NORMALIZING HAPPINESS: THE RHETORIC OF DEPRESSION IN DIRECT-TO-CONSUMER ADVERTISING

by

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TABLE OF CONTENTS

LIST OF FIGURES

ABSTRACT

Direct-to-Consumer advertisements for antidepressants suggest to a broad audience of American consumers that it is desirable to be productive in work and supportive of friends and family members in addition to being happy and well. The consumers' inability to reach this norm is ascribed to a possible medical condition that can be treated with particular pharmaceuticals. In this way, the ads act as rhetorical agents, defining some inclinations as desirable (normal) and others as undesirable (abnormal), and persuading consumers to regulate their behaviors through medication. Ultimately, these advertisements reinforce the boundaries between normal and abnormal emotional health.

CHAPTER 1: "WHEN YOU KNOW MORE ABOUT WHAT'S WRONG, YOU CAN HELP MAKE IT RIGHT": AN INTRODUCTION

On May 14, 2003, the satirical online newspaper *The Onion* ran an article called "Pfizer Launches 'Zoloft for Everything' Ad Campaign," in which it reports that Pfizer, GlaxoSmithKline, and Eli Lilly's antidepressants can be used to treat more than just depression, anxiety and post-traumatic stress syndrome. In fact, the drugs can be used for anyone who "[doesn't] have time to deal with mood changes" ("Pfizer"). In a fictional quote, Pfizer president James Vernon says, "Zoloft can help anyone who needs their emotions leveled off. Do you find yourself feeling excited or sad? No one should have to suffer through those harrowing peaks and valleys." The article even makes reference to new ad slogans such as "Paxil…Give it a try" and "Pot Roast Burnt? Husband Home with the Flu? You're Having One of Those Prozac Days."

This short article is based in the commonplace that the prescribing of medication has become normalized in American culture. It pokes fun at the idea that antidepressants seem to be prescribed for the ups and downs of everyday life and says people should not have to "suffer" through the "harrowing peaks and valleys" of mood shifts—even emotions such as excitement or sadness. We would expect that any good doctor would never actually prescribe an antidepressant for burned pot roast—or so we would hope. Furthermore, the article satirizes the way advertisers have been stretching the diagnostic limits of depression by showing that Zoloft could be used for everyday troubles.

Humor is often used to discuss depression and draws attention to the changing discourses of mental illness. At the end of her best-selling 1994 memoir *Prozac Nation*, Elizabeth Wurtzel writes that she never thought that Prozac, the "antidote to a disease as serious as depression[,] […] would become a national joke" (296). In supporting her claim, she details several instances in which national newspapers and magazines poke fun at the effects of the happy pill, even citing cartoons in *The New Yorker* illustrating "a serotonin-happy Karl Marx declaring, 'Sure! Capitalism can work out its kinks!'" (296). She attributes this shift toward comedy to "the mainstreaming of mental illness in general and depression in particular," because mental illness, specifically depression, has become so completely ubiquitous it seems fair game for satire (296). Wurtzel's claim that depression and mental illness have become mainstream is fair, and I would also add that taking medication has become commonplace. In *The Onion* article mental illness is under less scrutiny than the idea that Americans can take a pill to fix any emotional change. This is not to say that medication is not effective in treating depression. What it does suggest is that jokes like these are humorous because they reveal a kernel of truth about our culture: emotional displays are unwanted.

In our personal lives, emotional outbursts are usually unwanted, although in the public sphere, they are often treated as spectacles. People tune into shows such as *Jerry Springer* to see how wildly emotive some people can be. The crowds cheer as someone breaks a chair on stage in anger over the results of a paternity test, and viewers shake their heads as mothers cry on stage because their children will not behave. People tune in to see the train wrecks as a way of distinguishing themselves from the guests on stage.

There are other public shows such as *Dr. Phil* that teach people to get in touch with their emotions, but only to the extent that they need tools for managing them. Those shows encourage people to move beyond sadness or loneliness toward happiness and fulfillment. Television shows like these reinforce that emotional displays are not acceptable in our real lives by turning guests into spectacles that highlight the differences between "them" and "us." In our day-to-day behaviors and interactions with others, certain codes of conduct are normal while others, especially sadness, loneliness or apathy are not.

The relationship between eliminating unwanted emotions and taking medication could not have been made any clearer than in the 2003 advertising campaign for Pfizer's antidepressant Zoloft. In these advertisements, the pharmaceutical company claims that if people are lonely, sad, or anxious, they should take medication to correct the chemical imbalance that causes these feelings.

In a series of advertisements, Pfizer created an animated commercial that featured "Dot," a small white circle with eyes and a mouth. As the commercial begins, there is a close-up of Dot. The viewer can see it is raining but does not see a rain cloud above. As the screen zooms outward, the grey rain cloud appears. Momentarily, a blue bird flies into the picture. The background of the advertisement is white, and a long, black line cuts across the screen, representing the break between the ground and the sky. Dot looks at the bird, turns away and moves a few feet while giving a small, high-pitched groan. The blue bird flies away, and Dot is left all alone. The narrator speaks in a soothing male

voice; as he does so, Dot reacts with different facial expressions. For example, when the announcer says the word “hopeless,” its mouth turns into a squiggly line.

Halfway through the commercial the screen shifts to visually demonstrate the chemical imbalance perceived to be responsible for depression. The advertisers show two nerves with small dots moving back and forth between them. The announcer explains, “While the cause is unknown, depression may be related to an imbalance of naturally occurring chemicals between nerve cells in the brain.” At the top of the animation the Zoloft logo is shown as the announcer continues, “Zoloft, a prescription medicine, works to correct this imbalance.” Then, the screen moves back to Dot, this time with a yellow flower near the dark black line. The rain stops, Dot looks up and smiles, and the rain cloud breaks apart. Dot looks back and the blue bird flies toward her. Dot smiles more and hops along, playing with the bird as it moves its way across the screen. Finally the bird flies into the next screen where the Zoloft logo finishes the commercial.

In this commercial, Dot represents the depressed individual. Dot’s eyes are downcast, suggesting sadness. She trembles because of anxiety, and she sighs heavily revealing her hopelessness or loneliness. Dot embodies all of the emotions of a person with depression: hopelessness, anxiety, loneliness, and sadness. But then, after taking Zoloft, Dot instantly becomes content, joyful, happy, and even at peace with the world, as evidenced by her closed eyes and a smiling face. Dot is allowed to express joyful and happy emotions, not sad, lonely, and depressed ones. In this advertisement, not all emotions are undesirable, only the ones coded as negative.

This advertisement draws on societal norms. Expression of negative emotions is rarely encouraged in our contemporary society. We must manage our anger and temper our rage. We must look on the bright side and find the silver lining in the clouds. We mustn't cry over spilled milk or get down in the dumps. Whereas in the past, people were expected to pull themselves up by their bootstraps or seek advice from friends, family, or priests, now medicine will do it for them.

The relationships among medicine, self-reliance, health, and emotions are at the heart of this project. The process of changing our attitudes toward medicine and its relationship to health is fundamentally a concern for rhetoric because this shift isn't accidental or sudden. It is a deliberate process meant to redefine our sense of normal emotional behavior. Emotional health is not a stable, fixed entity; it is a rhetorically-constructed concept that, in recent years, the pharmaceutical companies have been a persuasive and pervasive force in developing. In this project, the rhetoric of science, and more specifically the rhetoric of health and medicine, is the symbolic system by which knowledge about health and medicine is produced and disseminated. The pharmaceutical industry influences the practices of psychiatry and psychology to construct our health, and they create advertisements that define particular codes of conduct, thereby persuading consumers to engage in practices that normalize our emotional health. Using depression as a case study, I examine the ways in which the pharmaceutical industry rhetorically constructs emotional health.

Using Michel Foucault's theories of normalization, technologies of the self, and governmentality, I argue that Direct-to-Consumer advertisements produce a discourse of

depression that creates specific knowledge about normal and abnormal behaviors. Everyday emotions such as sadness, loneliness, and apathy are medicalized into illness, and this produces a medical discourse around depression. When these behaviors become pathologized, the pharmaceutical companies can persuade audiences that they can regulate their behaviors through the use of medication. The advertisements rely on the persuasive nature of the norm to encourage people to take drugs to treat their depression. However, these behaviors only work to further reinforce the distinction between normal and abnormal emotional behaviors.

The Relationship between Science and Rhetoric

The rhetorical study of science and medicine is a relatively new area of research for rhetoricians. Because science has often been considered an antidote to "mere rhetoric," science was not often analyzed as a persuasive domain. In *Health and the Rhetoric of Medicine,* Judy Segal outlines two changes that occurred in the underpinnings of rhetorical theory to include the study of science in rhetoric's purview. First, science had to be understood as a system of persuasion, and second, rhetoric had to be theorized as a system of knowledge production (10-11).

These two shifts have been mostly attributed to Thomas Kuhn and Kenneth Burke. In *The Structure of a Scientific Revolution,* Kuhn contends that major shifts in scientific paradigms occur as a result of persuasion. In this 1962 text, Kuhn begins his discussion of paradigm shifts by examining normal science. Normal science is the

practice of problem solving that reproduces certain ways of knowing the discipline (Harris xiii). Kuhn then contrasts normal science with revolutionary science—science that radically changes what the scientific community acknowledges as truth.

In order for revolutionary science and paradigm shifts to occur, scientists must persuade the community that their new evidence, beliefs, and values trump the already agreed upon belief system. A paradigm begins a shift when a few individuals notice that certain data does not fit into the established paradigm. When a scientist discovers a piece of data that does not fit, she engages in normal science to try to make sense of the information he she has (Kuhn 144). At this point, she is not testing the paradigm. She is collecting evidence to better understand the results of a particular experiment. If the results of the normal science studies reveal more anomalies, a crisis of the dominant paradigm may occur only if the "crisis has evoked an alternate candidate for paradigm (145). Any evidence produced that supports a new paradigm will be opposed by a majority of the scientific community, but those objection mean that scientists will need to continue to produce knowledge that either supports the new, proposed paradigm or supports the existing one. If enough data is produced to support the new paradigm, then it will replace the old one. Kuhn writes, "Paradigms gain their status because they are more successful than their competitors in solving a few problems that the group of practitioners has come to recognize as acute" (23). This entire process "emerges first in the mind of one or a few individuals" (143). These bold individuals and their belief that a finding or series of findings is worth exploring are the catalysts for a paradigm shift.

By reconceptualizing science as a series of belief systems, Kuhn opened the door for rhetoric. Once science was theorized as a series of mutually-agreed upon contingencies instead of brute facts, rhetoricians could explore how scientists worked to persuade one another. Following Kuhn and others' discussion of persuasion, rhetoricians began studying the textual markers that make certain texts more persuasive than others and how those markers define scientific discourse. Scholars drew on Aristotelian methods of analysis, examining, for example, how ethos is developed in scientific texts or how classical rhetorical figures are figured into scientific discourse (see S. Michael Halloran and Jeanne Fahnestock later in the chapter as examples).

In addition to Kuhn, Burke also significantly contributed to the study of the rhetoric of science because he introduced terms that were useful for its study. In his extensive writing, Burke developed a vocabulary for studying human interaction. One particularly useful term for studying the rhetoric of science is "terministic screens," or the words we use to name our world. In examining the implications of choosing certain terms over others, Burke writes, "Even if any given terminology is a reflection of reality, by its very nature as a terminology it must be a selection of reality; and to this extent must also function as deflection of reality" (45). In other words, by privileging certain terms we are ignoring other ways of understanding the world. For example, in *Flexible Bodies: The Role of Immunity in American Culture from the Days of Polio to the Age of AIDS,* Emily Martin discovers that certain metaphors of violence and imagery of war and battle were used to understand the role of the immune system in the body. Terministic screens such as the words "fight," "battle," and "kill" in reference to the role of the white

blood cells have defined a reality for what happens inside our bodies. These screens deflect a reality in which the white blood cells could, for example, persuade the pathogens from taking up residence in our bodies. Using Kenneth Burke and his approach to language, rhetoricians can examine the ways in which language constructs a reality.

Since Burke and Kuhn's scholarship opened the door to the study of rhetoric and science, many rhetoricians have been examining the relationship between these two frameworks. In *Risky Rhetoric: AIDS and the Cultural Practices of HIV Testing*, J. Blake Scott divides the waves of rhetoric of science into three categories. The first group of rhetoricians uses traditional rhetoric (or Aristotelian rhetoric) to "closely read the texts' rhetorical features and authors' rhetorical moves" (17). These scholars such as John Angus Campbell and S. Michael Halloran interpret "the text in light of its immediate context, account for such factors as the writer's motives, the audience's values, and any rhetorical constraints imposed by the situation" (17). For example in "The Birth of Molecular Biology: An Essay in the Rhetorical Criticism of Scientific Discourse," Halloran argues that Watson and Crick utilize an ethos that is distinct from other scientists of the time because it is situates the scientist within a community of thinkers. For example, Watson and Crick use the pronoun "we" to refer to the scientific community. Furthermore, Watson and Crick spend the beginning of their essay establishing good will toward their audience by citing them and trying to acknowledge the important work that has been done in the field. Halloran claims that this unique ethos makes the writers persuasive to their readers.

Scott claims the second group of rhetoricians focuses less on the rhetorical features of the texts and more on the "dynamic, social, and intertextual knowledge-making practices of science" (18). In this way, rhetoric's definition is broadened from the Aristotelian definition. Rhetoric isn't a study of the available means of persuasion. It is a study of how language is epistemologic. The work of rhetorical scholar Martha Solomon is an example of this second classification. In "The Rhetoric of Dehumanization: An Analysis of Medical Reports of the Tuskegee Syphilis Project," Solomon considers the ways that the form of medical reports work to "obscure ethical issues" (234) by specifically dehumanizing patients. The Tuskegee Syphilis project was a forty-year study conducted to better understand the "natural" progression of untreated syphilis in black men and the scientists in the study were discouraged from administering any treatment to the participants so as to record the effects of the disease (Solomon 233. Needless to say, men died as a result of the non-actions of these medical professionals. While there had been outrage against the study from the government and the public *after* the study was completed, no one had examined why no one in the medical community responded to the reports published *during* the study. Solomon analyzed those medical reports and found that the genre and language of scientific reporting created a way of knowing that obscured the dehumanizing effects of the study. By casting the participants as subjects and making the creation of knowledge the purpose of the reports, the scientists reading these reports did not see the ethical problems at play. The scientific writings created certain ways of knowing.

Finally, Scott's third category of rhetoricians is called public or external because they study "the rhetorical controversies about science and technology that are played out in different public forums such as in policymaking hearings or popular media texts" (18). In this category, rhetoric is often studied in light of accommodation, how scientific knowledge is translated to the public. For these "externalists," the texts available for study under the purview of the rhetoric of science are widened to include any text *about* a scientific topic. Jeanne Fahnestock's "Accommodating Science: The Rhetorical Life of Scientific Facts" examines the ways in which public intermediaries (news people, advertisers) interpret science for lay readers. She claims they must "accommodate new knowledge to old assumptions and [try] to bridge the enormous gap between the public's right to know and the public's ability to understand" (330). Rhetoricians who fall into this category attempt to reveal how writers accommodate science by discussing discourse in terms of underlying assumptions or values of the audience.

A study in the rhetorical constructions of emotional health blurs the lines among Scott's categories. Pharmaceutical marketing falls into Scott's definition of public science. Advertisers must accommodate scientific studies to present discoveries to the public; however, examining accommodation does not account for the ways these advertisements *create* ways of knowing our bodies. These advertisements may accommodate science, but they also define normal and abnormal behaviors, which is a rhetorical strategy to sell drugs that has much larger implications for our culture.

Normal is the Watchword: Normal as Rhetorical

One of the most influential thinkers in the study of norms and normalization is Michel Foucault. In all of Foucault's work he examines the ways that knowledge is produced and how the individual positions him/herself in relation to that knowledge. In his early work *Discipline and Punish*, Foucault examines the ways technologies of domination and power, such as the prison system, produce knowledge. Through hierarchical observation, normalizing judgment, and examination, these institutions can gather information about normal behaviors and discipline the body to fit into those normal behaviors (*Discipline and Punish* 170).

In Foucault's later work, he argues that not all systems employ disciplinary power over people. Some systems also employ biopower, which encourages people to regulate their own bodies through techniques of the self. These techniques are practices that people perform on themselves to conform to the norm. At the end of his work, Foucault also explored the idea of governmentality which is a power exerted on people by the state. This kind of power still requires individuals to regulate their own bodies, but a discourse of security that can be provided by government is employed. In all of Foucault's work, the norm is produced by discursive practices.

In *Enforcing Normalcy: Disability, Deafness, and the Body*, Lennard Davis argues that prior to norms, the concept of the ideal was what people strived toward. Since the ideal was never attainable, people did not concern themselves with how far away from the ideal they were. They simply accepted that they were not perfect. Davis makes a case for statistics as being the root of the concept of norms. According to Davis,

statistics, as a branch of scientific knowledge, was born in the early modern period and around the same time of the advent of the Industrial Revolution.

Statistics are arguments made about what is normal. During industrialization, bodies were expected to produce a similar amount of work, so manufacturers relied upon statistics to determine what each employee could be expected to produce in a given amount of time. Then, a manufacturer could *evaluate* productivity based upon an expected average. People were scientifically watched, evaluated, and regulated because science was able to determine the characteristics of an average person (norms of weight, height, etc), an average worker (norms of productivity and distribution), and an average citizen (norms of participation and kinds of non-delinquent or non-criminal behaviors).

Defining behaviors in terms of norms is a way of shaping our expectations. In *Conceiving Normalcy: Rhetoric, Law, and the Double Binds of Infertility,* Elizabeth Britt writes,

> The norm can be regarded as an argument about which qualities or characteristics should be measured, about which units of measurement should be used, about the dividing line between the normal and the deviant, and in a more general sense, about the importance of ranking and comparing individuals in a population and about ascribing significance to an occurrence of an event. (11)

To put Britt in context, take, for instance, a chart of weight ranges found on the Weight Watchers website. The chart has four columns: height, minimum joining weight, minimum health weight, and maximum healthy weight. To figure out what one *should*

weigh, she finds her height and reads across. A person who is 5'6" should weigh between 124 lbs and 155 lbs. Falling outside of those numbers a person is either underweight or overweight. By ascribing this range of numbers as "healthy," they have been also defined as desirable since most Americans would claim they want to be healthy. These numbers are seemingly objective. In order to be considered in good health, a person should weigh a particular amount. However, how these numbers are determined is not provided in this booklet. Presumably, these numbers have been based upon some agreed upon set of qualities that have been determined to indicate healthiness. What those qualities are, how they were measured, and who decided which units to measure are hidden within these "objective" ranges. Many Americans want to be in a healthy weight range. By defining this range numerically, these numbers on the scale make an argument about what is considered normal or deviant.

If someone falls outside of that range, she is not considered in a normal, healthy weight range. This place is undesirable, and many people will make changes in their behaviors to try to fall into that normal range. They will diet, exercise, join support groups, or take pills to help change the number on the scale. For the "deviant," these ranges are not only representative of the normal; they also act as catalysts for changing behaviors so as to achieve the desired outcome.

Normalization is the process by which the norm is established and reinforced. In order for something to be considered normal, it often has to be associated with the desirable. For example, the normal weight range may be the norm because it is not associated with the consequences of being overweight: high blood pressure, high

cholesterol, heart attacks, etc. People who are in the "normal" weight range are not often associated with these adverse outcomes. Since these are undesirable effects of being overweight, many people seek to avoid that situation. They are persuaded to remain normal or work toward the norm. In addition to persuasion, normalization can only achieve its "purposes through negotiation and agreement about language" (Britt 11). That is, normalization "attempts to settle on common definitions, terminology, and categorizations" (11). The consumer must agree with Weight Watchers' definition of a healthy weight. If there is no agreement between the two, then the consumer behavior may not change.

Once a norm has been established, it must be reinforced. Drawing on French philosopher Georges Canguilhem, Britt argues that "certain techniques of normalization [such as individualizing and homogenizing …] create and perpetuate the distinction between the normal and the abnormal. The normal and the abnormal, therefore, exist not as discrete entities to be observed but as functions that stimulate modification" (9). In other words, when a norm is identified, the norm stimulates modifying activities, like going on a diet. The more people that engage in these in modifying activities, the more the norm is enforced and the more marginalized are those who do not modify themselves to fit the norm.

Britt's move to define normalization as rhetorical provides an important framework for the study of depression. Since most of the scholarship on DTC advertising is produced by marketing and communication scholars, many analyses examine the relationship between sales, texts, and effective communication of the risks and benefits of

the products. While important, these areas of analysis ignore the ways in which our subjectivities are shaped. Pharmaceutical companies deliberately attempt to shift public perspectives of what is normal emotional behavior while also relying upon perceptions of abnormal social behaviors. Britt provides a way to open up the discussion beyond marketing and communication toward a discussion of the ways they act to shape our discourse, our beliefs, and ourselves.

The pharmaceutical companies are finding ways to make abnormal what has been considered normal. In the prologue to *Selling Sickness: How the World's Largest Pharmaceutical Companies Are Turning Us All into Patients,* medical journalist Ray Moynihan and medical policy researcher Alan Cassels state:

> The marketing strategies of the world's biggest drug companies now aggressively target the healthy and the well. The ups and downs of daily life have become mental disorders, common complaints are transformed into frightening conditions, and more and more ordinary people are turned into patients. (ix)

For example, in the Zoloft advertisement, the announcer says, "Do you feel sad or lonely? These are common signs of depression." The advertisers are not lying: in fact, sadness and loneliness are considered signs of depression by the medical community; however, to be diagnosed as depressed, these emotions must be persistent, severe, and unusual for the individual. Without qualifying these emotions, the pharmaceutical companies have taken common human emotions and given them pathology. If more and more people define their behaviors as symptoms of an illness, then presumably more and

more people would be eligible for pharmaceutical intervention. This widening of the market is an interesting phenomenon that results from direct-to-consumer marketing and one I will explore further in this project.

Another effect of these DTC advertisements is that the perceived norm becomes harder and harder to achieve. If depression is defined so broadly so as to include everyday sadness and loneliness, almost every American would be depressed. Depression would be pervasive. If everyone was in fact depressed and that was the expected human emotional state, then the need for pharmaceuticals would perhaps be unnecessary. The ads work to continue to make depression undesirable, to maintain the distinction between normal and abnormal. In the Zoloft advertisement, Dot walks along under a rain cloud and does not acknowledge the flowers or bluebird that flies nearby. Dot is alone. After Dot takes Zoloft, she is transformed to a figure who is bathed in sunshine, plays with her friend the bluebird, and stops to see the flowers. These behaviors are coded as positive, attainable behaviors. While everyone may feel sad or lonely at times, the advertisement does not work to make it normal to have these feelings. In fact, they actively discourage experiencing these emotions by persuading the consumer that they are negative. These advertisements also provide a modifying activity that will help people become more normal: taking prescription medication.

Medicating Our Selves: The Relationship between the Government and Pharmaceutical Companies

Medication has always been part of our emotional health. Tonics and homeopathic remedies have been recommended for centuries to stop heartache or the pangs of grief. But those medications were folk remedies and passed from family member to family member or privately sold by alchemists. Never before in history has prescription medication been as institutionalized as it is today. Through a series of consumer-protection laws, the government has forced a relationship between itself and the pharmaceutical companies that has led to this shift in the role of prescription drugs in our contemporary society.

Conjuring up the image of a modern American pharmaceutical company usually elicits images a large manufacturing site with doctors and researchers busying themselves in their labs with test tubes and computers, working to discover the next miracle drugs. Or in a more jaded scenario, the scene consists of a group of businessmen sitting around their plush offices, smoking Cuban cigars, and devising new ways of making billions of dollars, perhaps through the practice of disease mongering.[1] Either way, these depictions are built around very recent constructions of the drug-making industry. While the pharmaceutical business is a relatively modern one, it has radically evolved since its creation in the 1880s and 1890s, and the US government has been in lockstep with its advancement.

[1] Disease mongering, as defined by Ray Moynihan and David Henry is "The selling of sickness that widens the boundaries of illness and grows the markets for those who sell and deliver treatments. It is exemplified most explicitly by many pharmaceutical industry–funded disease-awareness campaigns—more often designed to sell drugs than to illuminate or to inform or educate about the prevention of illness or the maintenance of health." (Moynihan and Henry 0425)

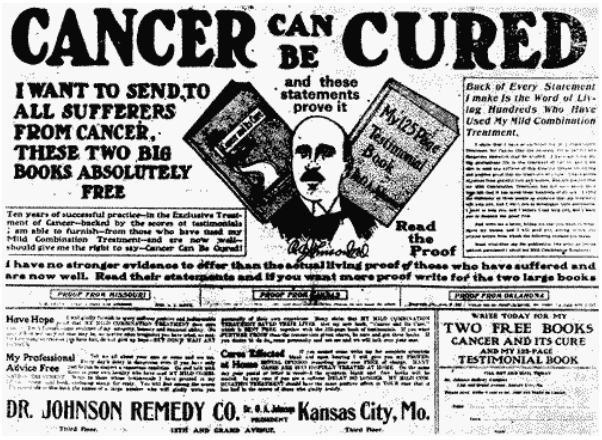
There is very little research to explain why the 1880s and 1890s mark the beginning of the pharmaceutical industry. Prior to those decades, in response to increased tariffs and limited supplies from Britain, American apothecaries developed their own medicine in the backrooms of their pharmacies. Herbs, roots, minerals, oils, etc, were manufactured into healing concoctions. Eventually, those backrooms were bought (often by chemical companies) and turned into manufacturing plants because many chemical companies (i.e. GlaxoSmithKline, Pfizer) were looking to broaden their market (Jones 1). At the time, the processes between pharmaceutical development and chemical development were similar (i.e. crushing and drying), and it cost very little for companies to diversify their business (Liebenau 11-12).

At the advent of the pharmaceutical industry, the federal government had very little involvement in the distribution of medicine. The medicines, termed patent medicines (which was a misnomer as the drugs were not patent protected), were sold in stores and pharmacies; however, they weren't regulated by a federal agency. These drug makers made grand claims about the healing-powers of the drugs, but they were not systematically-tested. According to Bernice Schacter in *The New Medicines: How Drugs are Created, Approved, Marketed, and Sold:*

> Physicians in the United States had to struggle to learn which medicines were safe and effective and which were useless and perhaps dangerous. Pharmacists were torn between concern that the patent medicines they might sell were useless or even dangerous and the reality that significant profit could be made from their sale. (14-5)

If the authorities that the general public turned to for cures or treatments for their illnesses were confused or couldn't be trusted, then the people were at risk.

In an attempt to protect the people from harm, the federal government stepped in. The first of the consumer protection laws, the Pure Food and Drugs Act, was signed on June 30, 1906. The Pure Food and Drugs Act "prohibited the interstate commerce of misbranded and adulterated food, drink, and drugs" (Schacter 16). This act was the catalyst for the removal of hundreds of worthless and dangerous products to be taken off of the market, but it did not prohibit the making of false claims, as ruled by the Supreme Court. For example, in the case of "Dr. Johnson's Mild Combination Treatment for Cancer," (see Figure 1) the promoter could not be prosecuted for misleading advertising because he did not make false statements about the identity or ingredients of the drugs (Janssen).


CANCER CAN BE CURED

I WANT TO SEND TO ALL SUFFERERS FROM CANCER, THESE TWO BIG BOOKS ABSOLUTELY FREE

and these statements prove it

My 125 Page Testimonial Book

Back of Every Statement I make Is the Word of Living Hundreds Who Have Used My Mild Combination Treatment.

Read the Proof

Ten years of successful practice—in the Exclusive Treatment of Cancer—backed by the scores of testimonials I am able to furnish—from those who have used my Mild Combination Treatment—and are now well—should give me the right to say—Cancer Can Be Cured!

I have no stronger evidence to offer than the actual living proof of those who have suffered and are now well. Read their statements and if you want more proof write for the two large books

PROOF FROM MISSOURI | PROOF FROM KANSAS | PROOF FROM OKLAHOMA

Have Hope

My Professional Advice Free

Cures Effected at Home

WRITE TODAY FOR MY TWO FREE BOOKS CANCER AND ITS CURE AND MY 125-PAGE TESTIMONIAL BOOK

DR. JOHNSON REMEDY CO. Dr. O. A. Johnson PRESIDENT Kansas City, Mo.

15TH AND GRAND AVENUE.

Figure 1: A 1908 advertisement for a cancer cure. Source: "Cancer Quackery"

Until the 1960s, the revisions following the initial 1906 Food and Drug Act mostly addressed issues of labeling and not advertising regulations. The only regulation that initially addressed advertising was the Wheeler-Lea Act of 1938 that restricted the advertisement of prescription drugs in the United States to medical journals and other professional publications (Arney and Rafalovich 2). According to Jennifer Arney and Adam Rafalovich, "Such federal regulations operated under the assumption that only

professional audiences should be privy to advertising from pharmaceutical companies and that this exclusivity would protect consumers from making uninformed healthcare choices" (2). This belief would be challenged at the end of the century when companies started advertising directly to the consumer.

In the 1980s when a few companies advertised to the consumer, the government once again intervened by suspending advertising while they pursued the implications of DTC. Interestingly enough, the drug companies complied with this moratorium, until 1985 when the FDA withdrew the moratorium in a Federal Register (FR) Notice (50 FR 36677), which stated that the ''current regulations governing prescription drug advertising provide sufficient safeguards to protect consumers.'' The federal government gave the green light to the pharmaceutical companies to advertise to the consumer (Department of Health and Human Services).

This move by the FDA didn't immediately flood the market with Direct to Consumer advertisements because the guidelines in place were cumbersome. Advertisements had to include a brief summary of the adverse effects of the drugs, and this statement most often was written in language that was confusing to the consumer. According to Nancy Ostrove, Deputy Director of the Division of Drug Marketing, Advertising, and Communications, in a statement before the Subcommittee on Consumer Affairs, Foreign Commerce and Tourism:

> Advertisements were limited because FDA and industry did not believe that it was feasible to disseminate the product's approved labeling in connection with the ad. The extensive disclosure needed to fulfill this

> requirement essentially precluded the airing of such ads. For example, one way to satisfy this requirement would be to scroll the ‘‘brief summary,’’ which would take a minute or more even at a barely readable scrolling rate. (Department of Health and Human Services)

For example, depression advertisements seem to be between thirty seconds and one minute long. In order to include a full statement of risk, the advertiser would need to add approximately another minute to the advertisement making it one and a half minutes or two minutes long. The commercial would be too long to hold the consumers' attention and, most likely, too costly for the company.

However, as technology, like the internet, evolved, so did the relationship between the government, the companies, and the advertisements. In 1997, the FDA revised (or clarified according to Ostrove) their position and allowed advertisements to reference "convenient access to the advertised product's approved labeling" (Department of Health and Human Services). A toll-free telephone number, a website address, a concurrently running print advertisement, and health care professionals are among the preferred methods of communication. Since the technology was now available to get consumer's risk information easily, the advertisements became more feasible, and pharmaceutical companies wasted little time spending millions of dollars to make their product's advertisement available to the consumer.

As of 2002, the total spending on direct-to-consumer advertising for prescription drugs has more than doubled since 1996 (Rosenthal et al 504)[2]. In 2000, GlaxoSmithKline spent $91.8 million in the direct-to-consumer advertising of Paxil (more than Nike spent on advertising sneakers!) to make it the fourth most heavily promoted prescription drug in America (Elliott and Chambers 6-7). Just because there has been in an increase in spending on DTC advertising and two of the most heavily advertised drugs are in the top 10 list does not necessarily mean there is a direct correlation between the two. The relationship between Direct-to-Consumer advertisements and sales is muddy, at best. In a 2002 article in the *New England Journal of Medicine,* two preliminary conclusions are drawn: 1) awareness for prescription drug advertising has increased over time, and 2) patients have initiated conversations with their doctors about drugs they have seen advertised on television. However, less than 6% of the people surveyed actually received the drug they requested from the doctor (Rosenthal et al 504). While this study isn't able to conclusively argue that DTC advertising resulted in increased prescriptions for patients, it does suggest that these advertisements have been persuasive to the general American audience because the viewers followed the suggestion of the advertisements; they asked their doctors about the drug[3].

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[2] According to this same article, DTC advertising accounts for 15 percent of the promotion-related budgets of pharmaceutical companies.

[3] Most of the promotional budget of pharmaceutical companies actually goes toward doctor awareness campaigns because pharmaceutical companies believe that doctors are more likely to prescribe a drug that they are familiar with (Rosenthal et al 504). The physician's degree of familiarity with a drug explains why so few people were prescribed the drug that was advertised. The physician may have prescribed a different drug in the same drug class or the physician felt the patient was not a candidate for that drug. It has been

As the pharmaceutical companies have grown into multi-billion dollar corporations, the federal government, particularly through the FDA, has regulated its relationship with the consumer. The FDA sanctions what kinds of information are allowed to be marketed to the American audience through its guidelines for advertising. It would seem that the pharmaceutical companies are at the mercy of the FDA, but they have found ways to still advertise their products through advertisements that do not specifically mention an illness or the use of the particular drug. Through magazines, television, the Internet, and a variety of other venues for advertising, the FDA and the drug companies have created a drug-seeking culture.

"Drugs Can(not) do a (Socially-Constructed) Body Good": The Intersection of the Social and Material Body

At their most basic level, pharmaceutical companies create, research, and test compounds that will have a biological effect on the human body. Historically, researchers would isolate a chemical from a plant or synthesize it in laboratory in order to discover a drug, but today, the process is rooted in molecular biology. In *A Healthy Business: A Guide to the Global Pharmaceutical Industry*, Mark Greener writes the following about identifying a lead compound (the first step in the drug discovery process):

> As molecular biology progressed, scientists began to unravel the complex biochemical pathways that cause an effect […]. They knew the enzymes

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found though that doctors do feel pressure to prescribe a drug to a patient when the patient asks for the advertised drug.

> and receptors responsible and, in many cases, their 3D structure. Through a combination of computer modeling and chemical modification, researchers were able to develop specific drugs that bound to the enzyme or receptor. The targeted approach increases the likelihood that the researchers will develop an agent with the desired therapeutic effect. (49)

The drug discovery process begins with the premise that the body is a biochemical entity. Scientists target particular biological structures in order to find chemical compounds that affect workings of the body. The drugs cause biochemical reactions that influence the body's behavior. And since the pharmaceutical companies are ultimately looking to produce and sell their products to consumers, they are looking for ways to improve the body. Pharmaceuticals are meant to chemically improve the body's current functions.

Approaching the body as a biological or chemical entity has come under scrutiny. For example, in 1993 Susan Bordo's influential text *Unbearable Weight: Feminism, Western Culture, and the Body*, the medical approach to the body is criticized because it leads to the slippery slope of ignoring cultural factors that may be responsible for human behaviors. In her chapter "Whose Body is This?" Bordo examines a handbook of eating disorders that states that there may be physiological difference in the way men and women respond to "chronic energy restriction." Bordo scoffs at this idea:

> My point is not to deny that biological factors may play a contributory role in determining which individuals will prove most vulnerable to eating disorders. But to suggest that biology may protect men from eating disorders is not to be open to the possibilities. […] Looking to biology to

> explain the low prevalence of eating disorders among men is like looking to genetics to explain why nonsmokers do not get lung cancer as often as smokers. (32)

Bordo's point is well made: genetics, anatomy, and physiology are not the only factors that influence a body's behavior. The body is also part of a complex and dense "institutionalized system of values and practices" (32).

In the early 1990's feminist scholars like Bordo were trying to move discussions of the body away from the physical and into the cultural. Bordo writes,

> Over the past hundred and fifty years, under the influence of a variety of cultural forces, the body has been forced to vacate its long-term residence on the nature side of the nature/culture duality and encouraged to take up residence, along with everything else that is human, within culture (33).

Bordo credits Karl Marx as a major influence for moving the body away from a purely physical definition by arguing that Marx's conception of the body as historical made way for feminists to conceive of the body as part of a cultural system. They acknowledged the corporeal body, but focused their scholarship on the lived experiences of a person within a cultural system. Jane Ussher edited a collection titled *Body Talk: The Material and Discursive Regulation of Sexuality, Madness, and Reproduction*. In this volume, writers argue that we need to move away from a "binary divide between material[4] and discursive analyses[5] of the body, towards a position which allows us to recognise the interaction and interrelationship between the two" (2). Materiality is the way that the

[4] The study of the physical body
[5] The study of the socially-constructed body

corporeal body is affected by physical aspects of experience, “the literal implementation of institutional control, the impact of the social environment, or on factors such as social class or economic status” (1). Social constructions of the body rely on discursive signs and symbols that manifest themselves in talk, visual representations, ideology, and culture (1).

It is inappropriate to study depression or the body as either exclusively material or exclusively discursive. Ussher writes, “To understand phenomena such as […] madness, […] we need to examine both bodily processes and practices, and the ways in which these processes and practices are constructed in the realm of the symbolic” (7). Depression is a complex illness because it is psychobiological and it is socially stigmatizing. Some bodies respond to medication, thereby suggesting that it may be in some part a biologically determined disorder. It is also socially-situated insofar as it is defined by a community of doctors (influenced by the pharmaceutical companies) who generally agree upon the defining characteristics of the illness. Furthermore, bodies engage in modifying activities to attempt to conform to the norm that has been established by this community. As a result, the body must be studied as both a social entity and a site of materiality.

I’m SO Depressed: Defining Depression

Drug companies advertise for depression for three reasons. First, the prevalence of depression as compared to the prevalence of mental illnesses is generally higher

(National Institute of Mental Health). The only mental illnesses with high prevalence are anxiety disorders such as Obsessive Compulsive Disorder (OCD) or Post-traumatic Stress Syndrome (PTSS), which are also advertised for. Since pharmaceutical companies (like any business) seek to target the widest market for their product, they are well-served by marketing antidepressants.

The second reason I believe pharmaceutical companies advertise for depression is that mental illness has become mainstream. Mental illness has a strong stigma attached to it. Stigmas of violence can be strongly associated with mental illness and often threats of institutionalization follow a diagnosis. In a very recent, public example, consider the current irrational behaviors of pop star Britney Spears. As soon as she was diagnosed with bipolar disorder (by the court of public opinion), there were cries for her to be put in mental institution because she was a threat to herself and her children ("Britney Needs to Be Institutionalized in Actual Institution"). Depression, on the other hand, no longer has the same stigma attached to it (unless it leads to suicide or attempts of suicide) even though it is considered a mental illness. The stigma has diminished into, in Wurtzel's words, "a national joke" (296). Pharmaceutical companies can then encourage people to seek treatment for the illness because admitting to depression does not bring with it severe social repercussions.

Lastly, depression has already made it into our vernacular in a way that suggests people already think of themselves as depressive. For example, in 2006 third season episode of *Starting Over (*an Emmy-winning, daytime reality series that chronicles women who want to change their lives "with the help of life coaching and therapy— all

while living together under the same roof" (Fearless Living Institute)), resident psychologist Dr. Stan Katz led a group session in which he asked the women to describe their current emotional states. Many of the women stated that they felt depressed, but Dr. Stan (as he is called) encouraged the women to find other descriptors for themselves beyond depression. He urged the women to interrogate their feelings further by thinking about using terms such has lonely, sad, angry, exhausted, etc. Depression, he told them, is a serious psychological state that no one in the room had been diagnosed with, and the use of the word was inaccurate. By making this distinction, Katz argues that depression is not synonymous with "temporary low mood states" because "serious suffering" is associated with depression (Downing-Orr 24). However, these women thought of themselves as depressed, and probably wouldn't have been the least bit surprised if they were clinically-diagnosed with the term. Pharmaceutical companies can and have capitalize on this self-diagnosis.

For all of these reasons, pharmaceutical companies can advertise antidepressants to the consumer so as to encourage them to see their doctor for a prescription. But obtaining that prescription is not easy. For psychologists and psychiatrists, the definition of depression is based on the *Diagnostic and Statistical Manual of Mental Disorders*, a manual published by the American Psychiatric Association that provides diagnostic criteria for mental illnesses. According to the most recent edition, *DSM-IV-TR*, depression is classified as a mood disorder (a disturbance in a person's emotional experience) in which a person will experience at least one of the symptoms from Category 1 and three or more symptoms from Category 2. These symptoms must be

present for most of the day, nearly every day for at least two weeks. This definition is general as depression is further broken down into several different subcategories such as Major Depression, Dysthymic Depression, Unspecified Depression, Adjustment Disorder, with Depression, and Bipolar Depression.

Using only the diagnostic criteria to extrapolate a definition of depression[6], depression is a psychological disorder that is characterized by bouts of mood disturbance, which manifest psychologically and physically and are unrelated to external factors. By defining depression in this way, its scope is limited to psychology, thereby eliminating the validity of a biological approach to understanding the illness. This is problematic because many researchers believe that "depression is caused by an imbalance of naturally occurring chemicals, serotonin and norepinephrine, in the brain and the body" (GlaxoSmithKline). This biologically-based definition is also limiting because it excludes the emotional and psychological nature of the illness. Because of these conflicting definitions, many researchers have now called for a definition that stresses that the illness is "psychobiological in nature---a physical illness with a whole range of symptoms including emotional, motivational, and concentration disturbance" (Downing-Orr 24). This new definition is an attempt at integration of the current medical and psychological theoretical underpinnings of depression.

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[6] This criterion has undergone scrutiny as well. Andrew Solomon writes:

> Psychiatry's bible-the Diagnostic and Statistical Manual, fourth edition (DSM-IV)-ineptly defines depression as the presence of five or more on a list of nine symptoms. The problem with the definition is that it's entirely arbitrary. There's no particular reason to qualify five symptoms as constituting depression; four symptoms are more or less depression; and five symptoms are less severe than six. Even one symptom is unpleasant. Having slight versions of all symptoms may be less of a problem than having severe versions of two symptoms. (20)

While there are drawbacks to defining depression, most doctors will rely upon the *DSM* to guide their practices, which makes the *DSM* an important document to analyze. The *DSM* III and IV have a complicated history of tension and disagreement among their writers. The substantial revisions that occurred between the drafts of the second and third editions can be traced to shifts in knowledge about mental illness, particularly from the influence of pharmaceutical companies.

Conclusion

DTC advertising for depression is a rich area for study because at its very core it defines and reinforces what we believe about emotional health. These ads are not simply selling drugs; they are selling a way of life, a normative framework for which to view and behave in the world. In this chapter I have provided an overview of the terms, concepts, and relationships I will draw on, develop, and revise throughout this project.

One of the major controversies in the current psychiatry/psychology conversations has been the definition and classification of depression as a normal human emotion, a biological disease, a social condition, and/or a neurotic disorder. In chapter two, I provide a history of depression. This history shows that depression has been defined by shifts in science which have led to its current definition as a disease of the body. This history is necessary for my subsequent chapters because pharmaceutical advertising cannot be effective if depression is not based in biology.

In chapter three, after setting up the theoretical and historical intersections among depression, the body, and drugs, I closely attend to two particular artifacts of depression: branded and non-branded advertising campaigns. In this chapter, I analyze non-branded campaigns. These "disease awareness ads" act to educate the public about particular illnesses by disseminating information about disease, but not referencing a particular treatment drug. Pharmaceutical companies use the power of the norm to try to convince the viewer that her behaviors are abnormal. Drawing on Foucault's theories of discipline, I argue that these advertisements encourage the audience to confess depression. This confession stems from a desire to be normal.

In chapter four, I argue that once a pharmaceutical company has constructed the illness in a particular way, they need to create a drug that will "cure" it. In these branded advertisements, drug companies attempt to sell their product. In this chapter, I rhetorically analyze the strategies that the advertisements use to persuade consumers to buy their product. Drawing on Foucault's ideas of technologies of the self and governmentality, I argue that the pharmaceutical companies invoke tropes of control and rely on the power of governance to turn the audience into patient-consumers.

Finally, in chapter five, I will examine the ways the pharmaceutical companies have shifted the concept of the normal closer to a concept of perfection, an unattainable norm. I then outline the implications for the knowledge produced by Direct-to-Consumer advertisements on a variety of populations, such as health professionals and politicians. Finally, I offer implications for the study of normalization for rhetoric and composition scholars.

CHAPTER 2: "DEPRESSION MAY BE CAUSED BY A CHEMICAL IMBALANCE IN THE BRAIN": SCIENTIFIC DISCOURSES OF DEPRESSION

On March 9, 2007, a special one-hour episode of the television talk show *The View* aired on ABC. This episode featured medical professionals, celebrities, and "regular people" alike in an attempt to provide a definition of, personal stories of, and treatment options for depression. Host Rosie O'Donnell began the show by orienting her audience toward a particular way of thinking about depression. She said, "Depression is a disease, and it needs to be treated like a disease," and people with depression should not be ashamed to seek treatment because they "wouldn't be ashamed if [they] were anemic […] or if [they] had diabetes" ("Depression"). In that definition, depression is not a shameful, personal illness but a disease over which people have little control. More precisely, they have no influence over the *etiology* of the disease. In an attempt to be reassuring, O'Donnell does say people have the power to seek treatment for this disease, much like they would find treatment for any other biological illness.

Following O'Donnell's attempt at reducing the social stigma of depression, special guest professor of psychiatry Dr. Gail Saltz offered a corroborating and slightly convoluted definition of depression that the rest of the show hinged upon:

> Depression is a medical illness. It has a constellation of symptoms different than being sad or blue or even bereaved. We have a scan here of a brain of a normal person. There's a lot of activity in the normal brain. In a depressed person, not so. Less activity is one of the symptoms of

> depression… Depression is a …there's a chemical issue going on. All feelings are transmitted through chemicals in our brain. In a depressed brain, you have less serotonin. ("Depression")

Saltz's description of depression is a decidedly medical one; depression is a brain disease. To her credit, Saltz is careful not to make causal connections between a lack of chemicals or activity in the brain. Instead, she shows the brain scans and says that the depressed brain has "less serotonin" and less activity than a normal brain. In doing so, she suggests that a lack of serotonin might be the reason why someone is depressed.

This line of reasoning should feel familiar as the pharmaceutical companies also draw on this common definition to sell their products. Zoloft's announcer tells us: "While the cause of depression is unknown, it may be linked to a chemical imbalance in the brain" (Zoloft) and Cymbalta's newest advertisements inform us that the drug "works on serotonin and norepinephrine," two chemicals likely responsible for depression when they are over-or-under produced (Cymbalta).

In the medical community, some researchers criticize serotonin theory. In an interview for the documentary *Selling Sickness,* British psychopharmacologist David Healy maintains that "early theories suggesting that a serotonin imbalance causes depression have not been verified by later research" and that "serotonin theory has been overplayed in order to help sell the selective serotonin reuptake inhibitory drugs" (Moynihan and Cassels 27-28). Healy's position, while gaining traction, is certainly a minority voice in the public domain as shows like *The View* and drug commercials for

antidepressants continue to ingrain a medical and chemical definition of depression to its viewers.

Popular culture artifacts like talk shows and advertisements did not invent this definition of depression; they reinforce a disciplinary paradigm. In the 1970s, the psychiatry community, through its referential bible called the *Diagnostic and Statistical Manual III* (DSM-IV), shifted diagnosis of mental illness to patterns of observable behavior which manifest themselves in actions of the corporeal body. This swing toward observational classification has veered our collective attention toward medical discourses of depression, especially in the advent of brain scans like the one Dr. Saltz shows to *The View's* audience, opening the door for pharmaceutical companies to peddle their wares with the blessing of the scientific establishment. By creating a common language of depression around chemicals and physical processes, the psychiatric community has oriented the public discourse around normal emotional behaviors and abnormal pathological ones.

In this chapter, I argue that the current psychiatric and scientific discourses of depression lay the foundation for the pharmaceutical companies to aggressively market antidepressants. To do so, I provide a brief history of depression's definitions prior to the current *Diagnostic and Statistical Manual's* (*DSM*) classification system and its relationship to scientific paradigm shifts before providing the current, widely-accepted definition. I trace the history of the revision of the *DSM* (specifically the third edition) to show that the definitions of depression have evolved. Finally, I connect this history to the

current critics of the pharmaceutical companies who argue that the drug companies have exploited their role in providing a treatment option for depression.

The Importance of Definition in the Rhetoric of Science

Science's fundamental role in our society is to produce knowledge. Through methodical and often empirical inquiry, researchers and scientists seek to understand nature, which can include human nature, the nature of our bodies, and the natural world around us. Furthermore, they discover meaningful ways to organize and classify data to better understand patterns in our natural world. In our culture, this knowledge is privileged because it rests on "the bedrock of reality beneath a world of appearances" (Gross 21). Scientists are thought to be detached observers of the world, reporting only on what nature is trying to tell us.

Given the methods and tasks used in science, it would seem that rhetoric, the study of persuasion, has no or very little dominion over science. However, in the last forty years, the rhetoric of science has emerged as an exciting and powerful study of how scientific knowledge is produced. In *The Rhetoric of Science,* Alan Gross writes, "Rhetorically, the creation of knowledge is a task beginning with self-persuasion and ending with the persuasion of others" (3). In science, knowledge is created after a scientist (or group of scientists) is convinced that gathered data is meaningful and then persuades others that the information has meaning.

By analyzing science as a persuasive discourse, rhetoricians do not deny that facts are necessary to the study of science; however they do argue that information only becomes knowledge if it is given language. Gross clarifies,

> Facts are by nature linguistic—no language, no facts. By definition, a mind-independent reality has no semantic component. It can neither mean, nor be incorporated, directly into knowledge. Incorporation by reference is the only possibility. […] Only such utterances can become part of bodies of knowledge. (203)

Real events happen in the world (a television turns on, music exists), but these facts are not knowledge. Only when we give these events language can they have meaning. One of the ways that scientists make meaning of their work is through definition and classification. For example, a certain chemical reaction in the body becomes part of the knowledge about depression if depression is understood as a chemical imbalance in the brain. By giving a definition to a phenomenon or placing a phenomenon into a schemata, scientists are positioning people into a particular way of seeing that data. This is not to say that the chemical reaction does not exist, but by arguing that it fits into a specific paradigm, it creates knowledge.

Kenneth Burke gives us a way to think about how definitions shape our knowledge and our reality: terministic screens. Terministic screens refer to the way language shapes how people understand a particular concept. To elucidate his point, Burke uses an example of several photographs of the exact same subject. Each picture is taken with a different lens, and even though each picture is of the same object, the

different lenses reveal different textures and colors (45). The same can be done with terms. A single phenomenon can be described (and understood) differently depending on the terms we use to name it. For example, when someone such as Dr. Gail Saltz on *The View* refers to depression as a medical illness, certain associations begin to emerge: ones of doctors, medicine, and science. On the other hand, if depression is described as a gift from God, an entirely different set of associations are present: ones of prayer, reflection, and faith.

These terms become screens (terministic screens) because they, like the lenses of a camera, filter out other ways of seeing. In *Language as Symbolic Action: Essays on Life, Literature, and Method*, Burke writes, "Even if any given terminology is a *reflection* of reality, by its very nature as a terminology it must be a *selection* of reality, and to this extent it must function also as *deflection* of reality" (45, emphasis in the original). In the example above, the scientific definition leaves very little room for a religious one and vice versa. Therefore, while both definitions offer a way of seeing reality, they also deflect other realities.

In his discussion of terministic screens, Burke makes a distinction between "scientistic" and "dramatistic" language that is also important for my purposes. In *Language as Symbolic Action*, Burke writes:

> The 'scientistic' approach builds the edifice of language with primary stress upon a proposition such as 'it *is*, or it *is not*.' The 'dramatistic' approach puts the primary stress upon such hortatory expressions as 'thou *shalt* or thou *shalt not*.'" (45)

A scientistic approach to language is one focused on definition. If this project were taking that approach, I might ask the question: *what IS depression?* Instead, I'm concerned with taking more a dramatistic approach, which focuses on the context, by asking the questions: *how have we defined depression and what are the implications of that definition?* The latter question focuses on who created the definition in a particular context and acknowledges the role of humans in the creation of the definition.

Others exploring language and medicine and/or science have also turned their attention toward the power of definitions and the reasons why those definitions were created. For example, in *Conceiving Normalcy: Rhetoric, Law, and the Double Binds of Infertility,* Elizabeth Britt spends her first chapter defining infertility in order to reveal "the context of [the definition's] production. In other words, how a culture defines infertility says as much about that culture as it does about the condition itself" (18). Since humans who have unique experiences create definitions, these definitions will reveal the beliefs, assumptions, and values of a particular culture, society, and group. In the rest of this chapter, I will follow Britt's lead as I explore how people who are situated in a particular context have defined depression.

Depression and Melancholia before Freud

I began this chapter with a snippet of a talk show host and her guest trying to persuade an audience that depression is a medical—a biological—illness. This introduction may have been a bit misleading because it might suggest that depression has

not historically been a disease of the body. In fact, depression, under the name of melancholia, has almost always been referred to as an illness of the body with only one brief historical movement to the contrary.[7] This movement, lead by Sigmund Freud, believed in reactive depression—a kind of depression that was decidedly *not* biological. Before getting to Freud and his powerful school of thought, however, I want to briefly trace the medical origins of depression/melancholia.

In everyday discourse, the words "melancholia" and "depression" might be used interchangeably, but the two terms are different. Melancholia, in ancient Greek, usually refers to a "mental disorder involving prolonged fear and depression" (Jackson 4). Melancholia, as a term, resurfaced throughout the centuries, briefly appearing in the Renaissance to refer to genius and giftedness, but usually referring to a illness that was characterized by "any state of sorrow, dejection, or despair, not to mention respected somberness and fashionable sadness" (Jackson 5). The word 'depression' used to indicate a saddened or dejected state did not enter common medical vernacular until the eighteenth century (Jackson 5)[8] and gained prominence during the nineteenth century.

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[7] I should also say that alongside the medical community's definition of depression was also a religious one. The Judeo-Christian world believed in a religious melancholia. According to Dr. David Balzer, the causes of this melancholia might be "direct from God as a punishment for sin, direct from God for self-improvement as a purge of sins, or abandonment by God to the devil or demons" (44). The Bible has several references to religious melancholy. For example, Job experienced severe despair and King David had a bout of grief while pursued by Saul (Balzer 44-45). Since this chapter focuses on the medical community's definitions of depression, these religious ones are a bit tangential, but it does help to prove my point that the pharmaceutical companies could not persuade people to take pills for religious depression, as it is believed to be caused by a biochemical process.

[8] In chapter 7 of Stanley Jackson's *Melancholia and Depression: From Hippocratic Times to Modern Times*, the relationship between how melancholia became associated as depression is explored. He credits Samuel Johnson having an important role in these discussions.

During ancient Greek times, melancholia was considered to be a disruption in the harmonious workings of the body. According to the ruling medical theory of the time, the body needed to maintain a balance among the four humors: black bile, blood, yellow bile, and phlegm. The theory maintained that the body should never be too hot or cold or wet or dry. People became diseased if they were excessively or insufficiently dry, wet, hot or cold (Leventhal and Martell 3). During the latter part of the fifth century, Hippocrates, considered the father of medicine, drew on the scientific paradigm of the time and speculated that melancholia was the result of too much black bile (Jackson 7), which resulted in being too cold and underactive.

Since Hippocrates was relying on the prevailing medical theories of the time and defined melancholia as a bodily illness, therapies for depression were performed on the physical body. The treatments for imbalances in the humors included blood-letting, enemas, purgatives, or emetics (Healy 8). Since doctors thought it was essential that the humors remain in harmony, shifting the levels of blood, yellow bile, or phlegm in the body was thought to correct way to treat melancholia.

Psychological definitions of melancholia emerged through the seventeenth and eighteenth century[9] as the humoral theory's cache waned[10]. As scholar of psychopharmacology David Healy tells the history of depression, one of the major

[9] Stanley Jackson's *Melancholia and Depression* is by far the most comprehensive and most cited book on the history of depression and melancholia. While I am quickly glossing through these centuries since my concern is more with the twentieth, the first half of his book has one chapter to each century/time period: Ancient, Medieval, Renaissance, Seventeenth Century, Eighteenth Century, Nineteenth Century and Twentieth Century. Jackson is certainly the authority on the most influential figures in the history of melancholia/depression.

[10] Even though bacteriology didn't become accepted until the nineteenth century, there were chinks in the humor's armor—namely the church frowned upon this theory and as it became more powerful, its influence impacted the medical community.

reasons the humors began to fall out of favor was the emergence of bacteriology. Healy writes of the paradigm shift: “Until the last decades of the nineteenth century, the idea that there might be a specific remedy for a specific ill was tantamount to quackery” (10). Once Robert Koch isolated bacteria responsible for cholera in 1884, the medical establishment took notice of bacteriology because it suggested that there could be a specific cure for a specific illness (Healy 10). Bloodletting and other humoral treatments fell out of favor since those treatments targeted the whole body, instead of a specific agent. Since it was becoming accepted practice that disease was caused by bacteria, certain practices, such as blood-letting, were no longer permitted (Leventhal and Martell 11). Bacteriology changed the way the medical community understood disease. It suggested that every ailment/disease/illness had an underlying specific cause.

As bacteriology changed the model of disease, the classification system and the definition of mental disorders also changed. In 1886, Emil Kraepelin divided mental illness into two categories: manic-depressive insanity and dementia praecox (Healy 13). Dementia praecox became later known as schizophrenia, and manic-depressive insanity was described as the following:

> Manic-depressive insanity … includes on the one hand the whole domain of so-called periodic and circular insanity, on the other hand simple mania, the greater part of the morbid states termed melancholia … Lastly, we include here certain slight and slightest colourings of mood, some of the periodic, some of them continuously morbid, which on the one hand are to be regarded as the rudiment of more severe disorders and on the other

> hand pass over without sharp boundary into the domain of personal predisposition. In the course of the years, I have become more and more convinced that all the above-mentioned states only represent manifestations of a single morbid process. (qtd. in Healy 36).

One of the reasons that Kraepelin is important to this discussion of depression is that he was the first to combine all 'peculiar' depressive states into one category. Prior to Kraepelin's research, the medical community thought there might be a connection among various manic and melancholic disorders, but Kraepelin solidified this association with his longitudinal studies (Jackson 190). Furthermore, as suggested in this quote, Kraepelin also saw mania and depression on a continuum. Kraepelin was not concerned if mania did not manifest itself in someone who was depressed or vice versa (Healy 36). Kraepelin's work became of vital importance in the mid-twentieth century, but received very little attention in the United States until then because in the US, Freud and social psychiatry gained prominence.

Freud(ian) Slips (In): Reactive Psychiatry as Dominant Psychiatric Model

If the Greek definition of mental illness was focused on a biological process, Freudian definitions were strictly mental. Sigmund Freud's reign over the psychiatric community was so powerful that to this day, psychiatrists are still reacting against it. Freud's belief that unconscious processes was the underlying cause of illness set up disease as a personal, individual, and moral infliction. Allan Horowitz and Jerome

Wakefield write, “The heart of [Freud’s] approach was the effort to understand pathological symptoms in terms of unconscious mental processes, rather than in terms of biological predispositions and organic etiologies” (73). While religious communities prior to the late nineteenth century also suggested this, the medical community never fully invested in illness in this light. Freud however changed that belief. Mental illness was a disturbance in mental processes—not biology.

As mentioned above, as bacteriology grew in scientific prominence, the medical community held a belief that illnesses were the result of a specific underlying condition, and Freud, along with his followers, was no different. Freud did not believe there was an underlying faulty nervous system that contributed to mental illness. In fact, he advocated that a healthy nervous system underlay psychopathology (Fancher 100). For Freud, the underlying condition that led to mental illness was a conflict between society and the psyche. This conflict manifested itself in neurosis.

Freud’s terministic screen of neurosis (and depression), shifted the definition away from the body and into the mind. In *The Age of Melancholy: “Major Depression” and Its Social Origins,* Dan Balzer explains how neurosis can manifest as depression. He writes,

> A neurosis, such as melancholia, arose because of anger originally directed outward toward a lost object of social support; for example, a dead spouse. Expressed anger toward a lost object is not tolerated by society (and the internalized representation of society—the superego). Anger is thus directed inward, leading to melancholia. The conflict

> between the innate drives and society is inevitable for civilization requires the sublimation, suppression, or repression of fundamental human drives. (61)

Unlike the Greek definition of melancholia where the body was unbalanced, Freud's definition of melancholia stemmed from the relationship of the mind to society. Unsurprisingly then, treatments for depression in the early twentieth century were not chemical or biological. There was no drug or no blood-letting to treat the person with depression. Obviously, these treatments would not work for someone who was in their mental state because of a conflict with society. The terministic screen of neurosis turned attention toward these conflicts. With this definition, pharmaceutical companies (although they did not exist in the way we now know them) would not have been successful advertising drugs for the treatment of depression. Instead, psychoanalysis was the primary treatment.

Psychoanalysis, a term coined by Freud, is a type of talk therapy that is used to help the individual cope with their illness. According to Robert Fancher[11],

> The *therapeutic* task is to lead *the patient* to analyze the manifest contents of her life so that the patient herself is led ever closer to revealing and experiencing the repudiated elements of herself. As a result these elements can be acknowledged, owned, and taken up directly into new ways of thinking, feeling, and acting. (108).

[11] Fancher's text, *Health & Suffering in America: The Context and Content of Mental Health Care* has an excellent chapter on the psychoanalytical process: "The Faded Glory of Psychoanalysis." He goes into great detail about the steps and roles of psychoanalysis that cannot be addressed here because they fall outside the scope of this chapter.

Since the etiology of depression is considered to be a personal conflict with society, this psychoanalysis was thought to be successful. Patients reached into their minds to find which behaviors/thoughts/etc were in conflict. Once the patient was able to do that, then they could change themselves. It is interesting to note that even though this neurosis was thought to be a conflict between the person and society, no one tried to change society. The assumption is that these neuroses existed because the individual couldn't reconcile their emotions with society's expectations. Attempts were not made to change how society viewed certain emotional states[12].

Getting off the Couch: Crisis in the Field

Freud wasn't without his critics, but no one can dispute his influence on the field of psychiatry. Psychoanalysis was one of the primary therapeutic treatments of mental illness through World War II and into the mid-1960s. However, the 1960s ushered in an uncertainty in the field of psychiatry. The profession's methodologies and purpose came under attack, not just from outside the discipline, but from within as well. This conflict was one of the reasons psychiatry began to take stock in the way it defined and classified depression.

In the mid-1960s, Thomas Szasz, the leader of the antipsychiatry movement, called psychiatry's legitimacy into question by asserting that mental illnesses were not diseases at all. He writes in "The Myth of Mental Illness,"

[12] Social psychiatry does deal with these issues as it works to "focus on the ills of society" and identifies "the elements of a more effective society and supporting them" (Balzer 62). This form of psychiatry has its roots in Freud and French sociologist Emile Durkheim, but shifted attention away from the individual to the larger social society.

> [T]he phenomena now called mental illnesses [should] be looked at afresh and more simple, that they be removed from the category of illness, and that they be regarded as the expressions of man's struggle with the problem of how he should live. (118)

For Szasz and other "antipsychiatrists," mental illness should not be categorized as a disease, to be treated by therapists and psychiatrists. Szasz tried to change the definition of what was perceived as mental illness, away from biology and disruptions of the mind. The definition he wanted to prevail was outside of the field of medicine into a human condition that strikes us all as we figure out how to behave in our societies.

Szasz makes this definitional distinction because he believes that the psychiatric community's current definition relies on the assumption that the world is a harmonious place. He puts it best when he writes:

> The term "mental illness" is widely used to describe something which is very different than a disease of the brain. Many people today take it for granted that living is an arduous process. Its hardship for modern man, moreover, derives not so much from a struggle for biological survival as from the stresses and strains inherent in the social intercourse of complex human personalities. In this context, the notion of mental illness is used to identify or describe some feature of an individual's so-called personality. Mental illness—as a deformity of the personality, so to speak—is then regarded as the cause of the human disharmony. It is implicit in this view that social intercourse between people is regarded as something inherently

> harmonious, its disturbance being due solely to the presence of "mental illness" in many people. This is obviously fallacious reasoning, for it makes the abstraction "mental illness" into a cause, even though this abstraction was created in the first place to serve only as a shorthand expression for certain types of human behavior. (114)

For Szasz, and it is hard to dispute his point, human life can be hard, especially the "social intercourse" expected of humans. People have different personalities that do not always fit with others'. Szasz argues that the stress humans feel trying to fit into the perceived norm causes emotional distress. Of course, Szasz is also working through his own terministic screen. For him, disease is biological. His definition of disease excludes anything that is not occurring in the body, and mental illness, as he understood it, is not a biological process. For Szasz, emotional distress is not mental illness; this is a problem with how the norm has been established, not to mention who has established it.

One of Szasz's concerns with mental illness derives from how people were defining the illness and who had the power to make those kinds of decisions. Rick Mayes and Allan Horowitz sum up Szasz's concern nicely. They write:

> For Szasz […], psychiatry was an authoritarian extension of the state used for controlling nonconformists. Psychiatric labels were arbitrary designations that, instead of serving the needs of the patients, severed professional needs and the needs of dominant groups. (252)

In other words, Szasz argued that psychiatrists needed to create a group of people to label as abnormal, so that they had a role to play in the medical community. Since they were

not doing biological research but still wanted the prestige of being part of the medical community (although their status was certainly debatable), the psychiatrists needed to maintain dominion over the mind, and in turn, mental illness.

Foucault makes similar claims in *Madness and Civilization* and *Birth of a Clinic.* In *Madness and Civilization,* Foucault insists that madness is contingent upon society's cultural, intellectual, and economic structures. He argues that madness is located in a certain cultural "space" within society and that particular society determines how madness is perceived. In *Birth of a Clinic,* Foucault studies the power dynamics of the doctor and the patient, which is manifested through "the gaze." The gaze is a metaphor for how doctors use the power of science to turn people into patients, and thus in a subordinate power position. If a person is ill, the doctor has the power to diagnose and treat a person. In order for the system of medicine to work, Foucault argued, the doctor needs to remain in the power position. The gaze maintains the structure of the institution. For both Szasz and Foucault, and among others like sociologist Thomas Scheff, diagnosis of mental illness and the mechanisms that support them were not "natural" but known through linguistic structures.

To be clear, Szasz does not believe that emotions and emotional responses are non-existent. He does not dispute that people are living with real angst. His concern, and the one that rocked the psychiatric community, is that psychiatrists are not the right people to study mental illness. His belief is that mental illness is a myth. He uses myth in a similar way to Roland Barthes: the facts have been presented to make people see the world in a particular way. Burke might refer to this as terministic screens. Szasz

believed that science needed to be grounded in empirical research, which psychiatry at the time currently was not. He believed that scientists—psychiatrists included—should be researching the biological impetus for mental illnesses—seeking understanding of the body and the brain, not the mind. He implicitly argued that mental illnesses, as myth, should be left to those in the social sciences, whose disciplinary framework is better suited for problems of social living (Cresswell 25).

This suggestion was taken as an attack by people within the field. Perhaps it would not have been such a powerful condemnation if Szasz did not have such a credible ethos. As a psychiatrist and psychotherapist, Szasz's writings had an authority because of his insider status in the field. Also, during the 1960s, there was a general political movement in the country to challenge authoritative structures, of which medicine would fit. The antipsychiatry movement had a profound influence on the field as insiders began to question their purpose and their role in the healthcare industry.

Reverberations of the antipsychiatry movement are still felt today, although response to it is less favorable. For example, in the spring of 2005, actress and model Brooke Shields spoke with various magazine reporters and appeared on *The Oprah Winfrey* show to announce that she had post-partum depression and used Paxil as a way of treating it. Following her appearance and the magazine releases, actor Tom Cruise appeared on *The Today Show* and had an interview with host Matt Lauer. In the interview, Tom criticized Shields's uses of drugs saying, "The thing that I'm saying about Brooke is that there's misinformation, okay? And she doesn't understand the history of psychiatry" (Leiby). Meaning, Shields was touting the benefits of drug therapy without

actually understanding where drug therapy fit into the history of the field. Cruise also told Lauer, “Psychiatry is a pseudoscience” and “There is no such thing as a chemical imbalance in a body” (Leiby).

As a follower of the Church of Scientology, Tom’s outburst was mostly seen by reporters like Richard Leiby of *The Washington Post* and entertainment shows as the ravings of a religious man without the authority to make such statements. Leiby, for example, writes, “Okay, should we address him as Dr. Tom Cruise from now on? Or will the Rev. Dr. Cruise suffice?” For many, Cruise was not sanctioned by the medical community to make these claims. Therefore, his argument (while it may have been articulated better) was seen, to put it mildly, as simple fodder for the tabloids. In the 1960s, however, these claims were taken to heart by the discipline.

Part of what stung about Szasz’s criticism was that he suggested that psychiatry was, in the words of Tom Cruise, a pseudoscience. Stuart Kirk and Herb Kutchins summarize the state of the field as follows:

> If mental illness does not exist, if psychiatric symptoms have little to do with medical science, if the entire mental health enterprise is a carefully structured fiction about life’s normal troubles, and if psychiatrists are policemen in white coats, then psychiatry confronts a much more serious challenge. […] they questioned the *conceptual* integrity of the entire enterprise. (22, emphasis in the original)

The field was vulnerable to these attacks because people were questioning if mental illness existed and in what ways were diagnostic judgments being made. The field had no

way to defend themselves against these attacks, especially because psychotherapy was beginning to be practiced by practically anyone (Mayes and Horowitz 254). Clinicians, social workers, psychologists, and counselors were all practicing psychotherapy, leaving very little distinction as to what made psychiatry unique.

Making the Move to the Grown-Up Table: Psychiatry's Move to Instantiate Itself in Healthcare

In the 1970s, psychiatry found an opening to define itself as a formidable scientific discipline. At that time, the field had been loosely operating under the *Diagnostic and Statistical Manual II*, a small text that include 182 diagnoses and generally reflected the influences of psychoanalysis. In 1973, following discussions at the National Institute of Mental Health-sponsored conference in 1969, the APA agreed it was time to revise the *DSM-II (*Healy 233). The APA board appointed Robert Spitzer to chair the committee. He came in with the following vision: "Whether we like it or not, the issue of defining the boundaries of mental and medical disorder cannot be ignored. Increasingly there is pressure for the medical profession and psychiatry in particular to define its area of prime responsibility" (quoted in Healy 233-4). Spitzer saw his appointment and this revision as an opportunity to legitimize the field by creating a classification system based on empirical research.

Spitzer made some interesting choices as he created his team, appointments that would help him move the field toward legitimacy in the eyes of the medical

establishment. He appointed people interested in diagnosis and diagnostic methodology instead of people interested in therapy and psychodynamics and he also brought neo-Kraepelinians on board (Healy 324). According to Healy,

> The neo-Kraepelin approach held that psychiatry was a branch of medicine, that there was an identifiable boundary between the normal and the sick, that discrete and identifiable mental illnesses exist, and that psychiatry should treat these and not the problem of living and unhappiness. Psychiatric research should, moreover, be geared to establishing the validity of diagnostic criteria. (233)

These appointments were obviously significant as the team assembled already had a terministic screen in place. For them, psychiatry was medical—not psychological. Illnesses had a connection to biology that previous schools of thought did not see. In setting the establishing criteria for mental illness, the group generally favored Kraepelin's (not Freud's) classification system, which focused on a visible symptom diagnostic system derived from careful observation (Mayes and Horowitz 260). Critics argued that the revision task force was biased and did not represent the dominant theories of the field (Healy 234). Again, definitions were at the core of the disputes.

The task force attempted to make some radical changes as it reconceptualized the classification system. Obviously, the entire system was radically changed as *The DSM* moved toward a more descriptive, symptom-based system, but there were other changes that drew political, as well as medical, scrutiny. One, which I will not cover here, was

the attempt to eliminate homosexuality from the manual[13], and the other was the removal of the term neurosis, and specifically neurotic depression.

The task force members argued that neurotic depression did not have a clear definition, and the committee needed to convince the larger community that this term was ineffective. Gerald Klerman, Robert Spitzer, Jean Endicott and Robert Hirschfield published an article in *American Journal of Psychiatry* that attempted to persuade its readers that neurosis was a useless term in psychiatry because of its vagueness and that the term should be eliminated and replaced with a better classification term.

The writers begin the article with an appeal to the reader's sense of duty. They write:

> Even with the clinical frequency of diagnosis and the epidemiological evidence for high prevalence of depressive neurosis, there continues to be a lack of clarity and precision as to the range of phenomena to be subsumed by the nosologic class and vagueness as to the criteria for the diagnosis. This contributes to a relatively low reliability of diagnostic agreement among clinicians in clinical settings if not in research efforts. (57)

In this section, the writers appeal to psychiatrists' need to provide good care to their patients by saying that vagueness leads to low reliability. In a sneakier move, the last clause attempts to reach the researchers, not just the clinicians. By putting the statement

[13] Robert Spitzer himself has an interesting article about this dispute in an article "The Diagnostic Status of Homosexuality in DSM-III: A Reformulation of the Issues." In it, he argues that judgment surrounding homosexuality was at issue, and not factual concerns.

about research at the end of the clause, it becomes almost a throw-away, an afterthought. However, as I have written above, the field wanted to try to distinguish itself from social workers and therapists, and research was a way to do that. Therefore, in the last clause, the authors are trying to reach researchers to get them aligned with the revision to the *DSM-III*.

Following the introduction to the article, Klerman et al. identified six overlapping definitions of neurotic depression in an attempt to show how many different ways one illness could be defined (see Appendix A). Medicine depends on certain symptoms giving rise to one disease. For example, tuberculosis is defined from a series of symptoms. Medical science can define a disease as tuberculosis because of the given criteria. These neurotic depression classifications presented did not have a series of symptoms associated with them. For example, one descriptive definition is as follows:

> *Neurotic depressions are less socially incapacitating.* This usage is synonymous with a judgment of mild severity of social dysfunction. These depressions allow the individual to continue his or her social functioning, although there may be personal distress and inner misery." (Klerman et al 58)

This description is not characterized by diagnostic criteria. There is no objective tools to measure "personal distress and inner misery" in this classification system. Klerman et al found this kind of definition to be useless for scientific inquiry, and by listing them in the article, the writers attempted to persuade the readers of the lack of utility.

Using the first four descriptions listed in the article, the researchers sought to apply them to a group of patients diagnosed with depression. The study found that all of the definitions did not apply to all the patients. Meaning, one definition of neurotic depression did not apply to approximately half of the patients and another didn't apply to half of the patients and so forth. These findings were important because it suggested that the definition of neurotic depression was vague and too all-encompassing. The argument was that by labeling someone as a neurotic depressive, researchers and practitioners alike were creating a meaningless label.

Klerman et al. ended their article with a solution to this "problem," by eliminating neurotic depression and create new categories of depression. They write in the conclusion:

> The results of this study have influenced and supported the decision of the American Psychiatric Association's Task Force on Nomenclature and Statistics to drop the category of neurotic depression and instead to enable the clinician to characterize depressive disorders along the following dimensions, using a multiaxial approach: 1) course (episodic versus chronic) (Axis I); 2) presence or absence of bipolarity (Axis I); 3) severity (including psychotic or not) (Axis I); 4) personality pattern or disorder (Axis II); 5) presence of life stress (Axis IV); 6) highest level of adaptive functioning in the past year (Axis V). (60)

These criteria were much more precise than the previous definitions. One could measure accurately if a person had one or multiple courses of depression and if bipolarity existed

or not. There was still some ambiguity, as the "highest level of adaptive functioning" is up for interpretation, but the task force agreed that the axis approach would more clearly define depression.

This article was an attempt from the task force to persuade the psychiatric community that depression needed a more precise definition based on observable criteria, and not vague descriptive definitions. While it might have been persuasive to some, the critics refused to be swayed. In an attempt to please the voters (the APA community would need to vote on the *DSM* revisions), Robert Spitzer suggested dysthymia (a term not used in over half a century) as a replacement for chronic depression (Healy 236). Eventually, a compromise was reached to include "Dysthymia (or Neurotic Depression)" to the classification system. With this revision, the *DM-III* passed as a more empirically-based diagnostic manual.

By creating a diagnostic system based on empirical data, the field as a whole hoped to gain legitimacy in the scientific community. If diagnosis was based on quantifiable data, then the field could distinguish itself from social workers and other practitioners; it could become a respected scientific discipline. Furthermore, since science held a valuable and revered space in the American cultural landscape, the scientific community could sanction psychiatrists' work on mental illness. The revision of the *DSM* was the first step toward credibility in the larger scientific community and beyond.

Science as Savior: Pharmaceutical Companies Market Themselves

During the disciplinary crisis of psychiatry, pharmaceutical sciences and the drug industry in general gained prominence. Pharmaceutical companies were not new by the middle of the twentieth century. At the end of the 1800s, the pharmaceutical companies expanded rapidly. By 1885, a buyer could "choose between Merck, SmithKline, Parke Davis, Eli Lilly, Sterns, Schieffelen, John Wyeth, Upjohn, Mulford, Sharp & Dohme and many others for a complete line of basic medications in convenient forms" (Liebenau 34). Historically, there has been speculation as to why the pharmaceutical companies exhibited such growth during that time. Jonathan Liebenau credits two reasons: the shift in the structures of the companies themselves and the use of scientific and medically trained personnel in a systematic fashion (30).

And while pharmaceutical companies did exhibit rapid growth during those times, they did not secure their place within the American commercial medical landscape until World War II. Companies such as Merck and Pfizer responded to a call from the United States government to manufacture penicillin to treat the infections of the Allied soldiers. Pfizer, who had recently developed a fermentation technology, used deep-tanks to mass-produce the antibiotic and became the largest producer of the "miracle drug" (Pfizer).

The pharmaceutical companies continued to develop new drugs and invest in research and development of medical supplies (Chandler 183-191). During the 1950s, new drugs such as the first oral contraceptive, Cortisone, blood pressure drugs and heart medications were developed. In addition to these kinds of medicines, drug companies also developed vaccines and antibiotics.

These companies even advertised to the consumer the beneficial role pharmaceutical companies played in public health. For example, Parke-Davis created a series of advertisements (see Figure 2) that ran in popular magazines such as *Ladies Home Journal* and *Life.* Figure 5 is a representative example of the advertising done during the middle of the century. A pharmaceutical company such as Parke-Davis would create a compelling image to draw the reader in. In this instance, the company chose a picture of a young girl with a doll looking up at her older sister who is holding up a wedding dress. The title of the advertisement is: "This is what we work for at Parke-Davis, the better health and longer life that comes with better medication." The small print on the side tells the reader that Parke-Davis is "proud of the contributions


This is what we work for at Parke-Davis

. . . the better health and longer life that come with better medicines

She's stepping up in life. Tonight a girlhood dream—her first "formal"—will become a reality. In time, she will doubtless know the happiness of marriage and the warmth of motherhood. And should illness ever come between her and the full, rich life she deserves, she can count on modern medical care to help her.

Parke-Davis is proud of the contributions it is making in developing medicines that help make possible today's better medical care. Proud, too, of the part it plays in the future of this girl—and in the life that lies ahead of that younger sister. The prospects of escaping serious childhood diseases grow brighter each day. Polio, smallpox, whooping cough, diphtheria and tetanus are but a few of the threats from which today's children may be protected.

In Parke-Davis laboratories research scientists are constantly striving to develop new and better medicines. Together with improved medical knowledge and greater skill in diagnosis and treatment, these medicines will mean better health and longer lives for millions.

Better medicines resulting from PARKE-DAVIS research and manufacturing skill play their part throughout life's entire span. Vaccines prevent many serious childhood diseases; vitamins help build resistance and aid body growth; antibiotics and other antibacterials minimize dangers from infections; and an increasing number of products guard against the hazards of later years.

PARKE-DAVIS

. . . PIONEERS IN BETTER MEDICINES SINCE 1866

Figure 2: Parke-Davis advertisement in *Life.*
Source: Parke, Davis, and Company

it is making in developing medicines that help make possible today's better medical care." It goes on to say that it is also proud of the part Parke-Davis will play in "the future of this girl—and the life that lies ahead of that younger sister." The advertisement ends with a statement about Parke-Davis's ambitions as a company that creates medicine to contribute to better health and longer lives.

These advertisements, widely circulated in these magazines, attempted to persuade the reader that medicine was essential for ensuring a healthy future. Other advertisements specifically about the polio vaccine and tuberculosis (see Appendix B) reminded the reader that medicine saved the lives of people. They worked to instill an image of the drug companies and, in turn, the drugs themselves as agents of prosperity and goodwill. Furthermore, these advertisements added to the public discourse about how the scientific world—one of medicine and science—could help keep America healthy.

Breakthroughs in Scientific Discovery: The Role of Psychotropic Drugs in Defining Depression

As these public moves were going on, scientific breakthroughs were also occurring. In 1952, chlorpromazine, also known as Thorazine, was discovered, and became, in the words of Healy, "the critical event in the foundation of psychopharmacology" (43). Like many drugs, Thorazine was discovered accidentally while researchers were seeking a way to treat cardiovascular stress and shock (Healy 43).

What they found was that chlorpromazine had remarkable behavioral effects on the patients in the Hôpital Sainte-Anne, an asylum in France. In *Comfortably Numb,* Charles Barber recounts the following story about a patient given Thorazine. He writes,

> Jean Perrin gave Thorazine to a barber from Lyon who had been hospitalized for years and been unresponsive to any intervention. When given Thorazine, the barber awoke from his stuporous state and told his doctor that he now knew who and where he was and he wanted to go home and get back to work. Perrin hid his shock and asked the patient to give him a shave, which the patient did, perfectly. (76)

This story is only one of a number of remarkable tales of Thorazine. Doctors at asylums began giving Thorazine to their psychotic patients to great success, making it the first antipsychotic used to treat the mentally ill.

Following Thorazine's success, the industry rallied around finding indications for other chemical compounds. During the 1950s, Swiss researchers were studying the effects of antihistamines, and given the success of Thorazine decided to pursue a line of inquiry into whether the compounds they were testing could be used to treat depression. The drug, imipramine seemed to be effective at treating depression (Manners 92).

It is still curious to me that these scientists would even be searching for an antidepressant since at the time, depression was still considered a mental illness derived from loss—not a chemical imbalance. Furthermore, depression was still considered rare: few patients had been diagnosed with depression. Since depression was not at the forefront of the medical community's agenda, perhaps that is why Thorazine did not gain

any traction in the psychiatric community. Between the 1950s and up until around 1960, three drugs were on the market for depression but drug sales were not worth noting (Manners 93). The drugs were seemingly effective, but not prescribed.

Several historians have theories as to why the first antidepressants did not more dramatically burst onto the scene, mostly revolving around the lack of a theory and a market for antidepressants. The first problem, a lack of theory, was a hurdle the scientific community had to jump in order to make sense of their antidepressants. One major point of contention was whether or not the brain was chemical or electrical. The other was that different antidepressants had very different effects. The MAOs (monoamine oxidase—an enzyme that breaks down serotonin, norpinephrine, etc) acted as energizers, while tricyclics such as the drug Tofranil was sedating. The scientists had trouble reconciling the two effects of the drug.

However, by the 1960s, scientists had created a story that fit the pieces of evidence that had; they found a workable hypothesis. Stephen Manners in *Super Pills: The Prescription Drugs We Love to Take* offers the following summary of the theory:

> [E]lectrical signals travelled down a nerve fibre and stimulated a release of a chemical neurotransmitter, such as serotonin or norepinephrine. The chemical crossed the gap separating one nerve from another, […] where it was taken up by specific receptors. The interaction of chemical and receptor propagated the electrical signal in the downstream nerve, and the message was then passed along. The "signal strength" depended on the amount of neurochemical available. This is where the MAO and reuptake

> theories converged. MAO inhibitors blocked the breakdown of neurochemicals. Tricyclics blocked the nerve from putting the neurochemical back into storage. The net effect of each of the two classes of drug was comparable: more neurochemicals were immediately available in the synapse to transmit nerve signals in the brain. (94)

The brain was then both chemical and electrical and the two different types of drugs were able to do their part to 'transmit' the appropriate signals.

While this theory gained support and traction, Manners points out that there were still several problems with the theory. First, he argues response to drug therapy does not indicate that the low neurochemicals *caused* the depression. In fact, low serotonin could be a symptom of depression—not the cause of it (95). If we return to Dr. Saltz's definition of depression on *The View*, we see she says "there's a chemical issue going on," careful not to make a causal link. Another concern Manners raises is that the scientists could not measures levels of neurochemicals; they had to be inferred through other tests (96). Also, since so many neurotransmitters were involved in the brain function and the brain had so many structures, it was unclear if the theory of how the brain worked was accurate. Scientists, including proponents of the theory by Joseph Schidkraut, addressed these issues, which boiled down to, in Manners' words, "If you didn't respond to an antidepressant, then presumably you didn't have depression by some subtype of the syndrome or another problem entirely" (96). Depression started to become defined as a particular chemical imbalance in the brain. In addition to the moves away

from psychoanalysis toward a more empirically-driven classification system, the research community argued for biological connections between the brain and emotions.

The other reason antidepressants did not take off in the way people had hoped was there was no initial market for the drug. Doctors were not prescribing antidepressants for depression because depression was not much of a medical concern; it was considered rare. The pharmaceutical companies had to persuade doctors that depression was in fact an illness that needed attention. They needed to sell the *illness* in order to sell the drug. According to Carl Elliott in *Better than Well: American Medicine Meets the American Dream*, the pharmaceutical company Merck distributed 50,000 copies of *Recognizing the Depressed Patient* to doctors; apparently it worked, as prescriptions for amytriptaline [an antidepressant] "took off" (123).

Furthermore, the revision of the *DSM* also helped to convince doctors that depression was an illness that needed to be treated with drug therapy. The *DSM* named symptoms of depression. The drugs produced treated those particular symptoms. Since the *DSM* classified depression in the way it did and these drugs provided relief from these symptoms, the drugs could be used to treat the illness. This is an important point. The drug industry was not necessarily looking for a treatment for depression. When they began experimenting with particular compounds, they simply wanted to see if the drugs had any psychotropic effects on a person. What they discovered was that the drugs improved mood, not that they specifically treated depression. The companies needed to figure out a way to *market* this compound to doctors, and to do so, they needed to figure out how to sell doctors the merits of these drugs. While there is no evidence that the drug

companies coerced the psychiatric community to define depression in the way they did, the revision of the *DSM* did help the pharmaceutical companies market their compound as an antidepressant. The existence of the category and the definition of this particular illness in this way allowed for the drug companies to market more effectively to doctors.

Conclusion: Definitions of Depression and Their Role in Normalization

Definitions are essential for determining what is normal and abnormal. In *Conceiving Normalcy,* Britt writes, "Seeking to eliminate ambiguity in measurement, normalization attempts to settle on common definitions, terminology, and categorizations" (11). In the current version of the *DSM,* the revision to observable criteria was an attempt at eliminating the ambiguity once associated with definitions of depression. By setting up certain definitional boundaries, the psychiatric community has given itself an external standard to point to for diagnosis. It is not an individual decision if a person has depression, it is now assumed to be an empirical fact.

In addition to standardization across the field, the definitions work in other ways to define what is normal. The *DSM-III* and its newer version the *DSM-IV* have been heavily criticized for its role in normalization. In *Making us Crazy: DSM: The Psychiatric Bible and the Creation of Mental Disorders,* Herb Kutchins and Stuart Kirk write:

> [The *DSM*] proposes how we as a society should think about our troubles. By creating categories for certain behaviors, DSM determines which

> behaviors should be considered a result of illness or disorder and should therefore fall under the purview of psychiatrists and other mental health professions. Mental disorder is, by definition, a matter of internal dysfunction, an indication that something harmful has gone wrong with a persona's mental apparatus. (11)

One of the byproducts of its categorization is the distinction between normality and abnormality. The definitions put forth in this book implicitly give people terministic screens for what is healthy and what is disordered; after all, the purpose of *The DSM* is to define mental illnesses, which is already considered deviant from mental health.

The drug industry has gone even further to objectify normal behavior. Its reliance on science, in the forms of clinical trials, empirical evidence, brain scans, and biological and chemical testing, has also worked to define normal bodily behaviors. They have argued that if a person's body tests a certain way, then they have depression. Abnormal brain scans, insufficient neurotransmitters, and responses to drug therapy define modern medical definitions of depression. These "objective measures" have dominated the discourse of depression. For example, in an online Frequently Asked Questions page the following question is posed: "I've been told to snap out of it. Depression must be my fault, right?" The answer is as follows:

> Wrong. Depression is a medical illness which affects an organ, the brain, which in turn affects the rest of the body. One can no more snap out of depression than one can snap out of diabetes or heart disease. It would help to have a positive outlook, but the very nature of depression is a lack

> of positive outlook. Unfortunately, having depression still carries a stigma, though not nearly as bad as in the past. If there is any consolation, you are in good company: Winston Churchill, Abraham Lincoln, Peter Illych Tchaikovsky, Frederic Chopin, and Mike Wallace, just to name a few, all had crushing depressions. (McManamy)

Even here, when there is an opportunity to discuss the complicated definitions and history of depression, the author responds that depression is a disease of the brain. Less than 100 years ago, that answer would have been very different.

To be fair, part of the reason that people cling to these seemingly objective measures is to help erase a stigma associated with depression. As Rosie O'Donnell did in the opening monologue on *The View*, making depression into a no-fault disease reassures people that they are not to blame for depression, that it isn't just a weak will keeping them from being normal as it was in Freud's era. However, we have just traded in one paradigm for another.

I have argued in this chapter that the definition of depression is not a static term. It is a fluid concept that shifts depending on a number of factors: the dominant medical theories of the time, the critiques of a discipline, the role of scientific discovery, and the need for commercial profits. I have specifically examined the changing definitions of depression because they give us insight into how disciplines determine normal emotional behaviors are and more importantly who defines what acceptable behavior is. As we have seen in recent years, the psychiatric community has, for a variety of reasons, shifted the definition of depression. The drug companies have done the same. In order to

capitalize on their discovery of a new indication for a chemical compound, they needed to convince themselves and doctors that these drugs were effectively treating depression. Each step along the way has moved depression toward a more biologically-situated disease. As the *DSM* changed toward a more empirically-based classification system, it, perhaps unintentionally, sanctioned the use of drug therapy. Without these moves, the modern day advertising could not be as effective as it is today.

My intention in this chapter is to lay the groundwork for future chapters that analyze direct-to-consumer advertisements. My contention is if depression had not been defined as it has—a disease belonging to medical sciences that can be treated with drug therapy—then, the advertisements would be ineffective. If depression was not situated in biology and the medical sphere, it could not be treated with drugs. The enthymeme sold in the advertisements would fall flat. In the next two chapters, I examine the strategies that Direct-to-Consumer advertisements use to persuade an audience that depression is abnormal and can be corrected through medication.

CHAPTER 3: "DEPRESSION HURTS BUT YOU DON'T HAVE TO": SEEKING CONFESSION IN NON-BRANDED PHARMACEUTICAL ADVERTISMENTS

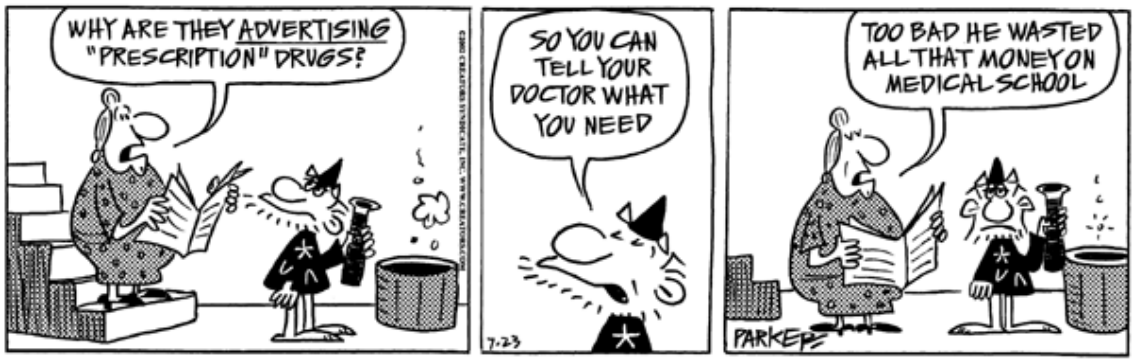

Figure 3: "Wizard of Id" comic strip on DTC advertisements. Source: Parker and Hart

The above cartoon's final frame strikes many people as funny because of its poke at the changing roles of doctors in our media-driven world. Like so many other advertisements in our consumer culture, drug ads work to persuade us into buying "what [we] need" whether we actually need it or not. The implication in this cartoon is that if we really *needed* a drug, a doctor with years of training from medical school—not a magazine ad—should be able to diagnose us. But that's what makes Direct-to-Consumer advertisements such interesting artifacts for analysis: they circumvent traditional doctor/patient roles and invite consumers to accept the pharmaceutical company's perspective on an illness/disease. This invitation requires the viewer to identify with the behaviors of actors in the magazine/commercial, to be persuaded that these behaviors are abnormal, and then to confess to a doctor that he/she might have, for example,

depression. In choosing to accept this invitation, then the individual must also accept a particular subject-position as patient and all that that entails.

In the pharmaceutical advertising industry, there are three different types of advertisements: product-claim advertisements, reminder advertisements, and help-seeking advertisements (also referred to as non-branded advertisements). The FDA has created a guide for consumers to provide information about the different types of advertisements. They write, "Prescription drug advertisements can provide useful information for consumers to work with their health care providers to make wise decisions about treatment" ("Be Smart about Prescription Drug Advertising"). They then provide examples of each kind of advertisements.

Product claim advertisements include a product's name, its use, and a claim or representation about a prescription drug (see Figure 4 and Appendix C, for larger view) for FDA example in which the product name is Arbitraer and it treats Seasonal Allergy Symptoms). For a depression example, in the early Zoloft advertisements that feature "Dot," a depressed, white ball, these advertisements were specifically seeking to sell Zoloft. This advertisement used the drug's name and asked the consumer to seek out their doctor for a prescription. All product-claim ads must include a balance of risks and benefits and must provide all risk information included in

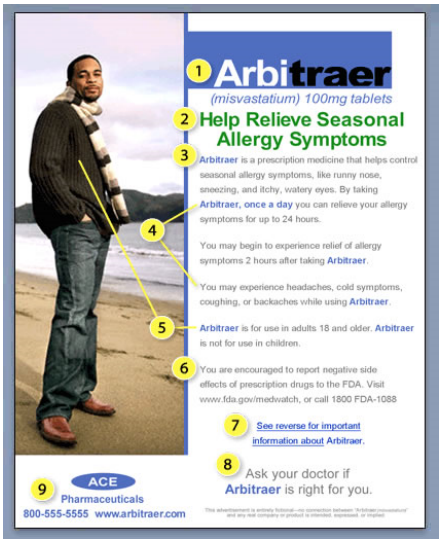

Figure 4: FDA example of a product claim advertisement. Source: "Sample Prescription"

the product's FDA-approved labeling or, for broadcast advertisements, provide convenient access to this information ("Be Smart about Prescription Drug Advertising").

The second type of advertisement is called a reminder (see Figure 5 and Appendix C for an FDA example in which the product is Arbitraer). The FDA regulations specifically exempt this type of ad from statements of risk. Reminder ads are allowed to disclose the name of the product and certain specific descriptive or cost information, but they are not allowed to give the product's indication (what it can be used for), dosage recommendation, or any claims or representations about the product[14]. Reminder ads are not for products with serious warnings (called ''black box'' warnings) in their labeling. For example, if aforementioned Zoloft ad had a reminder ad, it would likely include an image of "Dot," the Zoloft logo and a command to "Ask Your Doctor" about the drug. The advertisement would not mention depression, the risks, or benefits of the drug. The advertisement relies upon the audience's familiarity with the logo, drug name, and/or the visual design to remind them of what the drug is indicated for.

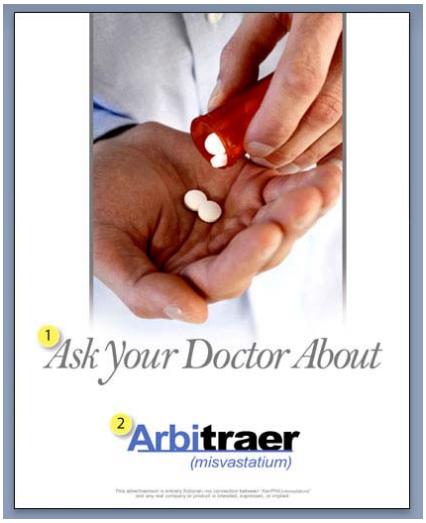

Figure 5: FDA example of reminder advertisement. Source: "Sample Prescription"

Finally, non-branded or ''help-seeking'' advertisements present a disease or condition and advise the audience to ''see your doctor'' for possible treatments (see

[14] The exemption for ''reminder'' ads is for promotions directed toward health care professionals, who presumably know both the name of a product and its use. While others may read these ads, they often appear in medical journals and in mail or materials sent directly to the consumer.

Figure 6 and Appendix C for FDA example). Because no drug product is mentioned or implied, the FDA does not define this type of ad as a drug ad and therefore does not regulate it. This advertisement makes no claims about how a particular drug works because it does not advertise a specific drug. For example, if Pfizer ran a non-branded advertisement for depression, it would create a campaign that defines depression and its symptoms. The advertisement would also suggest seeing a doctor for possible treatment options. It would never mention Zoloft by name although it would *probably* use a similar motif/design as its branded advertisement (i.e. the white ball "Dot"). Since these advertisements are not directly selling a specific product, they, more than the others, invite the consumer to become a patient. In the branded advertisements that name a product, the goal is to create consumer-patients, people who will buy a drug to treat an illness. In the non-branded ad there is no expectation of a brand-name-drug purchase; there is only hope that the consumer will accept the invitation to become a patient and seek a doctor's advice.

Figure 6: FDA example of help-seeking advertisement. Source: "Sample Prescription"

In this chapter, I explore the relationship between confession and normalization in the context of non-branded pharmaceutical depression advertisements. I argue that normalization as a technique of biopower affects behaviors and that the Direct-to-Consumer advertisement is a technology of normalization, for it works to identify the abnormal and creates procedures by which the abnormal can be subjected to reform

through techniques of the self—specifically the act of confession. The pharmaceutical industry uses Direct-to-Consumer, non-branded advertisements to define certain behaviors as pathological and encourage individuals to confess their innermost feelings to a person of authority. The branded ads also work to define behaviors as normal or pathological, but they encourage their consumers to go to their doctors to ask for a *prescription medication*. This confession is the practice necessary to begin transforming their abnormal behaviors outlined in the ads. By confessing depression, the consumer believes he/she is on the way to remedying what makes him/her abnormal. Through confession they think they are taking their first steps toward normalcy. However, if he/she follows the steps outlined by the advertisements, his/her normalcy is a manufactured one—one created through medication. By taking medication, a person is not 'naturally' normal. His or her behaviors are managed through medication and cause the person to be dependent on the drugs for his/her normalcy.

The pharmaceutical companies anticipate and hope for this kind of reaction to these advertisements because it maintains their hold over the consumer. If a person feels abnormal without the medication but normal with it, he/she will need to continue taking the medication—thereby, hopefully, ensuring the use of the drug and the maintenance pharmaceutical company's profits.

I'm Bad, and I Know It: Foucault's Discipline and Normalization

In his seminal work *Discipline and Punish,* Michel Foucault examines the shift from forms of bodily punishment such as hanging and quartering to the less physically-brutal system of prisons. The text begins with a graphically-intense account of the techniques of punishment that lasted until the mid-eighteenth century, and then shifts to an examination of the subsequent penitentiary system. In his analysis, Foucault argues that even though the corporeal body is not physically marked in the ways it once was, the body is still subjected to physical prohibitions. Through a complex system of regulation, order, and evaluation, the prisoner's body is still the site of cultural inscription in which certain behaviors are punished and the body is disciplined to conform to a particular set of expectations.

In order for the prison system to work as a site for punishment, the body must be made docile. During the eighteenth century, new techniques of control were exercised on the body. First, the body was not treated as part of a whole collective; it was impacted individually through subtle coercion of movements, attitudes, and gestures (*Discipline and Punish* 137). Second, the object of control shifted from the "signifying elements of behavior or the language of the body [to] the economy, the efficiency or movements, [and] their internal organization" (137). Finally, the modality of control changed. No longer would the attention be placed on the result (torture or death), but now it would focus on the "uninterrupted, constant coercions, supervising the processes of the activity" (137). In other words, the body would be disciplined through a system of surveillance, normalization, and examination.

Foucault observes three instruments for disciplining the body: hierarchical observation, normalizing judgment, and examination (*Discipline and Punish* 170). Hierarchical observation is the instrument in which the disciplinary apparatus makes it possible for supervision of everything in its purview. Foucault cites the Pancopticon as an example of how a particular disciplinary structure (the prison space) allows for constant surveillance of its subjects. Because of the spatial design of the structure, the prisoners can always be watched. The assumption is that the act of being watched will force the person to conform to a particular set of behaviors for fear of consequence.

Another instrument of discipline is normalizing judgment, which works to measure the individual against the collective. This instrument compares, differentiates, hierarchizes, homogenizes, and excludes: it normalizes. Foucault writes of normalization:

> For the marks that once indicated status, privilege and affiliation were increasingly replaced […] by a whole range of degrees of normality indicating membership of a homogeneous social body but also playing a part in classification, hierarchization and the distribution of rank. In a sense, the power of normalization imposes homogeneity; but it individualizes by making it possible to measure gaps, to determine levels, to fix specialties, and to render the differences useful by fitting them one to another. (*Discipline and Punish* 184).

Normalizing judgment then has the power to individuate as well as homogenize. This instrument of discipline works to identify abnormality and subject it to punishment so as to reform the body.

The third instrument of disciplinary power is the examination. The examination (also known as the normalizing gaze) is made up of a combined effort of hierarchical observation and normalizing judgment to form "a surveillance that makes it possible to qualify, to classify, and to punish" (*Discipline and Punish* 184). Medicine offers one of the clearest examples of the gaze. Physicians who exercise knowledge and power measure their observations against the judgment of normalcy as they ritually observe the sick. The examination involves both individuating the sick person by documenting observation and judgments of normalcy, and depersonalizes the sick by making her a case. Once classified as abnormal, the physician can attempt to make the patient normal (Ellis 215). However, techniques of normalization do not actually make a patient normal because the very designation of patient would make a person different from normal. These techniques reinforce abnormality; they do not normalize.

In outlining these three instruments of discipline, Foucault is analyzing the ways in which institutions exercise power over individuals. Given Foucault's project in *Discipline and Punish*, this conclusion seems appropriate. In Foucault's early work, particularly in *Birth of the Clinic* and *Discipline and Punish*, he conducts an archeology, meaning; Foucault traces an institution or structure—like the clinic or the prison system—to examine how it exerts power upon the individual and society. This premise

in this method is that an archeology can shed light on how structures and their relationship to other structures construct subjects and subjectivities.

In a project on pharmaceutical advertisements, however, I am not able to argue that the "pharmaceutical industry" is an institution in which consumers are subject to discipline and reform, for the industry's power is diffuse and fragmented (as I outlined in chapter one). In his analysis of the prisons, Foucault argues that for institutions to discipline the body there must be control of space, a concentrated center of power. The "companies" in and of themselves do not have the power to act upon individuals like prisons, asylums, hospitals and schools can because an individual is not required to watch, read, and/or listen to their texts. Pharmaceutical companies do not occupy space in the ways these other institutions do. Instead, the non-branded ads work in an attempt *to persuade*, not coerce, consumers to define certain behaviors as normal/abnormal, and in a *desire* to achieve normalcy they subject *themselves* to particular disciplinary practices. It is a more private, individual action than Foucault describes in *Discipline and Punish.*

Foucault does address issues of more diffuse power in his later work. Arthur Frank and Therese Jones argue in a special edition of the *Journal of Medical Humanities* that there are "two" Foucaults: an early Foucault and a later Foucault. They define these two halves of the philosopher by his shift from an interest in institutions that perform subjection to the ways that people create themselves as subjects. They write,

> If the core concept of the early Foucault is the *gaze* of the expert upon the body to be subjected to whatever disciplines that experts claim are required for normalization, then the core concept of the later Foucault may

> be the *desires* by which subjects come to identify with some preferred version of who they want to be. Subjects then subject themselves to whatever disciplinary practices […] that society promises will assist in the reproduction of the desired version (emphasis in the original). (182)

In a way, Frank and Jones are describing two different methodologies that Foucault employs in his writing. In his early work and during his structuralist period, such as in *Discipline and Punish*, Foucault writes archaeologies; he traces structures through time to examine how they exert power. In Foucault's later works and post-structuralist period, such as *The History of Sexuality*, he conducts a genealogy. In this particular method, Foucault examines the history of a position of the subject throughout history as a way of discovering how discourses and knowledge are created.

For Foucault, power is not a repressive force in which one entity solely exerts power onto another. He writes, "Power must be understood in the first instance as the multiplicity of force relations immanent in the sphere in which they operate and which constitute their own organization" (*History of Sexuality 92).* Power is not unidirectional, it has a "net-like" organization and is "everywhere not because it embraces everything but because it comes from everywhere" (93). Instead, power is productive, in that it produces knowledge, or ways of knowing.

"Depression Hurts Everyone": Description of the Advertisement

Before the pharmaceutical company Eli Lilly received FDA approval for their newest antidepressant[15] Cymbalta, they[16] released an advertising campaign named "Depression Hurts." This non-branded, or help seeking, advertisement won a third place award for "Best Non-Branded Print Campaign" by DTC Perspectives Inc., the largest publishing, conferences/training, and consulting company that specializes in pharmaceutical marketing ("DTC 2007 Advertising Awards"). By awarding this honor, the industry has marked the ad as an example of excellence. However, this award isn't the only reason why "Depression Hurts" is an important campaign to analyze. One of the most compelling reasons is that this campaign has continued to be used in 2009, almost six years after the initial non-branded advertisement was released. Very few antidepressant companies can boast this continuity because many antidepressants were developed well before the 1997 revision of the DTC guidelines, and their patents have since expired, leading to a generic drug release. Companies rarely advertise drugs that have come off patent; there is very little monetary gain in doing so because people will more likely buy a generic medication instead of the name brand. Cymbalta, approved in 2004, is one antidepressant developed after the 1997 revision and continues to remain under patent. Therefore, the "Depression Hurts" campaign could very well extend through the life of its patent, making it an important campaign to consider.

The opening scene of the advertisement defines depression through the embodiment of a woman. The advertisement opens with the picture of a woman, alone, off to the left-hand side. Her eyes are cast downward indicating that someone with

[15] Eli Lilly's other major antidepressant is Prozac
[16] Foote Cone & Belding is the advertising agency that developed the campaign

depression does not interact with the rest of the world. She is isolated and alone. The woman wears a light-colored bathrobe that contrasts the black background of the ad, suggesting that she is unable to do even the most basic of human actions, like dress herself. By resting her chin in her left hand, the woman appears to lack the physical energy to hold her head up. The physical manifestation of depression becomes one of slovenly loneliness.

In the same scene, the rest of the image is completely black until the following words appear on the screen: who does depression hurt? The word "who" is larger than the rest of the text and it sits on a line by itself, drawing emphasis to the word. Since there is no one else in the picture, the viewer can only assume that depression hurts the person *with* depression. However, in a move to remind the reader that humans are in fact social beings with responsibilities, the words then fade away and with it the black background, revealing the image of a sad little girl sitting at a piano. Her eyes are directed toward the woman in the bathrobe, whom we assume is her mother. The mother does not acknowledge the girl; her back is facing her. Once the full image is before the viewer, the word "everyone" appears as the answer to the question. Through the emotional appeal of the image and the word "everyone," the viewer is persuaded that depression may seem isolating, but it is in fact an illness that impacts the social network of the individual[17].

After establishing that depression is not an individual illness, the advertisement uses guilt as a way of persuading the reader that depression is something to be addressed.

[17] There is a secondary audience for this advertisement as well, the family and friends of someone who they believe is depressed. Since the ad invokes the 'you,' in its message, the advertisers are seeking a confession from the person with depression; however, the advertisement can and most likely does appeal to others.

Once the word “everyone” disappears from the screen, the following text appears: “Depression affects the people around you the people who mean the most.” The sentence is broken into two parts; the first half (depression effects the people around you) appears in the top right half of the screen. The word depression is in a larger typeset than the rest of the sentence, drawing attention to it. The rest of the sentence appears below the first after an obvious break. A period rests after the word “most.” This page suggests that by allowing oneself to suffer from depression, one is allowing her family to be hurt.

Drawing on the seemingly natural instinct of a mother to protect her child from harm, the advertisement appeals to her responsibility as mother. The screen turns to black and the following words appear: “Take the First Step in getting better.” The words “take the first step” are larger than the others and are also capitalized, again drawing attention to them. At the bottom of the page is the URL for the website depressionhurts.com. If a mother does not want to harm her family, she needs to take responsibility for her depression. By visiting the website, she is taking action.

The last scene of the advertisement reveals the results of a woman who takes action: happiness with her family. In the last scene, a bright picture illuminates the top half of the screen. The same mother sits with her two children in a bright and sunny park. They all look at one another smiling, interacting. There is a young boy on his mother’s lap looking up at her while the mother smiles and looks over at her young daughter who sits beside her. Presumably this is the same young girl who in the previous slides was being ignored by her depressed mother. At the bottom of the screen, the tagline appears: “Depression Hurts but you don’t have to.” Also, at the bottom of this page, like all the

others is a URL for a website. This time, however, the word "visit" precedes the URL creating the line "visit depressionhurts.com," suggesting that by taking action against an illness that causes harm to oneself and her family, the mother and her children can achieve ultimate happiness.

Cymbalta Defines Depression: The Making of the Subject

The Cymbalta ad's narrative structure is similar to most anti-depressant advertisements. The advertisement follows a "black/white" fallacy, a strategy that presents one situation and then another in succession to suggest that these two events are different because of a particular product. In "A Rhetorical Analysis of the Discourse of Advertising Herbal Medicine in Southwestern Nigeria," Adeyemi Adegoju explores how the rhetorical strategy of the black/white fallacy, also known as the post hoc, ergo propter hoc" fallacy, is used in advertising herbal medicines to the people of Nigeria. He writes that the advertisers use this strategy to create a situation in which herbal products "[promise] relief from the worries and pains of perceived incurable diseases and gives hope of cure" (5). Most product-claim advertisements also follow this strategy by presenting a drug as a catalyst for an entirely different life. In the branded Zoloft advertisements, for example, in one scene Dot is depressed, takes Zoloft, and is happy. The drug changes Dot from one scene to the next, giving the perception of a quick cure. However, in non-branded advertisements, there is no product advertised. In this Cymbalta advertisement, the woman's visit to 'depressionhurts.com' for more information is what

changed her fate. *She* is the catalyst; *her actions* create a better relationship between her and her children.

In order for these advertisements to be persuasive, the reader must accept that it is her responsibility to provide a particular kind of environment for her children. She must accept that her lack of action has negative consequences in her family's lives, and her actions can have a positive impact on them. She must believe that she has agency in her own life. If she does, then this fallacy becomes a reality for her, or so the ad suggests.

Using a "later" Foucauldian framework, we can see how these advertisements exist in a set of power relations that act upon and discipline us[18]—how these ads work to make human beings into subjects. In Foucault's early work, he was interested in the ways dividing practices are techniques of domination; Foucault's later work looks at the "processes of self-formation in which the person is active" ("Ethic of Care" 11). In these pharmaceutical advertisements, the viewer as subject must be active in her own life. The subject is formed by accepting an invitation given to her by the advertisement and then acting in accordance with the way she's been positioned. Unlike a prison or another institution that coerces people in subject positions, these ads persuade the viewer *to accept* one.

By actively choosing to engage in particular subject-making practices, viewers are creating their own subjectivity. Foucault writes, "Games of truth no longer are concerned with coercive practices but with the practice of self-formation of the subject" ("Ethic of

[18] As I outlined in chapter one, for Foucault, power does not emit from a central, sovereign figure or nation state. It "must be analyzed as something which circulates, or rather as something which only functions in the form of a chain. Power is employed and exercised through a netlike organization" (*Power/Knowledge* 98).

Care" 11). These practices, known as technologies of the self, are how a person defines herself as an individual. However, as Foucault would argue, there is no true self, but a socially constructed one. These patterns of behavior and seeming choices she has are found in her "culture and which are proposed, suggested and imposed on [her] by [her] culture, [her] society and [her] social group" ("Ethic of Care" 11). Rebecca Lester explains this idea well in her article "Let Go and Let God" when she writes, "Notions of what kinds of selves are desirable (and which are not) and of what certain practices communication to others about our internal states are laden with cultural significances" (149). As one participates in particular kinds of technologies of the self demanded by her culture, others are also reading into her actions from their own culturally-situated perspective. In other words, our behaviors are signified in specific ways depending on our cultural surroundings.

In the Cymbalta advertisement, the viewer is asked to take on the subject position of a mother with all of the rights and responsibilities that position entails. The advertisement reinforces the specific practices, or techniques of the self, which a mother engages in to affirm her position as mother: a mother does not hurt her children, a mother is available to her children, a mother plays with her children, and a mother creates an environment in which the children are happy and healthy. These practices of being a parent, and a mother in particular, are not created in these advertisements. These practices have been created by the culture in which the subject lives. In an American culture, mothers engage in these practices.

However, if the viewer is a mother and does not engage in these practices, then she is not fulfilling her subject position. The Cymbalta advertisement makes clear that when a mother is not, for example, spending focused time with her children, she is 'hurting everybody.' In order to maintain her identity as a mother, the woman in the commercial visits the "Depression Hurts" website so she can regain what she imagines to be her ideal identity as a good mother. This advertisement invites all other mother-viewers to visit 'depressionhurts.com' if they are not fully engaging in these self-formation practices.

These advertisements also ask the reader to take on another, competing, subject-position: one of the depressed individual. These advertisements ask the viewer to read depression in a particular way. According to these ads, depression does not carry a biomedical definition. It does not ask the viewer to check off a list of symptoms such as "loss of appetite" or "irregular sleep patterns" (University of Michigan). Instead, it defines depression in a different way altogether. Depression is a way of hurting your family. When a person is depressed, he or she is not the only person who is in pain; her family suffers. The family—and specifically in this ad—the children are hurt because of this woman's behaviors. The children seem neglected, almost forgotten about, as evidenced by their occupied space in the darkness and background of the commercial. In these ads, depression is bad parenting. Therefore, a person with depression is a bad parent, and not engaging in practices that constitute her self as a mother. By asking the viewer to read depression, depressed parent, and parent in these ways, the ads demand self-condemnation and a confession from the viewer.

Needing to Admit it: Confession as a Technique of the Self

The confession that these advertisements require goes well beyond a simple admittance of illness. By admitting, or confessing, depression, the viewer produces a truth that she must uphold thereby leading to a need for reform, a normalization of the self. Lester writes, "Technologies of the self rest on the association of the moral and the practice. Foucault argues that one of the most important and successful techniques for building this association is confession" (149). In the introduction to *The History of Sexuality,* Foucault explores the relationship between confession and the discourses of sex/sexuality. His theories can also illuminate the way that confession is used to produce certain truths of depression in non-branded advertisements. The confession acts as a technique of the self that positions viewers to discipline their own bodies.

The ritualized confession required from non-branded advertisements is similar to the ones described in *The History of Sexuality*, but it is done privately. In the chapter "Scientia Sexulais," Foucault makes the case that Western societies use confession as a ritual for producing truth. He writes:

> Since the Middle Ages at least, Western societies have established the confession as one of the main rituals we rely on for the production of truth: the codification of the sacrament of penance […], the declining importance of procedures in criminal justice, […] and the development of interrogation and inquest. (58)

Western societies have developed religious and secular procedures for the confession in our churches, our legal systems, military institutions, etc. For example, in the Catholic Church, a person who has committed sins follows the ritual of going into a private space with a priest and says a particular prayer. Then the priest prompts her to detail her sins. Following her confession, she is then expected to repent according to the priest's prescription. In non-branded advertisements, a person must also follow a ritual for confession, but it is perhaps a more private one than Foucault outlines above. The advertisements encourage the individual to make a private confession that results from a dissonance between her actions and her aspired identity. If there were a ritual it might take the following shape: watch a television advertisement, notice the ways the person on screen behaves in similar ways to you, realize that your behaviors are in conflict with the cultural narratives that you ascribe to, admit that you may be experiencing the illness, take action by seeking help from a doctor or by visiting the "informational" website. In branded advertisements, the action of seeking help becomes public because an individual seeks a doctor's opinion (the normalizing gaze of the physician), but since these advertisements encourage people to visit a website, the act of confession is still a private matter.

If a person feels conflicted about confession, it is, for Foucault, because of "a constraint [that] holds it in place, the violence of a power [that] weighs it down and it can finally be articulated only at the price of a kind of liberation" (*History of Sexuality* 60). In the case of depression, a person may not confess because of the stigma attached to it. The power of the cultural and social implications of a confession of depression outweighs

the need for people to free themselves of their perceived guilt and assume a particular subject-position since the subject-positions are conflicted. If a person confesses to the depression, she is abnormal and the embodiment of the stigma, but if she does not confess, she remains abnormal. Confession seems to free a person, but it may in fact produce a different discourse laden with sentiments of abnormality.

According to Foucault, our confession and our need to confess has become so much a part of our culture that "we no longer perceive it as the effect of a power that constrains us; on the contrary, it seems to us that truth, lodged in our most secret nature, 'demands' only to surface" (*History of Sexuality* 60). In many ways this "secret nature" that "demands to surface" is our conscience that needs to be relieved of our guilt by confessing. As socially and culturally constructed beings, our values, identity, and "secret nature" are defined by the power networks in our culture for it is "impossible to know the materiality of the body outside its cultural significations" (McNay 30). In the non-branded Cymbalta advertisement, the viewer is expected to confess depression because she feels guilt over hurting her family. She is, as Althusser might say, "hailed" into her subject position. This guilt has been assigned by her cultural positioning.

One key aspect of the confession for Foucault is that the ritual unfolds

> within a power relationship; for one does not confess without the presence (or virtual presence) of a partner who is not simply the interlocutor but the authority who requires the confession, prescribes and appreciates it, and intervenes in order to judge, punish, forgive, console, and reconcile. (*History of Sexuality* 61-62)

For example, in a church, the sinner confesses to a priest because he has the authority to judge, punish, and forgive the sinner. He listens and acts on her confession. In this non-branded advertisement, the initial confession is made to oneself as she takes action to visit the website. While the power dynamic is certainly skewed, both the advertisement (or advertisers) and the depressed-subject act as "vehicles of power" (Power/Knowledge 98).

The website is a vehicle of power as it becomes the authority on depression, drawing its legitimacy from and acting as a surrogate for the medical establishment and telling the visitor what depression is and how to take action against it. In "Psychopharmaceutical Advertising Strategies: Empowerment in a Pill?," sociologist Ruth Chananie argues that DTC advertisements are persuasive because they, among other things, establish medical legitimacy. She writes,

> The construction of a disorder relies heavily on the establishment of the condition as properly belonging to the realm of the medical. It makes sense then that establishing medical legitimacy in the DTCs is a crucial and necessary step toward convincing the consumer that the speaker who represents the pharmaceutical company is an 'expert' in the medical field and should be taken seriously and believed." (496)

In this particular passage, Chananie is specifically referring to branded advertisements, ones that refer directly to medications. While some non-branded advertisements do specifically mention seeing a doctor or the science of a particular illness, this particular non-branded Cymbalta advertisement does not. The website, however, can replace the

word DTC in Chananie's passage above for it works to convince "the consumer that the speaker who represents the pharmaceutical company is an 'expert in the medical field" (496). The authority it garners from that ethos helps the reader trust in it.

The website uses strategies to assert its credibility and exert its persuasive power. On the depressionhurts.com website, five menus appear near the top of the page: System Body Map, Self-Assessment Checklist, Patient Stories, Treatment, and Support Partners. One the right hand side of the page, a faceless body exists next to the link for the Systems Body Map. Two boxes below that box, there is a picture of a person's brain. Next to the brain the words read "Watch how chemicals may affect the body and mind." The images and the System Body Map place the location of depression squarely in the body, making depression in the purview of the doctor, which is in line with shift in disciplinary perspective outlined in chapter 2. Also the titles to the Patient Stories and Treatment sections work to place people with depression at one end of a medical gaze, working to exert its power over the subject. As Foucault teaches us, a person becomes a patient as she is given the symptoms of a disease. The patient is observed and classified through the lens of an authority figure.

However, the subject is also a vehicle for power exerting her knowledge over her own body and becoming an active participant in her diagnosis. She has already practiced a technique of the self by admitting depression, and now she has taken the active step toward normalizing her behaviors. The website provides other opportunities for the subject to judge herself and more fully confess her depression. One of the links on the sections of the website is Self-Assessment checklist. After clicking on the page users can

fill out a Self-Assessment Checklist. The checklist makes statements in four untitled sections. If the visitor agrees with the statement, she checks the box. Each question begins with a personal possessive pronoun or a personal adjective. Several statements begin with the word “I’ as in “I don't enjoy hobbies, leisure activities, or time with friends and family anymore” (Eli Lilly). Other statements start with “my” such as “My sleep patterns are irregular.” First, the use of personal statements allows the visitor to take ownership over her activities and shift her from put-upon subject to self-aware subject. In other words, if the statements were questions such as “Do you still enjoy your hobbies?,” the use of the word ‘you’ implies a differentiation between a you and a me. The “you” and the “me” are not the same person, and the “me” is administering the test to decide if the “you” is depressed. An explicit distinction would be made. By using the personal, the visitor is announcing her position, not as different from another but personal to her. Her gaze is cast inward; there is no one else observing her. Secondly, the statements themselves require a degree of interpretation, which the observer must make a decision about. For example, the survey asks a person to declare that her sleeping is irregular. The woman then must decide if her habits are irregular based on her previous sleep patterns or those she perceives as normal for others. In this way, the medical authorities are not forcing the woman to quantify her sleep based on numbers. Instead, they are asking her interpret her behaviors through her own lens. By allowing her to engage with the document in these personal and interpretative ways, the woman is exerting her own power in her confession.

But is she really exerting her own power at this point? The advertisements have already positioned her as depressed, and now the website is reinforcing that position in a specific, medicalized way. While her acceptance to the invitation might have initially come from a belief that she was being a bad parent, the website has shifted her into a pathological position, instead of, for example, a cultural, and perhaps class-based, expectation that has been socially constructed. Her bad parenting has now become a symptom of depression, a medical disease. Each of the sections on the website forces her to take on that position. So while it seems she has agency as she clicks through the website and makes decisions about her body, she is, for all intents and purposes, being subjugated by the makers of Cymbalta. Her choice is manufactured by the drug companies.

This manufactured choice is at the center of Foucault's concept of the self. Arthur Frank and Therese Jones articulate it best by writing,

> Foucault's question [in his work] was not who we are, but how we claim to know who we are. He led us to take seriously how we […] think about whom we are and condition others to think of who they are. This *who* is never an essence but always a social construction, and Foucault showed us how to study the practices through which people create their sense of who we are." (179) (emphasis in the original)

For Foucault, analysis is not about discovering a true self or even The Truth. It is about discovering why we think of ourselves in the way we do. These advertisements and, in turn, these websites condition people to think of themselves as depressed, and the

practices we engage in, such as confession, are our ways of trying to break out of that subjectivity and escaping to another, more desirable condition.

Admitting You Have a Problem Is Only the First Step: Confession and Normalization

Ruth Chananie concludes her article about non-branded advertisements by suggesting that the strategy of empowerment is the most important one advertisers use to increase interest in the drug (508). For Chananie, empowerment derives from the way the branded ads encourage a control over their disordered lives through the use of drugs (505). I argue that if branded ads offer empowerment through drug use, the non-branded ads offer a way of gaining control. The non-branded advertisements explicitly require a person to take control over her emotional life. *She* has to pull herself out of her depression, admit her condition, and actively work to change it.

In *Conceiving Normalcy: Rhetoric, Law, and the Double Binds of Infertility,* Elizabeth Britt seeks to understand the ways in which women actively seek to change their materials circumstances. In her ethnographic study, Britt explores the values of middle-class women who seek infertility treatment. In her penultimate chapter titled "Control and Constraint" Britt examines how women are caught in a double-bind of control and restraint as they treat their infertility. The women in Britt's study all held a core value of control, and because of this, they believed they should have the choice of whether and when to have a child (121); however, infertility infringed upon that choice as

they no longer had control over procreation. With a mandate in Massachusetts (the context for Britt's project) that provided for medical treatment for infertility, women felt the mandate gave them control over their bodies again. However, by entering into treatment, the women's lives were constrained by the invasive nature of the medical treatment. The treatment offers a sense of control for the women because they are actively trying to change their circumstances, but at the same time the treatment is constraining their circumstances. The women are caught in what Britt calls "contradictory logics imposed […] by competing normative frameworks (13). In other words, the women are in a bind, stuck in the contradiction of control and constraint while working to be normal, which Britt calls the double-bind.

In developing her theory of the double-bind, Britt draws on the work of Gregory Bateson and his work with childhood schizophrenia. While Batesons's work on schizophrenia has long been discredited, his concept of the double bind is still useful. Bateson argued that schizophrenia can be produced when a child is stuck in a contradictory communication, a double bind. Britt relays the example of a child who is told "I want you to disobey me." By obeying the order, the child disobeys, but also by not following the order, the child disobeys (12). From this work, Britt argues that a double bind is "a way to understand how both discourses create spaces within which individuals act and how individual act within these spaces" (13). Throughout her book, Britt explores how women are caught in the double-bind when a technology of normalization (such as the Massachusetts mandate) is introduced into their lives.

I believe a similar phenomenon occurs as people confess their depression. They are both controlled and constrained. Much like Britt's women, people who accept the invitation to confess to depression have to take control of their lives. In taking control, they are also constrained by the definitions and subject position of depression, as established by the drug companies. In other words, if after watching the non-branded advertisement, people agree that they hurt their families because they are too depressed to engage with them, then they will 'visit the website.' By visiting this website, they are engaging in a technique of the self by taking control of their undesirable behaviors. However, the very act of taking control and visiting the website, constrains them to a particular subject-position: depressed. They need to then fill out self-assessments forms, see their doctors, and seek treatment for their depression. They are caught in Britt's double-bind—a rhetorical device used to maintain a distinction between the normal and the abnormal. The advertisement defines for the viewer what are normal behaviors and what are abnormal behaviors, and it seeks her confession as the first step toward becoming enacting normal behaviors, as they define them, which of course can never truly happen as long as she takes medication.

At the end of her book, Britt articulates a relationship between the double-bind and normalization. She writes, "Normalization can thus be regarded as a matrix of double binds created not by one individual for imposition on another but by intersecting institutional and cultural discourses" (146). In this chapter, we have seen how the non-branded advertisement demand that people confess to a particular behavior as a way of gaining control over their undesirable behaviors, but how they are then also caught in the

constraints of a subject position. The non-branded advertisement works as a technology of the normalization because it presents desirable behaviors (being a good mother) and tells the viewer how to achieve that behavior (by going to the depressionhurts.com website). In order to do so, a person must practice a technique of the self, the confession, before visiting the website, which functions as a technology of the self.

In attempting to be normal, which in these ads is defined as a person who is a good parent and in control, these women actually confess to being *abnormal* because depression has been defined by the pharmaceutical companies as a mental illness, stemming from physical abnormalities. By admitting to depression, a person maintains her abnormality, which is exactly what the drug companies are hoping for. By existing in the contradiction of normal and abnormal, pharmaceutical companies profit. By taking control, consumers also admit to abnormal behaviors, and ultimately have to seek out a doctor and, if prescribed, begin a regiment of drug therapy. In the next chapter, I will explore how branded advertisements offer drugs as the solution to depression by turning people into patient-consumers and relying on them to engage in practices Foucault calls technologies of the self.

CHAPTER 4: "ADDING ABILIFY HAS MADE A DIFFERENCE FOR ME": BRANDED ADVERTISEMENTS, CONTROL, AND GOVERNMENT SPONSORSHIP

In the previous chapter, I closely analyzed one representative disease-awareness advertisement to establish that non-branded pharmaceutical ads intend to elicit a confession from the viewer. This confession, a technique of the self, is brought about by convincing the viewer that depression makes people neglect their responsibilities. To try to relieve the guilt and shame associated with being irresponsible or disengaged, a person with possible symptoms confesses that she *does* exhibit those behaviors, and consequently has depression. In doing so, the individual has accepted the ad's invitation to define herself as depressed. By taking on this particular subject-position, the individual is also subject to the value-laden discourse associated with depression. In the non-branded advertisements, it is clear that depression is *not* a desired emotional state, and in fact, is antithetical to normal emotional behavior.

By situating depression at the far end of a healthy spectrum, depression, as defined by the pharmaceutical companies, becomes something abnormal. In producing these non-branded advertisements, the pharmaceutical companies create a desire for a technique of the self that will help make people normal after they have confessed to depression. This desire is fulfilled once the branded, or product-claim, advertisement is released for public consumption. The branded pharmaceutical advertisements provide consumers with a technique that governs their behaviors: taking medication.

By convincing the audience to take medication, the ads are persuading the audience to be patient-consumers. The pharmaceutical companies need the viewer to be persuaded that taking medication will subject his body to the reforms necessary to render himself normal. Otherwise, the companies will not sell their product. The company needs the viewer to become a patient-consumer to make profits from his perceived illness. To persuade the viewer, the advertisements make two appeals: they draw on a person's desire to take control of himself, and they invoke the name of the Food and Drug Administration (FDA) to create trust with the viewer.

Given these persuasive strategies, I argue in this chapter that branded advertisements attempt to persuade viewers to engage in a particular technology of the self, which is a practice used to regulate behavior. In doing so, the viewer becomes a patient-consumer. To make this argument, I draw on Foucault's concept of technology of the self, and I complicate it with Foucault's notion of governmentality. By drawing on these theories and doing this analysis, I conclude that branded advertisements are extensions of the state's attempt to normalize large populations' emotional health.

Biopower Is the New Black: Foucault's Revision of Power Dynamics

From his first major book *Birth of a Clinic: An Archeology of Medical Perception* to his last published book *The Care of the Self: The History of Sexuality Volume 3,* Michel Foucault has theorized the way human beings know themselves in terms of their sexuality. In his early work, Foucault explored the "modes of inquiry which try to give

themselves the status of science" ("The Subject and Power" 208). In his next phase, he examined the ways structures and institutions divide the normal from the abnormal. In the third phase of his scholarship, he studies how humans turn *themselves* into subjects. In this third phase of scholarship, Foucault's concern over how people subjugate themselves led him to revisit his earlier definitions of power. Whereas in his early work, Foucault wrote about disciplinary power, in his later work he also developed a theory of biopower.

Foucault begins to develop his theory of biopower in *The History of Sexuality.* He devotes the chapter "Right of Death and Power over Life" to the shifting role sovereign powers and individuals have had over the right to life and death. Foucault argues that during the classical age, the sovereign power, such as the king, had control over who would live and who would die, and in using that control, affirmed his right to life. Foucault writes, "The sovereign exercised his right of life only by exercising this right to kill, or by refraining from killing; he evidenced his power over life only through the death he was capable of requiring" (*History of Sexuality* 136). The king's actions demonstrated a technology of domination over his nation.

Since the classical age, the power to save or eliminate life has drastically changed. Foucault cites the death penalty as an example of how different modern power relations are from ancient times. At one time, if a person attacked the sovereign's position or power, he would die on the scaffold (*History of Sexuality* 138). Today, capital punishment is carried out usually by "[invoking] less the enormity of the crime itself than the monstrosity of the criminal, his incorrigibility, and the safeguard of society" (138). The state would need to convince its citizens that the criminal could not be rehabilitated

and poses a threat to their safety in order to carry out what a king once could have done without ceremony.

By analyzing shifting roles of the state, Foucault expanded his notion of power. He defines two kinds of power that are "not antithetical" but constitute "two poles of development linked together by a whole intermediary culture of relations" (*History of Sexuality* 139). The idea that these two descriptions of power are not antithetical is important for Foucault because he does not believe that power operates unilaterally. Power has a net-like circulation, so if we imagine disciplinary power and biopower as two poles, the cultural relationships between them will weave back and forth and around the poles. These two types of powers are connected to one another.

The first pole, disciplinary power, Foucault describes as follows:

> [This pole] is centered on the body as machine; its disciplining, the optimization of its capabilities, the extortion of its forces, the parallel increase of its usefulness and its docility, its integration into system so efficient and economic controls, all this was ensured by the procedures of power that characterized the *disciplines: an anatomo-politics of the human body*. (139, emphasis in the original).

This kind of disciplinary power is explored in Foucault's *Discipline and Punish,* which I explored in detail in chapter three. Foucault then describes the other pole, biopower. He writes:

> The second […] focused on the species body, the body imbued with the mechanics of life and service as the basis of biological processes:

> propagation, births and mortality, the level of health, life expectancy and longevity, with all the conditions that can cause these to vary. Their supervision was effected through an entire series of interventions and *regulatory controls; a biopolitics of the population.* (139, emphasis in the original)

In this pole of power, the larger population is subjected to procedures that regulate their behaviors.

While disciplinary power is concerned with techniques of normalization, classification and division and observational hierarchies, biopower is concerned with techniques of power that control life, death, and health of populations. Claire O'Farrell writes, "Forms of knowledge and practices related to hygiene, public health, the control of reproduction and sexuality became the subject of administrative interest with very detailed forms of knowledge being put in place to gather knowledge and manage populations" (106). In terms of depression, a technique of biopower might include the detailed and personal inventories that health professionals collect. In terms of pharmaceutical advertising, it might be the detailed information collected on pharmaceutical websites from people filling out online questionnaires about their health.

The reason biopower is often associated with Foucault's later work is that biopower can only be productive if humans engage in practices that make themselves into subjects. Whereas disciplinary power coerces the body into a subject position—such as the criminal in the prison or the "madman" in the asylum—biopower provides individuals with practices that they do unto themselves in order to make themselves a subject. Since

Foucault's later work on sexuality focuses on how we know ourselves as sexual beings, biopower is at the core of his analysis. Institutions rarely *force* a person into a sexual subject position, but they do encourage certain behaviors—ways of dressing, for example—that a person must do unto herself. These practices, known as technologies (or techniques) of the self, are the mechanisms by which a person exercises self-subjugation.

I Do It for Me: Technologies of the Self and Health

Given his framework of biopower, Foucault became extremely interested in better understanding technologies of the self. In *Technologies of the Self,* Foucault laments that he has been too occupied with technologies of domination and power, and in his later work is curious to explore technologies of the self. He writes, "I am more and more interested in the interaction between oneself and others and in the technologies of individual domination, the history of how an individual acts upon himself, in the technology of the self" (19). Foucault's early archaeologies uncovered the way institutional discourses subjected a person to particular reforms. In this later work, he hoped to explore how people subject themselves to reform.

In his essay "Technologies of the Self," Foucault outlines the four major types of technologies he believes produce knowledge. He delineates:

> 1) Technologies of production, which permit us to produce, transform, or manipulate things; 2) technologies of sign systems, which permit us to use signs, meanings, symbols, or signification; 3) technologies of power, which

> determine the conduct of individuals and submit them to certain ends or domination, an objectivizing of the subject; 4) technologies of the self, which permit individuals to effect by their own means or with the help of others a certain number of operations on their own bodies and souls, thoughts, conduct, and way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection, or immortality. (18)

Of all of the different technologies named above, the technologies of the self are the most detailed and certainly most poetic of the descriptions. Technologies of the self are the practices by which people transform themselves into what they want to be. Whereas technologies of domination decide the subject position of the individual, technologies of the self are engaged in by the freewill of humans. While Foucault is not explicit in this essay on technologies of the self, I argue that it is impossible for technologies of the self to be performed outside of the pressures and powers of the culture in which a person is situated; technologies of the self are still practiced within a larger cultural and political system that may implicitly, or in the case of direct-to-consumer advertisements, explicitly encourage an individual to participate in these practices.

Since Foucault explicitly lists attainment of happiness and perfection as desired outcomes of technologies of the self, it is no wonder that health professionals and those who analyze the healthcare industry have used Foucault as a starting point for their scholarship. In the edited volume *Foucault, Health, and Medicine*, Editors Alan Petersen and Robin Bunton put together a collection of works that draw upon Foucault and offer interesting analyses and critiques of the health and illness. Not all the articles

deal specifically with technologies of the self, but one in particular makes an argument about how technologies of the self are practiced in the doctor-patient relationship.

In "Foucault and the Medicalisation Critique," Deborah Lupton problematizes the distinction between technologies of the self and technologies of domination. She writes,

> One major problem is the tendency of Foucault and those using his work to neglect examination of the ways that hegemonic medical discourses and practices are variously taken up, negotiated or transformed by members of the lay population in their quest to maximize their health status and avoid physical distress and pain. (94-5)

Lupton's critique is spot on. Foucault's discussion of technologies of the self does not address the way in which technologies of the self are practices enacted within a larger hegemonic system. While Foucault writes that he is interested in learning about how people subjugate themselves, he does not make clear if he is interested in how competing discourses may require a person to negotiate which practices of the self to engage in and to what degree. Foucault's work tends to be written from a more macro-perspective, rarely examining the *individual* differences among people.

Lupton provides a nice example to help illuminate her point. She writes about the doctor-patient relationship and compliance with the "doctor's orders." Whenever doctors and patients meet, some may "attempt to struggle against, challenge or subvert those disciplinary techniques they experience as restricting of their autonomy" (105). In other words, if a person defines herself as autonomous and self-reliant, then the doctor's discourse and behavior during those sessions may force the person into a variety of

behaviors. Others, Lupton says, may go along with the doctor's advice and those people should not be viewed as "passively accepting the orders of the doctor or the medical gaze, but rather could be seen as engaging in practices of the self that they consider are vital to their own well-being and freedom" (105). While the desires behind the behavior are probably unknowable without interviews or some other kind of ethnographic research, Lupton's argument is important to keep in mind as we attempt to understand how people know themselves.

By taking into account Lupton's argument about technologies of the self, my analysis of direct-to-consumer advertisements does not focus on *why* people decide to take medication. Instead, this analysis seeks to explain how the *pharmaceutical industry* makes a particular technique of the self an appealing practice. The goal of the advertisement may be obvious—the sale of drugs—but the ways in which they go about appealing to the audience is designed to get them to view themselves or others in a particular way.

I'm Telling You to Do It for Yourself: Regulatory Control and Suggested Practices in Branded Advertisements

Branded advertisements fill the void left by non-branded advertisements. After the branded advertisement has elicited a confession, the individual is left believing she is abnormal, and the branded advertisements give her a way of restoring herself to "normality." Every branded advertisement attempts to persuade a person to take

medication; it is the fundamental purpose of the advertisement. Andrew Wernick in "Advertising and Ideology: An Interpretative Framework," reminds us that no matter what other effect advertisements have on our knowledge production, the expressed goal of an advertisement is to sell a product. He writes:

> Normally […] brand name ads are constructed with one single-aim in mind: to sell commodities. Consequently, whatever seemingly surplus signifying material they contain should be comprehended in the first instance in how they discharge that promotional function not as an automatic and unremarkable effect of mass media's subordination qua "means of mental production" to the interests and consciousness of the dominant class. (19)

Advertisements rely on persuasive appeals to sell their goods, and any analysis of an advertisement has to acknowledge that expressed goal of a company.

While Wernick's point is fair and does inform this analysis, DTC drug advertisements are slightly different from the kinds of advertisements Wernick references to in his article. DTC advertisements, by the nature of the product, are different from other goods purchased in the grocery store, mall or on the Internet. For example, some commercial product advertisements can show that the cost of a product is proportional to the benefits of the product. For example, if a Domino's pizza is only $5, a customer might think the pleasure of eating that pizza is worth $5. DTC advertisements, on the other hand, are not trying to persuade the consumer that the cost of the medication is commensurate with its impact because healthiness is a basic human need. Whereas we all

need extra time in the day, we need our health above all else. Buying prescription drugs is not like buying a pizza: one is a (supposed) need and the other is a want. We want pizza; we need our health. In general, people want to be healthy and they realize the impact of unhealthy behaviors. Of course, maintaining and achieving good health can be challenging, so drugs provide a way for people who are unhealthy to achieve healthiness (or so the story goes). Since people need to be healthy, the pharmaceutical companies hope people will take prescription drugs.

Branded advertisements are trying to sell a product, but they are also "selling" the argument that taking medication will reform our abnormal behaviors. Norms are extremely powerful motivators for taking action. Lois McNay writes, "Individuals are controlled through the power of the norm and this power is effective because it is relatively invisible" (94-5). According to the pharmaceutical companies, this technology of the self will seemingly transform a person's unwanted emotions into healthy, desired, and normal ones. In his discussion of biopower, Foucault writes that large-scale practices of regulatory control encourage people to engage in techniques of the self. These branded advertisements are a practice in regulatory control because they attempt to define how a person with depression should behave: they should take medication.

The branded Cymbalta advertisement is a good example of when and how advertisements suggest this technology of the self to reform ourselves. The branded advertisement follows a similar narrative structure as the non-branded advertisement. The commercial begins with several frames of solitary individuals in dark spaces, sitting or laying alone. Their bodies make gestures of pain and sadness. In the middle of the

commercial, Cymbalta is described as a drug that treats the physical and emotional pain of depression. Following a rudimentary scientific drawing of a silhouetted body, the commercial ends with these same individuals, now smiling, surrounded by their loved ones in bright, sun-filled spaces. The final tag line, "Depression huts but you don't have to," solidifies the idea that Cymbalta is the catalyst for living a happy, fulfilled life free from the pain of depression. The argument in the advertisement is that by taking medication, a person can live a healthy, normal life.

Part of the appeal of these advertisements is simply that they provide a way out of a subject position that is undesirable; people do not want to be depressed, they want to be normal. By accepting the invitation to try Cymbalta, the individual is creating a new subject position for herself: patient-consumer. If the viewer does visit the doctor, she becomes a patient and by buying into the advertisement and beginning a regime of antidepressant therapy, she becomes a consumer. First, however, the person needs to accept the invitation the pharmaceutical advertisements have sent out.

"I'm Not Where I Want to Be with My Depression": Tropes of Control in Branded Advertisements and the Construction of Depression

In order to engage in the regulatory practices the pharmaceutical companies recommend, the viewer needs to be persuaded by the advertisement. In some ways the viewer is already open to receiving medical information because modern consumers want to take a more active role in their healthcare. A 2002 article in the *New England Journal*

of Medicine begins, "During the past two decades, there has been an irreversible change in the nature of the doctorpatient [sic] relationship. Patients are seeking much more medical information and are actively participating in decisions affecting their health" (Wolfe 524). Whereas at one time the gaze of the doctor and his prescription pad would discipline the body, now, the medical community encourages a more open dialogue between the patient and the doctor. The discourses surrounding the power dynamics of the patient and doctor have changed.

With this kind of audience in mind, the advertisements rely on persuasive strategies that appeal to the viewer. The first is an appeal to our need for control. Running through almost all Direct-to-Consumer advertisements is the trope of control. In the Cymbalta advertisement above, the final clause "you don't have to" suggests that a person has a choice and therefore control to be depression-free. This same notion of control appears in other depression advertisements taglines. Zoloft, for example, says, "When you know more about what's wrong, you can help make it right," and Paxil's tagline is "Your Life is Waiting."[19] Both of these lines have implied agency: a person can make their life right and start living life, if she takes control of the situation and sees a doctor and ask for Cymbalta/Zoloft/Paxil.

Antidepressant advertisements visually and textually argue that depression is responsible for a loss of control in two areas of our lives: social engagement and production. In these advertisements, the pharmaceutical companies try to persuade the

[19] These taglines have been read differently by other writers. Charles Barber writes that the slogans are indicative of how the drugs were sold as "lifestyle agents" (50). In other words, antidepressants are marketed not as relieving symptoms but as something that will restore us back to our true selves. In this way, the drugs are marketed not only to the sick, but to a wider audience.

viewer that people are productive and socially engaged because they have taken control of their behavior.

Abilify, a new add-on antidepressant, is an excellent representative example of how advertisements present depression as a loss of control over engagement and production. These advertisements also offer medication as a technology of the self that is supposed to make us normal. In 2002, Abilify[20] was approved by the FDA as a medication used to treat schizophrenia (NDA 21-436). In 2004, the drug was newly indicated and approved for use in treating "acute manic or mixed episodes associated with Bipolar Disorder" (NDA 21-436 / S-002). Then in 2007, the drug was approved to act as an "adjunctive treatment to treat patients with major depressive disorder" (NDAs 21-436/S-018 21-866/S-005 21-729/S-005 21-713/S-013). That is, while the drug is not an antidepressant, studies have found that when Abilify is combined with antidepressants, patients' depression symptoms are impacted. While there was no Direct-to-Consumer advertising for Abilify's use in treating schizophrenia, the drug was marketed as a treatment for bipolar disorder, and more recently as an additive treatment for depression.

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[20] It has been pointed out to me that the name Abilify seems to have the word "able" at its -root. While I have not found any literature discussing the naming of this drug, drug names are purposeful. In *Comfortably Numb: How Psychiatry is Medicating a Nation*, Charles Barber writes the following:

> Before Prozac, the brand names of drugs were generally some simplified version of their scientific and generic names […] Prozac, the scientific name of which is fluoxentine, was the first drug whose public name was specifically created to evoke saleable images and ideas: in this case, the "pro" connoting positivity, and the "zac" the reassurance and exactitude of science. Since Prozac's smashing success, it has become all but de rigueur that new blockbuster drugs have brand names that simultaneously soothe, invigorate, and inspire. (49)

Barber goes on to cite a professor of pharmaceutical marketing that says naming drugs is big business these days. Hard sounds like X, Z, C, and D are often used because of the decisive nature of the sound. He quotes James L, Detorre who says, "The harder the tonality of the name the more efficacious the product in the minds of the physician and the end user." (49). Naming a drug is estimated to cost anywhere from $500,000 to $2.5 million (49).

Social Engagement

The Abilify commercial follows two people, a man and a woman, through their journey with depression and implied treatment with Abilify. The woman's story is focused on her role as a social being as we see her transform from a woman walking through her backyard by herself to the perfect hostess at her party. The ad begins with the woman walking outside by herself. In the background, a person puts down a blanket for a picnic. The woman does not acknowledge the people as she passes by. The video is dark and the voiceover says, "I'm taking an antidepressant but I think I need more help" (Abilify). As the video progresses, we see the woman sitting on her couch, reading information about Abilify. In the final scenes of the commercial, the woman is at her party. She brings a tray of fruit and cheese around to her guests. She helps choose which record to play for music, and she converses with the guests. She is actively engaged with the activity around her.

In the second part of the advertisement, the viewer is supposed to see the woman in her role as party host as the desired state of being. The woman in the advertisement makes eye contact with one guest as she provides him with refreshments, and she takes an interest in another guest's music choices. These actions are to be understood as a good thing, and we can read from the advertisement, a person without depression is someone the advertisements encourage us to be: connected with others.

Productivity

The other story in the advertisement is the man's. His narrative begins with him sitting behind his desk. The desk isn't in a big office building somewhere and the man does not wear a suit. Instead, he is in his home in a pair of casual slacks and shirt. The desk behind him is a mess of papers and folders. He rubs his head as if he cannot concentrate. His voiceover is heard saying, "I'm on an antidepressant, but I'm still not where I want to be with my symptoms" (Abilify). In the next scene, he stares out the window, suggesting he may not be able to focus on the work he has to do. After the narrative break to tell the viewer about the effects of Abilify, the man's story resumes as he is putting his finished work into a large manila envelope. The desk is straightened up and the man is smiling. Finally, in the last scenes of the commercial, the man walks to the mailbox with his finished work, and says, "Adding Abilify has made a difference for me."

The intended reading of his story is that people are supposed to want what the man has at the end of the commercial. The advertisement shows that the man has worked hard and finished his task, as evidenced by mailing the envelope. Viewers are supposed to want that feeling of accomplishment and of knowing that results were produced.

Both of these characters are intended to be positive representations of someone with depression because neither the man nor the women allow himself or herself be defined as depressed. In the man's dialogue, he is particularly powerful when he says that he is "not where [he] want[s] to be with [his] symptoms." This sentence reveals that he has a plan for managing his depression and taking medication is the technology of the self that he engages in to achieve that plan. The ad represents him as the model patient-

consumer because he does not passively allow himself to be subjected to an abnormal subject-position. He takes control over his own actions by taking Abilify, and the hope from the drug companies is that the viewer will identify with this man's actions and take the same ones.

By appealing to a need for control, the branded advertisements are making a claim about the role of the self in depression. They are implicitly arguing that a depressed subjectivity is not the true self. In the beginning of antidepressant advertisements, people with depression are constructed as people who have lost control of their lives. The advertisements often show friends, pets, or family in the background while the person with depression is all alone. In the Abilify commercial, both the man and the woman presumably have friends and work, but the depression has kept them from fully engaging with the self that they are. These background images and hints of what the person once was or could be suggest that everyone can be normal, not depressed. Depression is depicted as a detour away from what is "natural": engagement and production. Also, in *Comfortably Numb,* Charles Barber argues that the slogans of the advertisements are indicative of how the drugs are sold as "lifestyle agents" (50). In other words, antidepressants are marketed not as relieving symptoms but as something that will restore people back to their true selves.

Since pharmaceutical discourses of depression often position the person as sad, lonely, tired, and unable to cope with the ups and down s of everyday life, it is slightly surprising that they would also appeal to someone who would be persuaded by an appeal to control. One of the reasons this appeal is hoped to work is that depression is also being

defined as a temporary mask to a person's true self. In these advertisements, underneath depression lay a person who is not depressed but normal. The drug companies want us to believe that if we engage in the practice of taking medication, then we fully realize our normal selves. In actuality, we would be taking on another prescribed subject-position: the one of the patient-consumer.

"The Nerve Cells Connected to the What?" Challenging Expected Techniques of the Self

In a system where patient-consumers want to be involved in her maintaining or reforming her health, resistance to the "informed" role of the patient has been scrutinized as has the pharmaceutical companies' attempt to unilaterally define which technology of the self to practice. Individuals are creating their own "commercials" about depression and antidepressants. These videos, mostly hosted on sites like YouTube, draw attention to the fact that most consumer-patients do not fully understand the science, risks, or benefits associated with taking medication.

One of the templates most often used to make these anti-commercials is the Zoloft advertisement. In that original commercial, Dot starts the commercial under a rain cloud. She is despondent and disinterested in the things she once loved. Then she takes Zoloft and she becomes gleeful, hopping around and playing with a butterfly that flies into the scene. The advertisement sets up the logic: If you are unhappy, take Zoloft and then you will be happy. This advertisement was one of the first depression advertisements, and

perhaps for that reason it is also one of the most spoofed depression advertisements. One of the funnier spoofs comes from *Mad TV* (a show likened after *Saturday Night Live*). In the video, the advertisers follow the same logic and even use the same characters, but this time instead of Zoloft, the drug is Ecstasy.

This fake DTC advertisement appropriates the language of a branded DTC advertisement and consequently subverts the dominant discourse. It opens on an image of Dot crying three big tears while the male voiceover says, "You feel a little tired lately, run down. You're not yourself. You're losing interest in the things you once loved. Your relationships are suffering." This language is almost identical to the language in the authorized version. But then, the video starts to change as a strange red bug-like figure floats through the frame. The voiceover says, "If this is your life, there may be a way to fix it." As the announcer says these words, Dot hops over to a nightclub featuring "The Beetles" while the announcer says, "A little pill called Ecstasy. Ask your dealer if it's right for you." By substituting the drug Ecstasy for a Zoloft and the word "dealer" for "doctor," the spoof questions the difference between the two.

As the fake DTC advertisement continues, the creators continue to question what the consumer really knows about the way chemicals work in the body. The advertisement relies on a similar crude scientific model of the neural brain pathways and the chemicals that pass between them. During this scene the voiceover says, "Ecstasy works by releasing a series of chemicals into your system: endorphins and serotonin." At this point the video zooms into a motley crew of chemicals who make silly references to feeling their skin move (a benefit of the drug, I suppose). The voiceover continues to list the

benefits of the drug, including allowing someone to feel a "sense of bliss lasting hours on end."

While the fake-ad is intentionally silly, it uses the same pseudo-scientific language of the company-sponsored advertisements. The science invites us to believe in the charade that we know enough about drugs that we can make the informed decision to start a medication regimen. This fake-ad makes us question why we believe that the crude drawings in the drug ads. Most of us do not understand neuroscience or chemistry well enough to know if the drug advertisements depict a scientific truth, but we are asked to believe in them. By including science through elementary drawings and language such as "scientists have shown," the advertisements carry with them an undeserved credibility.

As the spoof advertisement finishes, it also challenges the viewer to unpack the enthymeme that exists in many pharmaceutical advertisements. It's asking: if we take medication, are we really going to be OK? Will we really achieve happiness like the drug companies want us to believe? At the end of the video, the Dot has a great time at a rave hosted by performing artist "Moby," but then dies. The voiceover lists the side effects, including death and "in extreme cases a tendency to waste votes on the Green party." As we have seen, most depression advertisements end with the actors in a state of happiness. Even while the announcers list the side effects, the images on the screen are always of people fulfilling their assigned roles. We are expected to believe that taking the drug is a benefit, even though we've been told the side effects. The spoof advertisement challenges that visual image and reveals the negative effects of taking drugs. The logic does not hold up, especially since many people must try several different antidepressants

and combination of drugs like an antidepressant and Abilify, for example, before they find a drug therapy that works for them. Some people will discontinue use of a drug because of lack of effect or adverse effect. By ending the spoof advertisement in this way, we are forced to confront how the advertisements rely on rational arguments to persuade us of something that simply is not true.

Parody advertisements challenge the dominant discourses of the pharmaceutical companies and even of the healthcare industry. The pharmaceutical companies are appealing to our need for control over our own bodies, but in doing so they are providing us information that many people may not understand, so they accept what the companies present. While these advertisements seem to be giving the viewer control over becoming a patient-consumer, they are actually exploiting our desire to know our bodies. This information operates as a technique of biopower for it tries to use scientific language to define the norm, and persuading people to medicate.

The spoof advertisements challenge the pharmaceutical companies' authority to turn us into patient-consumers. Pharmaceutical advertisements rely on the viewers' belief that they can control their healthcare decisions. These parodies make people wonder if they do in fact have enough information to be in charge of their medical purchasing practices. These spoofs make people question if they should engage in practices that would subject them to the position of patient-consumer.

The Persuasive Power of the FDA: Governmentality and Technologies of the Self

Up until this point in my analysis, I have argued that the pharmaceutical companies have created a discourse of medication as a treatment for depression. The viewers of the pharmaceutical branded advertisements locate themselves within that discourse based on how they identify with the behaviors of the actors in the advertisements. The persuasive power of the norm encourages the viewer to seek out practices to be normal, and the DTC advertisements provide that solution: taking medication. If the consumer buys into the advertisement, she will engage in what Foucault names a technology of the self: taking medication. By engaging in this practice, the viewer takes on the subject-position of the patient-consumer, which fulfills the two-fold goal of the drug companies: medicalize certain behaviors and sell a product that will "cure" that illness. While there has been resistance to these goals in the form of parodies, the branded pharmaceutical advertisements use one other strategy that offsets those critiques: they invoke the sanctioning of the FDA.

In many DTC advertisements, drug companies will either explicitly or implicitly refer to the FDA. For example, in the Abilify advertisement, the announcer says, "Only Abilify is FDA approved to treat depression in adults when added to an antidepressant." In some printed advertisements, such as one for Cymbalta, the advertisement presents that the drug is "approved only for adults over 18," implying the agency that gave approval is the FDA ("Depression Hurts. Cymbalta Can Help").

By invoking the power of a federal regulatory agency, the drug companies are drawing on the power of governmentality. Governmentality is a term Foucault develops in the final years of his life. He does not completely rewrite his previous theories of

power, but he revises them. Whereas Foucault theorized disciplinary power and biopower, he had not fully theorized the power of governance.

Part of what Foucault means by government is in reference to the state. Foucault is not referring to sovereign power, but instead refers to the protection of individuals. He writes in "Governmentality":

> [Government is] the ensemble formed by the institutions, procedures, analyses, and reflections, the calculations and tactics that allow the exercise of this very specific albeit complex form of power, which has as its target population, as its principal form of knowledge political economy and its essential technical means apparatuses of security. (20)

Up until this point in his writings, Foucault had not fully dealt with the government's role in security and protection as a kind of power. The state administers certain aspects of its citizens' lives, such as schooling, and therefore has a persuasive power over the actions of its citizens.

In this project, the FDA acts as an agent of the state in monitoring what kinds of knowledge are produced by advertisements. According to the FDA website:

> The FDA encourages companies that offer DTC advertising to include accurate information in their ads. Through a comprehensive surveillance and enforcement program, the agency ensures that consumers are not misled or deceived by advertisements that violate the law. ("Keeping Watch")

In its governing role the FDA can issue a warning letter to the company who has misled the consumer and potentially fine them for breaking the law. The FDA does not approve advertisements before they hit the market. As the statement makes clear, they surveille different media to ensure that the companies are providing accurate information.

One of the major main critiques of DTC advertisements is that the FDA has been *inadequate* as a regulator of DTC advertisements. There are hundreds of advertisements each year and not enough government workers to review them all. The fines the FDA can be inconsequential for a multi-billion dollar company, and finally, once the information has been disseminated there is little the FDA can do to change what has already been communicated.

Even with these critiques leveled at the impotence of the FDA, consumers still think that the FDA will protect them from misinformation. In a 2000 study published in *Health Affairs,* researchers found that consumers believe the FDA does in fact protect them from erroneous advertising and unsafe drugs. The researchers state:

> Few health professionals and even fewer members of the general public understand the regulations surrounding drug promotions. We therefore asked what assumptions consumers make about the regulation of DTC advertising. Half of respondents believed that DTC ads had to be submitted to the government for prior approval, 43 percent believed that only “completely safe” drugs could be advertised directly to consumers, 22 percent thought that advertising of drugs with serious side effects had been banned, and 21 percent believed that only “extremely effective”

> drugs could be marketed directly to consumers. (Wilkes, Bell, Kravitz 118).

Every statement above is false. The FDA does not approve an advertisement before it is published, nor does it monitor which kinds of drugs can be advertised, i.e. only the "extremely effective" ones. In order for a drug to be approved by the FDA, the clinical trials must show that the benefits of the drug outweigh the risks, but drugs are never "completely safe." While many people got the facts of the information wrong, the underlying assumption in many of the answers is that the FDA's goal is to keep consumers safe by not allowing the pharmaceutical companies to give people false information—which is part of what the parodies were suggesting.

The paternalistic role of the FDA was recently up front and center in the last year when Bayer Pharmaceuticals was cited for misleading its consumers in a Yaz (a birth control and medication approved for treatment of PMDD) DTC advertisement. In October 2008, Bayer received a warning letter from the FDA that began as follows:

> The Division of Drug Marketing, Advertising, and Communications (DDMAC) has reviewed two 60-second direct-to-consumer (DTC) broadcast television advertisements (TV ads) entitled "Not Gonna Take It" (lYRA-6323) and "Balloons" (lYRA-6567) for YAZ. […] The TV Ads are misleading because they broaden the drug's indication, overstate the efficacy of YAZ and minimize serious risks associated with the use of the drug. Thus, the TV Ads misbrand the drug in violation of the Federal Food, Drug, and Cosmetic Act. […] These violations are concerning from

> a public health perspective because they encourage use of YAZ in circumstances other than those in which the drug has been approved, over-promise the benefits and minimize the risks associated with YAZ. ("Warning Letter" 1)

In this warning letter the FDA draws on several statements in the commercials as well as the way the images distract from the voiceover message to prove that Bayer has tried to market Yaz as a product that will do more than it has been formally approved to do.

The FDA letter goes on to require the Bayer to develop a plan to stop the dissemination of false information. Additionally the FDA requests that the submission include a "comprehensive plan of action to disseminate truthful, non-misleading, and complete corrective messages about the issues discussed in this letter to the audience(s) that received the volatile promotional materials" ("Warning Letter"6). Rarely does the FDA require that a company publically retract statements made in advertisements, but the FDA felt that misinformation communicated in these advertisements was too risky to ignore. According to the *New York Times,* Bayer did submit a comprehensive plan at the cost of $20 million that included new commercials that ran from December 2008 to July 2009 (Singer 1). The new commercials begin with the phrases, "You may have seen some Yaz commercials recently that were not clear. The FDA wants us to correct a few points in those ads" ("Yaz").

These new commercials that explicitly state the FDA wanted a company to fix misleading information reinforce the audience's belief that the role of the FDA is to protect the consumer from the overzealous at best and self-serving at worst actions of the

pharmaceutical companies. Even though the FDA did not cite a depression advertisement specifically, the impact of the role it took in "protecting" the consumer from Yaz will be felt in all DTC advertisements.

When a branded advertisement invokes the governing power of the FDA to sanction the use of the medication as a way to treat depression, the advertisement may become more persuasive given the audience's understanding of the government's role in communicating this information. If the viewer is persuaded, she may be more likely to take medication (or at least go to her doctor to try to obtain a prescription). The power of the government in these advertisements cannot be understated as the state does sanction this particular technology of the self.

The government invoked in these advertisements is one that protects the security of the people it governs. The government, and by extension the advertisement, is expected to conduct itself truthfully, ethically, and with an acknowledgement that citizens value their freedom. Governmentality "allows for the incorporation of freedoms into the mechanisms which guide people's behaviors in a social body" (O'Farrell 106). The difference between governmentality and biopower is that the techniques of governmentality have expressed purposes of overseeing the way populations govern themselves.

Conclusion

In non-branded advertisements, the pharmaceutical companies' interests are being represented in the artifact. If we agree with Wernick, then everything the companies do is in their own self-interest of selling their product. In the case of these drug advertisements, the pharmaceutical companies are making depression into a disease that can be treated with medication. They are taking our fears of being abnormal and providing a solution that makes the companies a profit. Many writers support this perspective on pharmaceutical advertising and the drug industry in general in book such as *The Loss of Sadness: How Psychiatry Transformed Normal Sorrow into Depressive Disorder; Comfortably Numb: How Psychiatry is Medicating a Nation; Prescriptions for Profits: How the Pharmaceutical Industry Bankrolled the Unholy Marriage between Science and Business;* and *Selling Sickness: How the World's Biggest Pharmaceutical Companies Are Turning Us All into Patients.* While this is a perfectly appropriate way to read the advertisements, it ignores the ways that the individual has agency in trying to be normal. These advertisements, along with the non-branded ads, *have* narrowed the definition of normal and they *have* infiltrated our media in pervasive ways. However, they have also had to *persuade* us to engage in certain technologies of the self to make ourselves normal.

One of the key differences between the persuasive strategies of non-branded and branded advertisements is that that the branded advertisements rely on governmentality to persuade the viewer to take medication to be normal. Peaceful governance requires that people engage in practices that make them normal. Governments present information to populations as a way to ensure personal security and safety. For example, during an

influenza outbreak, the government reminds consumers to engage in certain practices that will keep them safe. In the advertisements, the companies argue that depression does not keep an individual or her family secure—it can result in a loss of job or estrangement from friends and family. The advertisements suggest medication as a way of governing one's body, and this suggestion is sanctioned by the FDA. If a person does not engage in these practices, then they threaten their own safety and the safety of others.

In a system of power where techniques of biopower encourage people to engage in techniques of the self, governmentality cannot be overlooked because people will engage in techniques of the self if the practices will help keep them secure and free. These two kinds of power are not antithetical to one another; techniques of biopower can invoke the persuasive nature of governmentality, as we have seen with DTC advertisements. In the advertising of depression, the pharmaceutical companies produce knowledge from its discourses of normalization that are invoked through personal appeals to individual need for control and to our desire for safety, security, and ultimately happiness.

Throughout this project, I used the Direct-to-Consumer advertisements for depression as an example of normalization and the role of persuasion in that process. In his work, Foucault clearly delineates the techniques of disciplinary power, but he does not have the same taxonomies for biopower. The process of normalization outlined here is one that takes place in a non-coercive environment in which people have free will and free dominion of their own bodies. Foucault began to address these ideas at the end of his work, and may have successful outlined the techniques for biopower, but since his last

volumes of *History of Sexuality* were not written due to his death, subsequent scholars are left to develop their own theories of normalization in biopower. In this last section, I will outline the rhetorical process of normalization for biopower as revealed through my project as a useful heuristic for other rhetoricians.

Normalization is the process by which people are subjected to technologies that attempt to distinguish between the normal and the abnormal. This project has revealed six stages to normalization:

1. Establish the norm
2. Identify with the abnormal
3. Confess to abnormality
4. Seek ways to become normal
5. Become persuaded by practices to become normal
6. Engage in behaviors that promote the normal

The first stage of the normalization is establishing the norm. This step is vital to the process of normalization because it is the standard by which people conform. The norm can be established through statistics gathered from observation or from a process of consensus and agreement. In this project, we see part of the way the norm is established is by locating depression in a discipline that seeks to reform the abnormal: psychiatry.

The second stage of normalization is identification with the abnormal. In order for a person to try to become normal, they have to recognize and identify with the abnormal. In the Direct-to-Consumer advertisement, the viewer has to think of herself as embodying the behaviors of the abnormal characters, otherwise she will not engage in

self-modification. The abnormal becomes a persuasive concept that moves the viewer to action.

This action is the third step of normalization: the confession. In chapter three, I outline the details of the confession by drawing on Foucault. The important point is that the confession is a speech-act that makes the viewer abnormal. Even if a person was engaging in behaviors that others thought were abnormal, it is not until he confesses to this subject-position that the process of normalization will occur. In this project, the process of normalization began with the persuasive nature of the advertisements. The viewers will have to be persuaded that the "abnormal" behaviors are negative and need to be changed. Understanding the abnormal as negative is culturally and historically situated and may vary from group to group and nation to nation. Depression, however, because of the place it occupies in our culture—in psychiatry and medicine—it is perceived as abnormal and negative.

If the abnormal has been established as negative, a person needs to seek out practices to change behaviors, the fourth stage. A person can confess to being abnormal, but not want to change behaviors, particularly if that change in behavior is difficult. For example, many people admit that they are overweight, even obese, and do not take action to change the behaviors that make them that way. A behavior can only be changed when a person is willing to take action to be normal. Many times, these actions need to be easy. In Direct-to-Consumer advertisements, the ads encourage people to take drugs by making it seem easy. Every depression advertisement follows the same logic: If you are sad, take a drug and you will feel better. Of all the options for depression, this one may

seem the most appealing because it is seemingly the easiest—or at least the least time consuming.

Once someone is actively seeking a change in behaviors, they need to be persuaded to engage in modifying activities. While there are many ways to be persuaded, the Direct-to-Consumer advertisement relies on two strategies that seem to be effective: an appeal to control and an appeal to governance, which are related. In health, often people feel out of control because they are engaging in behaviors that make them abnormal. These advertisements tap into that insecurity and encourage people to take control over their actions—which is exactly what they are seeking to do if they are in this stage of normalization. Also, taking medication can be scary for some people because they fear the risks associated with the drugs. By invoking the FDA, DTC advertisements attempt to quell those fears since the FDA's role is to protect US citizens.

If the individual is persuaded, he will engage in practices that change his behaviors. This final stage of normalization would seem to make the person normal, but as Foucault points out, this normalization does not necessarily normalize. In this project, I have argued that even if a person engages in taking medication, their emotional behaviors may seem normal, but the fact that they have positioned themselves as a depressed subject, they will continue to be abnormal. In the case of the pharmaceutical companies, this is the best case scenario because it means that people will need to continue to take medication indefinitely. If a person identifies as depressed, then he will always need antidepressants.

In the next and final chapter, I will address the problems with the way these advertisements represent the human experience. I will show that the DTC advertisements attempt to make the “normal” the ideal by relying on a trope of happiness. I will also explore how DTC advertisements rely on and encourage happiness as a basic right, desire, and need of the American consumer.

CHAPTER 5: NORMALIZING HAPPINESS: THE RELATIONSHIP BETWEEN HAPPINESS, RHETORIC, AND DTC ADVERTISING

At the end of DTC antidepressant commercials, a series of images appear that represent life after taking a drug. The image represents the subject as happy and in good health. In the early days of Zoloft advertising, the after-medication images were of Dot smiling, hopping along, and playing with her friend, the blue bird. Later, the advertisements also featured people smiling, but the activities that they were engaged in were more defined. In the later advertisements, particularly in both Cymbalta and Abilify ads, the desired outcome often takes on a typical middle-class, American-Dream quality. At the end of the Abilify advertisement, the woman throws a successful party, complete with a large fruit tray and wedges of cheese. An expensive platter is a symbol of wealth and prosperity that the advertisements associate with those who are well. Also, when the man in one of the advertisement completes his work, he walks out to his home mailbox and mails his project. Wearing a business shirt and slacks, the man embodies the dream of having a white-collar job, working at home, and still being prosperous. The Cymbalta advertisements also draw on a desire for an American (upper) middle-class existence. These advertisements do not show class in a monetary way, as the Abilify advertisements do. Instead, they rely on representations of leisure as a benefit of a middle-class existence. For example, at the end of the Cymbalta advertisement, the characters are engaging in activities that they had been ignoring. For example, an older couple goes out to dinner, a mother takes her children for ice cream, and a man takes his dog for a walk.

The underlying argument is that these people had the time and resources to engage in these activities, but the depression kept them from doing so.

These advertisements create an image of a happy life in which individuals have time for leisure activities, monetary resources, and the support of family and friends. The problem with this representation is that it is an unreasonably optimistic depiction of our everyday lives. Parties, productivity, dinner with friends, and ice cream in the park are not everyday occurrences, and in turn, those smiles and laughs that are part of the commercials are also not a constant way of life. Normal—burned dinners, rained-out visits to the park, money problems—is not normal in these ads. Normal has become perfect happiness. From the way the commercials tell the story, if a person deviates from the laughs, smiles, and parties, then he has depression. Life has to be perfect, otherwise we are depressed. This definition of happiness is unattainable because it is unrealistic, and yet, the companies are trying to sell this definition—and succeeding.

In this final chapter, I argue that Direct-to-Consumer advertisements offer an oversimplified view of emotional health without leaving open the possibility for emotional individuality. Whereas Aristotle offered a view on happiness that came from living a fulfilling and virtuous life, DTC advertisements offer a superficial rendering of happiness. One of the problems with defining happiness as the ads do is that they publicly praise the behaviors exhibited in the ads. By arguing that the advertisements are examples of epideictic rhetoric, I intend to show how DTC advertisements attempt to normalize happiness.

Classical Happiness and DTC Advertising

In the after-medication sections of DTC commercials, images of smiling consumers, parents hugging children, and people accomplishing projects appear on our television screens. The representations of happiness are of production and engagement with family and friends, and the images contrast starkly against the bleak, sad, hopeless images of depression. The dichotomy between desirable behaviors and undesirable ones is palpable, and without question, the advertisements persuade us that happiness, as they have defined it, should be desired.

Happiness as the aim of human existence is a concept that Aristotle gives some attention to in *The Rhetoric*. He writes:

> There is pretty much an objective at which everyone aims, both each in private and all together, both in pursuit and in avoidance. And this, to put in a nutshell, is *happiness* and its elements. […] For all exhortations and dissuasions are concerned with happiness and things conducive to it and contrary to it—one must do things that procure happiness or one of its elements, or make it larger rather than smaller, and not do those things that destroy or hinder it or produce its opposites. (87)

In this passage, Aristotle contends that people seek happiness in their lives, and he argues that they must do whatever they can to live a life that brings them happiness. He urges people to avoid actions that will not contribute to a life of happiness, for happiness is the ultimate goal of humanity.

In suggesting that we strive for happiness, Aristotle does not mean that we should buy a new car or laugh more at the movies. His definition of happiness is based on living a virtuous life in which we are self-sufficient and secure. He writes, “Let happiness, then, be the virtuous welfare, or self-sufficiency in life or the pleasantest secure life or material and physical well-being accompanied by the capacity to safeguard or procure the same” (87). He expands on his definition by outlining the elements of happiness. He explains that happiness includes:

> Gentle birth, a wide circle of friends, a virtuous circle of friends, wealth, creditable offspring, extensive offspring and a comfortable old age; also the physical virtues (e.g. health, beauty, strength, size, and competitive prowess), reputation, status, good luck and virtue. (87)

From this extensive list, we can extrapolate that Aristotle does not believe that happiness exists in the fleeting moment of an emotion. Happiness is something that one understands nearer the end of life and encompasses a virtuous life from birth to old age. A person’s self-sufficiency is a result of “internal and external advantages” (87). He writes, “The internal advantages are those connected with the soul of those with the body; the external are good birth, friends, cash and status, to which we deem it appropriate that positions and luck should be joined” (87). The combination of internal and external factors constitutes a fulfilled life.

On the surface, Direct-to-Consumer advertisements seem to draw on Aristotle’s concept of happiness. The advertisements show happiness in the context of good health (an emotionally and physically healthy body), good friends (the advertisements focus on

engagement with others), and wealth (the Abilify advertisements are an example of prosperity). Although there is little attention to luck, birth, and creditable offspring, these advertisements do exemplify his concept. Furthermore, antidepressant advertisements (and most pharmaceutical advertisements in general) suggest that happiness is a result of self-sufficiency and a capacity to safeguard one's happiness. In the context of the advertisements, self-sufficiency suggests taking action that will make a person healthier and, in turn, happier. The advertisements tell patients to consult their doctors if they have the symptoms of depression. They encourage patients to self-diagnosis and take the responsibility of seeking out a doctor. By doing so, the advertisements infer that a person can be physically well.

However, the key differences between Aristotle's happiness and the happiness portrayed in DTC advertisements are time and internal factors. In the advertisements, drugs are the quick fix for achieving a happy life. They suggest that popping a pill will bring a wide circle of friends, loving relationships, and good health. In contrast, Aristotle believes that by living a virtuous life a person could achieve happiness, not through artificial means. The advertisements promise to give people the life that Aristotle suggests but without the time it takes to achieve it. Also, the advertisements focus on external factors for happiness, but do little to reveal the ones that are connected to the soul. The advertisements do little to reveal how wealth, friends, and family are virtuous. Direct-to-Consumer advertisements do show that happiness is contingent upon self-sufficiency and material and physical well-being. They argue we achieve happiness by attainting a particular socio-economic status, having a job that affords a certain lifestyle,

and having a wide circle of friends and family. These ways of defining happiness do not account for love, fulfillment, altruism, virtue, spirituality or any other number of reasons why someone might be happy. The advertisements have superficially defined happiness for an American audience who might be persuaded by their "happiness-in-a-pill" campaign.

Epideictic Rhetoric, Advertising, and Normalization

As these advertisements receive more and more airtime, print space, and internet resources, their message becomes more and more pervasive. While the advertisements demand action from us by requiring us to confess to depression and seek out treatment, they also have another effect. They tell us what we should accept and what is unacceptable. In other words, they are examples of epideictic rhetoric and reinforce what the community (should) value(s). In doing so, the advertisements normalize happiness by maintaining a distinction between desired and derided.

In *The Rhetoric*, Aristotle sets out three different branches of rhetoric: deliberative, forensic, and epideictic. Deliberative rhetoric is concerned with issues of the future for it attempts to persuade an audience to take action (Aristotle 80). Forensic rhetoric focuses on actions of the past to determine if a person or topic should be prosecuted or defended, and finally, epideictic rhetoric is concerned with praise and denigration in which no action is required in the moment (80). In *The Rhetoric*, Aristotle's discussion of happiness is specifically related to deliberative rhetoric. He

believes people will take future action if it is connected to the virtue of happiness. These categories are slippery as George Kennedy reminds us when he writes, “Aristotle admits that epideictic and deliberative rhetoric overlap and suggests that the difference is often one of style. A great deal of what is commonly called epideictic oratory is deliberative written in an epideictic style” (87). Because of this overlap, I argue that Aristotle’s concept of happiness is compounded by epideictic rhetoric because it praises or blames based on how much a person or an event deviates from or adheres to values/virtues of happiness.

Of course, when Aristotle wrote about epideictic rhetoric, he was not referring to advertising. For him, the quintessential example of epideictic rhetoric is the funeral oration in which the orator praises a person for living a virtuous life. Since Aristotle, scholars have expanded the epideictic branch of rhetoric to include texts such as advertisements. In a 1999 conference paper at the Rhetoric of America Society conference, Steve McKenna urges rhetoricians to more seriously consider advertising as a rhetorical enterprise by arguing that it is a rich example of epideictic rhetoric. In “Advertising as Epideictic Rhetoric,” he argues that advertising has not been fully appreciated by rhetorical scholars even though it is the “largest, most pervasive, and most rhetorical enterprise on the planet” (103). He contends that advertisements are examples of epideictic rhetoric because they embody the values of a culture and are persuasive because they appeal to our desires. Expanding on McKenna’s call, Judy Segal does the work of connecting epideictic rhetoric specifically to pharmaceutical advertising. In “The Rhetoric of Health and Medicine,” Segal writes:

> The premise of my research is that pharmaceutical advertising operates not only as deliberative rhetoric exhorting an audience to acquire a drug, it is also epideictic rhetoric, exhorting an audience to acquire a drug *according to a hierarchy of values*. (229)

Persuasion from epideictic rhetoric rests on the audience's adherence to the values presented, and Segal's argument that the advertisements are persuasive because they appeal to our values makes advertisements examples of epideictic rhetoric that should be analyzed. Whether or not these values should be persuasive is another matter all together, but the acknowledgement that the advertisements appeal to our values is key to understanding how the advertisements normalize virtue.

As public texts, advertisements must appeal to the largest contingency of people to be persuasive. Chaim Perelman and Lucie Olbrechts-Tyteca write that in epideictic discourse "the speaker readily converts into universal values, if not eternal truths, that which has acquired a certain standing through social unanimity. Epideictic speeches are most prone to appeal to a universal order […] and supposedly unquestionable values" (51). The advertisements do this because they want to sell their product to the largest population of people. This is why the advertisements for depression are so successful. The values espoused in the ad (happiness derived from wealth, friendship, and family) are universal, and the emotional states it derides (loneliness, sadness, and depression) are universally unacceptable. The advertisements do not challenge the status quo; they build upon and use it as a selling feature. The advertisements would not be persuasive if they encouraged feelings of sadness. Who would take a pill if it made you miserable?

This idea of happiness is universal in our culture. It is expected, seemingly obvious, and an even "natural" definition of happiness. Often we believe that a person's happiness should trump everything else and that we should seek out ways to be as happy as possible. For example, people want to find jobs that make them happy or they want to get divorced because they are unhappy. One person even told me: buy a car that makes you happy; you only live once! These tropes of an insatiable need for happiness are everywhere. We are, as Eric Wilson writes, obsessed with happiness (5). The problem is that we cannot always do the things that make us happy. People have to get jobs to pay the bills, and people stay together because of tax advantages, for the children, or for companionship. And instead of the Maserati that would make me smile, I ended up with a practical Nissan Sentra. So while our culture is telling us to do things that make us happy, we cannot always give in to this advice. But we want to, and epideictic rhetoric reinforces those desires. In fact, for the advertisements and epideictic rhetoric in general to be successful, the advertisers must tap into what is desirable for the audience.

By using antidepressant advertising as an example of epideictic rhetoric, we can see how epideictic rhetoric normalizes our values. Foucault's concept of normalization is not a way of indicating what is usual or even prevalent. Normalization is the process by which a distinction between the normal and the abnormal is maintained. Antidepressant advertising embodies this process because it negatively critiques one set of behaviors while celebrating a different set. Epideictic rhetoric also has a normalizing effect. By praising certain values and blaming others, epideictic rhetoric maintains the boundary between what we *should* desire and what we *should not.* Perelman and Olbrechts-Tyteca

argue that the purpose of epideictic rhetoric is to "increase the intensity of adherence to values held in common by the audience and the speaker," (52). Epideictic rhetoric is not simply reflective of our values, but it *increases* our adherence. It makes our conviction to our values stronger. Antidepressant advertisements do this too, and by increasing our adherence to the messages that they present and given the way these advertisements do this (with a clear divide between depressed and happy), they normalize.

The consequence of the normalization in these advertisements is that they inscribe our bodies with accepted ways of performing our happiness. The advertisements tell us how to feel about how our bodies perform, how they should perform, how the body should perform in comparison to others, and how the body allows people to engage with others. We are inscribed with this particular freight when we can identify with the subject(s) of the advertisements. In commercials and print advertisements, the subject matter is represented as visual images, and the audience must identify with the actors that are embodying the subject. In antidepressant advertisements, the actors are the visual representations of depression and happiness; they extol the virtues of happiness while admonishing the behaviors of depression.

The audience needs to identify with the actors and adhere to the message being sold to them for the process of normalization to occur. In *The Rhetoric of Motives,* Kenneth Burke argues that identification, the primary aim of rhetoric, is necessary for communication. He begins outlining his theory by explaining that two people are not identical, but they can identify with one another if they share common interests. By identifying with one another, the two remain unique but share a locus of motives; they are

"joined and separate, at once a distinct substance and consubstantial with another" (21). In the advertisements, the viewer is not identical to the actors on the screen, but he shares similar patterns of behavior with them. Because of this similarity, he identifies with the people in the ads and is motivated to take antidepressants like they do. However, since the audience is not exactly like the people in the advertisements, there is division between them. Burke writes, "Identification is affirmed with earnestness precisely because there is division. Identification is compensatory to division" (22). Because of this division, the audience has to be persuaded to engage in the activities outlined in the advertisements. In order for these advertisements to achieve their goal, they must convince the audience to identify with the actors on screen. This identification may mean disregarding the differences between the actors and the viewers or at least it requires the viewers to strongly identify with the states of depression and happiness. Normalization cannot happen without this negotiation between the text and the audience. There must be identification; otherwise, the advertisements cannot persuade.

The problem is that the advertisements are limited in how they represent the human experience. The values perpetuated in these advertisements may not match the lived realities of different kinds of bodies and experiences. For example, my own happiness is not necessarily predicated on a wide circle of friends, wealth, luck, and good offspring. And more significantly, I am not automatically happy when acting as a perfect hostess or productive worker. Also, my sadness motivates me in ways that my happiness does not, and while I do seek ways out of my unhappiness, I am aware that unhappiness provides me with important reflective and strengthening moments. I do not fully identify

with the characters in the commercials, because I do not see loneliness or sadness or sullenness as wrong and in need of fixing. I believe that we need more representations of non-normed bodies in the public sphere so as to open up conversations about how the pharmaceutical companies are attempting to normalize our behaviors to serve their own needs. In the best case scenario, having a variety of rhetorics of the body to engage with may allow for more acceptance, understanding, and conversation about the human experience.

Moving Beyond Advertising

Unfortunately, instead of showing a wider range of emotions, our mass media seems to be perpetuating the same tropes about medicine that are found in DTC advertising. Consider the following exchange between one of the main characters and her neighbor on HBO's provocative series *Big Love:*

Margie: I'm so sad. Why am I so sad?

Pam: I don't know sweetie. (She takes a pill out of a case and hands it to Margie). Zoloft. You should get your own prescription but these will get you started though. They take a couple of days to kick in.

Margie: Oh, I'm not depressed.

Pam: Oh, I know. Neither am I. It's hard. We're supposed to be perfect, and it is really hard to be perfect. But we have to be, right? ("Fight of Flight")

In the series, Margie, played by the vivacious Ginner Goodwin, is a young, upbeat 23-year-old woman who often solves the problems of her unusual family with the power of her gumption, sexuality, and positive outlook on life. At this point in the season, Margie's satisfaction with her life as a wife and mother—a mother to her children and the children of her sister-wives—is waning. Her own mother has recently died, her family is in crisis because one of the children has had a miscarriage, a wife is refusing to have more children, and the father of one of her sister-wives is in jail and is threatening to expose the family as polygamists. Margie's world, to say the least, has been turned upside down, and her perkiness and charm can't survive the severity of these situations. Instead of interrogating Margie's feelings about sadness, Pam's interpretation reinforces the rhetoric of the advertisement: sadness needs to be eradicated. This scene is similar to *The Onion* article referenced in the first chapter. Taking medication means that a person does not have to deal with the "harrowing peaks and valleys" of emotions. While *The Onion* created its advertisement as a parody of drug commercials, this scene in *Big Lov*e is a dramatic portrayal of two women whose emotional lives are bound up by the expectations of others.

According to this TV drama, these women are pressured to be perfect by their homogenous community in Sandy, Utah. Being a normal woman in this community means embodying the three M's: married, mother, and Mormon. The women of Sandy, UT, save the three main characters are generally portrayed in the most superficial ways: smiling, happy homemakers who chase after their children and support their husbands. Pam, the only adult Mormon woman the viewers know in any substantial way, is unable

to have children. She does not fit into the normative framework established by her environment and, therefore, sees herself as imperfect. Her depression or, as she puts it, her quest to appear perfect, requires the use of pharmaceutical intervention. Her community has told her implicitly (and quite possibly explicitly) that she needs to be a mother to achieve the happiness that is expected in her world. Margie, on the other hand, does have children, although from the community's perspective, she is unmarried and not Mormon. She is not able to be a married woman in the eyes of her community, as her polygamy is kept hidden for fear of the backlash of the community. While the viewers do not see Margie take the Zoloft Pam hands her, they see her interested expression as she contemplates the idea of happiness in a pill.

Before DTC advertisements, television dramas and sitcoms rarely talked about antidepressants so openly (unless in the context of an institution or hospital), and now we can see how the advertisements and the commercials share similar lines of reasoning. The advertisements reinforce happiness by showing people who are, as Peter Kramer would write, "better than well," a phenomenon that explains how some patients feel "better than well" after taking antidepressants (xvi). In other words, they felt better than they did before their depressive episode, better than their "old selves." The advertisements show people whose actions after taking the drug are at least as good as if not better than the ones prior to depression. On *Big Love*, Pam also suggests that she needs medication to be better than well; she needs medication to make her perfect. In *Better than Well: American Medicine Meets the American Dream*, Carl Elliott explores how antidepressants are an enhancement technology used to pursue happiness. He writes

that “in those tablets is a mix of all the American wishes” (297). The relationships among the concept of better-than-well, pharmaceutical advertising, and drug consumption is bound up in the concept of the normal. Antidepressants advertising have created and reinforced such a strong division between normal and abnormal that people even believe that they can achieve perfection if they take a pill. Being abnormal is not an option.

Drug advertisements act as a technology of biopower to exert regulatory control over viewers. This technology suggests that people engage in certain practices to make themselves normal, and the advertisements want people to take medication to try to achieve the given parameters of normal. However, the picture of normal presented in these ads is simply unattainable. The normal has become the perfect, which will require people to keep taking these medications to try to achieve that desired state, only to never get there. People will want to be “better than well,” but the problem is there is no picture of just well. This idea does not only exist in advertising, it is spilling over into our television shows, movies, and other popular culture venues.

Conclusion

In this dissertation, I have argued that the pharmaceutical companies, primarily through their antidepressant advertising campaigns, have rhetorically constructed depression around a set of behavioral norms and encourage consumers to regulate their behaviors to normalize their bodies. Since I define rhetoric as the study of symbol

systems that produce knowledge, I argue that these advertisements create a desired way for people to be in the world: namely not depressed. The advertisements serve as examples of how rhetoric motivates our bodies to perform normal emotionally healthy behaviors. These examples of epideictic rhetoric inscribe consumers' bodies with normed values and discourage other kinds of seemingly undesired behaviors. The advertisements suggest that only certain kinds of people—ones who perform normal—can be happy. They argue that people who perform outside of the norm cannot be happy; they must be depressed. They are depressed because they do not have the lifestyle represented in the advertisements, depressed because they do not look or act like the people in the ads, and depressed because they do not perform happy in the way they are expected to.

In *Against Happiness: In Praise of Melancholy* published in 2008, Eric Wilson challenges our search for happiness arguing that melancholia is necessary for creativity in our world. He writes:

> Melancholia pushes against the easy "either/or" of the status quo. It thrives in unexplored middle ground between opposition, in the "both/and." It fosters fresh insights into relationships between oppositions, especially that great polarity life and death. It encourages new ways of conceiving and naming the mysterious connections between antinomies, to play in potential without being constrained to the action. Such respites from causality refresh our relationship to the world, grant us beautiful vistas, energize our hearts and minds. (148-9)

Wilson argues that if we constantly push a culture of happiness on ourselves and treat our sadness with medication, we only encourage a culture of fear: fear of sadness, of lack of insight, of death, and of stagnation. Sadness, sullenness, and melancholia are all parts of the human experience that are used to bring something unique to our lives. He argues that unhappiness has "created our great epics […] and concocted our memorable symphonies" and without it, these "sublimities would have remained in the netherworld of nonexistence." (147-8). And while I would not argue that we should start advertising and extolling the virtues of melancholy, I do believe that positively showing the full range of human emotions is necessary to keep us fully human.

In advertising, the rhetoric of depression has become a rhetoric of unhappiness, and the advertisements from these pharmaceutical companies draw on cultural and social norms to reinforce happiness as the goal of life. The limited way the ads define happiness and the narrow types of experiences represented in these advertisements are pushing a culture of conformity on the American public in which only certain ways of being are acceptable. In this project, I have looked at the persuasive power of these advertisements at the large, collective level. I have thought about the twentieth and twenty-first century American society as the audience for these advertisements, and the values we hold as a large community. However, happiness is difficult to define at this macro level because I believe that the happiness defined by one's culture may only be part of what a person experiences when she is happy. While culture does impact it, happiness is personal, individual, and should not be sold to us in sweeping generalities. As a society, we need to be more accepting of individual, unique ways of being happy

and not get caught up in mass media's portrayal of what happiness looks like. Unfortunately, there are few acts of resistance to counterbalance the persuasiveness of these advertisements. As scholars, rhetoricians, and humans with various lived experiences and emotions, we need to start adding voices to an all-too-limited conversation about emotional well-being.

APPENDIX A: KLERMEN ET AL'S DEFINITIONS OF NEUROTIC DEPRESSION PRIOR TO THE *DSM-III*

1. *Neurotic depressions are less socially incapacitating.*

This usage is synonymous with a judgment of mild severity of social dysfunction. These depressions allow the individual to continue his or her social functioning, although there may be personal distress and inner misery.

2. *Neurotic depressions are nonpsychotic.* In this usage, neurotic depression is a residual category for those patients not showing psychotic features and is contrasted with a psychotic depression; the patient is considered to have a neurotic depression if there is an absence of hallucinations, delusions, confusion, memory impairment, or other signs of impairment of reality testing and intactness of higher mental functions.

3. *Neurotic depressions do not present endogenous symptoms.* This usage defines a clinical picture without "endogenous" symptoms, i.e., early morning wakening, weight loss, retardation, guilt. Some observers have asserted that in neurotic depression there is not only the absence of the endogenous symptom pattern but also the presence if a characteristic constellation of symptoms of its own, with self-pity, irritability, reactivity, and fluctuating symptoms (labeled the self-pitying constellation) (10).

4. *Neurotic depressions follow a stressful event that is usually, but not exclusively, psychosocial in nature.* This usage is synonymous with "situational depression" or

"reactive depression." It is presumed that the stressor is the immediate proximate or contributing cause and has temporarily overwhelmed the previously normal individual's capacity to cope and adapt. Such depressions are seen as extensions of normal states, quantitatively rather than qualitatively different from the normal reactions of loss, separation, disappointment, and other precipitants of a normal mood shift.

5. Neurotic depressions are the consequences of a long-standing maladaptive personality pattern. These depressions represent merely the latest 'ripple' on a long-standing wave of personality inadequacies and social maladaptations. This type of depression is sometimes called "characterological depression" (11) or 'depressive personality.' This concept emphasizes predisposition, in terms of long-standing preexisting personality structure and character pathology of the patient.

6. Neurotic depressions are the result of unconscious conflicts, according to psychoanalytic theory. These depressions depend on four basic factors: I) mood changes following interpersonal loss, disappointment, or deprivation; 2) a fall in self-esteem; 3) conflicts over the aggressive drive; and 4) a premorbid personality structure involving narcissism, dependency, and ambivalence (6).

APPENDIX B: PUBLIC PHARMACEUTICAL ADVERTISEMENTS PRIOR TO THE FDA REVISION TO DTC POLICY

SIX MONTHS AGO, when Tom came down with tuberculosis, his friends feared that he would disappear from the world of the well to spend *years* in a hospital.

Those fears might have been justified some time ago. Now, fortunately, when cases like Tom's are discovered early, doctors can often restore good health without the long stay in a hospital, and all the attendant worries about the problems of finances, family and future.

Tuberculosis is still a great problem when diagnosis is delayed and the disease has progressed. But experts agree that medical science has surely gained the upper hand . . . through earlier detection, improved surgery and the anti-tuberculosis drugs. These advances have reduced tuberculosis from first to sixth place among the ten leading causes of death.

Hospitals, universities and research laboratories the world over are searching constantly for more effective medicines of potential value in treating this once-deadly disease.

As a maker of medicines prescribed by physicians, Parke-Davis is proud to be among those engaged in this great, world-wide fight against tuberculosis.

PARKE, DAVIS & COMPANY

MAKERS OF MEDICINES SINCE 1866

Working with your physician, your pharmacist and your hospital to make modern medical care one of the most rewarding investments of your life.

This is what we work for at Parke-Davis

. . . the better health and longer life that come with better medicines

WILL THIS LITTLE BOY—will your little boy—grow up to fill his father's shoes?

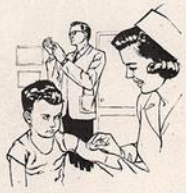
Today, thanks to new medicines and methods of treatment, our children's chances of growing to strong, healthy adulthood are better than ever before in history.

Take polio, for instance. Right this minute your physician has the means to help prevent this dread disease. With the help of the safe, effective, proven vaccine against polio, paralytic cases in the past two years have declined over 80%.

But this summer, in spite of the fact that there is plenty of vaccine for everyone, thousands of cases of polio could occur among those who have not been vaccinated.

The tragic fact is that over 48 million of those in the susceptible age group under 40 still have not been vaccinated. More important, over 19 million people under the age of 20, one in four, have not yet had a single dose of the vaccine. And millions more who have started their shots still haven't had all three recommended injections.

How about your family? Have your children had the full course of the three polio shots they need for maximum protection? Have you? Remember, polio often strikes adults, too . . . usually in a severe form. Be sure *everyone* in your family is protected before it's too late.



In 1953, Parke-Davis produced the first trial vaccine for the vital polio "pilot test." Since that time, Parke-Davis has become one of the largest producers of polio vaccine in the entire world.

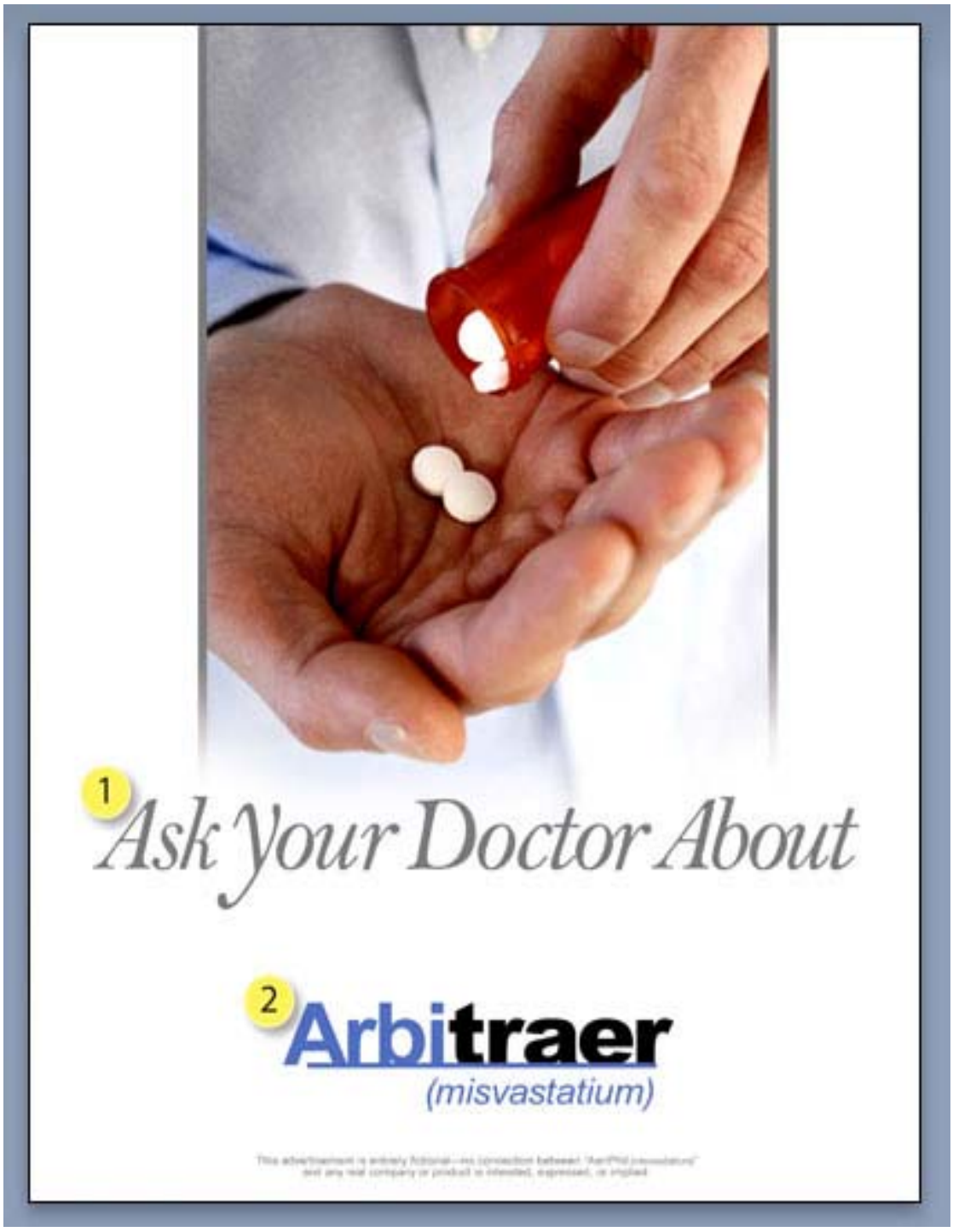
PARKE-DAVIS

. . . PIONEERS IN BETTER MEDICINES SINCE 1866

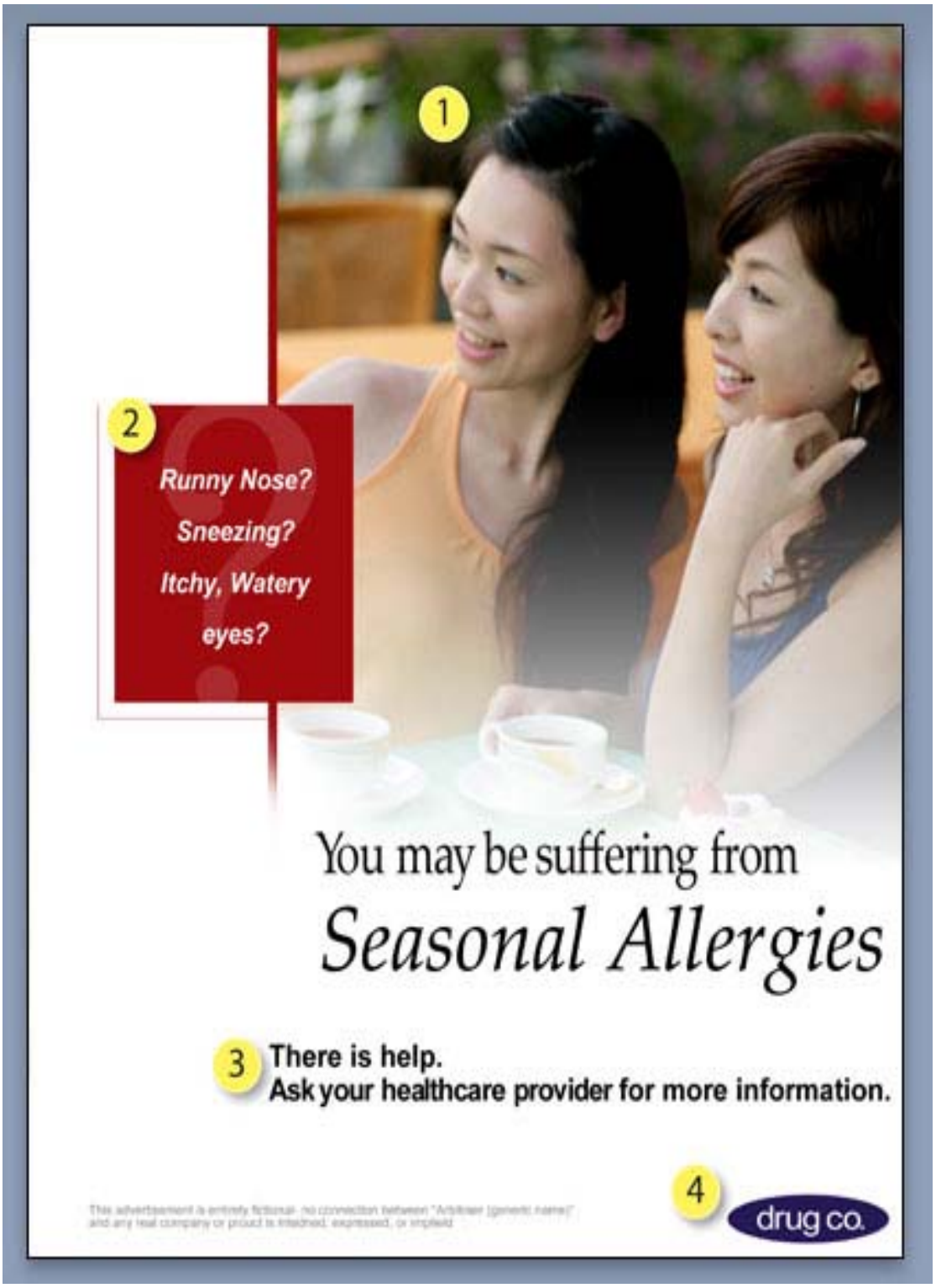
APPENDIX C: FDA EXAMPLE DTC ADVERTISEMENTS

FDA Example of a Product Claim Advertisement

FDA Example of a Reminder Advertisement



FDA Example of a Help-Seeking Advertisement



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