its gradual, relational, metabolic, and existential undoing. The task of phenomenological psychiatry is to articulate what such recovery looks like: not "fine," not "on an even keel," not "functional", but genuinely, resonantly, vulnerably alive to the world.

Two decades after Svenaeus proposed that phenomenology should listen to Prozac, the conversation has come full circle. Phenomenology has listened, carefully and at length. What it has heard, in the testimony of those who have lived the pharmacological management of their attunement, is something the serotonin hypothesis was never designed to explain: the specific texture of a life lived behind soundproofing glass, and the specific quality of what it means, finally, to take it down.

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