Medicine, Health Care and Philosophy (2007) 10:153–166
DOI 10.1007/s11019-007-9060-8

Scientific Contribution

Do antidepressants affect the self? A phenomenological approach

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Abstract. In this paper, I explore the questions of how and to what extent new antidepressants (selective serotonin-reuptake inhibitors, or SSRIs) could possibly affect the self. I do this by way of a phenomenological approach, using the works of Martin Heidegger and Thomas Fuchs to analyze the roles of attunement and embodiment in normal and abnormal ways of being-in-the-world. The nature of depression and anxiety disorders – the diagnoses for which treatment with antidepressants is most commonly indicated – is also explored by way of this phenomenological approach, as are the basic structures of self-being. Special attention is paid in the analysis to the moods of boredom, anxiety and grief, since they play fundamental roles in depression and anxiety disorders and since their intensity and frequency appear to be modulated by antidepressants. My conclusion is that the effect of these drugs on the self can be thought of in terms of changes in self-feeling, or, more precisely, self-vibration of embodiment. I present the idea of a spectrum of bodily resonance, which extends from the normal resonance of the lived body, in which the body is able to pick up a wide range of different moods; continuing over various kinds of sensitivities, preferences and idiosyncrasies, in which certain moods are favored over others; to cases that we unreservedly label pathologies, in which the body is severely out of tune, or even devoid of tune and thus useless as a tool of resonance. Different cultures and societies favor slightly differently attuned self-styles as paradigmatic of the normal and good life, and the popularity of the SSRIs can therefore be explained, not only by defects of embodiment, but also by the presence of certain cultural norms in our contemporary society.

Key words: antidepressants, attunement, embodiment, Martin Heidegger, phenomenology, self, SSRIs, Thomas Fuchs

Introduction

Depression and anxiety are growing problems in the Western world today. It is hard to find reliable data on prevalence and incidence, but according to studies carried out by the World Health Organization, depression will soon become the second most common cause of disability, trailing only ischemic heart disease (Kramer, 2005: 152). Anxiety disorders – whether they occur together with depression or on their own – are also on the rise and are also receiving increased attention. An obvious sign of this attention is the ever more sophisticated taxonomies of anxiety-related psychiatric conditions found in the diagnostic manuals of mental disorders published by medical associations (particularly the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders*, or *DSM-IV* [2000]). It is estimated that more than 5% of the inhabitants of Western countries suffer from depression or an anxiety disorder at the present time, and that at least 25% will fall ill at one time or another in their lives. These numbers are astonishing, considering the fact that depression and anxiety disorders were rare conditions only 20 years ago (Healy, 1997), and their rapidly increasing prevalence certainly calls for an investigation. Why have we become so depressed and anxious?

The most important factor underlying the increased frequency of these disorders is probably the emergence of a new class of antidepressants, the selective serotonin-reuptake inhibitors (or SSRIs) – the best known of which is fluoxetine, or Prozac – which are frequently used to treat patients diagnosed with depression or anxiety.[1] The availability of these drugs has led doctors (and

people in general) to look upon certain conditions as pathologies with a biological basis, rather than as the painful experiences of a normal life. Indeed, it appears highly probable that the development and aggressive marketing of these new drugs by pharmaceutical companies have resulted in a more liberal interpretation of the diagnostic criteria for depression and anxiety disorders (in both psychiatric manuals and medical practice) (Healy, 2004). This liberalization of criteria is not necessarily a bad thing, since, clearly, many people have been helped to a far better life by the new drugs. Moreover, many psychiatrists and neuroscientists argue that the prevalence of depression and related mental disorders (including anxiety disorders) has remained relatively stable over time, and that the real reason for the recent increase is that doctors are getting better at diagnosing episodes of depression that previously either manifested themselves as somatic problems or were endured silently by people who never sought medical attention (Kramer, 2005).[2] To visit the doctor seeking help for psychic complaints associated with depression or anxiety appears to have become more socially acceptable during the last 20 years. These conditions have undergone, in other words, a process of ''de-stigmatization''; at the same time, other forms of mental illness, including schizophrenia, do not appear to have become de-stigmatized.

It is highly unlikely that, solely by studying brain chemistry, we will ever be able to understand the differences between normal and pathological suffering; we may nevertheless become more adept at changing the biology of our brains in ways that make us feel happier and live better. As Maartje Schermer shows in her contribution to the thematic section on ''Psychopharmacology and the Self'' of *Medicine, Health Care and Philosophy*, which this paper is also a part of, this project of psychopharmacological enhancement has deep roots in our culture, and it has been dealt with by researchers and novelists in dystopian, as well as utopian, ways for a long time (Schermer, 2007). Maybe we are now approaching an age in which the old fears and/or hopes will finally come true? Despite recent breakthroughs in the biology of depression, however, it is important to point out that we are still very far from an understanding of its causes that resembles, for instance, our understanding of diabetes mellitus. Lack of serotonin is surely not the only cause of depression – the biological processes involved are far more complex.[3] It may turn out that depression is actually several different diseases at the biological level. Or, with regard to anxiety disorders, the symptoms and signs that are currently classified as several distinct disorders may in the future prove to have a single significant biological cause.

A lingering suspicion, ever since the first reports of the success of Prozac, has been that the new antidepressants, in addition to relieving the symptoms of depression and anxiety disorders, also have other effects that help explain their popularity. The more specific issue I want to explore in this paper is whether antidepressants also affect self-perception (our sense of who we are), in the way Peter Kramer illustrates by way of clinical examples in his book *Listening to Prozac* (1993). According to Kramer some of his patients went through the experience of ''becoming themselves'' while on Prozac, whereas others had the experience of ''losing themselves,'' despite feeling better on the drug. Similar characterizations of the effects of SSRIs can also be found in other studies,[4] but it is difficult to know how we should interpret them, since we lack a comprehensive understanding of what the term ''self'' means in this context. What might ''enhancing the self'' or ''becoming oneself'' or ''losing oneself'' possibly mean in the case of antidepressants? Has the significant change taken place in the dimension of feelings (self-feeling) or in the dimension of thoughts (self-understanding)? The self (or personality) is apparently a concept that refers to a basic *disposition* to feel, act, and think in certain ways (Goldie, 2004). How could antidepressants come to have an effect on this basic disposition by relieving the symptoms of depression and anxiety? In order to answer this question, we have to develop a more comprehensive understanding of the traits characteristic not only of being a self but also of depression and anxiety disorders.

Phenomenology

The basic idea behind this paper is that a phenomenological analysis of the mood and anxiety disorders for which treatment with antidepressants is indicated will allow us to address questions surrounding the self and self-change in a more substantive manner, with the ultimate goal of arriving at a more thorough understanding of the effects of antidepressants on the self. It is important to point out that the moods that become ''disordered'' in these conditions also form part of a normal, everyday life. Indeed, as we will see, they play a very important role in that setting. If one wants to understand how anxiety, boredom and

grief can develop into pathologies from which one seeks relief, one also needs to examine the normal function of these moods. No life is, or should be, free from anxiety, boredom or grief; what we need to understand better is how and why they turn into pathologies. Psychiatry could by such a phenomenological approach arrive at a better understanding of its own place and function in contemporary culture and society. And this phenomenological approach might, in addition to broadening the focus of the psychiatric gaze, also make possible a critical stance towards the methods and goals of psychiatry (Crossley, 2003). The question of what kinds of problems should be medicalized (in the double sense of being conceptualized in terms of sickness and health and being treated pharmacologically or surgically) and what kinds of problems are better conceptualized and better treated in other ways (for instance, by social, psychological and political measures) is urgent – particularly in light of the recent, rapid increase in the prescription of antidepressant drugs. Phenomenology might be useful in this context, inasmuch as it takes into account both embodiment and culture in its investigation of the nature and structure of our everyday being-in-the-world.

By way of introduction, phenomenology might be described as the attempt to found a conceptual apparatus that is based on lived experience (Spiegelberg, 1982; Zahavi, 2003). The starting point is everyday life, viewed and investigated from a certain perspective: the phenomenological attitude. What is focused upon in this attitude is often called the *meaning* of experience. Lived experience, on the one hand, and the theories and results of natural science, on the other, are meaningful in entirely different ways; suffering from the ravages of an illness, for example, is something altogether different from coldly cataloguing the characteristics of a disease.[5] Science, as a human activity that strives to solve puzzles and produce new results, is no doubt meaningful, but the manner of explanation particular to science, with its focus on causal relations within nature, is not directly anchored in the everyday world. The meaning that phenomenology investigates is not found within the causal patterns of the world studied by science (the brain, in the case of the new antidepressants), but rather in the subjective perspective a person develops regarding himself and the world around him in the course of everyday life. Yet, though subjective, the ''first-person perspective'' of phenomenology is not insular, as its purpose is the discovery of generalizable concepts; for here we are interested not only in what makes your experience of something different from mine but also in the shared *structure* of meaning underlying and informing every kind of (human) experience.

Phenomenology, which started out as a philosophical movement – its most famous adherents were Edmund Husserl, Martin Heidegger, Maurice Merleau-Ponty, Jean-Paul Sartre, Paul Ricoeur and Hans-Georg Gadamer – quickly won converts within other disciplines, including aesthetetics, psychology, sociology, ethnography and pedagogy, and developed into a vast interdisciplinary network of research programs. During the past three decades, phenomenology has also gained some attention within the discipline of medicine (Toombs, 2001), particularly within psychiatry (Spitzer et al., 1993). My phenomenological approach in this paper should be understood as a conceptual, philosophical analysis, rather than a piece of qualitative, empirical research; the analysis is nevertheless grounded in interviews with doctors and patients on the subject of antidepressants, and in findings from empirical disciplines concerning mental disorders and the effects of psychopharmacological drugs.[6]

What should we expect from a phenomenological analysis of the use of antidepressants? What questions does the analysis need to address, to give us a better understanding of the issues involved? One pressing question is that of *normality*. The decision to prescribe an SSRI to a patient seems to imply that the patient is suffering from an illness. How should the dividing line be drawn between health and sickness when it comes to the kind of suffering SSRIs are meant to treat? The phenomenologist addresses this question at the level of the life-world (that is, the level of illness), and not at the level of the biological functioning of the brain (the level of disease). That this approach is particularly fitting in the case of SSRIs – despite the fact that the drugs do, of course, have a biological impact on serotonin levels in the synapses of the brain – will become clear when we consider the methods of psychiatric diagnosis. There are (at present) no diagnostic tests to measure serotonin levels in the brains of patients; instead, doctors rely in their decision to treat on their own clinical experience and on the guidelines of diagnostic manuals.

Diagnosis

The two bibles of psychiatric diagnosis are the *DSM-IV* (2000) and the tenth edition of the

International Statistical Classification of Diseases and Related Health Problems (or *ICD-10*, 2004). A brief look into the *DSM-IV* reveals the type of observations a doctor must make to determine whether a patient is suffering from a condition amenable to treatment with SSRIs. In the *DSM-IV*, the two major groups of diagnoses for which SSRI treatment is indicated are depressive disorders – including dysthymia, or chronic depressive mood – and anxiety disorders, such as social phobia and post-traumatic stress disorder.

The distinguishing characteristic of depressive disorders is the presence of what is called "a major depressive episode" (*DSM-IV*, 2000: 356). This condition is adjudged to be present if a depressed mood (sadness, emptiness) and a loss of interest or pleasure have been present most of the day, nearly every day, for at least 2 weeks, and if, in addition, at least three of the following seven criteria have also been fulfilled during this period: significant weight change; insomnia or hypersomnia; psychomotor agitation or retardation; fatigue or loss of energy; feelings of worthlessness or excessive or inappropriate guilt; diminished ability to think or concentrate; and recurrent thoughts of death. These symptoms must also have resulted in "clinically significant distress or impairment in social, occupational, or other important areas of functioning," and they should not have been directly caused by medication or bereavement (the loss of a loved one).

If we turn to how anxiety disorders are described in the *DSM-IV*, we find a similar litany of deviant feelings – of problems involving altered embodiment and estranged engagement with the world. Here, the common characteristic of the disorders that are treated with SSRIs is the panic attack – an excess of anxiety triggered by an alarming situation. A panic attack is specified as: "a discrete period of intense fear or discomfort," in which symptoms like pounding heart, sweating, trembling, shortness of breath, chest pain, nausea, fear of losing control, going crazy, or dying are developed abruptly and reach a peak within 10 min (*DSM-IV*, 2000: 432). The panic attacks are typically recurrent, and they are often associated with being in a special type of situation (meeting or speaking to strangers in social phobia, for instance). The sufferer not only experiences anxiety while *having* the attacks, he is also in many cases constantly *anxious about* having them.

Presumably, not all physicians strictly abide by these criteria when making their diagnoses; nonetheless, they give a clear indication of the types of matters physicians are expected to investigate in their encounters with patients. Diagnosis, in these cases, represents a pronouncement concerning the phenomenological life-world; yet, the criteria were not derived in any theoretically reflective manner. Indeed, the very rationale for the compilation of the *DSM* was to delineate psychiatric diagnoses without any reference to (psychoanalytic or biological) theory; it should thus come as no surprise that the manual does not feature an exposition of basic concepts or theoretical discussions of the nature of mental illness. Still, the manual's rationale should not discourage us from pursuing a potentially enlightening investigation of the phenomena it describes – or, more specifically, an investigation of what distinguishes the "pathological states" of depression and anxiety from the normal conditions of life. Phenomenology might help us in this task, by providing us with a form of understanding that is not predicated on scientific models of the psyche of either psychoanalytic or biological origin. The type of phenomena we should concentrate on in a phenomenological analysis of depression and anxiety disorders is made pretty clear by the lists of criteria presented in the *DSM-IV*: central to each diagnostic scheme is the presence of painful *feelings* and of problems involving altered *embodiment* and estranged *engagement* with the *world*. If we could find a way of understanding how these three phenomena are related to one another in everyday life, then we would have gained much in our attempt to understand the effects of antidepressants. In fact, we will have come even further if, by means of the same phenomenological analysis, we are able to arrive at a way of understanding the difference between normal and abnormal (that is, healthy and unhealthy) ways of being attuned, engaged with the world and embodied. And, finally, our understanding of the phenomena will be virtually complete if the analysis also results in a fuller account of normative issues in the sphere of feelings, embodiment and engagement with the world – issues including social processes, patterns of self-formation and matters pertaining to the good life. The concepts of self and self-change are relevant to all three phenomena, even though they are rarely discussed in the context of feelings or engagement with the world. It is often assumed that the self or person is some kind of basic entity to which a body and the capacity to feel, act and think belong. As we will see, however, it is, on the contrary, the case that the self *emerges* out of embodiment, attunement and being-in-the-world.

Attunement

The three basic feelings that are characteristic of anxiety disorders and depression are *anxiety*, *boredom* and *grief*. As is clear from the lists of criteria in the *DSM-IV* cited above, one could certainly choose to call these feelings by slightly different names and thereby endow them with slightly different meanings. Instead of grief, for instance, we might choose to speak of sorrow, sadness, guilt or loss. I will address the question of how feelings are designated below, specifically in my attempt to distinguish between normal grief and depression, but also in my general attempt to specify the differences between normal anxiousness and boredom, on the one hand, and the pathological forms of these phenomena, on the other.

It might seem, from the diagnostic schemes presented above, that anxiety disorders and depressive disorders are two entirely distinct species of mental derangement. One should not forget, however, that anxiousness and panic attacks are common features of depression, and that people who suffer from anxiety disorders are often depressed as well. The fact that SSRIs appear to be effective in the treatment of both types of disorders could be taken to indicate that the disorders are best understood in terms of biology – as dysfunctions of serotonin reuptake. But a biological approach does not preclude a phenomenological model of understanding. It should be stressed that even if we were certain that depression and anxiety disorders are caused by a lack of serotonin, in a manner analogous to that by which the lack of insulin causes diabetes mellitus (as pointed out above, at present, few neurobiologists or psychiatrists would support such a view), this model of understanding would not make a phenomenological approach irrelevant. To know the cause of a phenomenon is one thing; to understand its meaning and phenomenal structure is something entirely different.

One promising place to start looking for a phenomenology of feelings is the philosophy of Martin Heidegger. In his first major work, *Being and Time*, originally published in 1927 (1986), and in a series of lectures entitled *The Fundamental Concepts of Metaphysics*, given in the years 1929 and 1930 (1983), Heidegger offers extensive, in-depth analyses of, respectively, anxiety and boredom. In the two books, the feelings of anxiety and boredom are assigned central places and perform similar, in many ways parallel, functions. In later works, Heidegger also treats the phenomenon of grief (Haar, 1992), a feature of depression to which I will return below. What can we learn from Heidegger's phenomenological analyses in this context?[7]

The aspect of these analyses that I would like to call attention to is the way in which Heidegger makes it clear that certain feelings – moods – are world-*constitutive* phenomena. Moods open up to human beings a world full of things that matter to them. It is common in the contemporary philosophy of feelings to distinguish between sensations, emotions and moods. Sensations are localized in a distinct place in the body (for example, a pain or a tickle), and emotions have an object and are based upon beliefs (love or hate). Moods, however, are not localized within the body, and they lack a distinct object; rather, moods color the way in which things appear to the subject in general (for example, anxiety, boredom and sadness, or joy, curiosity and awe). Although moods certainly do not contain thoughts in the same way emotions do, they nevertheless determine what kinds of thoughts the thinker will be able to entertain. Moods are not something I append to my thoughts, to make them happy or sad, depending on how I am attuned; on the contrary, the moods I happen to be immersed in underlie and inform the very process of thought formation. Feelings of joy or sadness will give rise to very different kinds of thoughts, with very different content. This, of course, is the reason why thoughts of death, guilt and hopelessness typically occur in the mental life of a depressed person.

In order to explicate the constitutive role of moods more thoroughly, I will introduce a few basic concepts from Heidegger's phenomenology, as they are developed in *Being and Time* and *The Fundamental Concepts of Metaphysics*, including the concept of being-in-the-world (*in-der-Welt-sein*). The world, according to Heidegger, is not the totality of objects surrounding the human subject. In contrast to dualist, idealist or materialist conceptions of the world, the world in the phenomenological view is a meaning structure wherein the manner in which an object (or "tool," as Heidegger calls it) discloses itself for human beings is determined by the object's significance for the doing of different things. Here I intend for the word "doing" to have a very wide range of meanings: the term Heidegger himself uses is "understanding" (*Verstehen*). You can do things with words and thoughts, just as you can do things with your hands. What is important, in all these instances of doing, is that you manipulate certain things in order to bring about a specific result, either on

your own or – as is the case most often – together with other people. Thus, to understand what a hammer is (to cite the most well-known example from *Being and Time*) is, on the everyday level, to be able to use it to build something; and, on the phenomenological level, to see how it relates to other phenomena in the world (such as nails and boards) – that is, to see it in the context through which it comes to occupy its special place in a web of meaning (1986: 69 ff.). Humans in their being-in-the-world thus stand in a meaningful relation to the things they engage with: they are *with* the things and not just beside them, and in this being-with-the-things, humans also assign meaning to the things in various ways.

Feelings, especially moods, are in Heidegger's phenomenology basic to our being-in-the-world, since they open up the world as meaningful, as having significance. They are the basic strata of what Heidegger refers to as *facticity* – that is, of the state of affairs whereby we are thrown into the world prior to having had any thoughts or made any choices about it. We find ourselves *here*, always already engaged, together with other people, in tasks that matter to us; and this "mattering to" is predicated on an attunement, a "mood-state," which our being-in-the-world always already has (1986: 134 ff., 1983: 99 ff.). Every activity is attuned in a way that foregrounds its significance. Thus, meaningfulness, in all its forms, has a characteristic tune. The moods in question need not be powerful; in fact, we are often unaware of them. But they are always there, as the constitutive groundwork of our having been placed in a worldly pattern of meaning. Indeed, we do not choose our moods; rather, they seem to "well up" inside us and cannot easily be changed.

Anxiety and boredom

Let us now return to anxiety and boredom, which are quite peculiar moods (*Stimmungen*, in German). It is striking, and doubtless no coincidence, that these two feelings – characteristic pathologies of contemporary life – are granted the status of G*rundstimmungen* in Heidegger's phenomenological analysis from the late 1920s (Held, 1993). What is peculiar to anxiety and boredom is that they simultaneously open up and *block* the possibility of being in the world – the possibility of engaging with things and other human beings in a way that makes sense to us. They do this in distinct ways, however. Anxiety has a paralyzing quality to it, whereas boredom puts us to sleep. In anxiety, the world breaks apart; in boredom, it withers. For Heidegger, the disturbing experiences associated with these moods entail important possibilities for phenomenological analysis itself. In the grip of anxiety or boredom, it becomes possible for us to catch a glimpse of the very *structure* of the world in its meaningfulness – since the world is laid bare as a pure meaning structure with which we no longer can engage. The things of the world have ceased to have significance; thus, it becomes possible, even necessary, for us to adopt a stance in which we address the meaning of being-in-the-world as such. This stance underlies the *authentic*, philosophically contemplative, life for Heidegger – a life whereby, in contrast to the public anonymity of the "they" (*das Man*), we must face our own finitude and accept responsibility for our choices (1986: 260 ff.).

I would like to focus in this section upon two aspects of Heidegger's analysis of anxiety and boredom that I think would be useful for a phenomenology of psychiatry: being-at-home and being-in-time. Anxiety, in *Being and Time*, and boredom, in *The Fundamental Concepts of Metaphysics*, are both characterized as *unhomelike* phenomena (1986: 189, 1983: 120). They make settling in the world and being at home in the world impossible, since for people afflicted with either of these moods, the world resists meaningfulness. The world becomes alien; it is not *my* world anymore. Heidegger even writes of an "eternal homesickness" (*Sehnsucht*), which is experienced in boredom. Authentic understanding, according to Heidegger, is achieved by nurturing this unhomelikeness and this homesickness to fruition, at which point it becomes possible to exploit them for philosophical purposes. The problem from the point of view of psychiatry, however, is that anxiety and boredom can become destructive, rather than productive, life experiences: they can be so overwhelming that a return to homelikeness becomes impossible. Unhomelikeness is a necessary ingredient of life; it can be very rewarding insofar as it allows us to see things in novel, more nuanced ways. It must be balanced by homelikeness, however, lest we fall into a bottomless pit of darkness (Svenaeus, 2001: 90 ff.).

Time is a key issue here: shorter periods of anxiety or boredom might lend life greater depth – indeed, might perhaps even engender authenticity – whereas recurrent anxiety attacks or deep, unrelenting boredom might render life unhomelike, lending it a pathological quality. It is important to realize, however, that a mere measuring of the time

passed in anxiety and boredom by a person – the counting of hours, days, weeks, months and even years – does not sufficiently take into account the phenomenon of time itself as a basic structure of our being-in-the-world. Phenomenological time is *lived* time – the medium in which, from the meaning-endowed present, we summon our past in preparation for the future. For a person suffering from anxiety or boredom, a single second – which for the rest of us passes in the blink of an eye – can seemingly last an eternity. This experience of eternity differs, however, between the two moods. In anxiety, the present is intensified and concentrated; it threatens to implode. In boredom, by contrast, the present is stretched out to infinity and becomes inert. In both cases, the present takes hold of the sufferer and forces him back on himself: the present moment blocks the flow of life – blocks our capacity to engage with the world and take part in projects together with other people. Anxiety and boredom have at their core a feeling of loneliness, which no doubt fascinated Heidegger, as it has fascinated philosophers since the time of the Greeks. But this unwilled loneliness, the result of an attunement that blocks engagement with a world shared with others, is not only a philosophical posture; it is also, potentially, a pathological state.[8]

Body and world

To try to understand anxiety and boredom from a phenomenological point of view means to focus upon everyday life as a being-in-the-world in which moods play a constitutive role. Being-in-the-world is also being-in-time, or rather being-*as*-time, where time is understood as our manner of engaging in projects in the world together with other people. Each thing has its time, since all things are part of the world in which we act. The characteristic quality of anxiety and boredom, however, is that things no longer occupy their proper time, since they no longer interest us. We become locked in within ourselves in an everlasting, meaningless present – an unhomelike now – instead of approaching the future as a source of possibilities related to our past.

Since the world is always a "world with others" (*Mitwelt*) (1986: 118), the pathological forms of anxiety and boredom (as well as the authentic forms in Heidegger's interpretation) are characterized by loneliness. The world, including other people, becomes foreign and strange in anxiety and boredom; it no longer moves or engages us. If some fellow human being still interests me, if I still feel an urge to interact with the world, then it must be the case that I am not totally locked in – that I am still, to some degree, at home. This is not to say that all forms of shared activities will be pleasant or joyful for me; but it does underline the fact that the basic problem with anxiety and boredom is that these moods tend to block the possibility of being with others, since they disconnect us from spheres of shared meaningfulness. Indeed, there exists no private world, apart from other people, in which we can exist. All the things around us within the world presuppose shared practices and projects. You can choose to live as a hermit, but you cannot choose to live in your own private world (or rather, if you do, you will become psychotic).

Moods make possible our participation in the world of others – what Heidegger calls our *transcendence* to the world of others – by opening up a horizon of meaningfulness in which to live. Consequently, moods are not qualities of a subject, as contrasted to qualities of worldly objects, but rather phenomena that *connect* the self to the world, thereby making being-*in*-the-world possible. I have stressed that moods are not chosen freely, but rather confront us as a basic predicament of existence and transcendence. This being the case, however, it seems problematic to characterize depression and anxiety as mood *disorders*, as pathological states qualitatively different from the mere boredom and anxieties of everyday life. If moods are not qualities that belong to the subject – to the self, the person – but rather a structure of transcendence, a way of being-in-the-world, how are we to understand the essential difference between bored people, on the one hand, and depressed people, on the other; or between anxious people and "overanxious" people (who are abnormal and unhealthy)? Why do some people "get stuck" in boredom and anxiety in a way that transforms their being-in-the-world into a pathological condition of overwhelming unhomelikeness and "locked-in-ness," whereas other people experience boredom and anxiety, yet are still able to maintain a rich, homelike being-in-the-world?

I would like to start answering these questions by making use of some concepts and distinctions developed by Thomas Fuchs in his study *Psychopathologie von Leib und Raum* (2000). The starting point for Fuchs is the phenomenology of the lived body, which in German is referred to as *Leibphänomenologie*. Husserl and his successors made a central distinction between the body as it is

experienced from the first-person perspective – *Leib* – and the body as it is experienced from the third-person perspective – *Körper*. The *Körper* can be regarded as a *living* thing – when it is approached and studied from the point of view of the doctor, for instance; but it is only from the point of view of the patient that it is *lived – leiblich*. The lived body is not a thing – an object – that I live in; rather, it is itself the basic form of subjectivity that underlies my being-in-the-world. As this basic form of subjectivity, however, it still retains a certain thing-like quality. It offers resistance to my doings and maintains autonomic functions that I do not control; above all, it is something that I myself can objectify.

The lived body is not only material. By way of its peculiar subjective materiality, it is also spatial; by occupying a certain position in this world, the body makes it possible for us to have a world. The body's position is the perspective from which the world can attain significance for me. The position can be changed thanks to the body's mobility. Movement and perception are both sensorially and conceptually united (in kinesthesis), as can be demonstrated by experiments in perception psychology. But, as Fuchs points out, the true significance of this fusion of mind (*Geist*) and space (*Raum*) in *Leib* has rarely been appreciated by philosophers and psychologists. Perceiving is not the mind's window on the world; rather, it is a being-in, which establishes significance by way of moving and doing: making use of objects in establishing a world.

But the manipulation of concrete objects is just one aspect of human being-in-the-world. Our more complex capacities – to use language and create art, to think abstractly and develop theories, to form societies and write our history, and so on – enrich our world and endow it with a level of sophistication beyond simple tool use. Mental illness in its many forms is played out and attains significance in all these areas of personhood; nevertheless, claims Fuchs, it has its roots in malfunctions of the lived body. To appreciate this fact, we must connect the concept of the lived body to the Heideggerian concept of attunement explored above.

Fuchs introduces the notion of *leibliche Resonanz* – bodily resonance – to explain how the body "picks up" moods in its transcendence to the world of human projects. The lived body is the central vehicle of our transcendence to the world. By virtue of its capacity to be affected by the world – to become attuned – it constitutes a kinesthetic scheme of intentionality, which informs, at higher cognitive levels, our doings and our understanding. The lived body opens up a "mood-space" – a *Stimmungsraum* – in which our being-in-the-world can unfold itself. It does so by acting as a physical resonance chamber for "free-floating" moods – moods, that is, that have not yet taken hold of the subject. Fuchs views depression as a *loss* of bodily resonance – a loss that renders the sufferer unresponsive to the call of the world and thus leads to a failure of transcendence, to a condition of being locked-in (2000: 104). In depression, the lived body is *korporifiziert*: it is alienated – a stiffened, heavy thing no longer capable of opening up the mood-space required for a full-fledged, homelike being-in-the-world.

The obvious allusions to music present in Heidegger's discussions of moods, which are echoed in Fuch's notion of bodily resonance, should not only be interpreted metaphorically, I believe. On the contrary, they represent the best available vocabulary for the development of a phenomenology of moods. The closest we can come to describing what it means to be attuned is captured in the experience of listening to a piece of music that puts us in a pervasive mood – a mood which colors our entire being-in-the-world. This is not to say that sight, smell, taste and touch are not also part of the experience of becoming attuned and being mooded. The attunement of human being-in-the-world rests on a bodily scheme in which the separate sense modalities have not yet been singled out, but rather work together in a primal unity. Extending Fuchs's analysis, I would like to suggest that the lived body cannot only be *devoid* of resonance, but can also be differentially attuned, in the sense of being *sensitive* or *insensitive* to specific moods. In the case of anxiety disorders and depression, one might describe these conditions as a being-out-of-tune, or a being-attuned-in-a-minor-key, in the sense of being receptive to only the anxious, boring and sad tones of the world. This scheme would allow us to imagine a spectrum, featuring, at one extreme, the normal resonance of the lived body, in which the body is able to receive a full range of moods; in the middle, personal preferences and idiosyncrasies, through which certain moods are favored over others (for instance, in the melancholic or joyful person); and, at the other extreme, the cases we would label pathologies, in which the body is severely out of tune, or even devoid of resonance.

Indeed, the phenomenological rendering of the lived body as an instrument of resonance seems to

support the view that systematic alterations of the physiological organism (such as the inhibition, brought about by pharmaceuticals, of the reuptake of specific neurotransmitters in the synapses of the brain) could alter the attunement of a person and thus the person's being-in-the-world as well. The alien quality of depressed and anxious embodiment fits well with the idea of a disease process overwhelming the healthy organism. But, certainly, the qualities and contents of our being-in-the-world are not solely dependent upon what happens in our bodies – they are also dependent upon what happens in the world around us. Periods of depression and anxiety attacks are often triggered by specific events in the world – events that may or may not have something to do with the sufferer's personal history. Thus, the perspective of the lived body does not exclude the world, but rather points logically to it, and to the people who inhabit it.

Two of the main characteristics of depression are the feelings of grief and guilt. The person suffering from depression seems to mourn the loss of somebody or something, and he often blames himself for this loss and for the feeling of worthlessness it has left behind. Grief can be described as a mood (sadness); but when, in the form of mourning, it is coupled to the loss of a specific object, it is an emotion. It seems, however, that most depressed people do not know what or whom they are missing or mourning; their grief becomes a mood-state, in the sense that it colors and determines their entire being-in-the-world in an unhomelike way.

In his famous essay *Mourning and Melancholia*, written in 1915 (1957), Sigmund Freud seeks an explanation for the mourning and the feeling of guilt present in depression.[9] His hypothesis is that the reason the melancholic (or depressed person) does not know what he is mourning is that the object of the feeling has been repressed and consequently made unconscious. Early in his life, the melancholic was abandoned by his mother, but this loss was too hard to bear, and it has therefore been repressed. The feelings of loss, desperation and anger have instead been directed inwards, towards the melancholic himself, which explains the feelings of guilt and worthlessness.

There is, no doubt, something peculiar about the objectless grief and senseless self-blame of the depressive mood and depressive being-in-the-world that makes these states different from the sadness and self-criticism of everyday life. However, abstaining from evaluating the credibility of Freud's hypotheses, we should note that the unhomelike quality, outlined above, of the abnormal forms of anxiety and boredom, being rooted in an embodiment that is out of tune, can be said to be grounded in a primal loss made visible by the phenomenological analysis itself. The loss in question is not only a loss of the world, but also a loss of oneself, since it is only within the meaning patterns of being-*in*-the-world that one's identity can be established and one's life carried out. Here we have an explanation for the fact that the grief and guilt of depression (and, to some extent, of anxiety disorders) fail to find "normal" objects (that is, objects in the world) and are instead re-directed towards the self. The grief of depression is a mood rather than an emotion, since it suffuses the lonesome world of the melancholic in its entirety, and since it tends, owing to this lonesomeness, to reflect back on the melancholic himself.

Normality and the self

Through the phenomenological analysis above, we have established that feelings like anxiety, boredom and grief are constitutive of our being-in-the-world, but that they also can develop into pathologies. In the latter case, the self is no longer capable of engaging in a normal being-in-the-world but is instead consigned to a painful, unrelenting unhomelikeness. The line of demarcation between normal being-in-the-world and abnormal being-in-the-world certainly cannot be determined with the precision of the sphygmomanometer (with which one measures blood pressure) or the sensitivity of a tissue biopsy (with which one can detect the presence of cancer). This fact should come as no surprise, however, given the nature of phenomenological investigations, and the characteristics of mental illness in general. Recall the *DSM-IV* criteria for a depressive episode quoted above: the episode should cause "clinically significant distress or impairment in social, occupational, or other important areas of functioning." This is a life-world matter, dependent not only upon how things "really are," but also upon how the person and people around him (including family, friends, and the doctor) interpret them to be. In the domain of illness, in contrast to the scientifically more objective domain of disease, the question of normality is in the end always anchored in normative judgments.

The distinction between illness and disease, however, is not as clear-cut as it might first appear. Diagnosis – especially in psychiatry, but also, at

times, in somatic medicine – typically rests on criteria expressed in the vocabulary of illness, rather than disease.[10] The level above which a blood-pressure reading should be regarded as elevated – and on the basis of which a diagnosis of hypertension can be made and antihypertensive treatment prescribed – ultimately depends on a clinical judgment related to the person whose body is being investigated. A level that is too high for me might be all right for you, within certain limits, of course. The domain of the normal is getting smaller by the day, not only because doctors and scientists are learning more about diseases and becoming more adept at treating them, but also because the companies that manufacture and sell pharmaceuticals have a clear interest in expanding the domain of the abnormal (Healy, 2004). It is not only the case that doctors treat a state of the body because it *is* a disease; the body state *becomes* a disease precisely by virtue of the fact that it can be treated (Elliott, 2003).

At this point, we should probably focus on the concept of illness, rather than treat it as a mere foil to the concept of disease. In a way, that is precisely what I have been trying to do by approaching antidepressants from a phenomenological perspective. Although discussing serotonin may feel more comfortable than discussing human misery (for doctors as well as patients, not to mention politicians and representatives of pharmaceutical companies), such an approach will not get us very far toward understanding and helping people who suffer (Crossley, 2003). Do not get me wrong here. I am convinced that SSRIs have helped millions of people who, for medical, psychological, or political reasons, had no other realistic option. The phenomenological notion of "bodily resonance" explains well why serotonin levels could be relevant for feelings and being-in-the-world. But we enrich our biological accounts by providing them with this phenomenological dimension, by relating them to patterns of meaning constitution; otherwise, we risk mystifying biology – risk transforming it into something foreign to problems of everyday life. Discussing serotonin deludes us into blaming our brains, rather than ourselves and the societies we live in (Valenstein, 1998). "It is not I who is ill; it is my body." In one way, this view of depression (and anxiety disorders) gets it exactly right. The depressed person experiences an *alien* quality at the heart of his existence and being-in-the-world – the lived body. But the lived body is, of course, also the person, and not a mere thing.

The ways of the body (biological and lived) are changed, not only by drugs and other physical influences, such as suffering a stroke or burning one's hands on the stove, but also by the feelings and thoughts we have in life. Being depressed could certainly be caused by low serotonin, but it could also be the other way around: being bored, sad or anxious might cause a decrease in serotonin levels. Raising serotonin levels in the synapses of the brain by administering an SSRI may cure, or at least relieve the symptoms of, depression and anxiety disorders. But the same effect can be achieved, at least in some cases, by way of "talking cures" (forms of psychotherapy), which promote self-understanding and often result in beneficial changes in behavior.

Let us now focus on the question of self-change. As we have seen, our being as worldly situated selves rests essentially on the attuned understanding of the body, which opens up the world as a region of meaningful relations to be perceived and articulated together with other people. Human *Da-sein* – being there, existing – is, according to Heidegger, open to the world; it is disclosed (*erschlossen*), in that it makes itself *at home* in the world (1986: 54). This openness is a form of hospitality toward the world – a constant striving to find a place for new phenomena in the meaning pattern, in order to make sense of them. Nevertheless, this openness and hospitality to the world, which is constitutive of the being of the self, rests on a bodily resonance, which can be brought out of tune in various ways.

Thus, the self is grounded in a bodily attuned resonance, which makes transcendence to the world possible; but since the self *is* its being-in-the-world, it cannot be thought of as existing "outside of" or "prior to" this relation of being-in. If bodily resonance is too restricted, the formation of the self will not be possible; but, once established, being-in-the-world will inform bodily resonance in a variety of ways. Think about how falling in love, or being betrayed by the one you love, will change your attunement and thereby your entire way of responding to the call of the world. Antidepressants alter the concentrations of neurotransmitters in the synapses of the brain; therefore, their effects at the phenomenological, everyday level can be thought of in terms of alterations of bodily resonance – alterations that make new forms of transcendence to the world possible. It is likely that these effects are not limited to cases of deep depression and intense anxiety; but because antidepressants modulate the peaks of boredom

and anxiety, which profoundly affect our transcendence, their effects will be most striking in these cases.

The effects of antidepressants on the self should therefore be thought of in terms of changes in self-feeling or, more precisely, self-vibration. As was pointed out above, we are dealing with a spectrum of bodily resonance, extending from normal resonance, incorporating personal preferences and idiosyncrasies, to pathologies. 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. The popularity of the SSRIs can therefore be explained not only by the fact that we have gained new knowledge about defects of our biological makeup that we are now able to treat (Kramer, 2005), but also by the presence of cultural norms of self-styling, which pharmaceutical companies have been quick to exploit (Elliott, 2003).

Conclusions

In this paper, I have approached the effects of antidepressants by way of phenomenology, in response to a question posed by Peter Kramer in his widely read book from 1993, *Listening to Prozac*. Kramer asked whether SSRIs make both the ill and the healthy "better than well," by altering their personality traits. My strategy has been to dissect, at the phenomenological level, the relationship between normal and pathological feelings. My discussion above of bodily resonance – the capacity to be attuned – brings Kramer's question into focus, but it provides no final answer to whether Prozac is a treatment for mental illness, or merely a mood and personality enhancer. To be honest, I do not think it is possible to give a straight answer to this question, since the disposition of being attuned through bodily resonance is not necessarily either an illness or a personality trait. In fact, it could be both at the same time, since the lived body is at one and the same time both mine and something alien. I do not fully control all of the processes of the body; it leads, to a certain degree, a life of its own (for example, in the form of autonomous functions), through which it can take on alien qualities. And yet the lived body is also me, my point of view on the world, which makes transcendence to the world by way of attunement possible. Bodily resonance as our basic self-disposition is a kind of *activating passivity*. When the passive aspects of embodiment become too alienated or painful, we speak of a state of illness. When the passive aspects are simply the cornerstone of my being, we speak of personality (and melancholy, sanguine, choleric or phlegmatic personality traits, or the more modern differentiations made by latter-day psychologists).

We live in a culture in which self-formation has become more and more of a conscious mission, instead of something pre-given. This state of affairs may seem paradoxical. Has recent biomedical progress in areas such as molecular biology and neurophysiology not swayed our views on personality in a deterministic direction? Have we not come to regard the influence of the social environment on the individual as being of secondary importance for determining what the individual is and what he will become? Well, yes and no.

First, the social pre-determination of an individual's life plan has become less binding, at least in the minds of most people. One is no longer expected to follow in the footsteps of one's father or mother, and this fact has changed self-formation radically – especially for women, who are no longer destined to be only mothers and wives. This ideal of finding your own way in life, rather than relying on social traditions, has been spread throughout the Western world, during the last 50 years or so, often in the guise of "the American dream": what you end up being is up to you yourself and nobody else (Elliot, 2003).

Second, biomedical breakthroughs have not only made it possible to understand and model the causal networks of our biology in a much more sophisticated way; they have also made it possible to *intervene* in these networks. This shift from chance to choice regarding the makeup of our bodies will presumably influence the nature of future genetic treatments (Buchanan et al., 2000); it has already influenced the nature of plastic surgery and psychopharmacology (Elliott, 2003). Will genetics adopt enhancement as its goal (rather than the treatment of diseases and the amelioration of defects), in the same way as plastic surgery already has? And, most important to us here, given the manner in which SSRIs are prescribed today, has psychopharmacology already adopted the goal of enhancement? Are SSRIs taken to enhance the self, rather than to treat its diseases and defects?

I have already tried to explain why I think this question is complex, and perhaps unanswerable. It is often unclear whether a form of behavior should be regarded as a disease or defect or as an aspect of the self – even from a phenomenological point of

view. But let me, in conclusion, highlight three issues that I think it is necessary to address and to understand in order to answer this question. The first issue is that matters of self-enhancement, in the case of SSRIs, are best understood as matters *of self-revelation* and *self-adaptation*. Prozac is not a "happy pill"; it does not make you cheerful, although it might allow you to "be yourself," to a greater or lesser degree. Prozac removes something that I feel is not mine (in certain instances, we choose to call this "something" a depression; in other instances, we call it a character trait); by doing so, it could be argued, the drug allows me to rediscover the way I really am beneath the guise of disease, or helps me adapt to a world I no longer feel at home in. Self-creation is always played out and realized within the meaning patterns of society and culture – the setting in which we discover and judge ourselves. Through our daily activities and our striving towards self-fulfillment – authenticity and happiness – we underwrite the norms of what we consider a good and normal life. Needless to say, these norms are not established solely by psychiatry; they are also related to the high-speed, commercial culture of late-modern capitalism.

The second issue I want to highlight is that, with the advent of the SSRIs, it has become a tempting alternative to transform one's life pharmacologically, rather than by way of psychotherapy and self-reliance. In many ways, in fact, it has become a more *socially acceptable* alternative, since self-doubt and self-scrutiny – when they result in sick leave and psychotherapy – are expensive, not only for the individual but also for society. And yet, people of course do not stop talking about their lives, just because they start taking Prozac. On the contrary, they keep talking, but now SSRIs become a topic of their discussions. The third and final issue is the following: I feel we should start listening more systematically, not only to Prozac, but also to people talking *about* Prozac, in order to better understand two concepts I touched upon above: normality and authenticity.

Notes

1. Antidepressants can be divided into several different subgroups. Two subgroups of antidepressant drugs prescribed more frequently before the introduction of SSRIs about 15 years ago are the monoamine-oxidase inhibitors (or MAOIs), and the tricyclics (so named for their three-ring molecular structure). These drugs are often effective against depression but have bothersome side effects, such as decreased appetite, dry mouth, sweating, nausea, dizziness, constipation and sleeping problems. They are also toxic in high doses, and this fact, in combination with the risk of side effects, explains doctors' reluctance to prescribe them to patients who are not severely depressed. For the treatment of anxiety disorders, doctors have historically had access to other kinds of drugs than antidepressants, such as the benzodiazepines; these drugs, however, have become increasingly unpopular, since they are quite addictive. At the end of the 1980s, the SSRIs were introduced; they were made famous by the commercial success and cultural impact of Prozac (generically, fluoxetine). In some parts of Europe another SSRI, citalopram (Celexa), has been more popular than fluoxetine. Other widely prescribed SSRIs are paroxetine (Seroxat, Paxil) and sertraline (Zoloft). A class of similar antidepressants, which inhibit the reuptake of both serotonin and noradrenaline in the synapse, includes venlafaxine (Efexor, Effexor) and mirtazapine (Remeron). Although originally marketed to treat depression, the "new antidepressants" have also been shown to have beneficial effects on anxiety. In this paper, I will use the terms (new) antidepressants and SSRIs interchangeably. In most countries, prescriptions for SSRIs account for more than 75% of all prescriptions for antidepressants; moreover, the effects of self-change I am focusing on have been associated mainly with SSRIs. For an overview of the development of antidepressant pharmaceuticals since the time of the Second World War, see David Healy's excellent book *The Antidepressant Era* (1997).
2. For a critical review of Kramer's recent views on depression and antidepressants (see Elliott, 2007).
3. In the future, we will probably see the development of new kinds of mood-affecting drugs – drugs that will influence the levels, not only of neurotransmitters like serotonin that affect the brain, but also of circulating hormones that affect the entire body. Research on different receptors for the same substance (there appear to be at least 14 different serotonin receptors, for instance) might also lead to new breakthroughs in drug development. Although the dramatic rise in prescriptions for antidepressants can be attributed to the popularity of SSRIs, experts are in no way convinced that depression is caused by a lack of serotonin (at least not in the same way that diabetes mellitus, for instance, is caused by a lack of insulin). Matters are thought to be far more complex; see, for instance, Healy (1997), Kramer (2005) and Whybrow (1997).
4. References to such studies can be found in Kramer's latest work, *Against Depression* (2005: 293). This paper is inspired by an ongoing empirical research project based on interviews with doctors who prescribe SSRIs and patients who consume them in which the matter of self-change is explicitly addressed. Since I am now in the process of analyzing the empirical material, it will not be presented directly in the present text. I will instead restrict my analysis to conceptual issues surrounding the essence of this potential self-change. See also Elliott and

Chambers (2004) for an interesting collection of papers on SSRIs and questions of identity.
5. In this paper, the terms "illness" and "disease" are used in accordance with a standard distinction made in the fields of medical philosophy, psychology and sociology by which the former relates to personal experience and the latter to biological processes.
6. See note 3 and 4 above.
7. It should be mentioned at this point that I am certainly not the first person to try to make use of Heidegger's insights in the philosophy of psychiatry. Since the 1930s, several well-known psychiatrists and psychoanalysts have developed theories inspired by Heidegger's phenomenology, including Ludwig Binswanger, Medard Boss, Wolfgang Blankenburg and Jacques Lacan (Spiegelberg, 1972).
8. Heidegger himself in *The Fundamental Concepts of Metaphysics* refers to the famous comment by Aristotle, found in the *Problemata*, that all great and creative men have been melancholics (1983: 271). Heidegger writes on the same page that all philosophical thinking springs from a few basic moods, characterized by *Schwermut* (sadness, melancholy). Anxiety and boredom thus bear a relation to sadness and melancholy for Heidegger – a relation we will return to later in this paper.
9. Melancholia is the pre-modern term for depression and depressive personality traits. Ironically, the term disappeared from the vocabulary of psychiatry around the year 1900, only to be rehabilitated by contemporary psychiatry. It is used in the *DSM-IV* to describe a specified subtype of depression characterized by deep, persistent boredom (2000: 419). In twentieth-century psychiatry, this form of depression has been qualified by many different adjectives – "endogenous," "vital," "biological" – all contaminated, however, by etiological hypotheses, which has made the designations unsuitable for *DSM* classification. Even more important in this context is the reappearance of the old notion of "dysthymia" in the *DSM*, a notion similar to melancholia in its denotation of a certain temperament or personality type (2000: 376) (see Healy, 1997; Kramer, 1993).
10. The language of contemporary psychiatry circumvents this problem (and others), by speaking of mental "disorders," rather than mental diseases or illnesses. But, as should be clear from my discussion of diagnosis, the diagnostic criteria used in psychiatry describe phenomena related to illness rather than disease.

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