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Title: Bringing the Laboratory Home: Psychopharmaceutical Tapering, Intimate Experimentality, and Post-Pharmaceutical Personhood

Acknowledgments: This research was supported by the Wenner-Gren Foundation, The Fonds de recherche du Québec – Société et culture (FRQSC), and the University of Pennsylvania. My deepest gratitude to my advisor, Adriana Petryna, for her unwavering support and guidance, and to my interlocutors in the withdrawal community who shared their stories and their knowledge.

BRINGING THE LABORATORY HOME:

Psychopharmaceutical Tapering, Intimate Experimentality, and Post-Pharmaceutical Personhood

"*My bathroom counter looks like a chemistry lab,"* Mark tells me with a grim chuckle. "*Why don't I show you?*" He picks up his laptop and walks across the house, holding the screen at an angle so I can see. He points to different flasks and contraptions, lifting them as he narrates: *"I have a 100 milliliter burette, it draws up 100 milliliters of water, and I pull up three of those, so I get exactly 300 milliliters of water. And then I use a laboratory-quality pipette to draw up Valium, and I put that in with the water and dissolve it. And then I use these syringes to pull out the amount that I'm tossing. It's pretty complex.*" He heads back into his office, still holding his laptop: *"And then with the Effexor, I open the capsule and I count the beads, and so then I just reduce by one bead about once a week."* It was hard enough for Mark to get down to his current dose of Effexor, a serotonin-norepinephrine re-uptake inhibitor (SNRI). Reaching the limits of his reduction strategy, he planned to see if his primary care doctor would write him a prescription for a liquid form of the drug. He was afraid to ask his psychiatrist "*because then he gets suspicious as to what I'm doing*."

Mark is using his makeshift home laboratory—which also includes high-precision scales, spare capsules, symptom logs, and spreadsheets with dosage and dilution calculations—to painstakingly taper off Effexor and Valium (a benzodiazepine), two of the four psychiatric medications he is hoping to someday get off of completely. After decades of use, he no longer believes the medications are helping him. While he struggles daily with their increasingly untenable adverse effects, stopping has proven almost impossible, and following his doctors' tapering advice has left him with debilitating and persistent withdrawal symptoms. Like many others in the "withdrawal community" of people trying to safely stop their medications, the harm Mark experienced following mainstream medical advice broke his trust in psychiatry and led him to seek information and support elsewhere: "*That was when I realized that my psychiatrist didn't*

know what the hell he was talking about," he tells me. "*And that's when I switched over from trusting the medical professionals to trusting the online withdrawal community and the patients that have gone before me*."

Tapering is a process of gradually reducing one's medication in small increments to prevent or mitigate withdrawal symptoms. A growing number of patients, activists, and researchers believe that existing guidelines and clinical commonsense downplay or deny the risks of psychopharmaceutical withdrawal, encouraging patients to stop medications at what they consider a dangerously fast pace. Feeling abandoned by those tasked with caring for them, patients like Mark are turning to online peer support groups for tapering guidance, relying on a combination of lay-expertise and intimate self-tracking to carefully wean themselves off their medications over the course of months or years.

Over eighteen months of digital ethnographic fieldwork (Boellstorff et al. 2012; Fielding, Lee, and Blank 2016; Pink et al. 2015) on psychiatric drug withdrawal, I spoke with dozens of patients in the process of tapering. Part of what is loosely referred to as the "withdrawal community," they were in different stages of reckoning with the limits (and harms) of standard psychiatric practice, brought together by a shared struggle to discontinue their drugs. These patients and self-described survivors of what some call "prescribed harm" are gathering in forums and Facebook groups, seeking out and creating alternative resources to manage their own medication discontinuation.

Mark was not the first person who insisted on showing me his home "chemistry lab." Many of my interlocutors were eager to share the specificities of their instruments, techniques, and protocols for tapering. Some, like Mark, turned their laptop cameras on their tapering setups, while others sent me emails with excel spreadsheets, dosage schedules, diary pages, and

symptom logs. Tapering, as I came to understand, is at once a technical, cognitive, and affective challenge and a process of hard-won personal transformation. It binds together the mundane minutiae of managing life in withdrawal and the intimate experimentality of the tinkering, measuring, and observation that people undertake in pursuit of healing. Failed by mainstream psychiatric care, patients are turning their computers into clinics and their kitchens and bathrooms into chemistry labs, left to run their own personal experiments—each their own *n* of 1—requiring accurate calculations, precise techniques and tools, and meticulous physical and psychological self-monitoring and documentation.

Prescriptions of psychopharmaceuticals have exploded in recent decades. As of 2013, at least one in six Americans took a psychiatric medication (Miller 2016), and diagnoses and prescriptions have accelerated dramatically since the onset of the pandemic (Schmidt 2022). Antidepressants, in particular, have become an enduring part of the American pharmacopeia, increasing 65% between 1999 and 2014, and reaching 13% of the US adult population by 2018 (Pratt, Brody, and Gu 2017; Brody and Gu 2020). Unsurprisingly, given the institutional structures and incentives of pharmaceutical research (Dumit 2012), there is no robust literature assessing when or how to safely stop taking them. This historical juncture of psychopharmaceutical saturation and scientific uncertainty has produced a massive "public health experiment" (Aviv 2019), where patients trying to withdraw are left in a scientific vacuum.

Attentive to both the materiality and the social, affective, and subjective dynamics of tapering, in this article, I explore how the gaps left open by mainstream psychiatric science and practice shift the burdens of research and care—running experiments, seeking information, supporting others in distress—onto patients themselves. In this way, I suggest,

psychopharmaceutical tapering comes to function as both a set of epistemic and sociotechnical practices and a form of biological and subjective self-fashioning as people struggle to "get to zero," working to remake their bodies and identities in the wake of psychiatric treatment and its sequelae. A disciplined form of practical experimentation with bodily and social effects, tapering, I argue, acts as a structure through which patients produce technical knowledge, seek out healing and recovery, and create the conditions for a longed-for, if ambivalent, post-pharmaceutical personhood.

My Doctor Didn't Have a Clue

"*I was on 150mg of Effexor*," Olivia tells me. "*[My doctor] suggested cutting it in half, or by a quarter every two weeks. That was far too fast. I was so physically ill, I was completely non-functional. And then I was sick for two years after that*." A thirty-five-year-old actor and comedian in Los Angeles, Olivia was given fairly typical medical advice for discontinuing her SNRI antidepressant: cut your pills in half, and then in quarters, and then stop. Such protocols are commonplace, with many doctors advising halving or quartering one's dose at regular intervals, or else tapering by skipping pills—take one's normal dose every other day, then every third day, etc. Until recently, most medical guidelines suggested tapering antidepressants over 2-4 weeks and, while persistent patient activism and new research on the neuroscience of withdrawal (Horowitz and Taylor 2019; 2022) have finally led to a hard-won revision of some of these guidelines (Gregory 2023), in practice, it remains to be seen if and when psychiatric training and practice will shift to reflect these updates.

Most people in the withdrawal community had trusted their doctors and followed their advice dutifully, only to find that doing so made them sick. When stopping or reducing their

medications, people can experience intense and sometimes-debilitating physical and psychological withdrawal symptoms: insomnia, headaches, shakiness, flu-like symptoms, brain zaps, brain fog, panic attacks, anxiety, anger, depersonalization and derealization, to name a few. Stopping too fast, for many, inaugurated worse problems than whatever led them to seek treatment in the first place: as Olivia insisted of her rapid taper, "*it was far worse than anything I experienced that put me on the medication*." Having done as their doctors suggested, only to end up extremely ill, and with little additional guidance on offer, people find themselves grasping for alternative sources of information and care. As Lily told me: "*Three days into [withdrawal], in my almost manic, middle of the night sleeplessness that happens sometimes to people tapering…was when I found the Facebook group. I'm gonna just take to the internet, I'm gonna take to social media for medical advice, because I don't know what else to do and I'm desperate.*" I heard such refrains again and again, marking a clear disillusionment with the psychiatric care on offer and a newfound attention to its potential to do real harm. The majority of data collection, experimentation, and knowledge-sharing on drug discontinuation has thus been the responsibility of the peer support community, to whose accumulated knowledge and practical advice people turn in the grips of withdrawal, when they come to realize that their prescribers' guidance is either insufficient or actively harmful.

Tapering is the central concern of the peer support world, where knowledge produced by and for the withdrawal community is disseminated. Facebook groups and popular websites and forums like *Surviving Antidepressants* (SA) and *The Withdrawal Project* (TWP) offer protocols, spreadsheets, and resources for tapering, addressing both general best practices and the specificities of particular medications and tapering strategies. In addition to broadly shared frameworks for safely stopping psychotropic medications (summarized most simply by *SA*'s

"3KIS: Keep it simple. Keep it slow. Keep it stable"), these sites offer specific guidance tailored to medication classes (SSRIs, SNRIs, benzodiazepines, antipsychotics) and particular drugs (Prozac, Paxil, Effexor). The tapering guidelines these sites offer—as well as the one-on-one feedback offered by moderators and group members—represent the accumulated expertise of the lay withdrawal community, triangulating mainstream scientific research with thousands of community case histories.

Patient knowledge is specific in both epistemic and practical terms (Heyen 2020; Kallinikos and Tempini 2014; Kempner and Bailey 2019; Prior 2003). For Jeanette Pols, it is what patients "use and develop in their daily practices in order to live with their disease"; "a practical *knowing in action*…rather than a body of knowledge" (2014, 75). Patient knowledge, for Pols, "aims to *improve* the daily life of individual patients," and "patients use and develop this practical knowledge to translate knowledge from different sources […] into usable techniques" (76). She coins the term "know-now" to get at this "situated activity of knowing," which patients use to "interpret new situations, to establish what might be the problem, and how they could act" (80).

Much of the tapering advice in the withdrawal community might be understood as precisely this kind of know-now in action: built up through experiments, tinkering, observation, and trial-and-error, it is knowledge that is active and actionable—about what to try, how to do it, and what to do when things go wrong. It is a set of guiding principles and technical practices that adapts to different use cases and conditions, that gets "turned into science" (76) as it is made available to and for others. Tapering and the knowledge supporting it might be thought of primarily as a form of *techne*, or craft/art, rather than *episteme*, and, as many of my interviewees emphasized, as a form of daily *labor,* or work. Tapering *techne*, as I came to think of it,

comprises practical know-now about how withdrawal works and what to do about it, worked out collectively in online spaces where people share knowledge, dispense advice, and adapt community wisdom to their particular needs.

Tapering Techne

Core to the practical knowledge of with withdrawal community is a shared orientation to the nature of withdrawal and the principles of successful tapering. As Brassmonkey, a prolific member and moderator on perhaps the most popular and long-standing withdrawal forum, *Surviving Antidepressants*, summarizes in a post: "*Getting the drug 'out of the system' is not the object of a taper…The object of a taper is to reduce the drug in a way that the body can undo the physical changes the drug has caused, in such a manner that the body doesn't realize that it's happening. When the drug is removed too fast the body can't keep up with the healing required, gets confused and manifests the WD symptoms we experience."* Tapering aims not to stop a drug as quickly as possible but, rather, to account for the body's adaptations to a medication over time by very slowly discontinuing the drug, allowing the body time to readjust. It takes the stability of the central nervous system as its goal, based on an understanding that the body has made adaptations to the presence of a drug over time, and that only very slow, small changes in dose allow sufficient time to readapt to its absence. As Agnes, the founder of *SA,* puts it: "*you get withdrawal symptoms when your nervous system 'notices' the absence of the drug.*"

Taper "rate" is one of the core considerations in getting off a drug slowly enough that the body does not "notice," and there is a general consensus in the peer support community that an appropriate starting range for a taper is a 5-10% reduction of one's dose each month. Critically, this reduction should be a percentage of the previous month's dose, *not* a percentage of one's

original/starting dose. Unlike linear cuts, where the dose reduction is relative to the initial dose and results in larger reductions each time (as a percentage of one's current dose), with the exponential cuts of a "hyperbolic taper" (Horowitz and Taylor 2019), the percentage decrease stays constant, with the actual size of the reduction getting smaller and smaller over time.

A 2011 thread on *Surviving Antidepressants* entitled "Why taper by 10% of my dosage?" expounds on this logic of reduction, which Agnes explains as a form of harm reduction, based on the premise that physiological responses to stopping a drug can vary considerably, and there is as of yet no way of predicting who will get off with no trouble and who may suffer debilitating and enduring symptoms: "*While it is not a guarantee you will have trouble-free withdrawal, we believe this conservative tapering method will cause harm to the fewest number of people.*" Some people stop their medications quickly and easily; others find even a 10% rate too fast. Because of this variability, the withdrawal community operates under a precautionary principle: of course, you might quit cold turkey, or taper quickly, and emerge unscathed. But those who have suffered with severe withdrawal, sometimes for months or years, insist that the risk is far too great. "*Many people do fine with a faster taper. Are you one of them? You can't tell ahead of time,"* writes Agnes. The damage incurred is presented as a kind of tipping point: if you start too slowly, the argument goes, you can always speed up later, but if you start too fast, you can cause lasting damage to the central nervous system that cannot be easily reversed, even with drug reinstatement or updosing to one's original dose. "*It's a Humpty Dumpty situation,"* Agnes notes, *"Once your nervous system falls off that wall, there's not much that can be done to put it together again.*"

Unknowability across various scales haunts these cautionary entreaties: we do not know who will suffer withdrawal and who will not; we do not know how to treat it when it happens;

we do not know how long it will take to heal if you get sick. Indeed, due to a paucity of research, little is known about the science of withdrawal and tapering. Again and again, people spoke to me of their regrets at having "gone too fast," often without knowing anything about the risks of withdrawal. From within this morass of high-stake uncertainties, the peer support community implores everyone to take these risks seriously: to "protect their nervous system" at all costs and avoid "destabilization." You might be one of the lucky ones, but are you willing to take that chance?

And yet, more often than not, this question comes too late; while the withdrawal community aims to minimize harm through a precautionary approach, in practice, it is often only *after* a failed attempt at tapering that people find the groups—Humpty Dumpty has already fallen off the wall, so to speak, and we do not know how to put him back together again. The groups underscore the importance of starting slow even as they seek to help those who may have already crossed a critical threshold. The advice for such individuals is in practice much the same as for those starting a taper fresh: *Keep it simple. Keep it slow. Keep it stable*.

*

Once one has decided to taper slowly, there are calculations to be done, tools to be assembled, techniques to be mastered: all of which are seen as crucial to successfully stabilizing the nervous system and withdrawing safely and with minimal symptoms. Even with a 5-10% cut per month, decisions must be made about precisely when and how to make these "cuts." Choosing an appropriate "taper schedule" or "tapering plan" is a core concern in the forums, which contain resources to help people construct and follow tapering schedules: almost all of the groups link to online tools, calculators, and spreadsheets set up to account for different taper rates and help people calculate and track dosages and dilutions. Some people choose to make their cuts once

per month, with the rest of the month spent "holding," or keeping the dose constant (a "cut-and-hold" approach), and others opt for a "micro-taper" schedule, where they instead make very tiny reductions every day.

If the goal of tapering is to minimize symptoms and maximize stability, some people find these gradual micro-tapers gentler and easier to tolerate. As a downside, they are tedious and labor intensive, requiring more complex math, constantly changing dosages to manage, and very tiny cuts, all of which can be especially onerous for those dealing with brain fog and cognitive impairment due to withdrawal. No method is strictly slower or faster: the overall speed of the taper depends on both the frequency and magnitude of cuts made, as well as any additional "holding" periods, which may be more frequently required in a more aggressive taper plan. Individuals tapering must weigh these tradeoffs, considering their personal contexts and mental and physiological reactions. As much as possible, people strive to maintain what Gridley, a longtime *SA* user and moderator, described to me in an interview as "withdrawal normal": *"feeling your usual amount of crappiness"* rather than the exacerbated symptoms one experiences after a cut, or when tapering too fast. Symptoms, here, are a semiotic device that index the state of one's nervous system, sounding the alarm when one is reducing too fast, a warning which must be heeded to prevent "destabilization."

Combined with taper rate, taper *method* is understood as critical to one's success: how does one actually, materially, make reductions—turning a pill of a set dose into the precise amount of a drug one needs to take? Decisions about methods depend on the physical and chemical composition of the drug someone is tapering, the tools at their disposal (or financially accessible to them), their cognitive capacities for managing detailed math, their manual dexterity and

sensorimotor skills, and personal preference. Planning and executing a precise taper can thus require a great deal of knowledge, preparation and resources.

The mechanics of tapering rely on varying degrees of physical dexterity. At its simplest, you can break up your pills with your fingers, or use a knife or razor to shave them down, but this gets harder to do at smaller amounts, and consistency and accuracy are very difficult to achieve. You can crush up and weigh tablets (or pour out the powdered contents of capsules), using the most accurate scale you can get your hands on, and pour this back into a capsule. You can prepare a liquid mixture (either solution or suspension) by dissolving pills directly into liquid (water, milk, or alcohol are common choices, or you can purchase a pharmaceutical grade suspending liquid) or by crushing and stirring them in. You can break open capsules and count out tiny individual beads or pellets, one by one, pouring the correct amount back into a new capsule. If it exists for your drug and if you can afford the sticker cost (usually not covered by insurance), you can purchase an existing liquid formulation of your drug, or pay to have your medication personally compounded at a compounding pharmacy.

Some of the tools and supplies you might need include adapter caps, bead-counting surfaces, digital scales, empty capsules, graduated cylinders, pipettes, jars, mortars, pestles, pharmaceutical-grade powder filler, pill bottles, and slip tip syringes. These materials range from the mundane and accessible (jars) to the less familiar (pipettes) and can vary substantially in price (a cheap scale can be purchased online for around twenty dollars; a pharmaceutical grade scale will cost you hundreds to thousands). Many of them require manual dexterity on top of the mental acuity required for calculating reductions: counting and sorting tiny beads, transferring powders from scales into capsules, measuring out liquids in small syringes and pipettes. While such manipulations would be finicky at the best of times, for those dealing with withdrawal

symptoms such as brain fog, dizziness, tremors, and shaky hands, they can be extremely challenging to manage on one's own.

No matter which method you choose, the considerations are myriad, and the details, high-stakes: many in the withdrawal community believe that even tiny amounts of medication (far below what mainstream practitioners would consider a therapeutic dose) can have powerful effects on their "sensitized nervous systems," and tradeoffs between accuracy on the one hand and accessibility on the other haunt the process for many. Some will swear that they truly feel *every drop* of a medication reduction; others dismiss this homeopathic logic and do just fine with simpler and less precise methods and tools. For many, however, especially those with severe symptoms, getting their taper "right"—choosing the right method and the right reduction rate; calculating and implementing with utmost precision—can feel critical.

People in withdrawal are, in effect, tasked with becoming their own psychopharmacologists, assessing drug formulations and acquiring and learning to handle precision tools (like a lab quality balance, or Mark's elaborate system of pipettes/burettes). "*We're not chemists*," insisted one woman at a community event, "*I think the idea that we are left to our devices to cut/split/titrate our own pills to be ludicrous."* And yet, that is precisely what they are left to do.

In practice, people in withdrawal experiment with various taper rates, schedules, and methods, tinkering, monitoring their bodies, and asking questions of others who have been there before. There is a precarious balance at work in the peer mentorship system: while general principles are reiterated again and again (*go slow, aim to stabilize, hold, updose if appropriate*), it is widely acknowledged that everybody's body is different and that one-size-fits-all tapering is impossible. The knowledge required here is thus both collective and personal, located

somewhere between an "everyone is different" approach and the desire to produce useful, semi-generalizable patient knowledge that might be made actionable for oneself and for others.

Self-Tracking and Intimate Experimentality

It is in this gap between general principles and individual bodies that the daily work of tapering unfolds. Questions which haunt the support groups—how slow is slow? How precise is precise?—can only, ultimately, be answered at the individual level, through the careful everyday work of practical experimentation that brings those tapering into the simultaneous roles of doctor and patient, researcher and experimental subject. Within the space left open by mainstream psychiatry, I think of tapering as a kind of *intimate experimentality*: a form of self-experimentation that relies on lay-expertise, peer support and, above all, painstaking attention to one's own body. Unlike the pharmaceutical experimentality that characterizes research and treatment in psychiatry more broadly, intimate experimentality is situated in the *home-cum-laboratory* (*cf* Middleton 2021; Pols 2014) and, more directly, in the body, and constitutes the small-scale, trial-and-error work of people trying to heal themselves from the physical and psychological turmoil of withdrawal, which becomes its own (sometimes chronic) illness state. Like other forms of experimentality (Petryna 2007; 2009; Rajan 2017; Murphy 2012), it is the product of many unknowns—here, about the adverse/long-term effects of psychiatric medications; the challenges of withdrawal; and safe and effective strategies for tapering.

In the case of psychopharmaceutical tapering, this intimate experimentality is enacted through careful self-tracking and symptom monitoring paired with personal experiments with tapering rates and methods. Recent anthropological and STS literature on self-tracking, biosensing, and the "quantified self" movement has explored the strategies and purposes through

which people "turn their everyday experience into data" (Neff and Nafus 2016) (Lupton 2016; Nafus 2016; Schüll 2016). Scholarship on self-tracking productively emphasizes how these practices "blur the line between home and clinic" (Neff and Nafus 13), and how they offer a strategy for handling the mismatch between available scientific/medical data and one's personal state of being. Instead of asking, "what is normal?", you might ask: "what is normal for me?" (Neff and Nafus 2016, 43); "is what those studies found […] true *for you?*" (46).

Focusing on the question of what is *true for you* emphasizes the importance of the *n* of 1. In the lexicon of scientific experimentation, *n* refers to the number of participants in a study. As Dana Greenfield (2016) writes: "The *n of 1* rejects the requirements of large numbers of subjects for statistical validity and expert credentials, forging a new epistemology of health and being where the single case or person collecting data […] displaces the population as the locus of knowledge or intervention" (125). It emphasizes people's "ability to derive valid and useful knowledge from personally collected data," a process which Greenfield refers to as "paraclinical work" (136).

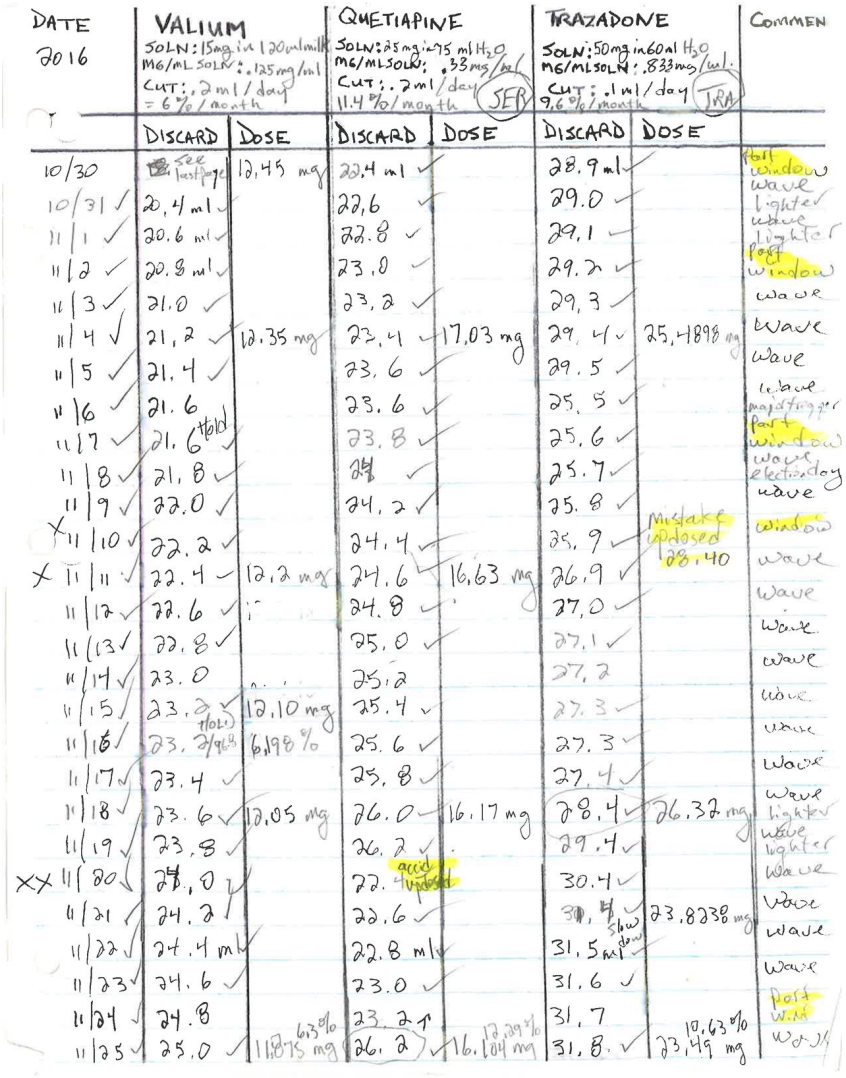
People tapering are, in a sense, each engaged in their own experimental study with an *n* of 1, where attention to their symptoms over time and in response to changes in dosages—as well as other potential triggers, like diet, sleep, and stress—gives them direct access to the knowledge that matters *to them.* While this experimental subjectivity is not a desirable state—indeed, one of the most common refrains I heard was how desperately people wished for more and better research on withdrawal and tapering; for doctors to take up the mantle of deprescribing in professional, informed, and well-resourced clinics; to *not* have to manage tapering on their own, with incomplete knowledge and makeshift resources—it does, simultaneously, offer people some amount of insight into their conditions, enabling them to "listen" to their bodies more attentively

(and, hopefully, objectively) and to render what they hear actionable, if imperfectly. And, while no one *wants* to find themselves in this position, the intimate labor of tracking and tapering, while a burden, simultaneously restores to people an element of agency and control over their conditions, offering hope of taming the uncertainty of their destabilized bodies and brains with precise self-knowledge and carefully-modulated reductions in medication.

Keeping a journal is the main way that people tapering track their mental, physical, and affective symptoms and adjust their strategies accordingly. A taper journal or log of some kind generally combines dosage information (and sometimes calculations) with some form of symptom tracking. By simultaneously noting when reductions are made and keeping a regular log of bodily, cognitive, and emotional states, the argument goes, it becomes possible to identify patterns in one's own symptomatology and, most crucially, to tinker with pace and techniques as necessary to minimize symptoms while continuing to reduce. The taper journal is thus a core technology that supports self-experimentation and the generation of practical knowledge. Symptom tracking takes chaotic and seemingly random fluctuations in bodily and mental states and attempts to create order, allowing patterns to emerge and helping people make decisions about how to proceed. Given the notable impact of withdrawal on cognitive capacity and memory, it also simplifies and organizes the cognitive work of recall and synthesis, freeing people up from the stress of remembering accurately and granting a greater sense of objectivity to their subjective experiences.

Symptom tracking can be carried out on any medium (pen and paper, mobile apps, spreadsheets, word documents). As with tapering schedules, pre-existing templates are frequently shared for those who might want them. While symptom tracking often involves some kind of quantification, some prefer purely qualitative logs, or more diaristic descriptions of how they feel

on a given day. Some people use symptom checklists and add up their daily "scores," and/or give an overall qualitative assessment of how they feel: as one *SA* user writes: *"I also give each day a single word to describe it overall: Awful, bad, ok, good, great*." In addition to specific symptoms and drug dosages, some people will log things like diet, exercise, medications or supplements, drug/alcohol intake (including caffeine), and life stressors/events, as such information offers greater insight into potentially causally-implicated factors, allowing for a birds-eye view of one's activities and lifestyle as well as physiological and affective states.



Sample taper schedule. "Windows" and "Waves" are common descriptors for periods of symptom improvement or worsening. https://withdrawal.theinnercompass.org/

Symptom logs are critical tools in determining how (and when) to proceed with a taper. As Karma, an admin on *SA* notes: *"I rate my symptoms daily on a scale of 1 to 10, 1 being 'awful, I feel like I'm dying, I can't take it any more,' 10 being 'great, flipping fantastic!', a 7 is when I feel the symptom, but I can tolerate it and get through the day—so for me a 7 is acceptable. Before I decrement my dosage I want at least two weeks of 7 or better in my symptom rating...especially anxiety and depression."* It does not matter that people's scales are not externally comparable; as Karma insists, recalling the ethos of self-tracking discussed above: "*it doesn't matter if my 7 and your 7 are different—this rating system is for you."* Flare ups of symptoms, made visible in logs and journals, allow the body to speak and direct one's actions.

If self-tracking makes possible the collection of personal data that both amplifies the body's voice and enables practical experimentation and adjustment, it also serves a more affective function, giving people purchase on their symptoms and offering some semblance of control over their out-of-control bodies; self-tracking grants some objective, externally-legible status to one's experiences and symptomatology, providing both concrete practices in which one can engage—symptom logging—and a feeling of greater mastery over one's condition.

For Heather, symptom tracking was an empowering process that restored a sense of agency to her taper: *"I did bead counting,"* she explained to me, *"And I kept a spreadsheet of that, where I just filled in the blank…If I feel good enough to drop a few more beads every few days, then I would do that. I would also chart my symptoms both morning and afternoon. And that way, I was actually able to take my power back and predict how I would be feeling and actually plan out my days. I would have some sort of semblance of control over this."* Similarly, Rebecca recounted how logging her symptoms helped calm her anxiety, making order out of the

distressing and overwhelming complexities of her condition: *"it was like everything was swimming around me. [Tracking] was almost a way to take all that and just focus it a little bit."*

Being forced to take on the intensive, sometimes all-encompassing project of managing a taper can provide a sense of agency, but can also become obsessive and self-destructive. The intense self-scrutiny people engaged in, while at times helpful, could also produce notable anxiety and a kind of constant hyper-vigilance. People frequently discussed how tapering "took over their lives," and many admitted that they had ultimately decided to relax their standards, use easier but less precise methods, and track less frequently (or not at all) because the labor, stress, and edginess of tightly controlling every aspect of their taper was taking too much of a toll.

Moving on from meticulous tracking can also be part decision to move forward with one's life. Rebecca, who used to track more precisely, spoke to me about moving away from this practice over time:

"*I had symptom journals for a few years and then this last year I just stopped because it was not helpful anymore. It was good to keep track of it at first, just so I can say, look, this is what's happening. But I'm trying not to let it rule my life…I just don't want to be tied to that…anymore."*

The affective life of self-tracking is thus ambivalent—while it can offer people a sense of agency and control over their unpredictable and often-debilitating symptoms, the heightened and constant self-scrutiny it demands can produce anxiety, frustration, and obsessive orientations in people who are already struggling. And yet, in the absence of support from psychiatry, such techniques are also all people have available to them. As Laura Delano, founder of the Withdrawal Project and something of a celebrity in the community, asserted in a Webinar on withdrawal: "*For anyone out there who's like, where's that doctor who's going to help me get off,*

where's that facility I can go to where they'll get me off my meds…I usually say, as diplomatically as I can: there isn't one. We are the best experts on this."

De-Patienting: The Post-Pharmaceutical Self

The development, uptake, and mainstreaming of psychiatric drugs in the late 20th and early 21st century led to significant shifts in how those consuming these medications, as well as the broader public, understood the mind, brain, and self. Anthropologists of science and medicine have proposed a number of variations on the concept of the "pharmaceutical self" (Jenkins 2010) since the early 2000s, each with subtly different emphases—Joseph Dumit's (2003) "pharmaceutical self"; Emily Martin's (2006) "pharmaceutical person"; Nikolas Rose's (2003) "neurochemical self", to name but a few. These concepts of psychopharmaceutical subjectivity allude, in their own ways, to how people's notions of personhood have been remade through the promises and material effects of psychotropic medications, proffering cures (and sometimes enhancements), shifting concepts of the normal and pathological (Benedict 1959; Canguilhem 1978; Foucault 2003), and re-locating the self in the brain and the chemicals which act in and on it, be it "naturally" or through pharmaceutical manipulation. To be a pharmaceutical self is to come to understand one's subject position, affects, actions, and identity as bound up in biochemical modulations, and to see the brain and its chemical composition as a critical site of personhood.

If taking psychiatric drugs can reshape people's sense of themselves, how might *stopping* these drugs affect one's identity and subjectivity? How might the practice of tapering engage a *different* kind of self? In addition to a material practice of tinkering undertaken in the hopes of healing, tapering, I suggest, also functions as a modality of self-fashioning (*cf* Dumit 2003), opening up new possibilities for understanding the self and for envisioning and embodying what

I call a "post-pharmaceutical self." In building this new self, people struggle through withdrawal and undertake the daily work of tapering; as they do so, they re-shape not only their brain chemistry and central nervous system but also their very understanding of themselves. Stopping one's drugs can thus act as a form of becoming (Biehl and Locke 2010; 2017; Deleuze 1994), where the desire to "get to zero," as people refer to completing their tapers, opens out onto new possibilities for a freer, truer self.

As we were wrapping up an interview, Agnes paused and reflected, somewhat pensively:

*"One of the things that's fascinating…if you read some of the longer case histories, is how people start to understand themselves, how they change their understanding...it's the process…that I call de-patienting themselves…How they change their minds, how they change their way of thinking and their frame of reference…It's just fascinating how people *do* change."*

She used the term "de-patienting" to refer to how people move on from seeing themselves primarily as a patient—their lives consumed by diagnoses, medication harms, and withdrawal—and, in the process of their recovery, carry on with their lives. As Rachel told me: "*After I took the drugs and did the withdrawal…I have to carry the reality that I am two people. I am the person that did that. And then I am the person that carries on."*

Tapering, for many people—especially those who struggle the most and over the longest periods of time—is part of this work of de-patienting: of getting back, in certain desirable ways, to an earlier version of oneself, or of becoming someone different. In this process, people become something new (or renewed), re-orienting their lives and identities around a post-pharmaceutical subjectivity, open to the surprise of who they may become, or (re)discover themselves to be.

For some, getting off their medications allowed for the renewal of a past self that had been lost or subdued under treatment and/or in withdrawal. As Elizabeth told me: *"I found myself randomly singing and dancing around my house. And my daughter just made an off the cuff comment about how long it had been since she had seen me act crazy. And I went into the bathroom and I cried, when I realized how accurate that was. And the relief that that piece of me still existed, because I thought it was gone."*

Laura Delano refers to herself as an "ex-patient." In a Facebook webinar on withdrawal, speaking warmly and passionately, gazing intently into the camera, a stack of books behind her, she explained the sense of awakening she experienced after coming off her medication:

"I'm finding my way back to myself, I'm rediscovering who I really am, my body is having a chance to figure out its true baseline after being medicated for a decade and a half…my body, my mind, my sense of self are coming back into oneness…I had this curiosity as to who I could become…it was what was driving me to get off the drugs in the first place."

If for some, there can be both pleasure and agency in rediscovering aspects of one's "baseline self," many people also acknowledge that there is, in a sense, no "going back." As Agnes put it: "*I hope you get back to that baseline, but the nervous system is a river where you can't step in the same spot twice. It's changed. You may feel better, but different."* There is, instead, a movement forward—which may be joyful, tentative, bitter, or nostalgic—into a different version of oneself; in Laura's words, "*who I could become*." For those who are still struggling to taper, or dealing with the post-acute effects of withdrawal after months or years, there is less a sense of starting over, or of going back in time, than a wistful resignation to a sometimes-painful present and the difficult project of continuing to rebuild oneself from the rubble. As Lucy told me, her voice heavy with acceptance: "*There's before, during and*

after…but before was the best. I've realized that I'll never...This idea of going back to who you were before is amiss, you just adjust to the person you've become after psychiatry. So I have to build a new person."

There is an aspirational, almost wistful quality to this version of the post-pharmaceutical self: a sense of nostalgia for a past self and grief over the loss of what might have been. Leah's voice is thick with emotion as she recounts the years she spent taking and withdrawing from her medications: "*even my mom would say things like 'I would look at you and I did not see who you were. You were not there. You were a different person*.'" Elizabeth, still laughing after telling me about dancing around her kitchen, feeling returned to herself, turned more somber as she reflected: *"being on these medications changed me so much…I feel like I lost seven years of my life…And looking back I can't help but be a little angry and just wonder what it would be like if they had just helped me get some sleep."*

As people taper off their medications, they work to slowly and carefully stabilize their bodies while also reinventing themselves: they may strive for a return to some kind of "baseline self" or, more often, acknowledge that they have been transformed in complex ways. The post-pharmaceutical self is a horizon of possibility and transformation; it embodies hopes of healing and recovery that often coexist with a profound sense of loss. For people who may once have understood themselves as "pharmaceutical selves"—defined by their brain chemistry; the medications they took to normalize it; and, during tapering, the adverse neurochemical effects of all-encompassing withdrawal symptoms—the intimate work of tapering allows them, day by day, to shift towards a different model of self-understanding, defined less and less by medication, but by something else, a "new brain," or whatever it may be: *I have to build a new person.*

The Only Way Out is Through

The completion of a taper is in some ways just the beginning…One of the big disappointments of reaching "0" is finding out you still don't feel 100%...the big question is: "how much longer?" (Brassmonkey, *SA*)

A common refrain in the peer support groups is: *the only way out is through*. While withdrawal symptoms can be miserable and life-altering and even very slow tapering can be an excruciating process, there is a sense of determination and resignation which motivates and encourages people to carry on: there is no going back, only forward; the only way out is through.

The desire to "get to zero" is voiced often by people tapering, a horizon of hope and transformation that marks the end of an ordeal and of their experiences with both psychiatric medication and withdrawal. Managing what Brassmonkey calls the "*endgame taper"* involves its own practical challenges. "*The term "Endgame,"* he writes on *SA*, *"comes from chess and refers to the final series of moves to complete a coordinated strategy with a successful outcome. Many chess masters consider it the most important part of a strategy. The same goes for the final phase of tapering psychiatric drugs. We have put a lot of time and effort into our tapers and to lose concentration and rush the final moves could slow the positive outcome.*

In a hyperbolic taper, the absolute values of reductions get smaller and smaller asymptotically over time, approaching but never *reaching* zero. It is accepted in the withdrawal community that the end of a taper is the most difficult part, with the smallest cuts having the largest impact on symptoms and often requiring the most holding and stabilizing. In practice, deciding on an "exit dose" involves considering the material constraints of one's tools (achieving sufficiently small doses will eventually become impossible with any method) in conjunction with symptom monitoring. Anyone tapering will eventually have to make the "jump to zero."

Tapering, as we have seen, involves a constant negotiation between what is ideal and what is possible, where people must make decisions about what to do based on incomplete information about both the science of psychiatric drugs and their individual neurobiology. The desire to "get to zero" presses up against the need to go slowly, and people weigh these factors as they decide how to proceed:

"Stable is relative," Lily told me. *"Because I never had any of these symptoms fully abate, they just become more manageable. And I figured that if I ever wanted to get off of this stuff, that would have to be good enough. Because if I waited until truly everything went away, I might be waiting for years before I could reduce again. And I was willing to have it take a long time, but I wasn't willing to have it be indefinite."*

And yet, despite the acute longing to "get off of this stuff," *it doesn't end at zero.* Many people I spoke with who had finished their tapers still struggled, for a time or to this day, with symptoms. Just as "withdrawal normal" is characterized by a stable, if still not *good*, status quo, "recovery normal" establishes a post-taper baseline which one hopes will improve with time, until "*one day you wake up and realize that it's all behind you.*" The horizon of recovery thus extends beyond the taper, into an unknown future, where the promise of healing is entangled with uncertainty over when, and if, one will ever emerge on the other side.

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