

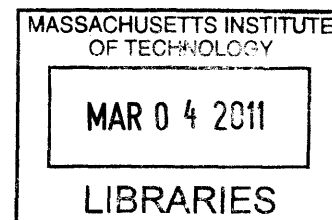
# PHARMACEUTICAL RELATIONSHIPS

## Intersections of Illness, Fantasy, and Capital in the Age of Direct-to-Consumer Marketing

by

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## PHARMACEUTICAL RELATIONSHIPS

### **Intersections of Illness, Fantasy, and Capital in the Age of Direct-to-Consumer Marketing**

By

Nathan P. Greenslit

Submitted to the Program in Science, Technology and Society  
on August 27, 2007 in Partial Fulfillment of the Requirements for the Degree of  
Doctor in Philosophy in History and Social Study of Science & Technology

#### ABSTRACT

This dissertation is a multi-sited ethnography among marketers, consumer-patients and psychiatrists in the U.S. It explores the recent history of styles of pharmaceutical advertising that have come about in response to FDA regulations and ethical issues raised by patients and the press about how the pharmaceutical industry shapes drug research. Specifically this dissertation explores the role of direct-to-consumer drug marketing (DTC) in the consumption and experience of antidepressants, including a cultural shift in the U.S. towards how the consumer negotiates new ethical injunctions to manage his or her own identity through pharmaceuticals. A key focus is how marketers carve out their own ethical niche from which they innovate on ways to persuade consumer audiences with scientific facts that double as public relations. This dissertation gives special attention to how individuals encounter and incorporate the putative neuroscience of DTC advertising of antidepressants to negotiate their personal knowledge of illness, and to manage their identity, everyday practices, and professional pursuits. From these ethnographic encounters I have identified “illness,” “fantasy,” and “capital” as three key themes for my analysis of DTC marketing. In turn I have combined the very different literatures on illness (which address patient advocacy movements and health care seeking and questions of how medical diagnoses can be deployed as social norms), fantasy (which address psychoanalytic conceptions of desire and self, as well as semiotic understandings of consumption), and capital (which address health care market competition, and negotiations with the FDA over truth in advertising). In sum, this dissertation offers a thick description of “ethical identity management” in the contemporary landscape of U.S. pharmaceutical consumption.

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## PHARMACEUTICAL RELATIONSHIPS

### Intersections of Illness, Fantasy, and Capital in the Age of Direct-to-Consumer Marketing

#### Introducing pharmaceutical relationships

My interest in pharmaceutical marketing was piqued in 2001. It was during this year that Prozac—the quintessentially famous antidepressant—had just gone off patent. The drug was subsequently rebranded as “Sarafem,” manufactured in a new pink-and-purple capsule, and marketed for the treatment of “premenstrual dysphoric disorder”—an illness that most of the public learned about, not through their doctors, but through the advertising campaigns for Sarafem. I will tell the story of Sarafem in greater detail in Chapter 4, but for the sake of introduction here is a quick topology of the issues that Sarafem had presented to me:

1. Professional boundaries and ethical interventions. Despite the fact that Prozac is one of the best-known drugs in history, the consumer-directed marketing for Sarafem never once mentioned Prozac. This was part of a deliberate strategy to disassociate the drug therapy of premenstrual symptoms from *psychiatric* medicine (even though premenstrual dysphoric disorder was first introduced in the DSM-III-R—the American Psychiatric Association’s diagnostic manual for mental disorders). Pharmaceutical industry representatives defended this move as an ethical decision to destigmatize the treatment of PMS as “medical,” not “psychiatric.”

2. Surplus health<sup>1</sup> and feminist pharmacology. Criticism of Sarafem often took the form of accusing the pharmaceutical industry of medicalizing (and therefore capitalizing on) female experiences, and of looking to a science of the body to reify gender inequalities. At the same time, other voices welcomed Sarafem as a long-overdue recognition of suffering that is uniquely female, and lauded the scientific legitimation of that suffering.
3. Material-semiotics<sup>2</sup> and identity fashioning. One MIT psychiatrist told me a story of how she had decided that one of her patients—a depressed male undergraduate student—should be put on Prozac. The psychiatrist wanted to get the student started on his medication right away, and she looked in her stash of drug samples to see if there was any Prozac. There was no Prozac, although there were samples of Sarafem—its chemical equivalent. But the student refused to take Sarafem. As the psychiatrist put it, there was *just no way* he could ingest a drug designed to treat PMS. She added that this student was not particularly macho in his refusal; on the contrary, he was apologetic in his acknowledgment of his own irrationality (*I know it's the same thing, but ...*)

Marketing is terrain of this topology. Sarafem was one of the first pharmaceuticals to be marketed “direct-to-consumer” (DTC) and, in the wake of its television and print advertising campaigns I have been witness to a set of local reactions on the part of doctors, patients, consumers, drug regulators and marketers. I wished to explore these

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<sup>1</sup> A phrase coined by Joseph Dumit.

<sup>2</sup> A phrase coined by Donna Haraway to denote how symbolic relationships and material relationships can be mapped onto each other. See: Donna J. Haraway, Modest Witness@Second Millennium.Femaleman(C)Meets\_Oncomouse(Tm) : Feminism and Technoscience (New York: Routledge, 1997).

reactions, to understand their implications for the changing doctor-patient relationship and specific uses of antidepressants in the broader context of American health care.

I have identified the themes of “illness,” “fantasy,” and “capital” as three key intersecting technologies for my analysis of DTC marketing. The social and cultural problematics of pharmaceutical branding have enabled me to combine the very different literatures on illness (which address patient advocacy movements and health care seeking and questions of how medical diagnoses can be deployed as social norms), fantasy (which address psychoanalytic conceptions of desire and self, as well as semiotic understandings of consumption), and capital (which address health care market competition, and negotiations with the FDA over truth in advertising).

In this dissertation I disaggregate what often gets lumped as marketing (i.e. simultaneously capital, desire, health care seeking), to show more clearly the historical and cultural sites of intersection where decision-making about illness and treatment occurs. Throughout I offer and explore individual experiences as ethnographic foils to these historical and cultural loci, in order to suggest some of the social and psychological contingencies in this complex terrain: “Pharmaceutical relationships” names the ways in which individuals (whether they are patients, physicians, or marketers) encounter and create experiences with medications that have assumed specific social lives as heavily marketed and advertised commodities.

Pharmaceuticals are manufactured to have effects but they are marketed to have meanings, which often starts with brand loyalty. One marketing industry source, commenting on Prozac’s patent loss, noted:

“[T]he news in August 2000 that Prozac had lost a patent fight and might face generic competition two years sooner than expected sent Eli Lilly’s stock down 30% in one day ... This may have been a dramatic overreaction, but it demonstrated that pharmaceutical companies—like Coca-Cola, IBM and Ford—increasingly are their brands.”<sup>3</sup>

Pharmaceutical companies increasingly are their brands, and the pharmaceutical industry is perhaps *the* central force within American health care. Indeed, the very scale of pharmaceuticals in the U.S. is unprecedented, and staggering: In 2005, over three-and-a-half *billion* prescriptions were dispensed; and the average insured American purchased thirteen different prescriptions.<sup>4</sup> Antidepressants are among the top five therapeutic classes (with over 120 million prescriptions dispensed this same year), and they are prescribed more often than antibiotics, hormones, diuretics, and oral contraceptives.<sup>5</sup> Spending on DTC has also significantly increased over the past decade, from over \$250

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<sup>3</sup> Paling, Michael. "The Role of Advertising in Branding Pharmaceuticals." Brand Medicine: The Role of Branding in the Pharmaceutical Industry. Eds. Tom Blackett and Rebecca Robins. New York: Palgrave, 2001.

<sup>4</sup> Department of Health and Human Services Centers for Medicare and Medicaid Services, U.S., National Health Expenditure Data, 2006, Available: <http://www.cms.hhs.gov/NationalHealthExpendData>, IMS-Health, Top-Line Industry Data, 2006, Available: [http://www.imshealth.com/ims/portal/front/indexC/0,2773,6599\\_5264\\_0,00.html](http://www.imshealth.com/ims/portal/front/indexC/0,2773,6599_5264_0,00.html).

<sup>5</sup> The only drugs prescribed more often were codeine, cholesterol-lowering statins (HMG-COA reductase inhibitors), and heart medications (ace inhibitors and beta blockers): IMS-Health, Leading 20 Therapeutic Classes by Total U.S. Dispensed Prescriptions, 2005, 2006, Available: [http://www.imshealth.com/ims/portal/front/articleC/0,2777,6599\\_73914140\\_77250318,00.html](http://www.imshealth.com/ims/portal/front/articleC/0,2777,6599_73914140_77250318,00.html).

million in 1994 to nearly \$4.5 billion in 2005.<sup>6</sup> DTC marketing has had a significant impact on prescribing practices, including a sharp rise in antidepressant prescriptions.<sup>7</sup>

### A brief history of DTC

Cultural frameworks shape how medicine is delivered, and DTC marketing is part of a uniquely American story of health care. Almost no other country allows DTC advertising.<sup>8</sup> DTC is a recent phenomenon of a health care system that has been defined by social and institutional tensions between medicine and commerce. Its historical predecessors range from debates over National Health Insurance proposals, to the American Medical Association clinging to a guild model of entrepreneurship, resisting any 'outside' intrusion into the doctor-patient relationship,<sup>9</sup> to consumer advocacy overlapping with patient advocacy. DTC advertising is born of these tensions. When pharmaceuticals were advertised DTC, for the first time consumers could choose them, much like they would any other advertised commodity. Thus marketers had to study and guide consumer desire for pharmaceuticals. However, this was consumer desire that had

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<sup>6</sup> IMS-Health, Total U.S. Promotional Spend by Type, 2005, 2006, Available: [http://www.imshealth.com/ims/portal/front/articleC/0,2777,6599\\_78084568\\_78152318,00.html](http://www.imshealth.com/ims/portal/front/articleC/0,2777,6599_78084568_78152318,00.html).

<sup>7</sup> J. M. Donohue and E. R. Berndt, "Effects of Direct-to-Consumer Advertising on Medication Choice : The Case of Antidepressants," Journal of Public Policy and Marketing 23.2 (2004).

<sup>8</sup> New Zealand is the only exception, although there has been recent backlash against DTC from the medical profession. See: Les Toop and Dee Richards, "Physicians' Negative Views of Direct-to-Consumer Advertising (Dtca) : The International Evidence Grows," New Zealand Medical Journal 117.1195 (2004). B. Burton, "New Zealand Moves to Ban Direct Advertising of Drugs," Bmj 328.7431 (2004).

<sup>9</sup> James C. Robinson, The Corporate Practice of Medicine : Competition and Innovation in Health Care, California/Milbank Series on Health and the Public; 1 (Berkeley, Calif.: University of California Press, 1999).



to be cultivated and shaped in the context of the doctor-patient relationship. The consumer may desire a specific drug, but only the doctor can prescribe it.

Pharmaceutical relationships develop and change within the broader context of institutional transformations between medicine, industry, and government regulation. In the early 1950s, the U.S. government introduced legislation that authorized the Food and Drug Administration (FDA) to distinguish drugs that could only be sold through a licensed physician's prescription.<sup>10</sup> Thus pharmaceutical promotion traditionally has been aimed at physicians, who subsequently have been viewed as "gatekeepers" and "learned intermediaries" between the consumer/patient and the drug company. There has never been any regulation against advertising drugs direct-to-consumer; until the rise of managed care in the 1980s, DTC just did not make much sense from a business perspective.<sup>11</sup>

But in 1981 a couple of pharmaceutical companies began running DTC advertisements.<sup>12</sup> The FDA quickly responded by issuing a voluntary moratorium on DTC,<sup>13</sup> requesting time to research whether the preexisting regulation for advertising to physicians would provide adequate safeguards for a non-expert consumer public. During this time the FDA, several pharmaceutical companies, and the CBS television network conducted independent studies on DTC and consumer education, each concluding that consumers wanted greater access to drug information. These conclusions were reached in the context of consumer movements that had already built up steam in the 1960s and

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<sup>10</sup> Specifically, the Durham-Humphrey Amendment, enacted in 1951

<sup>11</sup> W. L. Pines, "A History and Perspective on Direct-to-Consumer Promotion," *Food Drug Law J* 54.4 (1999), Tiffany Hartgraves, *Dtc Prescription Drug Advertising: The History and Impact of Fda Regulation*, Cambridge, MA.

<sup>12</sup> The companies were Merck (advertising the pneumonia vaccine "Pneumovax"), and Boots Pharmaceuticals (advertising the arthritis drug "Rufen").

<sup>13</sup> All pharmaceutical companies complied.

1970s, and to which the FDA had already responded by mandating that so-called “patient package inserts” (PPIs) be included in drug packaging. PPIs detailed drug safety and risk information (often in highly technical language), and represented the first time that drug information originally directed exclusively at the physician was directed at the consumer.<sup>14</sup>

The moves toward DTC included the pharmaceutical industry marketing *consumerism itself* as a progressive corrective to the paternalistic model of health care that government regulation had enabled. Pharmaceutical companies borrowed from the new paradigm of birth control, importing the theme of consumer empowerment into American health care. Birth control pills were the first prescription pharmaceuticals consumed by *healthy* people, whose decision to take the drug was supposed to be independent of medical authority. Birth control was also part of a larger social movement that enmeshed civil rights, health care, and consumer empowerment discourses.<sup>15</sup>

The moratorium on DTC was lifted in 1985. The FDA assumed jurisdiction over all DTC advertising, and declared that the preexisting restrictions for physician-directed drug advertisements would apply to consumer-directed advertisements as well. Primarily, this meant including full benefit and risk information, similar to what had already been contained in birth control PPIs. The FDA did not draft any new DTC-specific regulations, but did require that any medical benefit claim in the main body of any DTC ad have “fair balance” with risk information about the drug. Pharmaceutical companies began a

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<sup>14</sup> Shortly after, in the late 1970s and early 1980s, books about prescription drugs became widely available to the public, including the *Physician's Desk Reference* (PDR), which appeared in consumer bookstores. The PDA listed the official FDA labeling for hundreds of prescription drugs, but previously it had been sold exclusively to medical professionals.

<sup>15</sup> Tone, Andrea. *Devices and Desires: A History of Contraceptives in America*. New York: Hill & Wang, 2002.

number of DTC campaigns but, because of the vast amount of drug information that the FDA required, these campaigns almost always took the form of print advertisements (not broadcast). Moreover, because pharmaceutical companies perceived the “fair balance” requirements to be too vague, a large portion of those print ads were limited to so-called “help-seeking” and “reminder” ads, which avoided making full product claims: Help-seeking ads mentioned an illness (not a specific drug), and reminder ads mentioned a specific drug (but not an illness); both kinds of ads encouraged consumers to “talk to their doctor,” to inquire further about a medical condition or a pharmaceutical product. Because help-seeking and reminder ads did not make product-claims, they were not required to include the formidable safety and risk information, or the questionable fair-balance claims.

Until the late 1990s DTC advertising was a relatively modest and limited form of pharmaceutical marketing (which was still overwhelmingly directed toward the physician). But in the mid-1990s the pharmaceutical industry put pressure on the FDA to clarify its fair-balance requirements. Debates ensued over the sociomedical value of DTC: Pharmaceutical companies and proponents within the FDA argued that DTC was a valuable consumer health education program that could improve the doctor-patient relationship and medication compliance (especially in the context of managed care, which had led to shorter in-office visits); while certain consumer advocacy groups and opponents within the FDA (including then-Commissioner David Kessler) argued that the general consumer public did not have the medical expertise to sufficiently evaluate DTC, and that the ads could strain the doctor-patient relationship, lead to overdiagnosis or

misdiagnosis, and therefore increase doctor liability.<sup>16</sup> In response, the FDA held a round of public hearings on DTC in 1995.<sup>17</sup> In 1997 (after Kessler's departure), the agency finally released a "draft guidance" for DTC advertising, which included guidelines on how to present safety and risk information economically as a "brief summary" in broadcast formats.<sup>18</sup>

Once released the new draft guidance, as one news reporter put it, "opened the floodgates."<sup>19</sup> Between 1994 and 2000 DTC expenditures grew tenfold, to \$2.5 billion.<sup>20</sup> DTC became the new public face of the U.S. pharmaceutical industry. Public debate intensified, including greater attention in mainstream news and professional medical literature. The result has been a new nexus of tensions between medical authority, scientific expertise, consumer rights, and even debate about the constitutionality of corporate free speech under the First Amendment.

As Dumit & Greenslit (2006) have noted, we have since been witness to a corresponding "pharmaceuticalization of culture ... in which core metaphors of identity, health, illness, life, longevity, and relationships are mutated."<sup>21</sup> Within just a couple of years of the FDA's draft guidance, pharmaceuticals took on new social lives, and a new

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<sup>16</sup> There was a parallel debate over the potential economic impact of DTC. Proponents argued that DTC would lead to greater drug competition, which would lower drug prices; opponents contended that DTC would have the opposite effect, driving up drug prices through increased marketing costs.

<sup>17</sup> Full transcripts of these hearings are available at <http://www.fda.gov/cder/ddmac/DTCINTRO1.HTM>

<sup>18</sup> The guidance, finalized in 1999, required that broadcast ads direct consumers to other media where they could learn more about the drug, including a toll-free phone number, an Internet web site, the location of a print ad for the same drug (which would provide full PPI information), and encouragement that the consumer contact a physician to learn more. (The full version of the draft guidance is available at <http://www.fda.gov/cder/guidance/4114dft.htm> and <http://www.fda.gov/cder/guidance/1804q&a.htm>)

<sup>19</sup> Alexandra Marks, "A Harder Look at Prescription-Drug Ads," *The Christian Science Monitor* April 11 2001.

<sup>20</sup> Richard Frank, E.R. Berndt, Julie Donohue, Arnold Epstein and Meredith Rosenthal, *Trends in Direct-to-Consumer Advertising of Prescription Drugs*. (Washington, D.C.: Kaiser Family Foundation, 2002).

<sup>21</sup> J. Dumit and N. Greenslit, "Informed Health and Ethical Identity Management," *Cult Med Psychiatry* 30.2 (2006). (p. 127)

cultural economy of pharmaceutical relationships developed. DTC advertising quickly underwent creative transformations so that it could blend more seamlessly with advertising for other kinds of commodities, and DTC marketing eventually was regularly cited as a central force in rising prescription rates, and normalization of pharmaceutical consumption. Indeed, after the widely popular—and heavily advertised—painkiller drug Vioxx was pulled from the market, critics eventually would fault DTC for driving unnecessary pharmaceutical consumption to the point of patient deaths.

### **Creative control**

In June of 2004, the New York State Attorney General sued GlaxoSmithKline, accusing the company that it had fraudulently concealed information for its antidepressant Paxil, whose clinical trials revealed that the drug was not effective for adolescents and could even increase their risk of suicide. By this point Britain had already banned the use of the drug for children under 16. The FDA did not similarly restrict its usage outright, but the agency did mandate that GlaxoSmithKline put a so-called “black box” warning on the Paxil label—a bolded description of the increased risk of suicidal behavior, which also emphasizes that patients taking the drug should be carefully monitored by physicians.

And in September 2004, the pharmaceutical giant Merck withdrew its blockbuster painkiller Vioxx from the market, after one of its own clinical studies revealed that the drug led to an increased risk of heart attack. Merck had spent a number of years

defending against similar claims about Vioxx based on other studies,<sup>22</sup> all the while increasing its DTC advertising of the drug, whose 2003 sales alone topped 2.5 billion dollars. After its own follow-up study (which, incidentally, was not designed to reveal risk but to test Vioxx for the treatment of colon polyps), Merck finally capitulated. Pfizer immediately followed suit by temporarily halting the DTC marketing campaigns for its own heavily advertised painkiller drug “Celebrex.”

One lawyer representing patients who had suffered attacks while on Vioxx indicted DTC in a muckraking documentary:

“The reason twenty million people took Vioxx—and why many similar millions took Celebrex—was because of the advertising. It was because consumers saw Dorothy Hamill skating around on their televisions in those Vioxx ads we’ve all seen that so many people took Vioxx. So that’s a perfect example of how drug advertising skewed what drugs people took, and what they paid. Because Vioxx is many, many, many times more expensive than a bottle of ibuprofen, which, for most people, would have been just as effective. And there wouldn’t have been the heightened risk for heart attacks.”<sup>23</sup>

Following the scandals, the pharmaceutical industry changed up its marketing strategies to reflect that—contrary to the claim that DTC created demand—DTC was responding to the demand for pharmaceuticals that had always been there, and that instead of making consumers aware of specific drugs, the industry would help consumers to learn more about specific illnesses. The industry began turning towards less conspicuous means of marketing, including “unbranded disease awareness” campaigns, and by developing a new paradigm of “relationship marketing” to facilitate doctor-patient relationships, and to encourage consumers to spend more time on-line to monitor their

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<sup>22</sup> E.g. D. Mukherjee, S. E. Nissen and E. J. Topol, “Risk of Cardiovascular Events Associated with Selective Cox-2 Inhibitors,” *Jama* 286.8 (2001).

<sup>23</sup> Alex Sugerman-Brozen, attorney for the Prescription Access Litigation Project, quoted in John Ennis and Kathleen Slattery-Moschkau, “Money Talks -- Profits before Patient Safety,” (Hummingbird Pictures, 2006), vol.

own treatment progress.<sup>24</sup> After persistent criticism of DTC, and especially following the Vioxx scandal, relationship marketing was hailed as the new paradigm for pharmaceutical marketing—one that downplayed mass marketing messages in favor of seemingly more intimate and individualized efforts at medical and education and drug compliance programs. DTC is still big business. In fact, it is bigger than ever. Despite the industry scandals and public backlash, its spending has not slowed; in 2005 alone 4.65 billion dollars were spent on DTC—a figure that has more than doubled since 2000.<sup>25</sup>

Chapter 1, “Belief at the Edge of Ethics,” explores the recent history of styles of pharmaceutical advertising that have come about in response to FDA regulations and ethical issues raised by patients and the press about how the pharmaceutical industry shapes drug research. The shift from mass marketing television and magazine ad campaigns to so-called “relationship marketing” efforts began instructing individual patients and doctors on how to interact with the each other, including how to negotiate and manage each other’s understanding of how pharmaceuticals should be chosen and consumed. Relationship marketing deploys its own psychological understandings about how to hook consumers, especially under conditions of having to get consumers to persuade doctors. A growing discourse of relationality includes ads that focus on the doctor-patient relationship as a solution to FDA concerns about the presentation of drug risk and side-effect information, as well as a new focus on brand loyalty as a solution to marketing drug life-cycle dilemmas.

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<sup>24</sup> Relationship marketing refers to a model of long-term, evolving customer relationships over the course of a product’s or brand’s lifetime. It was introduced in the 1980s in distinction to transactional marketing (individual, point-of-sale transactions), but over the past few years, it has come to supplant “conventional direct marketing” as a strategy to connect consumers with specific brands. E.g. Stephen McGuire, “The Tools of Engagement,” *Medical Marketing & Media* 40.6 (2005). For an early example, see Levitt, T. (1983) “After the sale is over”. *Harvard Business Review* (September)

<sup>25</sup> Source: TMS Media Intelligence

## **Antidepressant marketing**

Most of this dissertation focuses on antidepressants. Like DTC, there is a unique American story here, too. Since the 1960s antidepressants have been consumed widely outside of inpatient populations. Over the years, these drugs have become objects of popular culture, and their use given rise to wide-ranging debates about free will, pleasure, and identity.

I am particularly interested in the marketing of antidepressants for two reasons: (1) Antidepressant effects are notoriously wily, as evidenced by the comparatively high rate of placebo effect in the clinical trial; and (2) the history of American psychiatry is characterized by a tension between the promise of the identification of concrete biological realities for mental illnesses, and the social construction of those illnesses in the first place. DTC marketing is a formidable presence here, since it borrows messages of destigmatization from mental health advocacy groups, and conveys simplified and interactive versions of neuroscientific theory to persuade consumers that they should take antidepressants. And since psychopharmaceutical advertising expenditures outstrip those of any other professional psychology or patient advocacy group, these messages are especially pervasive.

Historically, American psychiatry has been defined by professional tensions between biomedical approaches that privilege scientific objectivity, diagnosis, and



biomedical intervention; and psychoanalytic approaches that privilege doctor-patient intersubjectivity and talk therapy.<sup>26</sup> Psychopharmaceuticals, when they were first introduced in outpatient settings in the mid-1960s, did not fit squarely with either side; they were biomedical interventions, but ones that could be integrated into the ultimately psychological and interpersonal goals of talk therapy. Indeed, in the 1960s when psychodynamic approaches dominated professional psychiatry in the U.S., the use of psychopharmaceuticals ‘alone’ didn’t make much sense; rather, these drugs were understood as adjuncts to the real work of psychotherapy, which was talk therapy.

But in the 1980s, with the parallel rise of managed care and diagnostic standardization in psychiatry, psychopharmaceutical intervention became a mainstream, first line, and default treatment for depression and anxiety disorders. These drugs took on a new social life as the American Psychiatric Association tried to align psychiatry more fully with traditional medicine, including a complete overhaul of its diagnostic manual in 1987, which largely expunged it of psychodynamic language, and which deemphasized psychogenic etiologies in favor of descriptive nosologies.

Historically, American psychiatry has also been at the center of broader social tensions between mainstream social institutions, ‘countercultural’ movements, and civil rights. In the 1960s and 1970s, antipsychiatry groups interrogated and challenged the cultural authority of Medicine, especially psychiatry, making various cases that it was an institution of social control.<sup>27</sup> During this time licit psychopharmaceuticals were vilified

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<sup>26</sup> T. M. Luhrmann, Of Two Minds : The Growing Disorder in American Psychiatry, 1st ed. (New York: Knopf, 2000), Edward Shorter, A History of Psychiatry: From the Era of the Asylum to the Age of Prozac. (New York: John Wiley & Sons, Inc., 1997).

<sup>27</sup> E.g. Michel Foucault, Madness and Civilization. (New York: Pantheon, 1968), Irving Goffman, Asylums. (Garden City, NY: Doubleday, 1961), Thomas Stephen Szasz, The Manufacture of Madness: a Comparative Study of the Inquisition and the Mental Health Movement, [1st ed. (New York, : Harper & Row, 1970).

as “chemical straightjackets,” while illicit drugs were celebrated as countercultural expressions of pleasure, ‘mind expansion’ and self-exploration (epitomized by figures like Ken Kesey and Timothy Leary).

Minor tranquilizers, like Valium, were the first psychiatric drugs to occupy a social middle ground between the two perceptions; they were prescription medications for the treatment of anxiety, but they were also pleasurable and consumed ‘recreationally.’ But by the 1980s, American media and medical communities were reporting that Valium was overprescribed and overconsumed, and that people were becoming addicted to the drug. The sociomedical boundary of licit vs. illicit was blurred in both directions.

These blurry boundaries would come to shape the cultural life of the generation of antidepressants to follow Valium—those that were first to be advertised DTC, including Prozac. When Prozac first became commercially available in the late 1980s, it was hailed as the first antidepressant to have relatively few and comparatively minor side-effects, and it was used for a widening range of depression and anxiety symptoms. Prozac was also not supposed to be inherently pleasurable, nor was it supposed to be addictive. With its growing use and popularization came new questions—no longer about the use of antidepressants to cope with everyday stress and anxiety, but about the use of antidepressants to shape one’s personality and identity. Peter Kramer famously articulated these questions in his 1993 book, *Listening to Prozac*.

In this bestselling book, Kramer expressed a new willingness to use Prozac to tinker with his patients’ sense of self. Given the apparent safety of the drug, Kramer didn’t see this as medical bravado so much as a perfectly reasonable experiment made

possible by the newest generation of psychopharmacology. He asked rhetorically about a typical encounter with one of his patients, “Who was I to withhold from her the bounties of science?”<sup>28</sup>

And yet, with the rise of DTC in the years since Kramer’s book, the very science of psychopharmacology has been called into question, with epistemological ramifications for pharmaceutical explorations of the self. Social critiques of psychiatry have turned from the medical profession to the pharmaceutical industry, targeting DTC advertising in particular. And patient advocacy groups have since accused pharmaceutical companies of exaggerating claims of drug efficacy, downplaying the risks of antidepressant use, and attempting to grow drug markets by medicalizing everyday experiences like sadness, anxiety, and shyness.

On the other hand, the science of psychopharmaceuticals is contentious, not only because of how it has become intertwined with marketing, but because of its implications for the very experiences of antidepressants. In April 2002 there was a small media flurry around a Duke University study which found that the popular herbal remedy St. John’s wort was no more effective to treat depression than a placebo. In addition to reporting the specific findings about St. John’s wort, the news coverage tended to focus on the study as signaling a new kind of credibility for so-called alternative medicine, since herbal remedies were finally being compared head-to-head with mainstream pharmaceuticals. At the same time, the news coverage consequently downplayed the fact that the Duke study also included a comparison to Zoloft, which was also not found any more efficacious than a placebo. It is striking that *this* result was not the focus of the media buzz, since at the time Zoloft was the best-selling antidepressant in the United States, with annual sales

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<sup>28</sup> Peter D. Kramer, Listening to Prozac (New York, N.Y., U.S.A.: Viking, 1993). (p. 10)

topping nearly three billion dollars.<sup>29</sup> Three months later, an analysis of clinical trial data from the six most widely-prescribed SSRI antidepressants in the U.S. (obtained through the U.S. Freedom of Information Act) found that the placebo effect accounted for over 80% of medication response across all these drugs.<sup>30</sup> This was just-barely efficacy, which the authors argued could not reliably translate into real-world, everyday therapy situations.

### **Neuroscience as promise and possibility**

Whyte et al. (2002) introduce their edited volume *The Social Lives of Medicine* with a distinction between the social life and the material reality of medications: “[W]e propose to see them as things with social lives; we are more concerned with their social uses and consequences, than with their chemical structure and biological effects.”<sup>31</sup> But the phenomenon of DTC suggests that the science of psychopharmacology cannot be bracketed from the “social uses and consequences” of antidepressants. DTC advertises putative neuroscientific theories to sell the notion that antidepressants have a scientific (i.e. clear, objective, obvious) relationship to the symptoms they are supposed to treat. Patient advocacy groups have both embraced and resisted such theories and their

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<sup>29</sup> For instance, from *The Boston Globe*: “Thirty-two percent of patients taking the placebo improved significantly. Twenty-five percent responded to Zoloft. St. John’s wort pills brought up the rear, sparking a significant improvement in 24 percent of the participants, according to the data published in today’s *Journal of the American Medical Association*.” Anne Barnard, “Placebo Is Best in Depression Study : Us-Funded Trial Pits Herb, Rivals,” *The Boston Globe* April 10 2002. (p. A11)

<sup>30</sup> Irving Kirsch and et al., “The Emperor’s New Drugs : An Analysis of Antidepressant Medication Data Submitted to the U.S. Food and Drug Administration,” *Prevention & Treatment* 5.23 (2002).

<sup>31</sup> Susan Reynolds Whyte, Sjaak Van der Geest and Anita Hardon, *Social Lives of Medicines*, Cambridge Studies in Medical Anthropology, ed. Alan Harwood (Cambridge, MA: Cambridge University Press, 2002). (p. 3)

representations in marketing, according to whether they are interpreted as vindicating (biological explanations as exculpatory for socially contested illness) or constraining (biological explanations as oversimplified reifications of social and psychological complexity).

Indeed, the very notion of the ‘chemical imbalance’ has had social, epistemological and phenomenological implications for doctors, patients, and marketers alike. And in contemporary biomedical America, the circulation of scientific fact both constitutes and enables social and personal relationships with antidepressants. Scientific representations of drugs and brains have been prominent in DTC marketing for antidepressants. A number of critics have warned against the ways in which doctors and consumers alike learn to embrace pharmaceutical science, potentially at the expense of alternative explanations for depression or anxiety.<sup>32</sup> It is not a simple matter of ideology, however. The idea that neuroscience offers the truth of depression is split between claims that the science is known and that it is unknown. In the middle is a rhetorical gray area of imputation, suggestion, and belief on the part of scientists, psychiatrists, and consumer-patients. In this middle comes the ability to market the unknown to the FDA and to the public, to repeatedly claim *the possibility of neuroscience* so that it becomes common sense.<sup>33</sup> Indeed, former Eli Lilly Board member President George W.H. Bush had

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<sup>32</sup> See also Nikolas Rose, "Psychopharmaceuticals in Europe," Mental Health Policy and Practice across Europe, eds. M. Knapp, D. McDaid, E. Mossialos and G. Thornicroft (Buckingham: Open Press University, 2006), who argues that a strict biological discourse downplays or outright ignores socioeconomic factors behind depression.

<sup>33</sup> Cf. Gadamer's notion of "sensus communis"; and Fischer 1999, who connects the notion of common sense to Thomas Kuhn's cultural paradigms.

declared the 1990s—the first decade to witness DTC in its fullest incarnation—“The Decade of the Brain.”<sup>34</sup>

Thus relationships between neuroscience, illness, and pharmaceuticals are ultimately worked out through media, culture, and social movements.<sup>35</sup> At this intersection we ask, what exactly do psychopharmaceuticals do? Do they completely remove symptoms, or merely pave over them? Are they technologies of self-transformation, or technologies of social control? These questions are possible to ask only out of the context of the institutional and social tensions that have come to define the specific history of American psychiatry. But these are also anthropological questions, which can only be addressed by considering the local contexts in which these drugs are encountered and consumed, and by exploring the personal idioms through which experiences with these drugs are expressed.

In the end, my ethnography of direct-to-consumer advertising turned out to be a study of desire and fantasy. I have discovered that the production and circulation of scientific facts about pharmaceuticals is enabled in non-obvious ways by how people *buy into* those facts. Americans would seem to embrace skepticism about Big Business, and cynicism of the pharmaceutical industry in particular is certainly not hard to find. Popular books about scandals and systematic exploitation within the pharmaceutical industry have been increasingly numerous since the advent of DTC. *And still*, we are witness to growing prescription rates (for instance, as of the date of this writing, 28 million Americans have an active prescription for an antidepressant).

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<sup>34</sup> See J.C. Gillin, "The Decade of the Brain--Introduction," *Neuropsychiatry* 3.30 (1990).

<sup>35</sup> P. Brown and S. Zavestoski, "Social Movements in Health: An Introduction," *Sociol Health Illn* 26.6 (2004), P. Brown, S. Zavestoski, S. McCormick, M. Linder, J. Mandelbaum and T. Luebke, "A Gulf of Difference: Disputes over Gulf War-Related Illnesses," *J Health Soc Behav* 42.3 (2001), Kyra Landzelius and J. Dumit, "Theme Issue: "Patient Organization Movements",", *Social Science & Medicine* 62 (2006).

This dissertation explores pharmaceutical marketing through the themes of illness, fantasy and capital to open up the relationship between the apparent frailty of the clinical effects of antidepressants, and their continued growth in popularity as a mainstream, default treatment for depression in the U.S. The notion that marketing is what enables and perpetuates such a contradiction is not new,<sup>36</sup> although ethnographic explorations of how the contradiction is socially constituted are lacking.

As one critic put it, “Never has a theory with so little scientific evidence been so well accepted by the American public.”<sup>37</sup> However, even the marketing of antidepressants doesn’t make the definitive claim that “depression is caused by a chemical imbalance”; rather, the marketing claims that “a chemical imbalance *may be* to blame,” or, “*scientists believe* that depression is caused by a chemical imbalance.” On the one hand, such language might be understood as careful approximations of psychiatrists’ own disclaimers about the relationship between neuroscience and the best therapy. For instance, Rodrigo Munoz (former President of the American Psychiatric Association), defended biological research in psychiatry, arguing that it “may help us to learn which neurotransmitter, cellular membrane and cellular metabolism factors are important in triggering depression and causing its persistence. Until we have a better understanding, we will have to use these tools.”<sup>38</sup> On the other hand, antidepressant marketing inverts what I would call ‘the uncertainty of certainty’ (e.g. “we know that drug X affects neurotransmitter system Y, but we don’t yet know what that means for depression”) as

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<sup>36</sup> See David Healy, The Antidepressant Era (Cambridge, Mass.: Harvard University Press, 1997), Charles Medawar and Anita Hardon, Medicines out of Control? Antidepressants and the Conspiracy of Goodwill (Amsterdam: Aksant Academic Publishers, 2004), Elliot Valenstein, Blaming the Brain: The Truth About Drugs and Mental Health (New York: Free Press, 1998).

<sup>37</sup> Jonathan Leo, “The Biology of Mental Illness,” Society July/August (2004).

<sup>38</sup> Quoted in *Psychiatric Times*, vol. 27

‘the certainty of uncertainty’ (the pharmaceutical marketing refrain: “while we don’t know what causes depression, a chemical imbalance could be to blame”). Perhaps ironically, it is precisely this sense of *not knowing* neuroscience that has been leveraged in DTC marketing as a perverted scientific rationale, which underlies an ethical injunction to understand one’s depression as biology. DTC neuroscience is perhaps an inversion of Slavoj Žižek’s discussion of the fetishistic disavowal, in which ‘we know, but [we act despite knowing better]’; here it is ‘we don’t know, but ...’ In either case, it is a question of the ability of marketing to come up with a story about the togetherness of pharmaceuticals and illness, and the public’s willingness to go along with that story despite having cultivated a skeptical stance towards it.

Chapter 2, “Psychopharmaceutical Promises,” explores how drug marketing participates in social debates over what is scientifically known about mental illness. The chapter also explores how the popular circulation of neuroscientific facts plays into the relationship between psychopharmaceuticals, pleasure, and identity.

### **Paths of research**

My research has been multi-sited, although I didn’t start out with predetermined sites to compare. Instead, the sites emerged for me as I found myself following a network of actors: marketers, psychiatrists, patients, consumers, regulators. I quickly found myself among a polyphony of voices, and I realized that I wasn’t looking at drug marketing so



much as belief in scientific claims, and pharmaceuticals as material-semiotic objects, and as symbolic, ethical registers.

In 2002, along with my advisor Joe Dumit, and under the auspices of Sherry Turkle's Initiative on Technology & Self at MIT, I helped to organize a research group dedicated to exploring issues of identity and psychopharmaceuticals. The group was aptly named, "Rx-ID."<sup>39</sup> A number of us in the group began conducting interviews with individuals with experiences taking antidepressants, and we organized a number of interdisciplinary workshops on DTC advertising. The workshops, which often included industry representatives, proved to be excellent opportunities not only for learning and consuming 'insider' knowledge, but also for producing knowledge at the intersections of industry and STS. Drug marketers and science studies scholars are in many ways after the same thing; we both want to get inside of people's local worlds and explore their own understandings of how they relate to objects of high technology.

The patient/consumer interviews I conducted through Rx-ID taught me the rich and unexpected ways in which individuals transform and subvert the explanatory structures that are given to them through advertising, and in which they find themselves negotiating their psychopharmaceuticals (somatically, psychologically, culturally) towards personal meaning. I present material from three of these interviews during the dissertation: Sarah (Chapter 2) has suffered from life-long depression. In college she was compelled by Peter Kramer's popular writing on Prozac to pursue a career in neuroscience, which she was convinced would lead to greater "self-understanding." But Sarah was never able to bring herself to take antidepressants, despite devoting her

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<sup>39</sup> Its core members, over time, have included Joe Dumit, Sherry Turkle, Andy Lakoff, Ginger Hoffman, Paula Gardner, Jeremy Greene, and myself.

professional life to the science of their development. Terry (Chapter 3) was taking the antidepressant Zoloft as part of her treatment for bipolar disorder, but her bodily and psychological experience of the drug changed when her diagnosis changed to hypothyroidism. Robbie (Chapter 4) strives to present and experience herself as “gender neutral,” an identity that was challenged and then strangely and unexpectedly rescued when Robbie was prescribed the gender-coded Sarafem to alleviate side-effects associated with a hormone she was taking for ovarian cysts.

Sarah, Terry, and Robbie offer pharmaceutical relationships that are illustrative, not representative. That is, I have not selected their cases to represent how individuals typically encounter and experience antidepressants, for the sake of making generalizations about consumer-patient experiences in the age of DTC. Rather, I have selected their cases to illustrate some of the myriad ways in which individual experiences can *disrupt* any such generalizations about illness, identity, or pharmaceutical consumption that we might be tempted to make as participants in the age of DTC. I focus on pharmaceutical relationships that are disruptive rather than integrative as the ethnographic touchstones for this dissertation. I have paired my ethnographic encounters with Sarah, Terry and Robbie with analyses of DTC marketing to show how their individual experiences are not ‘merely’ unique, but that their experiences of illness, selfhood and identity can be understood to reveal the social contingencies of pharmaceutical consumption in the age of direct-to-consumer marketing. Indeed, the seemingly unique experiences of individuals can show to way towards social transformations in our collective understanding of illness and treatment.

As Sherry Turkle urges, “[w]e must cultivate the richest possible language and methodologies for talking about our increasingly emotional relationships with artifacts.”<sup>40</sup> I have found her notion of “relational artifacts”—and how it draws off of the psychological notions of selfhood and “identity play”—to be a compelling framework to start analyzing the increasing intertwined nature of psychopharmaceutical marketing and antidepressant use. Wondering about antidepressants as relational artifacts eventually led me to psychodynamic psychiatry. In 2004 I became an affiliate scholar at the Boston Psychoanalytic Society & Institute (BPSI), where I attended classes on psychoanalytic theory, practice and ethics, and where I also got to be a participant-observer in the presentation of clinical case material.

At BPSI I had the chance to deepen my own questions about the range of ways in which individuals can experience psychopharmaceuticals. I had been thinking primarily about DTC either as a site of cultural production (exploring how the ads conveyed messages of illness, health, and normality) or as a site of cultural appropriation (exploring how individual patient-consumers received and transformed those messages). The analysts-in-training at BPSI—most of who were practicing psychiatrists seeking specific psychoanalytic training—encouraged me to see pharmaceutical meanings as co-constructed in the context of the doctor-patient relationship, where even the very act of prescribing an antidepressant is potentially loaded with meanings about the stability of the doctor-patient dyad. Indeed, when I first talked about my interests in the psychological relationships that individuals can have with their antidepressants, one of the first-year trainees immediately shared a story: Recently she decided to prescribe an antidepressant for a patient who she had been seeing weekly for over a year, and who she

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<sup>40</sup> Sherry Turkle, *Relational Artifacts*, Cambridge, MA. (Manuscript)

thought had been making steady progress without medication. She found the decision to prescribe the antidepressant difficult, and she described the drug as a “transitional object” both for the patient, and for herself. That is, the antidepressant was overdetermined as a ‘transition’ between the psychiatrist and the patient, and the psychiatrist anticipated that its effects would have to be reckoned with interpersonally in these terms. In this psychodynamic framework, pharmaceutical relationships are always first and foremost doctor-patient relationships.

In 2004 I also became a fellow of the American Psychoanalytic Association (APsaA), which allowed me to attend the organization’s biannual meetings, and to develop relationships with other analysts-in-training. I was invited to present some of my own work at the 2004 APsaA winter meetings. Respondents on my panel, as well as audience members, identified deep questions of psychoanalytic subjectivity in the rebranding of Prozac to Sarafem. They discussed the brand itself as a fetish, and as a symbolically loaded object of fantasy and desire. One of the panelists, psychoanalyst Mitchell Wilson, articulated a process of “subjectification” of drugs-as-brands in which “we’re loyal to brands because we’ve invested them with self.” I was struck by how such language resonated with the way in which marketers would talk of defining a market as getting consumers to react to branding with, “yes, that’s me.”

Moreover, Mitch Wilson noted that the particularity of individual relationships to pharmaceuticals (including their brand meaning) revealed the patient-consumer as the “ultimate subject of desire.” These encounters with psychoanalysts were of obvious ethnographic interest to me. But these encounters also gave me a new vocabulary and set

of analytics to characterize pharmaceutical consumption, which in the age of DTC is so much about identity, fantasy, and fetish.

Through APsaA I also met Glen Gabbard, a prolific and well-known psychiatrist who has an endowed chair in psychoanalysis at Baylor College of Medicine—a rarity at an American medical school dominated by biological psychiatry. Through my BPSI seminars I had already become familiar with Gabbard’s writings on boundary violations in the therapist-patient relationship. In the BPSI library I had also discovered a textbook on psychodynamic psychiatry that Gabbard had published, which included a section (albeit small) on the ways in which patients and psychiatrists alike can transfer feelings towards each other onto the actual effects and side-effects of psychopharmaceuticals. He gave the example of an overmedicated patient as evidence of both frustration on the part of psychiatrists who found him otherwise intractable, and somatic resistance to the medication on the part of the patient as a way of acting out against feeling otherwise helpless.

Gabbard was president of APsaA at the time of my fellowship, and he had lunch with the fellows during the organization’s annual winter meeting at the Waldorf-Astoria hotel in Manhattan. The fellowship had been designed primarily to help “early career” psychiatrists, psychologists, social workers, and academics with opportunities to delve into psychoanalytic theory and praxis. Out of the fifteen or so fellows during 2005, I was the only academic. Gabbard’s time was stretched thin at the conference, and he didn’t have much more than a half-hour to have lunch with us fellows. The conversation in the room ranged widely, although themes of time and financial commitments to psychoanalytic training ran throughout. When I found what I thought might be my only

chance, I asked Gabbard a pointed question about antidepressants that his writing evoked for me, namely, whether he thought people could resist their effects. He responded, “Oh, definitely! It happens all the time. People resist the biochemical effects of antidepressants for all sorts of psychological reasons. Often those reasons aren’t immediately clear, however, which is where a psychoanalytic understanding can be really helpful.” The conversation moved on. I knew I would have to follow up with this fascinating perspective on the kinds of psychological relationships that people can develop with their antidepressants—a perspective completely underrepresented in public and even academic discourses that probe the new cultural life of antidepressants. When I returned to Boston I began uncovering a small psychoanalytic literature on psychotropic drugs at BPSI’s library and, a couple of months after the APsaA meetings, I ended up flying to Houston to interview Glen Gabbard at Baylor. The resulting interview material and analysis of the psychoanalysis literature are the basis of Chapter 3, “Fantasies of Illness.”

My engagement with psychoanalytic understandings of pharmaceuticals led me back to DTC marketing. I attended industry conferences, interviewed drug marketing experts, and surveyed American marketing literatures that have formed around major changes in FDA legislation. I wondered what kinds of ‘fantasies of illness’ I might find there, too. But I was surprised to find more than the expected psychology of consumer behavior. That was there, for sure (e.g. in the form of cognitive-behavioral “health belief models,” which will be described more fully in Chapters 1 and 3), but I also discovered some of the fascinating ways in which marketers convince themselves about their social value of their own work, including their role in the cultural adjudication of scientific facts

about illness and healing. Indeed, marketers have developed sophisticated and nuanced understandings of how consumers come to believe in pharmaceutical advertising messages, including how scientific theories of drug action and illness should be leveraged to manage consumer belief. Chapter 1, “Belief at the Edge of Ethics,” introduces and explores more fully the entanglements of business and medical ethics, and medical and scientific authority in the context of the doctor-patient relationship, whose triangulations with pharmaceutical marketing have rapidly become, since the advent of direct-to-consumer advertising, more convoluted than ever.

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I came to MIT’s History and Social Study of Science & Technology program very much excited about the promise of interdisciplinary work, and I’ve found both historical and anthropological research methodologies crucial to my own work. Indeed, some of my ‘sites’ include industry and medical articles that get compared across time, not space. Here I follow both Foucault’s method of analyzing historical sources as social commentary on contemporary discourse (“history of the present”), and I take seriously Marcus and Fischer’s encouragement that anthropologists should “approach issues of historical consciousness and context within the traditional conventions of ethnographic writing.”<sup>41</sup>

My methodology has been that of “emergent ethnography,” of not knowing in advance where the analysis will take me—“going along for the ride” as Mauer (2005) has

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<sup>41</sup> George E. Marcus and Michael M. J. Fischer, Anthropology as Cultural Critique: An Experimental Moment in the Human Sciences (Chicago: University of Chicago Press, 1986). (p. 96)

put it.<sup>42</sup> I started at psychopharmaceuticals and self fashioning, and ended up at edgy ethics and fantasy. This dissertation does not reflect the chronological unfolding of my research, however. It doesn't present the topic *as* it emerged; rather it attempts to present the topic once it had emerged. "Pharmaceutical relationships" refers to a set of ways in which, out of the mosaic of interaction between science, marketing, and patient subjectivities, the notions of belief, promise, credibility, fantasy, and truth are all invoked and mutually reconfigured in the production, dissemination, and consumption of antidepressants.

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<sup>42</sup> B. Maurer, "Introduction To "Ethnographic Emergences", "*American Anthropologist* 107.1 (2005).



## CHAPTER 1: Belief at the Edge of Ethics

### Regulated creativity

In the winter of 2003 I helped arrange a workshop at MIT on DTC advertising, which brought together marketers, psychiatrists and social scientists. One of the participants, Tim Claffey, had written and directed a number of television and print ad campaigns for the antidepressant Prozac and its chemical equivalent Sarafem (approved by the FDA for the treatment of “premenstrual dysphoric disorder”)—including a controversial television advertising campaign for Sarafem that Lilly later pulled off the air, at the request of the FDA. Tim described to me the work of advertising pharmaceuticals as “creating your market, getting people to say, ‘yes, that’s me,’ and then going to sell your product.” Tim has taught me that this is an effortful, laborious, delicate, and intensely creative process; that marketing is, as he put it, “the dog straining at the leash of popular culture,” always redefining by slightly pushing the rules of what can be said how; that successful marketing is about locating humanity (sadness, humor, irony, pride, disdain, patriotism, rebelliousness) and knowing how to connect it with commodities, and represent such a connection to diverse viewerships; that, simply put, you can’t sell products without making meaningful connections with the people who might buy them. And Tim showed wide-eyed interest at the kind of ethnographic analyses that Joe Dumit and I had been doing on the language of illness and personhood in DTC advertising. We had talked with Tim especially about a new kind of medical

citizen who we thought was being represented in DTC advertising, one whose health and happiness seemed especially precarious, and which ultimately must be propped up by pharmaceuticals. Tim expressed amazement at this notion of “dependent normality” that we “got” out of the ads themselves, and he even wondering about the ways in which advertising and STS might one day interact. Tim was never clear on exactly what this interaction might look like, but he seemed enthusiastic to convey that our work was somehow aligned.

I was struck by Tim’s readiness (and, at times, insistence) to disassociate himself from the pharmaceutical industry, which at one point he characterized as “picking markets apart one symptom at a time.” Tim enjoyed discussing the more creative aspects behind his work writing and directing advertising spots. He showed me a series of pilot Prozac commercials he shot for Eli Lilly, who ended up choosing two of the five spots. Tim asked me which I thought was best, and I chose a dramatic close-up of a woman’s sad and anguished face, which slowly started to appear relieved as the voiceover moved from talking about the symptoms of depression to talking about how Prozac could help. “Right! Exactly!” Tim agreed. But apparently the client, Eli Lilly, did not choose this spot, and Tim shared with me that he had been rather disappointed over that. He half-joked, “they chose the wrong ads!” Apparently Lilly thought that the dramatic ad was *too* dramatic, and that it might come off as manipulative.

There is sensibility in both Tim’s reasoning about why the dramatic ad was the best choice and Lilly’s reasoning about why that ad was the worst choice. But there is an important tension here between the DTC advertisement as a technology of fantasy (where consumer-patients can make deep identifications with messages of suffering and healing),

and the DTC advertisement as a site of regulated capitalism (where pharmaceutical companies must worry about whether the FDA will approve the ad, and whether the ad might end up being a royal road to liability). Indeed, Tim was quick to distinguish his own creative successes from whatever Lilly—and the rest of the industry—might have thought would make for the most successful antidepressant campaign. But he characterized drug companies as having “ego,” in that they are “proud of their little films.” Tim himself had won an advertising award for his work on the Prozac and Sarafem campaigns at the previous annual DTC National—the largest conference of its kind, devoted solely to direct-to-consumer marketing of pharmaceuticals.

Tim is an “agency creative” in the marketing industry – he is primarily concerned with creating the actual advertisements that will promote the products. Tim’s identity as an artist and his understanding of the creative goals of advertising generate productive tensions between the capitalistic goals of the pharmaceutical industry and the regulatory environment of the FDA. Indeed, the study of drug marketing offers a unique access to the shifting cultural forms of capitalism. Drug marketers are savvy cultural theorists in their own right. They develop theories of how people group themselves and develop collective identities, observe how people interpret and act on intended advertising meanings, and innovate the media through which advertising gets to consumers in the first place. For instance pharmaceutical marketers research and deploy “culturally relevant marketing,” including a recent Tylenol “youth culture” campaign in which “tip cards” about the common skateboarding injury colloquially referred to as “swellbow” are distributed at local sporting events, which give detailed anatomical explanation of elbow

injuries and how they should be treated medically.<sup>43</sup> Pharmaceutical advertisement designers are also cognitive psychologists in disguise, constructing and arranging the sounds and images of advertisements so as to push and pull the viewer's attention in highly strategic ways. The level of this kind of manipulation can be astonishing, for instance in a television commercial for the antiallergen Nasonex, which was analyzed by Duke University psychologists to reveal that a computer-generated bee flaps its wings four times less often when a voiceover delivered the drug's risk information.<sup>44</sup>

### **Constructed illness and 'real' ads**

I am interested in the kinds of relationships that marketers have with the products for which they're creating advertising campaigns. In Tim Claffey's case, he doesn't believe in the product he's marketing so much as the process of marketing itself. At some level, while consumers might assume that marketing is about the product (and of course it is), it is also about itself, insofar as it is a creative endeavor, and whose professionals may have goals that are largely displaced from the commodity in question. Indeed, Tim described to me how the filming for some of the pharmaceutical commercials he worked on actually took place in Hollywood; the Sarafem ads, for instance, were shot in a studio that was next door to where scenes for *The Matrix* movies were being filmed. Tim talked excitedly about being around directors who would receive calls from famous actresses.

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<sup>43</sup> This example comes from *Med Ad News*, 24 (6): 1, June 2005

<sup>44</sup> The ad was subsequently changed, so that the bee's movements were consistent throughout the presentation of both benefit and risk information (*Medical Marketing & Media*, 41 (4): 38, April 2006).

Tim Claffey presented a complicated picture of the role of marketing agencies as authors, whom he claimed often don't get recognition for what they produce, but who get bad press nonetheless. Tim mentioned the Sarafem campaign specifically: "We mixed the more dimensional humanity of a woman with the condition [premenstrual dysphoric disorder, PMDD], but the FDA didn't get the joke." Indeed, in the FDA's warning letter to Lilly, the agency claimed that the Sarafem commercials (which depicted a frustrated woman trying to extract a grocery cart from a line of others) "trivialized the seriousness of PMDD." When I shared the specific wording of the letter with Tim, he shook his head and defended the commercials by describing how many of the actresses who had tried out for them not only were not offended by the concept, but expressed that they "actually felt much better" after having the chance to wrestle with the grocery carts and emote. Tim said he thought this proved that these were experiences that women would be able to identify with. Of course, this wasn't a point of contention in the FDA's warning letter to Lilly. In fact, that was precisely the problem: The FDA expressed concern that the Sarafem commercials risked "trivializing" PMDD as a seriously debilitating illness that clinically seemed to affect a relatively small number of women precisely *because* it so well represented experiences that a large number of women might identify with. Tim's creative impulses ended up at odds with the FDA, and in general he bemoaned "how formulaic DTC is." When he returned to L.A. to reshoot the Sarafem spots, there were two Eli Lilly lawyers present.

In the short history of DTC advertising, the tension between advertising creativity and regulated claims about illness has been an important one for marketers. For example,

at the 2002 DTC National conference (the largest annual conference dedicated to DTC specifically), one marketer gave a presentation in which she discussed how DTC should strive to generate more “creative products,” and that one of the real challenges for DTC was to accomplish this in the context of regulatory environments that were unlike those for any other consumer product.<sup>45</sup> Specifically, the FDA has required that DTC advertisements present so-called “fair balance” information, which the Agency has defined as “the presentation of true information relating to side effects and contraindication ... comparable in depth and detail with the claims for effectiveness or safety.”<sup>46</sup> In print advertising, this requirement had been met simply by dedicating full pages to displaying all of the drug labeling information.

But another marketer described how, when DTC was first allowed in its first full broadcast form, pharmaceutical companies made the mistake of continuing to use the same health care specialty agencies that designed such print advertisements for professional journals: “Naturally, the agencies came up with professional-style ads: wordy, boring, and (so the Madison Avenue mavens complained) with too much fair balance. Not catchy enough. Not enough like real ads.”<sup>47</sup> This was a typical reaction on the part of marketers against early DTC; marketers felt that, if DTC were to be truly successful, it must be assimilated into the advertising milieu for other consumer products.

Another marketer poked fun of early DTC commercials as suffering from “the ‘woman-

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<sup>45</sup> These are FDA regulations, which require that drug advertisements are not “false or misleading,” that the ads only mention FDA-approved uses of the drug, and that the ads present a “fair balance” between drug benefits and side-effect and risk information.

<sup>46</sup> Under 21 CF202.1(e)(3)(iii): “The information relating to side effects and contraindications shall disclose each specific side effect and contraindication (which include side effects, warnings, precautions, and contraindications and include any such information under such headings as cautions, special considerations, important notes, etc. . . .) contained in required, approved, or permitted labeling for the advertised drug dosage form(s)” (<http://www.fda.gov/cder/guidance/5669dft.pdf>)

<sup>47</sup> Fran Hawthorne, *The Merck Druggernaut : The inside Story of a Pharmaceutical Giant* (Hoboken, N.J.: J. Wiley & Sons, 2003). (p. 152)

on-a-swing-in-slow-motion' syndrome." But this marketer expressed relief and celebrated how the "'taking it all too seriously' voice-over that sorely afflicted so many early DTC efforts" was seemingly beginning to disappear:

"In many cases these clichéd approaches have been replaced by genuine ideas that attempt to differentiate brands, use effective and unusual creative techniques, and, importantly, build strong links with consumers. We now see advertisements for Rx drugs that feature drama, bold and differentiating visuals, memorable soundtracks, unique language and even, amazingly, humor."<sup>48</sup>

I have discovered that this has turned out to be a productive tension, one that marketers sometimes frame as one of their key "challenges": On the one hand prescription drugs are supposed to be different – they are 'serious' medical products culturally sanctioned unlike other commodities, and with their own system of regulation; on the other hand, in order for prescription drugs to sell, they had better connect with consumers—they had better be desirable. It is in this nexus of regulation and consumerism that drug marketers often experience their work as making compromises at every turn.

### **Edgy ethics**

The pharmaceutical brand suggests an "ethical plateau"—Michael Fischer's phrase to signal "where multiple technologies interact to create a complex terrain or topology of perception and decision making" (2003:36). Since the introduction of DTC, the pharmaceutical brand has become a locus where patient subjectivities, doctor authority, government regulation, and marketers' own self-directed tactics of belief intersect and

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<sup>48</sup> Rob Rogers, "Dtc Creative: An Emerging Sophistication?," *DTC Perspectives* Spring 2003.

interact to produce a new ethical terrain, one that is shot through with challenges of the distinctions of rational and emotional persuasion—for consumer-patients and marketers alike. I have found the notion of “edgy ethics” good to think with in this respect. (The specific etymology of this phrase will be made clear later in this chapter.) Edgy ethics broadly characterizes how marketers manage their task of growing and intensifying illness markets in the face of increasingly critical and negative attention directed at the pharmaceutical industry. In the business world, to be “edgy” means to be new, innovative, and often daring. The metaphors are already familiar to us: *pushing boundaries*, thinking *outside of the box*—all rhetorical invocations of *going beyond*. “Ethics,” on the other hand, usually refers to a conservatism of action, a duty that *binds* and *reigns in*. Edgy ethics are both. They are reactive, to be sure, but they’re also productive: besides the perhaps unsurprising and predictable ‘codes of ethics’ that the industry’s lobbying groups have produced as public relations (PR), marketers have redesigned how DTC advertisements communicate to consumers, and have rescripted the role of the pharmaceutical in the context of the doctor-patient relationship.

“DTC in the New Era: Issues and Answers for the New Era of Uncertainty and Innovation”: At the date of this writing (August 2006), this is the title of the upcoming “DTC National” conference—the largest annual conference in the U.S. devoted specifically to direct-to-consumer marketing. One of the key issues to be addressed at this conference is how the ongoing public debate about drug safety might affect the content of DTC ads. On the one hand, it is not a new phenomenon for drug marketers to become reflexively critical and experience themselves in a “new era” of regulation that demands



its own new strategic ethical reconfigurations with doctors and patients. One industry article entitled “The Challenges to Drug Advertising,” was published in 1964.<sup>49</sup> Written soon after the FDA had responded to the thalidomide tragedy in Europe<sup>50</sup> by passing legislation to tighten control over prescription drugs (including the requirement that drugs be demonstrated to be effective in addition to being safe), the article posited that, “[t]he real challenge ... is how to cope today with a stringently regulated advertising existence.” The article went on to propose a strategy of “letting executives speak” as an effective response to “abuses of promotional techniques.” Essentially, this was a tactic to displace marketing decisions from the marketer to pharmaceutical company management, who the article encouraged to ask themselves questions like, “Is there a medical need for the product? ... Is it a better product? ... Is the product adequately supported by clinical studies? ... Does the physician need to be educated to the use of the product?” Here the drug marketer defers to the pharmaceutical executive as a way to negotiate his own<sup>51</sup> ethical responsibilities under new FDA restrictions. In so doing, the marketer also betrays some anxiety over the ways in which marketing had come to *represent* the pharmaceutical industry (and therefore anxiety over becoming the industry’s lightning rod).

In 1964, this marketer saw his business as being in an ethically conservative relationship with the pharmaceutical industry. But fast forward to 2004 at a downtown Boston Sheraton hotel, where I attended the annual DTC National conference. This conference occurred in the midst of the Paxil and Vioxx scandals, when marketers found

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<sup>49</sup> J.A. Baruch, “The Challenges to Drug Advertising,” Drug and Cosmetic Industry 94.202 (1964).

<sup>50</sup> Thalidomide was a drug marketed as a sleeping aid and as a means to prevent nausea. Many pregnant women took the drug, which led to widespread teratogenic effects in newborns, as well as infant fatalities.

<sup>51</sup> And it was almost always ‘his’ in the mid-1960s (Greene 2002)

themselves at the center of sustained criticism about the pharmaceutical industry. Bob Ehrlich, the president and CEO of the industry magazine *DTC Perspectives* and cofounder of the conference, gave the opening address. He warned: “Many DTC ads are closely resembling OTC [over-the-counter] ads – more humor, music, cute characters. But this is not necessarily a good trend, if Rx loses its premium, ethical edge in the race to be creative”.<sup>52</sup> Ehrlich expressed concern over how agency creatives had assimilated DTC ads into mainstream commercialism. At the same time, he framed ethics as a marketing tool, as suggested by the language of “edge.” In contrast to the 1964 article, Ehrlich argued that marketing itself should have a more central role in the creation and mediation of pharmaceutical ethics.

Ehrlich is not an agency creative. Rather, he is a marketing consultant to pharmaceutical companies, helping them conduct market research and formulate advertising strategies. The former vice-president of consumer marketing for the pharmaceutical company Parke-Davis, Ehrlich became one of the first and most prominent consultants to specialize in DTC. In his address at the 2004 DTC National, he articulated the tension between creating compelling advertisements and satisfying the unique legal and regulatory requirements of DTC. Ehrlich acknowledged that this tension was partly the product of differences between professional cultures: On the one hand, general advertising agencies do not distinguish pharmaceutical products from other commodities; on the other hand, in-house brand teams worry about regulatory scrutiny. Ehrlich said the trick was to be both creative and regulation-wary at the same time, and he suggested that the *ethical difference* between pharmaceuticals and other commodities could itself constitute the creative content of the ads.

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<sup>52</sup> From his talk handout at the 2004 DTC National Conference (Boston)

Ironically, the controversy around DTC was that the Madison Avenue advertising agencies were doing their job too well. One agency creative worked on the campaign for Novartis's "Zelnorm," a treatment for "irritable bowel syndrome," whose striking ads featured images of women's midsections with handwritten messages like, "I'm all twisted inside." She explained, "We don't and have never approached [DTC] as pharmaceutical advertising ... I just treat it the way we treat any other brand: It's coming up with human relevance and letting a creative idea spring from that."<sup>53</sup> But with respect to advertising, the FDA has often found "human relevance" to overstep medical relevance. One of the proposed DTC ads for Pfizer's Lipitor (the blockbuster cholesterol-lowering drug) featured an actress in her 30s. The FDA made Pfizer reshoot the commercial with actors two decades older, to more accurately depict those consumers most likely to have the drug prescribed to them.

Pfizer finally went with a series of ads that represented the first DTC to employ humor. One of the ads depicted a fit and handsome 50-year-old man confidently approaching a diving board in front of ogling onlookers, only to belly flop into the pool. The ad then displayed unfavorable cholesterol numbers. The take-home message was that, despite looking and feeling great, you might have poor cholesterol levels. A couple of years later at the 2004 DTC National, in the midst of the Vioxx and Paxil scandals, Ehrlich warned against such flippant portrayals of pharmaceuticals and health information.

By 2005, DTC advertisements had been 'toned down.' A new campaign for Lipitor exemplified the change. The new Lipitor ads featured Robert Jarvik (famous for

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<sup>53</sup> Quoted in "A Dose of Creativity: Are Drug Ads Ready for Their One Show Debut?," *Adweek* 44.31 (2003).

inventing the artificial heart), who gazed directly at the audience and discussed the importance of treating high cholesterol. A *Med Ad News* article reflected on the new trend in DTC, which included presenting “physicians as an authority figure”: “The ads featured a more sober, medical tone rather than the emotional feel of previous direct-to-consumer ads ... There is more of a focus on product performance and benefits than on emotional benefits.” Another marketer was more ambivalent: “Gone are the beaches and fields, the happy people living lives free of pain. The clichés du jour in today’s drug advertising are doctors and celebrities addressing the viewer dead-on and dispensing risk information with little subtlety.”<sup>54</sup>

On the one hand, this shift is part of an historical legacy to use scientific and medical imagery to lend advertisements social authority. A 1959 article on advertising, written by the widely influential marketing scholar Sidney J. Levy, claimed that:

“A doctor means Science, Health, Authority of the professional; and when the viewer sees a white coat in a commercial he is informed that the product is trying to show a serious attention to technical matters, product quality, and the consumers’ well-being.”<sup>55</sup>

On the other hand, some contemporary DTC marketers have worried about systematic transformations in DTC advertising towards the more ‘serious.’ One agency creative expressed his “ultimate fear” that, “in an effort to be careful, we end up being boring, and if we do that, our objectives can’t be met.”<sup>56</sup> The ultimate objective is to meaningfully differentiate the client’s drug from its competitors, to capture market share. At the 2004 DTC National, Stuart Klein (president of The Quantum Group, a consumer advertising

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<sup>54</sup> *Medical Marketing & Media*, 41 (4): 38, April 2006

<sup>55</sup> Sidney J. Levy and Dennis W. Rook, *Brands, Consumers, Symbols, & Research : Sidney J. Levy on Marketing* (Thousand Oaks, Calif.: Sage Publications, 1999 [1959]). (p. 214)

<sup>56</sup> Andrew Schirmer, EVP and managing director for McCann HumanCare, quoted in *Medical Marketing & Media*, 41 (4): 38, April 2006

agency) anticipated this concern, lamenting: “Unfortunately I don’t think there’s one DTC [advertisement] that fits the bill [to be considered a ‘classic ad’].” Klein was speaking from the professional culture of advertising where ads themselves are regularly celebrated as small works of art. He cited the FDA’s fair-balance requirements as a key culprit, echoing numerous other marketers who have decried fair-balance information as awkward to the creative process of advertising, and potentially fatal to the consumer’s retention of the brand name.

Some marketers have hailed a recent television advertising campaign for a new Johnson & Johnson contraceptive “Ortho Evra” as redefining the presentation of fair balance information in a post-Vioxx DTC world—one that preserves the creative endeavor of advertising. Instead of the traditional DTC ad in which risk information is typically presented as a rushed voiceover at the end of the commercial, the new Ortho Evra ad depicts a gynecologist discussing risk and side-effect information with a patient, as well as recommending that she avoid smoking. In contrast to previous generations of DTC advertising, which almost always depicted the consumer in nonmedical contexts, the Ortho Evra campaign markets the doctor-patient relationship itself.

Rich Pounder, president and CEO of the company that created the new Ortho Evra campaign, made the following observation:

“It was clear, particularly in the post-Vioxx environment that we needed to have a pretty clear assessment of where we were, but if you look at the work we did before, it was certainly not irresponsible. And all the information was there. In fact, the exact same information was there. It’s just a matter of presentation.”<sup>57</sup>

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<sup>57</sup> Quoted in *Med Ad News*, 24 (6): 1, June 2005.

Pounder acknowledges that the Ortho Evra campaign is a flexible response to criticism of DTC. But he also defends the older DTC campaigns, arguing that the fair balance information the FDA requires had always been present (i.e. “it’s just a matter of presentation”). However, another marketer noted that the doctor-patient relationship in the Ortho Evra spot represents a more ethical presentation of fair balance information:

“[The ad] uses the doctor-patient interface for the doctor to be completely honest about what the side effects of this birth control pill are [... and the ad] satisfies the need for the pharmaceutical company to disclose the real risks and benefits. But it does it with the doctor as the spokesperson, so the doctor looks like the trustworthy spokesperson in the deal.”<sup>58</sup>

It is ironic that the *appearance* of medical authority conveys “complete honesty.”

Rather than communicating to consumers that they can direct the doctor-patient relationship (“talk to your doctor”), the post-Vioxx DTC paradigm depicts the doctor-patient relationship itself.

### **Relationship marketing**

For the pharmaceutical industry, selling drugs becomes a problem not only of creating consumer desire as health consciousness, but also of channeling that desire through the doctor-patient relationship. Indeed, patient compliance is formally defined in terms of the doctor-patient relationship (does the patient follow the doctor’s orders?), and marketers do not seek to outwardly replace that relationship, but rather to seed it with the pharmaceutical brand—to reconfigure it as a *pharmaceutical relationship*.

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<sup>58</sup> Risa Bernstein (co-president of Flashpoint Medica), *Ibid*.

Prescription drugs are unique consumer objects, since their purchase is mediated by the physician, whose authority and expertise present simultaneous barriers and opportunities for pharmaceutical companies. For instance, part of the backlash against the first appearance of broadcast DTC advertising included criticism from physician groups (including the American Medical Association) that DTC was something of a home-wrecker in the doctor-patient relationship: DTC creates unnecessary consumer demand, which immediately translates into pressure on the doctor to prescribe on demand, as it were.<sup>59</sup> Physicians also complained that DTC was particularly straining on the doctor-patient relationship in managed care environments where patients could readily switch health care providers if they felt their needs were not being met. Pharmaceutical companies mainly responded by claiming that DTC could only *improve* the doctor-patient relationship by “educating” consumers about illnesses and new drug treatments, which (the industry said), would inevitably “build bridges” between doctors and patients.<sup>60</sup>

A related solution to the evolving problem of risk management is increased governmentality at the level of the doctor-patient relationship, as an ethical response to scandal. One industry source urged marketers to “facilitat[e] and accelerat[e] the flow of clinical information,” including “[a]ccessing and analyzing the anecdotal information on how drugs perform in the ‘real world’ that thousands of physicians are privy to in their

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<sup>59</sup> E.g. Hollon (1999) offered the following paternalistic lament: “Most important, by creating consumer demand, DTC marketing undermines the protection that is a result of requiring a physician to certify a patient’s need for a prescription drug. For the benefit of patients, physicians, and the public’s health, the FDA should consider stricter—not more permissive—regulations.” M. F. Hollon, “Direct-to-Consumer Marketing of Prescription Drugs: Creating Consumer Demand,” *Jama* 281.4 (1999).

<sup>60</sup> A. F. Holmer, “Direct-to-Consumer Prescription Drug Advertising Builds Bridges between Patients and Physicians,” *Jama* 281.4 (1999).

daily practices.” This is where relationship marketing comes into play. Relationship marketing is specifically designed to ‘facilitate’ and ‘accelerate’ doctor-patient flows, with the pharmaceutical company monitoring and mediating those social exchanges. The Boston-based patient communications company InfoMedics (which will be discussed more directly later in the chapter) even has one program called the “Brand Accelerator,” which is promoted with the same language of getting inside the patient’s “real world”:

“Brand Accelerator is InfoMedics’ flagship program in which patients are surveyed about their experiences taking a medication. Different from a clinical trial, Brand Accelerator focuses on how a medication is truly working for them in the real world.”<sup>61</sup>

Indeed, the health information that patients can provide about themselves has begun to play an increasingly important role in how drug marketers understand and guide the market economy of pharmaceuticals. At the 2004 Pharmaceutical Marketing Congress,<sup>62</sup> Rick Berard (director of a compliancy program at Biogen) argued that non-compliance rates translate directly to a decrease in drug efficacy rates, which lowers the profitability of the drugs themselves. Berard founded the company HealthMedia, Inc., which provides patient “behavioral support programs” to pharmaceutical companies. The company claims to help pharmaceutical companies “increase drug efficacy by adding quality behavioral education to prescription products.”<sup>63</sup> HealthMedia collects patient questionnaires, which their own team of healthcare professionals then analyzes and creates personal “health improvement plans” to be sent back to the patients.

Berard explained that, especially with respect to chronic illnesses like high cholesterol, diabetes, and depression, most of the “chronic condition management” is in

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<sup>61</sup> <http://www.infomedics.com/ProductsServices/BrandAccelerator.htm>

<sup>62</sup> Held in Philadelphia. PMC is the world’s largest annual pharmaceutical marketing conference.

<sup>63</sup> [http://www.healthmedia.com/products/custom\\_solutions.html](http://www.healthmedia.com/products/custom_solutions.html) (accessed June 2006)



the hands of the patient, not the doctor. Berard urged drug marketers to think about “creating expert patients” who could come to understand themselves as “leaders of their own health management team,” which would consist of their doctor, pharmacist, family, and friends. HealthMedia has developed its own patient communications program called “Care For Your Health.” A recent press release from the company described its goals as:

“[B]uild[ing] upon a patient’s motivation and self-confidence to improve their ability to comply with their medications, adhere with their treatment plan, deal with the stress, depression, sleep disorders and fatigue often associated with managing their condition(s), and partner with their doctors and pharmacists to execute their treatment plan. These positive changes in behavior lead to reduced health care costs.”<sup>64</sup>

In the DTC transition to relationship marketing, patient communications have begun to include the consumer as part of the pharmaceutical gift economy. For instance, InfoMedics’ patient information gets attached (literally) to the drug sample. After coming across promotional materials for the patient communications company InfoMedics (which will be discussed more fully below) at one of the pharmaceutical marketing conferences, I contacted George Paradis, a product manager at InfoMedics. I interviewed him to learn how marketing is becoming a part of doctor-patient relationships. George explained to me that he hoped the method of distributing surveys and health information as part of drug samples (with a return of patient information to the companies) would inspire drug companies to increase the number of samples that they distribute to doctors:

“On another side, getting more samples out there. We might say because of the measurable impact of what you’re doing [i.e. the pharmaceutical companies], why don’t you give more samples to the doctors, with the communication packaging? There are insurance issues here – distributing branded samples to people with no insurance. Pharma companies aren’t excited about giving away free stuff, but it could make sense. We offer free stuff for finishing our communication surveys, because we sympathize with people who can’t afford it.”

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<sup>64</sup> [http://www.healthmedia.com/products/product\\_types/CFYH\\_Case\\_Study\\_Final.pdf](http://www.healthmedia.com/products/product_types/CFYH_Case_Study_Final.pdf)

Health information itself is becoming part of a pharmaceutical gift logic. The pharmaceutical industry has long given gifts to doctors,<sup>65</sup> and now they are starting to extend their gift-giving to patients as well. But, following Mauss's gift logic, gift-giving is always accompanied by an expectation of return giving. Indeed, now the development of 'doctor-patient communications' programs (and the literal piggybacking of surveys with drug samples) is rapidly becoming a part of the gift economy of drug prescriptions. In the InfoMedics model, part of the exchange for the drug sample is the patient's reports of her own experiences on the drug. Appadurai (1986) defines the "commodity situation" as "the situation in which [a thing's] exchangeability (past, present, or future) for some other thing is its socially relevant feature."<sup>66</sup> In this case, the patient's health information becomes a new mark of exchangeability for the drug sample, which is given 'freely.' The use-value of the drug sample does not terminate in its consumption; rather it is returned as the exchange value of one's own health information, which pharmaceutical can use as a behavioral monitor.<sup>67</sup>

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<sup>65</sup> See also M. J. Oldani, "Thick Prescriptions: Toward an Interpretation of Pharmaceutical Sales Practices," *Med Anthropol Q* 18.3 (2004).

<sup>66</sup> Arjun Appadurai, *The Social Life of Things: Commodities in Cultural Perspective* (Cambridge [Cambridgeshire]; New York: Cambridge University Press, 1986). (p. 13)

<sup>67</sup> There is something akin to what Adriana Petryna calls "ethical variability" at play here. Petryna shows how U.S. guidelines for subject selection in clinical trials become ethically variable when they are moved to third-world countries. Here the pharmaceutical gift has its own ethical variability—ethics whose variation depends, for one, on cultural notions of excess and relevance. Adriana Petryna, "The Human Subjects Research Industry," *Global Pharmaceuticals: Ethics, Markets, Practices*, eds. Adriana Petryna, Andrew Lakoff and Arthur Kleinman (Durham: Duke University Press, 2006).

## The business of relationships

In the age of DTC, drug marketers understand the doctor-patient relationship to be crucial, but fragile. Drug marketing in particular is understood to be a special area of marketing in general, since often doctors—at whom the majority of drug marketing is still directed—are not the actual consumers of the product. As historian of medicine Jeremy Greene has explored, historically, the identification of drug marketers with doctors led to some interesting tensions. Perhaps most importantly, ‘detail men’ could not be seen as outright telling doctors what to prescribe (which would no doubt come off as presumptuous), but of course their goal was indeed to influence doctors’ prescribing habits. The compromise was one of professional identity: Detail men positioned themselves as professional *allies* of doctors.<sup>68</sup> Of course, this was a bit of a balancing act, since these precursors to contemporary pharmaceutical representatives did not want to overstep their boundaries with doctors. One industry guide warned “Don’t try to teach the doctor how to practice medicine” in bold typeface, further explaining that “nothing antagonizes a doctor quite as much as having a detail man attempt to teach him his profession.”<sup>69</sup> Marketers have recently worried about DTC being alienating in precisely this respect. One drug marketer noted that DTC advertising could actually backfire if it

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<sup>68</sup> The 1940s and 1950s were pivotal for the pharmaceutical industry, given the sudden proliferation of new drugs. There was a tremendous expansion in the market for prescription pharmaceuticals, as novel classes of therapeutics and individual products expanded at a rapid rate. There was a corresponding rise of physician-directed marketing during this time but, in this context, advertising directly to patients didn’t make sense for pharmaceutical companies. The very definition of “prescription drugs,” drugs that are distributed only under a doctor’s orders, casts the physician in the role of gatekeeper. As historian Philip Hilts argues, “The companies also created, through lobbying, the prescription drug system, in which doctors controlled medical drug use rather than patients. This meant that advertising and promotion need not be aimed at the entire American population, a costly and largely ineffective proposition” (p. 121).

<sup>69</sup> Jones, cited in Greene (2004)

led to a consumer's desire for a specific drug, which might end up straining the doctor-patient relationship:

“ ‘The doctor doesn't want the patient coming in and saying, ‘I want [Drug X] because I saw it on an advertisement on TV.’ They react negatively to that. On the other hand, you educate [patients] to know that when they're in with the doctor, they should say, ‘Doctor, I'm always so exhausted, I can't get out of bed, I can't make dinner for my family. What can you do for me?’ The doctor says, ‘I know what you're talking about.’ They're aware of the ads. [The drug companies] have been carpet-bombing the airwaves with this stuff.<sup>70</sup> If you can get the patient to say, ‘I'm having this problem, what can I do?’—the marketer grinned and raised his arms straight up—’touchdown!’”<sup>71</sup>

In this scenario, for both patient and doctor the ideal effect of DTC is that of insidious PR: for the patient, the ideal effect of DTC is a kind of self-realization that masks its own production (the patient is ideally supposed to come to experience himself as symptomatic in a rote way, but not desirous of a certain drug); for the doctor, the ideal effect of DTC is the automatic interpretation of the patient's symptoms as an illness for which he is likely to prescribe a certain drug (“The doctor says, ‘I know what you're talking about.’ They're aware of the ads”).

This triangulation of desire must preserve the doctor's authority while at the same time “empowering” the consumer. On the whole, DTC marketers—following wider marketing trends for other consumer goods categories—have been evolving a cultural studies model of the consumer (the savvy bricoleur, no longer the ‘hypodermic’ model of media effects), one who may “disregard the intended effects of television and take from it

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<sup>70</sup> The language of “carpet bombing” to characterize the widespread and indiscriminate nature of DTC advertising is not unique. For instance, Jerry Avorn gave a 2003 talk at Harvard entitled, “Drug Company Promotion: Weapons of Mass Destruction?”

<sup>71</sup> Quoted in Hawthorne (2003:162)

what best fits into their lives.”<sup>72</sup> Marketers now acknowledge the popular as a site of agency in which local and particular consumption allows meanings to be appropriated to local needs (including the popular as resistance to the hegemony of mass cultural production)—and advertising agencies are very interested in this. Indeed, the new corporate strategy is to acknowledge, show, and study how *consumers* produce brand meaning, not the corporation. This is part of an industry-wide shift away from the “lifestyle marketing” that was ascendant in the 1960s-1980s (and its corresponding development of a stream of new brands to be identified with<sup>73</sup>), towards so-called “consumer relations management,” which distinguishes itself by emphasizing long-term relationships with a single brand (brand loyalty).

The resulting strategy of brand management posited consumers as “active partners to a relationship and making what they do with or say about the brand matter to the evolution of its personality.”<sup>74</sup> As one marketer put it:

“Over the past decade, it has become resoundingly clear that the world is moving from an industrially driven economy where machines are the heroes toward a people-driven economy that puts the consumer in the seat of power ... Indeed, brands do not belong to corporations anymore, but to people!”<sup>75</sup>

This mentality has been applied to pharmaceuticals, as well. One drug marketer gives advice on strategically defining an illness market: “Define your market: ‘people in pain,’ *not* ‘the painkiller market’.”<sup>76</sup> Correspondingly, drug marketers have been

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<sup>72</sup> Stuart Hall’s “Encoding/Decoding,” excerpted in Tim O’Sullivan and Yvonne Jewkes, The Media Studies Reader (New York: St. Martin’s Press, 1997). (p. 381)

<sup>73</sup> Arvidsson (2006) cites the ‘Marlboro Man’ and the slogan “I want to buy the world a Coke” as exemplary.

<sup>74</sup> Adam Arvidsson, Brands : Meaning and Value in Media Culture (New York: Routledge, 2005). (p. 67-68)

<sup>75</sup> Marc Gobé, Emotional Branding ; the New Paradigm for Connecting Brands to People (New York: Allworth Press, 2001). (p. xvii)

<sup>76</sup> Janice MacLennan, Brand Planning for the Pharmaceutical Industry (Gower Publishing, 2004). (p. 13)

reconceptualizing their task from one of advertising specific drug products to one of building long-term relationships with consumers that span from ‘disease awareness’ campaigns to drug adherence plans. As one healthcare industry reporter recently argued, “As the relatively new field of DTC advertising matures, it is becoming increasingly clear to marketers that effective consumer messages operate on a continuum of action; it’s up to them to prod consumers almost every step of the way.”<sup>77</sup> A key ‘prod’ has been to reconceive of drug adherence as brand loyalty, and brand loyalty as an active relationship. Indeed: “Keeping consumers on these medications is a challenge that is landing squarely in marketers’ laps.”<sup>78</sup>

To this end, an entire industry around “patient-physician communications” has sprung up over the past few years. I met Paul Buta, CEO of a Boston-area company called “Optas” (a provider of DTC web-based marketing tools for the pharmaceutical industry) at the 2003 DTC National. I met with him at his office a few months later, to discuss the role of patient-physician communications in the evolution of DTC. Paul told me that physicians are increasingly under demands, that patients are confused and expected to know more, and that there is a new role for the Internet in this respect. He explained that pharmaceutical marketing has been quickly evolving to “integrate patient and physician marketing programs” (which have traditionally been kept separate), largely as a result from the backlash to the large and much more conspicuous DTC campaigns. He called television a “saturated medium,” and he anticipated that there would be a rise in “e-marketing” campaigns and patient-directed promotion in doctors’ offices.

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<sup>77</sup> Diane West, “Changing Lanes: You’ve Got Their Attention—Now What? Marketing Analysts Predict a Spending Shift from Branded Direct-to-Consumer Efforts to More Disease Awareness and Corporate Reputation Promotions.,” *Pharmaceutical Executive* 25.5 (2005). (p. 158)

<sup>78</sup> *Ibid.*

But at the same time Paul claimed that, “Health care is a business of relationships, and the consumer is starting to take charge.” He said that Optas is part of the industry’s response to this new consumer-centrism, and he explained that the company is largely in the business of facilitating drug compliance—part of an overall strategy to “market nice” in the face of negative publicity directed at the pharmaceutical industry. As the next section will show, it is precisely out of this tension between privileging the consumer and nurturing the doctor-patient relationship in terms of drug compliance that new subjectivities made, and new ethical relationships configured.

### **InfoMedics**

InfoMedics is part of a general effort on the part of marketers to design, promote and implement ‘consumer-centered’ branding to change the image of the pharmaceutical company. One recent industry article claimed that, “Consumers feel [pharmaceutical companies] are just trying to sell product. This is reinforced by news of recent clinical studies showing that older drugs are just as good if not better than expensive—and heavily marketed—new drugs.”<sup>79</sup> Once again, marketers consider the ‘me-too’ drug phenomenon as an appropriate challenge for marketing specifically (and not necessarily as a structural or systemic problem of drug development). One consequence has been a shift away from an exclusive focus on advertising to more involved relationships between pharmaceutical companies and consumers. One marketing article, for instance, suggested “user-centered design” Internet-based models for consumers to engage with

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<sup>79</sup> *DTC Perspectives*, 6/06, p. 63

pharmaceutical brands in a more “active” and “empowered” manner, with the overall goal of rebuilding consumer “trust” in the pharmaceutical industry. This interactive strategy included the showcasing of consumer-patient testimonials, tools to geographically pinpoint physician specialists, downloading “printable daily treatment diary forms,” and on-line community forums. The article suggested “dynamic profiles” for consumers: “a single customer profile with lifestyle information that gets updated, either deliberately or dynamically, over the lifetime of the customer.”<sup>80</sup> The goal of these “multidimensional, active relationships with customers” is maximum interpenetration into consumer identities and lifestyle.

In a sense, DTC has always been about consumer relationships in this respect. One of the first DTC brochures for Prozac taught consumers how to experience the drug’s probably subtle and long’ effects on their mood:

“Because improvement is often gradual, it may be hard to notice when you’ve started feeling better. Keeping a daily journal can help – just jot down a couple sentences a day about your general mood. You’ll be surprised to notice the change from day to day.”

In the Prozac pamphlet, getting better is not an experientially obvious phenomenon (“you’ll be surprised ...”); this represents an early DTC example of how pharmaceutical companies have begun teaching people how to experience themselves as getting better. Here we see a particular care of the self model—care of the self at the bequest of others. Such ‘care of the self’ tactics have quickly evolved from individual instances like this Prozac example, to a more organized and strategic part of the health communications business.

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<sup>80</sup> Ibid., p. 67



For instance, InfoMedics—one such Boston-based health communications firm, mentioned above—has developed its own Adhere™ program designed to “prevent patient non-compliance before it starts.”<sup>81</sup> Companies like InfoMedics have reframed the doctor-patient relationship in terms of the pharmaceutical brand. I attended the 2003 DTC National Conference in Boston, where I picked up InfoMedics’ literature promoting the Adhere™ program. The program is marketed to pharmaceutical companies, who are told:

“Build a new bridge from the physician to the patient that carries critical treatment information. One that identifies why a patient might not be compliant and provides that feedback to the physician so that the problem can be solved right away. One that makes it easy for physicians to manage the compliance process. One that motivates and educates patients through materials tailored to their needs and interests. One that puts your brand squarely in the middle.”<sup>82</sup>

Here, InfoMedics frames compliance as a phenomenon that the doctor should manage, but in which the pharmaceutical brand is supposed to mediate the doctor-patient relationship; it is “squarely in the middle.” The positionality of ‘middle’ is actually part of a larger discourse in pharmaceutical marketing about *the gap* in the doctor-patient relationship.<sup>83</sup> Being “squarely in the middle” implies both mediation, and filling in. Indeed, in its mission statement, InfoMedics claims that pharmaceutical companies can help “improve the quality of communications between patients and their physicians.”<sup>84</sup>

Whereas DTC marketing was originally about getting people into the doctor’s office to ask about a specific drug or a specific illness, it has evolved to be concerned

<sup>81</sup> [http://www.infomedics.com/\\_docs/WP\\_2006\\_0330.pdf](http://www.infomedics.com/_docs/WP_2006_0330.pdf)

<sup>82</sup> © 2002 InfoMedics, Inc.

<sup>83</sup> E.g. “I believe it’s down to 5 minutes to 7 minutes for the average visit ... This has created a knowledge gap for patients. Whereas they used to rely more heavily on their doctors for such information, they now have to find the information elsewhere. Thus, the new focus on disease awareness is getting increased attention to fill that gap.” (Bob Hogan, executive VP and general manager of Saatchi & Saatchi, quoted in *Med Ad News*, May 1, 2006)

<sup>84</sup> <http://www.infomedics.com/Company/index.htm> (accessed June 15, 2006)

with the nature of the doctor-patient interactions *afterwards*. InfoMedics discusses its mission as an adjunct to pharmaceutical detailing, noting that doctors have been spending less and less and time with pharmaceutical reps, and therefore have had increasingly less exposure to brand-specific messages.

After the conference, I interviewed George Paradis, Product Manager at InfoMedics, who explained that, whereas DTC campaigns have more of a ‘carpet bombing’ approach to the dissemination of health care information, health care communications companies like InfoMedics tracks individual interactions between patients and physicians. A pharmaceutical sales rep gives doctors samples and vouchers, which is packaged to include a survey kit that InfoMedics has designed. The kit includes pre-drug and post-drug surveys (“basically a snapshot of how you’re feeling before and after the meds,” George explained), whose responses are collected, analyzed, and sent back to both the patient and the doctor. The survey data are also sent back to the pharmaceutical companies, in a “generic form” that doesn’t reveal individual patients. In addition to the survey results, the patient is often provided with health information pamphlets, which George described as “an opportunity for the patient to be exposed to some more educational items to learn more about their illness.”

George acknowledged that the role of drug marketing in the doctor-patient relationship, while increasingly important, is at the same time fragile. InfoMedics offers a key example of changing the paradigm of marketing from one of mass marketing to one of consumer-centered, dialogue-oriented approaches. For instance, the InfoMedics “Brand Accelerator” service is promoted to pharmaceutical companies as “letting Direct-

from-Patient Experience deliver your brand message.”<sup>85</sup> As George explained to me, the “Campaign Booster” represents a move away from mass DTC marketing:

“I’ve talked to DTC people. On the consumer side pharma is broadcasting messages, but never really measuring the impact of those campaigns. There’s never any closure to what they’re doing. They’re kind of blind in that respect. We said, ‘why just have a consumer go talk to their doctor about Nexium?’ They need to find out why did they actually. It really surprises us how much money they throw at DTC without any real feedback about how the campaigns work. We measure on a doctor-by-doctor patient-by-patient basis. It’s funny that on the clinical trial side they’ll spend a fortune on a small group of patients, but once [the drug] is released, they don’t track it.”

George sees the efforts of doctor-patient communications companies to be extension of the clinical trial: It’s not just a question of *a drug’s* efficacy; it’s a question of *a brand’s* efficacy. And, as George argues, brand efficacy needs to be researched just as thoroughly. (Even the language of “campaign *booster*” evokes these intersections of business and medicine.) At the same time, doctor-patient communications companies need to widen the gap between ads and action in order to grow their industry.

George situated InfoMedics as part of a consumer empowerment movement, but one that simultaneously privileges the physician’s capacity to be a primary decision-maker in a patient’s health care:

“[Our programs are] structured around the prescription, whether it’s through a voucher or a sample – that’s how the communication of the Communication gets started. In age of DTC, let’s also approach it strictly from the consumer side. It also puts a lot of control in the doctor’s hands. What I hear a lot from the physicians is that we’re not doing lot to step on their toes. Doctors continually tell us they are the final say. [Our programs have] always had the underlying theme of being good for the doctor and good for the patient, and not at any cost for either of them.”

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<sup>85</sup> From an InfoMedics brochure, ©2001 InfoMedics

For George, the real question of marketing is figuring out how to structure doctor-patient “communication” and “control” around the prescription drug. The language of being ‘good for both’ and not coming ‘at a cost for either’ once again points to a challenge of edgy ethics. Relationship marketers don’t want the presence of the pharmaceutical company to be experienced as an intrusion of the doctor-patient dyad, but rather experienced as something that appears to be generated by the patient’s and doctor’s own accord.

George explained that InfoMedics programs don’t just measure doctor-patient communications, but are designed to change them:

“Instead of just accepting what the doctor says, [the patients] are asking more questions. It [the InfoMedics packet] prompts them to talk more, and this communication has been lacking because they’re spending less and less time with their doctors. [Our programs focus on] behavior, not just symptoms—the old model of the doctor sitting with patients, really getting to know their patients and their lifestyle. The trend has been for them to talk less; we’re trying to get them to talk more. Unfortunately there are so many doctors and patients out there, until we become part of what people do. Hopefully soon there’ll be a line item for us [in pharmaceutical company budgets], whether we call it Patient Communications ... whether it’s more accepted by the pharma world.”

In a managed-care environment that shrinks the length of the average doctor visit to a handful of minutes, marketing seeks to intensify doctor-patient communication by getting patients to “talk more.” And, as George explains, patients talking more means a kind of resistance and negotiation to expert knowledge (“instead of just accepting what the doctor says ...”), but also resistance and negotiation that takes the form of the patient explaining the role a pharmaceutical has in his or her life (“not just symptoms”). It is negotiated expression and co-production of self-knowledge in the pharmaceutical relationship.

Prompted by the InfoMedics literature that I had picked up at the DTC conference, I asked George about the role of the pharmaceutical brand in this changing doctor-patient relationship. He responded by claiming that doctors are often in denial over the brand-driven nature of the relationships that their patients might have with their medications: “What we’ve found is that physician behavior is – and they’ll never admit this – the one thing is that the pharma companies want to get brand loyalty out of these patients. If patients feel better, they don’t want to switch medications. Once they’re happy with some result, they won’t want to change.” George explained that part of the logic of the ‘Brand Accelerator’ program was to provide patients with the chance to request that they stay on a particular medication (and resist, say, being switched to a competitor brand or a generic—precisely the worry that AstraZeneca had for switching users from Prilosec to Nexium). He said that such “improved communication between doctors and patients” could actually help resolve the patent issues that the industry is so worried about, claiming that, “because of the communication [patients] are more inclined to ask their doctor ‘Can I stay on Paxil?’ which will help retain some of their market share.” The evolving role of pharmaceutical marketing is thus one of solving mass marketing problems by developing and directing the brand at the level of the doctor-patient relationship. There is ethics at work here, too: marketers give an edge to certain ethics (like patient comfort and identity) over others (like cost and efficacy).

George said that, in a market environment where branded pharmaceuticals are constantly fighting off generic erosion he sometimes “gets a little sympathetic with the brand manager.” He reflected:

“How do you stay active in a market, and get back all your R&D expenditures? Especially with the generic thing, that’s something pharma companies face all the time, spending insane dollars on developing these things. I mean the generics are good – they get drugs to people who can’t afford them, but from a business perspective you can see how it’s frustrating.”

George then compared the branded battles with generics to how major record companies have suffered in the wake of Internet file sharing. George sees InfoMedics as representative of a new mode of interaction between patients, doctors and pharmaceutical companies, and he will himself toggle back and forth among those viewpoints.

Sometimes he would emphasize how InfoMedics privileges the doctor’s authority; other times he would emphasize how doctors were either stubborn or blind to the increasingly central role of the pharmaceutical brand in sustaining the doctor-patient relationship.

Sometimes George pointed out how the InfoMedics program would increase the number of drug samples that doctors could distribute, which would benefit those patients with little or no medical insurance; other times he would sympathize with a pharmaceutical brand manager who faced enormous pressure to get the highest possible return on investment by staving off generic competition (yet generics also greatly benefit patients with little or no insurance). These different viewpoints are not contradictions, not at all – rather, together they illustrate the competing discourses and various social relationships around the contemporary doctor-patient relationship, and how the pharmaceutical is becoming a part of that relationship in complex ways. The marketer is constantly evolving his or her ability to leverage these relationships; and his or her identity can flicker in the meantime.

## Just capitalism

On the one hand, the pharmaceutical industry communicates to Wall Street exuberant messages of promise and innovation; on the other hand, the industry communicates to Capitol Hill conservative messages of control and regulation. Edgy ethics are defined by precisely this tension between providing health care and making profit. The following table sketches the Janus face of pharmaceutical public relations (PR).

**To Wall Street (We Have Full Agency):**    **To Capitol Hill (We Have Little Agency):**

We'll make you a huge return-on-investment	Our profit margins aren't much different from those of other industries
Our R&D is "innovative" and "cutting edge"	Our R&D is not in our control; it's in the control of government regulation
"Investing in the future"	Save us from ourselves (nobody will jump first)
We must "educate" consumers about their needs	We're just trying to meet consumer needs

Towing the line is tricky. Ehrlich's conference address was peppered with references to a growing number of popular books that had attacked the pharmaceutical industry for widespread and systematic deception at all levels of drug production—from the clinical trial to DTC advertising. It is in the face of intense and sustained criticism against the industry that drug marketers have had to carve out their own ethics. In one sense, 'edgy ethics' stays close to François La Rochefoucauld's darkly cynical maxim, "We try to make virtues out of the faults we have no wish to correct." On the other hand, it is rare to hear pharmaceutical marketers acknowledge or hint at any ill will on the part

of drug companies. Instead, marketers often wonder and lament how their work came to be so complicated and misunderstood. Roger Louis, the Chief Compliance Officer for Genzyme, recently asked:

“Can I stick up for the pharmaceutical industry for a second? One of the reasons we’re all sitting here [at a panel addressing ethics in the pharmaceutical industry] is because there’s been a lot of bad press. In my experience, people are attracted to this industry not just because they can make money; it’s about trying to do things for patients. Part of me gets annoyed at the bashing going on, because there are a lot of good people who generally want to do the right thing.”<sup>86</sup>

Ethics are not simply external cultural ideals that pharmaceutical marketers (mis)appropriate for themselves to reflect back a positive image as PR; ethics also constitute how marketers frame and negotiate their own work in the context of a highly contentious—often vilified—business.<sup>87</sup> In the quote above, Louis uses the language of defending *for a second*, becoming involved in the pharmaceutical industry *not just because*, and *part of me* getting annoyed: I argue that these are discursive microcosms of edgy ethics. But such part-of-me split consciousness is not just the schizophrenic voice of the marketer; rather, it invokes a tension that is constitutive of a broader social consciousness and ethical engagement with pharmaceutical marketing.

I also attended the 2004 Pharmaceutical Marketing Conference in Philadelphia, where Congressman Henry Waxman criticized the industry for spending such a large portion of its overall budget on marketing, which he claimed was hampering the

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<sup>86</sup> Quoted in Nicholas Capaldi, Kevin Soden, Patrick Clinton, Joseph Cohen and Raul Perea-Henze, "The Ethics of Pharma," *Pharmaceutical Executive* 24.12 (2004).

<sup>87</sup> See Emily Martin's recent ethnographic work with former pharmaceutical representatives: E. Martin, "Pharmaceutical Virtue," *Cult Med Psychiatry* 30.2 (2006).



development of truly new medicines. At one point during Waxman's speech, a market researcher sitting next to me leaned over and whispered to me, "It's just capitalism!"

On the one hand, "just capitalism" signals a Marxian truth about capital, namely that its relentlessness is part of its logic, which inherently happens 'of its own accord,' as it were—it's not tethered to human psychology or emotions. On the other hand, the exasperated "it's just capitalism!" is a thoroughly human response. Indeed, the automatic and reflexive nature of this marketer's response would suggest that, for her, the competition that Waxman criticizes is simply natural.<sup>88</sup> Moreover, her response is an *ethical* response: "Just capitalism" offers a way to separate what is inherent and inexorable from what is incidental and contingent. Indeed, the marketer's reaction to Congressman Waxman's industry critique didn't take the form of *he's flat out wrong*; it took the form of *this is just how it works—everybody knows that ... he's going after the wrong thing*.

A 2002 *DTC Perspectives* editorial entitled, "Unfair Media Can Harm Patients"<sup>89</sup> similarly complained:

"The idea that evil drug makers are passing off dangerous drugs for profit is appealing to the media looking for good vs. evil stories. The corporate villain plays well. How many Hollywood movies are based on the evil corporation gone mad for more profit? The reality is quite different. Of course drug makers want profit. And they want to market drugs with maximum claims on efficacy. But what ongoing business concern wants to have a tarnished reputation and billions of dollars of class action suits? Do bad drugs get to market? Yes, but I doubt it is because of a malicious intent or outright greed."

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<sup>88</sup> Sunder-Rajan (2003) has similarly written about how the commodification of the biosciences (specifically the market logic of 'speed' and high-throughput) can be internalized/rationalized as 'natural,' and therefore that such rhetorical invocations must be understood as cultural transformations that occur at the intersection of science and business. Sunder-Rajan writes: "In other words, the *apparent* naturalization of complete commodification as the condition for scientific innovation masks the fact that commodification is selected and contested, subject to conflicting interests and ethical representations" (p. 97). Kaushik Sunder-Rajan, "Genomic Capital : Public Cultures and Market Logics of Corporate Biotechnology," *Science as Culture* 12.1 (2003).

<sup>89</sup> March-April 2002, p. 40

This complaint is typical. Industry representatives respond to criticism by appealing to their own sense of serving the public good.<sup>90</sup> In one sense, the opposition of individual intent to institutional outcome is rather Freudian: The reaction of ‘how dare you accuse us of *meaning* for that to happen?’ is form of disavowed intention. Freud argued that the accident is the only possible way for a taboo or otherwise threatening desire to be expressed. It is not as simple as that we ‘really’ desire to injure someone who is the victim of our accident; rather that there are underlying psychological impetuses that resist being contained by conscious life. The same goes for a Freudian analysis of industry scandal: of course nobody really wants or intended for the accident to happen, but it reveals an underlying structure of relentless capital that occasionally reveals itself as a violation of another person, which subsequently must be defended and disavowed. Just like desire is often antithetical to the ego’s restrictions, capital is antithetical to regulation and good intentions.

Pharmaceutical executives downplay scandals by noting that they are singular events, but not necessarily systematic fallout from the capitalistic drives of the pharmaceutical industry. Of course, scandals can be transformed into political opportunities to demonstrate reform; the scandal is the exception that proves the rule. For example, the case the banning of pharmaceutical company gifts to doctors can paradoxically have the effect of securing the industry’s position in our lives, precisely by

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<sup>90</sup> This occurs in bestselling patient testimonials, too. Perhaps most prominently, in his 2001 National Book Prize-winning *The Noonday Demon*, Andrew Solomon writes, “It is fashionable at the moment to excoriate the pharmaceutical industry as one that takes advantage of the sick. My experience has been that the people in the industry are both capitalists and idealists – people keen on profit but also optimistic that their work may benefit the world, that they may enable important discoveries that will put specific illnesses into obsolescence. We would not have the selective serotonin reuptake inhibitors (SSRIs), antidepressants that have saved so many lives, without the companies that sponsored the research” (p. 13). Andrew Solomon, *The Noonday Demon : An Atlas of Depression* (New York: Scribner, 2001).

creating the appearance of that it is always responding quickly and definitively to seemingly isolated scandals—i.e. creating the appearance that it is being reformed.

Ever since the Vioxx and Paxil scandals, marketers have expressed an ethical ambivalence towards pharmaceutical companies—one that has demanded that marketers carve out their own ethical relationship with the FDA. One 2006 article in *Pharmaceutical Executive* urged marketing agencies to devise their own “internal credo ... to maintain a culture of compliance.”<sup>91</sup> The article explained that, especially in a tighter regulatory environment, the stakes were higher than ever for pharmaceutical companies and marketing agencies alike. Moreover, marketing agencies could no longer be entirely reliant on their pharmaceutical client’s own internal regulatory reviews. (The article specifically mentioned that in 2005 the FDA had issued to pharmaceutical companies more warning letters about DTC than ever before.)

At the same time, the article encouraged that such newly self-imposed regulatory scrutiny on the part of marketing agencies could only be to their favor. Edgy ethics, indeed: “regulatory savvy may well be an agency’s greatest competitive advantage.” Whereas marketers used to respond to public scrutiny by deferring to pharmaceutical companies, now they are inverting that relationship by developing their own ethical expertise with the FDA. They expect that pharmaceutical companies will in turn defer to the marketing agency on questions of marketing messages.

Shifts toward such regulatory savvy could be seen as early as 2002 when, in response to widespread public criticism about pharmaceutical gifting practices, the main industry trade group Pharmaceutical Research and Manufacturers of America (PhRMA)

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<sup>91</sup> Pines, W.L. & I. Levins (2006). The new competitive edge: Agency best practice in regulatory compliance. *Pharmaceutical Executive*. 26(2):14-20.

declared a voluntary ban on making certain enticements to doctors, including free lavish vacation trips. The new code distinguished between luxurious gifts that are for the private benefit of doctors, and practical, *ethical* gifts with “medical relevance,” whose ultimate end goal is patient benefit. One example of the new ethical gift was the “SafeSeal”—a disposable antimicrobial diaphragm that fits over the end of a stethoscope, which is supposed to help reduce germ transfer between patients. The diaphragm is designed to feature a drug company logo—an opportunity to provide “a good branding opportunity and physician and patient benefits.”<sup>92</sup> This is a good example of edgy ethics. SafeSeal (and the myriad products like it) is still a gift whose ultimate *raison d’être* is to get doctors to prescribe more and more drugs of a specific brand, but it is a *gift of relevance and moderation*.

Edgy ethics is shaped by the duality between capitalist impulses and notions of acts of medical good will, and it provides the space to do boundary work between the two. Edgy ethics characterizes the cultural consciousness of the political economy of the pharmaceutical industry. Indeed, internally, the industry reacted to the Vioxx scandal not as a straightforward predicament with clear-cut solutions, but rather as a “*challenge*” for future pharmaceutical marketing. One industry source preached, “Now is the time for the industry to provide real and visible leadership in finding faster and more comprehensive ways to identify and manage the risk associated with its products.”<sup>93</sup> The vision is a way for scandals to *strengthen* the public’s reliance on the pharmaceutical industry for the identification and management of risk. This starts with the strategy of reframing massive

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<sup>92</sup> Scussa, Frank (2002). No more: fun & games; new marketing code outlines the way sales representatives should interact with physicians and may save time and money. *Med Ad News*, 21 (7).

<sup>93</sup> *Pharmaceutical Executive*, 24 (12): 122, December 2004

advertising and overprescription as industry success that has in turn caused people *to mislead themselves* about drug safety:

“People are indisputably enjoying longer, more productive lives thanks to pharmacotherapy. Such success has lulled many into believing that approved medications are risk-free. In reality, no drug is absolutely safe or without side effects.”

In a fascinating rhetorical slight, people’s own enjoyment of pharmaceuticals induces a kind of social narcosis, one that “lulls” them into false belief about drug safety. (“Lull” is such a provocative word here, since its definition is somewhere between “calm” and “tranquilize.”) For marketers, disease is a business model; a greater number of drug-takers provides evidence of good business, despite that it might be offset by growing risk.

Indeed, there is a deep irony (i.e. not just trivial, but structural) in the fact that the pharmaceutical industry, while in the business of producing health, has cultivated a kind of antagonism to the patient/consumer. A slide that has circulated in pharmacoepidemiology presentations presents two views of an adverse event:<sup>94</sup>

Physician: “This drug could be a real threat to the life of my patient!”

Manufacturer: “This patient could be a real threat to the life of my drug!”

The FDA has two adverse event<sup>95</sup> reporting systems—a voluntary one for consumers and health care professionals, and a mandatory one for drug manufacturers. Adverse events are extremely underreported in all cases; the FDA’s adverse event report system captures

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<sup>94</sup> Quoted in Jerry Avorn, Powerful Medicines : The Benefits, Risks, and Costs of Prescription Drugs, 1st ed. (New York: Knopf, 2004). (p. 111)

<sup>95</sup> The FDA defines an adverse event as “any adverse finding, temporarily associated with drug use” (<http://www.fda.gov/cder/present/raps10-2002/judyraacosin/sld012.htm>)

only ten percent of serious events.<sup>96</sup> The system of reporting adverse effects is defined by a strange calculus of risk, in which a drug company must decide life and death through ethics. In many ways the doctor is the locus and focus of these ethical negotiations: Drug companies must convince them that side-effects, for instance, are more inevitable than they are avoidable.<sup>97</sup>

### **Belief in 35 seconds**

“Pharmaceutical companies need to realize that consumers do not care about your internal research. They do not ask for your drug because it is well researched. They ask because something you said in the 35 seconds made them interested. That is the end goal ... Unfortunately, in the scientific world of drug companies, “I think” is not allowed. ‘I know, I proved’ is the language rewarded.”<sup>98</sup>

This quote comes from a 2002 *DTC Perspectives* article, written by Bob Ehrlich—the same person whose above comments at the DTC National conference inspired me to think of pharmaceutical marketing tactics in terms of edgy ethics. In this article Ehrlich warns that the DTC development process should not mirror the drug development process. He discourages pharmaceutical companies from carrying out preliminary “lengthy market research” (including focus groups and segmentation studies<sup>99</sup>), emphasizing that the creation of a marketing campaign—which is based on “intuition supported by data”—is not like a clinical trial—which is based on “science driven by

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<sup>96</sup> *Pharmaceutical Technology*, 29 (7): 26, July 2005

<sup>97</sup> Cf. Jay S. Cohen, *Over Dose : The Case against the Drug Companies : Prescription Drugs, Side Effects, and Your Health* (New York: Jeremy P Tarcher/Putnam, 2001).

<sup>98</sup> R. Ehrlich, “35 Seconds to Dtc Success,” *DTC Perspectives* (2002).

<sup>99</sup> Segmentation studies refers to how a product should be differently marketed to various market demographics.

data.” With the logic of ‘shoot first, ask questions later,’ Ehrlich advocates that pharmaceutical companies generate marketing messages from the gut, and create the advertising *before* conducting any substantial consumer research. He urges companies to “start with the philosophy that your drug has benefits that are already well defined by your clinical profile.” This call to ‘start with philosophy’ deserves our attention, since it is an invitation first to step back—*away from* “the scientific world of drug companies”—and fantasize the ideal drug, whose ideal effects can be captivatingly communicated to a consumer audience in 35 seconds.<sup>100</sup>

In 2003 I was a teaching assistant for an MIT class entitled, “Drugs, Culture, and Politics.” One of the readings was a *Harper’s Magazine* article from essayist Joshua Wolf Shenk (who would later write a book about Abraham Lincoln’s struggles with depression). One line from Shenk’s article stuck with me. He succinctly quipped, “pharmaceutical companies exude certainty.”<sup>101</sup> In my reviews of industry literature, I noticed that ‘exuding certainty’ is not only a marketing strategy for a consumer audience, but it is a planning strategy on the part of the marketers themselves. For instance, a recent article on building strong pharmaceutical brands expresses this in more pragmatic terms, noting that:

“The symptoms of poor brand planning are obvious to the experienced marketing manager: One is the discomfort shown by brand team members when asked to articulate in a single sentence the essence of their brand ... Externally, customers

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<sup>100</sup> Marketing groups advertising their own services in these terms: “Dare To Create. That’s what DTC should stand for. With an ever-expanding universe of commercial messages vying for customers’ attention (and the growing option for these customers to tune out), ‘lassoing’ them in the first few seconds has become more critical than ever.” (From a print ad for the Grey Healthcare Group: *DTC Perspectives*, 2(2), Spring 2003, p.75)

<sup>101</sup> Joshua Wolf Shenk, “America’s Altered States : When Does Legal Relief of Pain Become Illegal Pursuit of Pleasure?,” *Harper’s Magazine* 1999. (p. 42)

are left scratching their head as to what the brand represents and how it may fit into their practice or lives.”<sup>102</sup>

The idea here is that a brand has an “essence,” which translates to a quick, clear, and emotional message for marketers and consumers alike. Even for *producers* of drug marketing campaigns, the brand is supposed to be automatically and reflexively evocative. Indeed, marketing literature commonly frames the challenge of brand differentiation in terms of “breaking through the clutter of a crowded marketplace,” claiming that “the success of your entire campaign may stand or fall on what is said in the headline.”<sup>103</sup> Similarly, one industry article proposed “executive ‘gut check’ sessions” as a means to “encourage alignment between the brand plans and the executive vision for the brand.”<sup>104</sup> This has become typical of “brand-guided companies,” for whom branding is not thought of as separate activity from other company operations.<sup>105</sup>

There is a certain excited mode of writing that I’ve discovered in the pharmaceutical marketing literature, a kind of cheerleading exuberance that almost seems a throwback to the “carivalesque” origins of early twentieth-century elixir peddling.<sup>106</sup> For example, Kathy Erskine Jenkins (Chief Creative Officer of The Quantum Group) wrote that “[B]illions have been spent to research and test the proposition that the compound at hand – your brand – will somehow work harmoniously with and within the

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<sup>102</sup> Michael Rowe, Chris Franck and Peter Lang, “Blueprint for the Brand,” Medical Marketing & Media 41.2 (2006). (p. 60)

<sup>103</sup> Camille DeSantis, “Ad Edge: The Makings of a Great Ad,” Medical Marketing & Media 38.6 (2003). (p. 53)

<sup>104</sup> Rowe, Franck and Lang, “Blueprint for the Brand.” (p. 64)

<sup>105</sup> For instance, a 2005 press release from the marketing company Wolff-Olins (whose clients include General Electric and General Motors) urged that all company employees should “share a belief in the brand, as well as a common understanding of it,” and that employee activities should be “aligned with the brand values [and should] contribute to building and strengthening the brand”: [www.wolff-olins.com/files/Wolff\\_Olins\\_Booz\\_Allen\\_Hamilton\\_press\\_release.pdf](http://www.wolff-olins.com/files/Wolff_Olins_Booz_Allen_Hamilton_press_release.pdf) (dated January 12, 2005)

<sup>106</sup> Jackson Lears, Fables of Abundance : A Cultural History of Advertising in America (New York: Basic Books, 1994). (p. 98)



human body to improve its condition.”<sup>107</sup> In an interesting rhetorical slight, Jenkins here equates pharmacology and the brand—essentially equating signifier (the drug’s brand) with the signified (the drug compound). Jenkins continued: “This must be true or the drug never would have been approved by the FDA. After all, the FDA advocates for the consumer. Fair balance educates the consumer. Side effects show that the drug is biologically active. That means it’s working!”<sup>108</sup> Jenkins is teaching other marketers how to come under the conviction that a drug will work, on the one hand by using an argument of authority (because the drug was approved by the FDA who advocates for the consumer “*it must be true*” that it will work), and on the other hand by making the phenomenological argument that side effects—which are, of course, undesirable—can in fact be reframed as evidence that the drug “is biologically active.”<sup>109</sup> Whereas Rick Berard urged fellow marketers to “know the science,” Jenkins urges fellow marketers to *believe* in the science.

Indeed, Jenkins preached that, “healthcare is no place for cynics”:

“Once you have created your brand and all the communications and effects that surround it, step back and see if you believe it. Have you, in fact, made ‘eye contact’ with your audience? Have you created a truthful, responsive brand? Have you laid claim to the truly superior and differentiating characteristics of your beautiful baby? Have you pointed out its defects – like the best real estate agent – in order to earn people’s trust? Ultimately, have you created an experience so empathetic and motivating that sufferers will vault over fair balance and gird themselves for doctors’ visits so they can get to the person they want to be? Aided and abetted by your brand, positively reinforced by your messages and supported

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<sup>107</sup> 2002:16

<sup>108</sup> Ibid.

<sup>109</sup> Such interpretations of effects and side-effects connect with an important distinction between licit and illicit drugs that is a major historical development of drug regulation (which will be discussed more fully in Chapter 2).

for the long haul by your tireless attention and contact, are your customers ready for the relationship that will change their lives? In the end, you gotta believe!”<sup>110</sup>

There is a lot going on in this fascinating quote, but the glue is *the marketer’s own belief in the pharmaceutical brand*. Here Jenkins emphasizes that the best drug marketer will always be in the act of believing the DTC ad. There is something distinctly de Certeauian about this, insofar as belief is not “the object of believing (a dogma, a program, etc.),” but is more fundamentally “the subject’s investment in a proposition, the *act* of saying it and considering it as true—in other words, a ‘modality’ of the assertion and not its content.”<sup>111</sup> Indeed, it would seem that this is precisely the rhetorical force behind “you gotta believe!”—you *must* put yourself into a mode of believing. At the same time, here there is also the rhetorical force of ‘you *ought* to believe’—that is, an *ethical* position that the marketer posits as a negotiated relationship towards the pharmaceutical product.

Ehrlich’s “starting with philosophy” and Jenkins’ “gotta believe” help articulate the marketer’s relationship with the pharmaceutical. They are both part of edgy ethics, especially insofar as ‘belief in the product’ overlaps with belief in the social good of the pharmaceutical industry. At the 2002 DTC National conference, Ehrlich himself decried the growing number of popular books that vilified the pharmaceutical industry. He showed a slide entitled, “My Recent Reading for ‘Pleasure’ List,” which listed the following book titles: *The Drug Lords: America’s Pharmaceutical Cartel*; *Over Dose: A Case Against the Drug Companies*; *Dispensing With the Truth: The Victims, The Drug Companies*; and *Bitter Pill: Inside the Hazardous World of Legal Drugs*. At the bottom of the slide, Ehrlich asked, “Do we see a pattern here? The drug industry is positioned as

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<sup>110</sup> 2002:17

<sup>111</sup> Michel de Certeau, *The Practice of Everyday Life* (Berkeley: University of California Press, 1984). (p. 178)

a profit hungry, unfeeling industry sacrificing safety for profit.” Ehrlich said that drug marketers especially needed to heed this perceptions, arguing that DTC advertising was rapidly becoming a “scapegoat” for the pharmaceutical industry writ large, because “DTC is what people see of the pharmaceutical industry.” Ehrlich’s comments made it clear that DTC had quickly evolved a dual role: on the one hand to advertise specific drugs for specific companies, on the other hand to create good PR for the entire industry. During the remainder of his talk, Ehrlich didn’t present counter-evidence to the claims that the books on his ‘pleasure list’ had made; rather he emphasized that DTC must be careful to not to present drug companies as rampant capitalists, but rather as agents of public good. Within edgy ethics, *belief* answers the call: Paraphrasing another leading drug marketer, a recent *Med Ad News* article reported, “the industry is clearly trying to change its image from one of deception for the sake of profit to an industry whose best interests are aligned with the best interests of the public. He believes that the pharmaceutical companies are being forthright and honest.”<sup>112</sup>

Applbaum (1998) describes how marketers enroll themselves in their own work, engendering “idealism in the service of [their] pragmatism,” which typically requires “the oft-invoked ‘belief in the product’.”<sup>113</sup> And in her work interviewing former pharmaceutical representatives, Emily Martin has explored how ‘belief in the product’ is invoked as an ethical stance within the pharmaceutical gift economy. Martin notes how nearly every one of her interviewees “spent considerable time, without prompting, telling me what makes their work meaningful to them and why,” quoting one former rep who said, “You actually don’t feel like a salesman; you feel like you’re educating, you

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<sup>112</sup> “Dtc Takes a Back Seat,” *Med Ad News* 25.5 (2006).

<sup>113</sup> K. Applbaum, “Pharmaceutical Marketing and the Invention of the Medical Consumer,” *PLoS Med* 3.4 (2006). (p. 337)

know?”<sup>114</sup> Martin argued that such responses were part of a complicated self-imposed morality, one that had been cultivated by drug reps especially in response to public criticism of the pharmaceutical industry, including the use of reps to woo doctors with lavish gifts. I argue that these narratives can be reframed as part of edgy ethics, in which the idiom of belief is invoked and inhabited to preserve the relationship between providing medicine and making profit (a relationship that, as we’ve seen, has been criticized as an unsustainable contradiction).

Following de Certeau’s analysis of belief (which emphasizes the modality of an assertion, not its content), the American news parody magazine *The Onion* has given a critical twist on the ways in which pharmaceutical company employees can assert belief in their products.<sup>115</sup> One of its issues featured a mock article about the launching of a new antidepressant, but which was negatively publicized at a press conference by the company’s clinically depressed CEO. The article was entitled, “Pharmaceutical Company Says Its New Anti-Depressant Is ‘Worthless and Dumb’; ‘So’s Our Whole Stupid Company,’ Says CEO.”<sup>116</sup> The article reported the CEO to have despondently reflected on the new drug, called “Cyntrex”: “Cyntrex? Yeah, right. More like, Stupidtrex,” a

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<sup>114</sup> Martin, “Pharmaceutical Virtue.”

<sup>115</sup> I make use of jokes and parodies like this more than once throughout the dissertation. I think Freud got it right when he analyzed the joke as the art of expressing forbidden or taboo content in a socially acceptable way. Jokes about the pharmaceutical industry pervade American media. Jon Stewart’s *The Daily Show* and *The Onion* are two examples of ‘fake news’ media that are masterful in their ability to joke about the pharmaceutical industry. As psychoanalyst and author Matthew Erdeyli put it, “the art of the tendentious joke is to permit us momentarily to suspend some of our repressions toward the forbidden material and enjoy it” (Matthew Hugh Erdelyi, *Psychoanalysis: Freud’s Cognitive Psychology*, A Series of Books in Psychology (New York: W.H. Freeman, 1985). [p. 174]). In the past few years, fake news and its ironical mode of confrontation has become an increasingly important cultural formation of public discourse, perhaps as the inevitable outcome of deadly serious world events having to be dealt with by an American public consciousness that would be otherwise tongue-tied by its own political correctness. *The Daily Show* in particular does a brilliant job of toggling back and forth between Freud’s distinction of latent and manifest content, for instance by conducting ‘mock’ interviews with real public figures about real current events.

<sup>116</sup> April 9, 1997 | Issue 31•13

visibly downcast [CEO] told reporters. ‘More like, Another-Awful-Product-That-Will-Probably-Make-Us-All-Bankruptrex. More like, I suck’.” The article went on to quote a fictional CEO of the company that produces Prozac—Cyntrex’s biggest competitor—who was on the other hand positively manic about Prozac:

“We will emerge triumphant, for I am Margaret Curry, president of Stafford Labs! My power is as of 50 CEOs! My marketing savvy is as of a legion of PR firms! My tricyclic monooinhibitor is a boon unto the people and a beacon unto the nations! My new promotional campaign to enhance brand awareness and increase market saturation of Prozac shall be cloaked in radiant beams of persuasive glory!”

Here *The Onion* plays around with the idea that the promotion of an antidepressant would depend on whether its marketers were actively taking it or not. This parody plays with de Certeau’s distinction between the content and modality of an assertion, since here it is a case of belief-in-the-product being directly given by the drug itself.<sup>117</sup> The exuberance here, while parody, nonetheless helps to contextualize Jenkins’ own exclamation of “You gotta believe!” Indeed, the parody works as a thinly masked testimonial for the antidepressant. This parody is good to think with, since it draws out how an individual’s experience with a medication can also be a personal relationship to a pharmaceutical company.<sup>118</sup> In the case of Jenkins and Ehrlich, they encourage a kind of idealistic

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<sup>117</sup> This is not an entirely new mode of joking with respect to antidepressants. In 1993, the year that Peter Kramer’s *Listening to Prozac* was published, *The New Yorker* published a cartoon that depicted Karl Marx on Prozac, excitedly claiming, “Sure! Capitalism can work out its kinks!”

<sup>118</sup> There are a number of similar parodies that poke fun at relationships with pharmaceutical companies as actual effects of drugs themselves. Another one from *the Onion*, entitled, “Wonder Drug Inspires Deep, Unwavering Love of Pharmaceutical Companies,” reports on “PharmAmorin” a fictional prescription drug developed by Pfizer for the treatment of “chronic distrust of large prescription-drug manufacturers.” The article made direct references to DTC advertising, reporting that in the clinical trials for PharmAmorin, “out of a test group of 180, 172 study participants reported a dramatic rise in their passion for pharmaceutical companies ... and 167 asked their doctors about a variety of prescription medications they had seen on TV.” (March 6, 2006 | Issue 42•10)

relationship to drugs and clinical claims that accompany them, in order to convince consumers (and themselves) through advertising.

On the other hand, recall Tim Claffey, the writer and director of the DTC campaigns for Prozac and Sarafem, who expressed cynicism about the motives of the pharmaceutical industry while distancing and distinguishing his own creative work from the business process. Tim talked about how the companies would go “cherry picking and building businesses around these indications [like depression or premenstrual dysphoric disorder].” In one talk that Tim was invited to give for Harvard Medical School students,<sup>119</sup> he half-jokingly called himself “an agent of the devil,” emphasizing that agency creatives like himself “just have to do what they’re told” by the pharmaceutical companies. Another drug marketer on the same panel agreed with Tim, adding that, “when the pharmaceutical company is your client, and not your employer, you can afford to have a unique vantage point on the kind of duplicity [that is behind DTC advertising].” To this effect he claimed—in direct contradiction to the industry’s own defense of DTC as consumer education—that, “as someone in the business of creating advertising, our jobs are not to be educators.” Tim nodded, adding that, “I came into this with absolutely no qualifications. I just knew how to give these products a ‘consumer feel’.” Now, as Ehrlich and Vanderveer would have it, this is precisely what good agency creatives do.<sup>120</sup> On the other hand, the 1964 industry article quoted earlier in this chapter sought to protect marketers from FDA and public scrutiny precisely by putting clear-cut

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<sup>119</sup> March 2, 2003

<sup>120</sup> Cf. especially Vanderveer (2006): “The bottom line for pharmaceutical marketers is this: given the tendency of the market to perceive products within established categories as essentially therapeutic equivalents or ‘me too’s’ based on their clinical performance or labeling, one can create a sense of positive differentiation by creating a unique ‘feel’ or sense of relationship with a new product by creating a strong brand identity.”

authority—including the guidance of marketing messages—in the hands of pharmaceutical companies. Tim shows us one kind of ethical ambivalence that can come out of a tension between the two.

This section has shown how the various ethical relationships that marketers can have with pharmaceuticals are tied up with the extent to which they believe in the drugs themselves, and in the motives of the pharmaceutical companies who manufacture them. Ultimately, coming under the conviction that a drug is a good product requires the development of concise and compelling statements about a given drug. As the next section discusses, there is a growing industry around the development and dissemination of concise and compelling scientific statements about drugs that are still in development.

### **Drug development and the marketing of “solid science”**

At the 2002 DTC National I first learned about “Apothecom,” a healthcare communications company in eastern Massachusetts. Apothecom had a vendor booth at the conference, where I picked up some of their promotional literature. One pamphlet emphasized the company’s expertise in “solid science,” and it promised to “bring creative communication solutions to contemporary market challenges.” Soon after the conference I contacted Patricia Patrick, a research associate at Apothecom, who agreed to meet with me at their Salem, MA office.

Patricia discussed an evolving relationship between marketing and drug research and development (R & D), which she said historically were kept separate until a company

filed its New Drug Application (NDA) with the FDA. She explained that, as a whole, the pharmaceutical industry has undergone a shift away from the historical disconnect between the clinical research scientist who would design the clinical trial and the product manager who would subsequently decide how to market the drug. Patricia emphasized that marketing considerations now *precede* research considerations:

“But now, it’s really impractical—even fatal—to pursue drugs without markets, just for research purposes. And now we have very sophisticated marketing analyses to identify unmet medical needs. It’s *the marketers* who now say [to the researchers], ‘Can you design a drug to do *x*?’”

Patricia explained that so-called “unmet medical needs” were being defined at the level of clinical exploration, but that it was “the marriage of marketing and medicine that creates the opportunity to better define that illness.”

The notion of “unmet medical needs” is a pharmaceutical promise,<sup>121</sup> one that depends on preparing illness markets for capital investment, and identifying new illness demographics as “patients in waiting.”<sup>122</sup> Specifically, pharmaceutical marketing has been shaping “unmet medical needs” by launching advertising campaigns about new illness categories before launching advertising campaigns for specific drugs. Playing off of the language of “positioning a product,” one marketing expert called this phenomenon “positioning a condition.”<sup>123</sup> One example is the product timeline for Sarafem, which Tim Claffey had outlined for me. The FDA approved Sarafem in July 2000, and Lilly launched [pmdd.com](http://pmdd.com) and other premenstrual dysphoric disorder “patient education” campaigns (for instance on WebMD) immediately afterwards. In October 2000 Lilly began running unbranded television commercials (“help-seeking ads”) about PMDD,

<sup>121</sup> On the notion of ‘promising’ in genomics see Sunder-Rajan (2006) and M. Fortun (in press).

<sup>122</sup> Dumit (2004)

<sup>123</sup> Richard B. Vanderveer, “Position, Position, Position ...” *Pharmaceutical Executive* 25.8 (2005).



which ran for an entire month before Lilly began airing ads for Sarafem. The development of the drug preceded public awareness of the illness, which was carefully orchestrated over time by the drug's maker.<sup>124</sup>

Pharmaceutical companies have also started to create and promote brand names for clinical trials themselves, in order to create pre-launch brand name recognition for specific drugs, and to distinguish those drugs from competitors in the same drug class. As one 2004 *New York Times* article reported:

“[N]ow it seems the drug companies have extended their competition into the arena of study names. Pfizer recently tried to demonstrate that Lipitor was better at slowing the progress of coronary artery disease than Bristol-Myers Squibb's Pravachol, and named its study ‘Reversal,’ for Reversing Atherosclerosis with Aggressive Lipid Lowering. But Bristol-Myers struck back with its own comparative study, called ‘Prove It,’ which the company hoped would show Pravachol was just as good as Lipitor.”<sup>125</sup>

Clinical trials themselves have become arenas for marketing battles, which get played out publicly even before the FDA decides whether or not to approve the drugs.

Marketing not only directs which drugs a company will develop for which illnesses but, as Patricia put it, marketing can also “better define” those illnesses. Patricia said that part of this process involves “publications planning” – the integration of R & D science with “consistent communications” in medical literature. She emphasized that it was important to ‘firm up’ a product’s scientific profile for doctors, which would then help them better understand certain illnesses. To this end, Apothecom employs their own staff of scientific and medical writers who work with early drug development teams at

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<sup>124</sup> Historian of medicine Jeremy Greene similarly writes about Diuril (an antihypertensive drug): its marketing was crucial for the creation of the *idea* of hypertension, but many historians of medicine deny (or at least do not acknowledge) that the disease coincided with the drug, and they insist that its science and commercialization are separate. J. A. Greene, "Releasing the Flood Waters: Diuril and the Reshaping of Hypertension," *Bull Hist Med* 79.4 (2005).

<sup>125</sup> Gina Kolata, "My Drug Study Sounds Catchier Than Yours," *The New York Times* March 7 2004.

pharmaceutical companies to develop “clear and consistent” explanations of drug pharmacology. Early on in a drug’s development Apothecom also identifies so-called “key opinion leaders”—well-known and well-reputed physicians and clinical scientists who will publicly advocate for the drug, even before it is launched. This PR is an example of the “third-party strategy” of enlisting authoritative outside parties to disseminate positive and expert opinions that double as marketing messages.

Through “publications planning” and related PR strategies, pharmaceutical science translates immediately to marketing strategies about the togetherness of specific branded drugs and specific illnesses. In an interview with the industry magazine *R & D Directions*, Richard Breier (vice-president of Lilly pharmaceutical products and product team leader for the antipsychotic drug “Zyprexa”) offered an example of how marketing and medicine intersect to help define mental illnesses. Breier discussed the interactions of marketing and R & D as “future life-cycle planning,” explaining that,

“[F]or the Prozac-type drugs, there are conditions that probably share some common biological roots. Lilly might create a plan that would look first at depression, and if that’s successful and gets on the market, we might want to find some preliminary information to determine if it will be effective for social anxiety.”

He continued, “*At Lilly*, bipolar and schizophrenia share an awful lot in common. They are not worlds apart in terms of symptomatology and types of patients. In fact, there are some people who think they have a common root” (emphasis added). Breier essentially brands scientific notions about mental illness: The language is not ‘out there in Nature’ bipolar disorder and schizophrenia are related to each other; but rather that *at Lilly*,

bipolar disorder and schizophrenia are understood to be biologically related to each other. The pharmaceutical brand twists notions of scientific objectivity and authorial credit.<sup>126</sup>

Science that is specific to pharmaceutical companies does not only have epistemological ramifications for the relationship between illnesses (a topic that will be further addressed in Chapter 4). As the next section discusses, the very ownership of slight variations of preexisting chemical formulations has become a central factor in how branded drugs compete in contemporary pharmaceutical marketplaces.

### **Marketing and surplus health**

It is much cheaper for pharmaceutical companies to develop drugs that compete with other drugs of the same class, rather than to develop innovative medications.<sup>127</sup> So-called “me-too drugs” are often slight chemical variations of other drugs that pharmaceutical companies have already developed. One consequence of within-class drug competition is that drug companies will often target chronic conditions in DTC advertising, like depression, high cholesterol, hypertension, arthritis, or allergies. These illness markets are the largest, and the easiest to maximize because they consist of the ideal health consumer—the one who balances being the most ill and living the longest. Following Marx’s analysis of capitalist exploitation of surplus labor, Joe Dumit has analyzed how it precisely this kind of consumer who is exploited for his “surplus health.” Chronic conditions are often defined in terms of clusters of symptoms (like depression

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<sup>126</sup> See also Mario Biagioli, “Aporias of Scientific Authorship : Credit and Responsibility in Contemporary Biomedicine,” *The Science Studies Reader*, ed. Mario Biagioli (New York: Routledge, 1999).

<sup>127</sup> Examples of drug classes with heavy DTC include statins like Lipitor and Zocor, SSRI antidepressants like Zoloft and Wellbutrin, and COX-2 inhibitors like Vioxx and Celebrex.

and allergies) or in terms of continuous variables (like blood pressure or cholesterol measurements). These are metrics that do not correspond cleanly to well-defined underlying biological processes, but whose slight adjustments can change the criteria for what counts as disease (sliding the threshold)—which in turn can grow an illness market.<sup>128</sup>

Changing the threshold for illness is one mechanism to extract surplus health. But in the pharmaceutical marketplace that is dominated by numerous drugs in the same classes that can't compete in terms of comparative therapeutic advantage, *brand loyalty* is another mechanism to extract surplus health. If demand is the underlying social mechanism of surplus health, then desire is its psychological one.<sup>129</sup>

To get a drug to market, a pharmaceutical company must demonstrate that its new drug is more efficacious than a placebo; the company does not have to demonstrate that its new product is more efficacious than a drug of the same class already on the market. The burden of success for these so-called “me-too drugs” thus often falls to marketing, whose job often is to make the ‘essentially indistinguishable’ ‘inessentially distinguishable.’ Marketing has a particularly important role in the case of chronic conditions, since a drug’s efficacy can be affected by patient “compliance”—i.e. whether and how long a patient remains on a drug. This is not a problem of product claim, since drug companies are actually not allowed to advertise comparative claims of efficacy (for the same reason that their clinical efficacy is determined in relation to placebo—not

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<sup>128</sup> A key example is Pfizer’s ‘health education’ campaign for Lipitor, which urged doctors and patients alike to rethink the ideal blood cholesterol measurement as 100—not the standard 130.

<sup>129</sup> For Baudrillard, consumption is never really about some intrinsic satisfaction of needs, but rather about generating social difference: “Consumer behavior responds to ... the metaphoric or displaced expression of desire, and the production of a code of social values through the use of differentiating signs” Jean Baudrillard and Mark Poster, *Selected Writings* (Stanford, Calif.: Stanford University Press, 1988). (p. 46).

competitors—in the first place). Rather, marketers understand this to be a problem of *perception*: A patient stops taking a drug, and *it looks to the doctor* like the drug is inherently inefficacious. (As one marketer put it, “Poor drug efficacy may result from patient non-compliance, *frequently undetected by the physician*, and may lead the provider to switch the patient to another medication or to question the drug’s effectiveness, contributing further to lost sales.”<sup>130</sup>) In the age of DTC, patient compliance has become a problem of brand loyalty. Along the way, the pharmaceutical brand has become an important social mechanism for the creation and extraction of surplus health.

One example is the case of the me-too drugs Prilosec and Nexium. In 2001, just as AstraZeneca’s blockbuster prescription heartburn drug Prilosec<sup>131</sup> was about to go off-patent and be sold in a (much less costly) over-the-counter (OTC) version, the company launched a large DTC campaign for another drug of the same class, called Nexium. Nexium was chemically ‘different enough’ from Prilosec to warrant its own patent, which AstraZeneca saw as a way to protect itself against the imminent generic versions of its bestseller Prilosec. The marketing for Nexium piggybacked directly on the Prilosec campaign (e.g. one slogan went, “Today’s purple pill is Nexium, from the makers of Prilosec”), with the goal of smoothly and seamlessly transferring consumers from one drug to the other—despite that “Prilosec OTC” became available at the same time at a greatly reduced cost. The marketing—among the heaviest for any drug advertised DTC—worked: since its launch in 2001, Nexium has been AstraZeneca’s bestselling

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<sup>130</sup> Lynn Benzing, Director of the Patient Marketing Group. From a *DTC Perspectives* article: <http://www.dtcperspectives.com/content.asp?id=165> (emphasis added)

<sup>131</sup> As of 2000, the most-prescribed drug in the world, with sales of \$6 billion (Source: TMS Health)

drug.<sup>132</sup> I suggest that the Prilosec-Nexium switch offers a complementary case of the extraction of surplus health, one whose core mechanism is *brand differentiation*. The capitalist mechanism here is *intensive* rather than *extensive*: That is, rather than growing the heartburn market by resetting the threshold for determining its symptoms, AstraZeneca maintains and intensifies it by keeping the prices for heartburn medication artificially high.

The success of Nexium has since been met with lawsuits brought on by consumer advocacy groups in 2004 and 2005, who claimed that Nexium was a mere me-too drug that had been misleadingly advertised as a genuine medical improvement over other, much cheaper heartburn drugs, including Prilosec OTC. The broader claims of the Nexium lawsuit was that AstraZeneca was driving up drug prices and creating “false” consumer demand. The specific target of the lawsuit was that, through its DTC, AstraZeneca was making the false advertising claim that Nexium was clinically superior to Prilosec. Indeed, part of the marketing strategy for Nexium was to advertise that it was in fact *a better* drug than its predecessor. To this end, in addition to the placebo trials, AstraZeneca performed head-to-head clinical trials that directly compared the two drugs. When the drugs were compared at the same doses, no reliable difference between them was found. But when 40 milligrams of Nexium were compared with 20 milligrams of Prilosec, then there was evidence of slight clinical superiority. The fact that these results were dosage-dependent did not make it into the DTC advertising, however, which simply claimed that Nexium was “clinically superior” to Prilosec.

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<sup>132</sup> In 2001 Nexium generated sales of nearly \$600 million, which was nearly tripled in 2002 (Advertising Age, 74 (46): S17, November 17, 2003)

An AstraZeneca representative defended Nexium by claiming that the lawsuit's accusations that its marketing was deceptive were "simply not supported by the facts":

"With respect to the advertising, from the time of launch to the present day we've advertised Nexium based on the strength of the data we have, [and] all the statements we've made and continue to make about Nexium are supported by the data."<sup>133</sup>

Since the FDA did not mandate that AstraZeneca include the dosage details in their marketing for Nexium, the advertising claims of clinical superiority are indeed "supported by the data." But the Prescription Access Litigation Project (PAL – the advocacy group who initiated the class action lawsuits against AstraZeneca) contends such a literalist mode of truth-telling to defend Nexium. PAL alleges that the pharmaceutical company acted fraudulently, "despite knowing that Nexium offered no meaningful advantage over Prilosec,"<sup>134</sup> But the AstraZeneca representatives claim that it is a question of data, not intent. A social and legal debate over the use of DTC to encourage people to take branded drugs quickly became a fight about the use of clinical science to produce and substantiate marketing claims. Again we see the ethical plateau of branded pharmaceuticals: The pharmaceutical brand becomes a site where science is decided, and where it persuades.

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<sup>133</sup> Quoted in a *New York Times* article, October 19, 2004: "Taking aim at ads for the purple pill, a lawsuit says the selling of Nexium is costing society billions"

<sup>134</sup> [http://www.prescriptionaccess.org/index.php?doc\\_id=592](http://www.prescriptionaccess.org/index.php?doc_id=592)

## Scientific deference and emotional information

Pharmaceuticals were originally called “ethical drugs”—i.e. the drugs were ‘ethical’ only if they were advertised to physicians and pharmacists, not the public. (Indeed, once upon a time the notion of ethical drugs being marketed directly to the public would have been considered oxymoronic.) ‘Ethical drugs’ was a social negotiation between doctors and nascent pharmaceutical companies, both of whom were struggling to establish their own legitimacy in contradistinction to traveling salesmen and ‘quacks.’<sup>135</sup>

One article on medical advertising published in the mid-1960s gave distinctly psychoanalytic readings of the relationship between the pharmaceutical salesman and the physician. The article speaks to a kind of identity crisis for the drug marketer, who again must triangulate to preserve the doctor’s formidable cultural authority while exerting influence over him as a salesman:

“As anything that looks extremely complex, the role of advertising, too, can be reduced to a clear and simple definition: it is the effective communication of information designed to encourage the purchase of merchandise. ¶ The reason why some pharmaceutical advertising does not look at all as if it would fit this definition is not so much a matter of poor technique *per se*. Rather, it reflects an *emotional denial of the definition itself*. Some practitioners of advertising feel a need to identify with the medical profession rather than with an industry; they revolt at the fact of being, in fact, salesmen. Some others may have outright guilt feelings: they hero worship the physician as a ‘man of science’ who should be protected from commercial interference, not be subjected to it. These conscious and unconscious feelings naturally lead to distortion of the true purpose of the task.”<sup>136</sup>

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<sup>135</sup> Greene, “Releasing the Flood Waters: Diuril and the Reshaping of Hypertension.”, Philip J. Hilts, Protecting America’s Health : The Fda, Business, and One Hundred Years of Regulation (New York: Alfred A. Knopf, 2003), Jonathan Liebenau, Medical Science and Medical Industry : The Formation of the American Pharmaceutical Industry (Baltimore: Johns Hopkins University Press, 1987).

<sup>136</sup> E.F. Linder, “Medical Advertising--Its Role, Ethics, and Concepts,” New York State Journal of Medicine 64 (1964). [emphasis added]



Here, it is the conflicted identity of the medical advertiser that gets in the way of pharmaceutical capitalism. “In fact salesmen” is the real self of the advertiser that is denied, and it is this denial—an *emotional* denial—that makes medical advertising ineffective as a means to sell more drugs. It is almost a kind of Stockholm Syndrome: the advertiser’s (mis)identification with the doctor alienates him from the reality of his true relationship to the doctor, and thus blinds him from seeing the doctor agonistically as a potential sale, not as a hero.

Forty years later, in a debate at the 2003 DTC National, Ralph Nader criticized how pharmaceutical companies market drugs to physicians. He quipped: “There’s no secret to what some here have been saying. Drugs are promoted emotionally. Your ad agencies make no bones about that. They’re not promoted to the doctors as if they are members of a scientific profession.” It would seem that, historically, the ‘emotional denial’ of the 1960s medical advertiser has been projected right back at the doctor as a form of emotional information that foils the “man of science.” Indeed, as one marketer recently put it, “Disseminating accurate scientific information is not enough; you also need to translate it in deference to your audience.”<sup>137,138</sup>

Nader’s critique of pharmaceutical advertising opposes science and emotion, which constitutes an ethical boundary: Advertising emotionally is unethical—it means going past science.

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<sup>137</sup> Carole Post, “What’s Keeping Your Audience Up?,” *Medical Marketing & Media* 39.8 (2004). (p. 53)

<sup>138</sup> One recent pharmaceutical marketing article went so far as to advocate “limbic market research”—a way to psychologically profile physicians to determine the emotional substrate behind their prescription decisions: “Knowing each respondent’s profile enables us to interpret their responses more meaningfully, provides new ways of segmenting markets, and tells us how to communicate with target audiences in a way that will connect with them emotionally”: John Mack, “Limbic Market Research : Plumbing the Subconscious Motivators of Physicians,” *Pharma Marketing News* 4.6 (2005). (p. 9)

The pharmaceutical industry has persistently countered criticism of DTC by arguing that it functions as an “educational campaign” about various illnesses and their treatments—one that democratizes healthcare by “empowering consumers” to interact more equitably with their doctors. There is a burgeoning history of advertising in public health initiatives, most notably Nancy Tomes’ work on “selling health” and the crucial role of advertising campaigns in public hygiene. Tomes argues that advertising helped to invent the culture of civic duty within public health initiatives; health became a civic duty.<sup>139</sup> Indeed, contemporary pharmaceutical advertising has inherited this legacy, and efforts to capture market share blur with efforts to generate a public health initiative (which is precisely the language that the pharmaceutical industry has adopted to justify and defend DTC).<sup>140</sup>

Pharmaceutical marketers rarely speak of selling drugs; rather, they talk about conveying health information. In a panel discussion at the 2003 DTC National, it was even suggested that the label “direct-to-consumer advertising” be changed to “health information for consumers”—a key example of an ideological shift in which the very hint of commodity advertising is removed. Another marketer at the 2004 Pharmaceutical Marketing Congress claimed outright, “We don’t sell drugs; we sell information on how to use them.”<sup>141</sup>

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<sup>139</sup> Nancy Tomes, *The Gospel of Germs : Men, Women, and the Microbe in American Life* (Cambridge, Mass.: Harvard University Press, 1998).

<sup>140</sup> For a history of the shaping of ‘detail men,’ especially their professional alignment with doctors as ‘educators,’ not peddlers, see also J. A. Greene, “Attention to ‘Details’: Etiquette and the Pharmaceutical Salesman in Postwar American,” *Soc Stud Sci* 34.2 (2004).

<sup>141</sup> Stan Bernard, quoted at the 2004 PMC (Philadelphia)

At the same time, however, marketers are quick to decry the ‘mere’ presentation of healthcare information as “advertising noise.”<sup>142</sup> While drug marketers describe their work as conveying health care information, they simultaneously worry about distinguishing their drug from others in the pharmaceutical marketplace. Indeed, in a contemporary consumer society, the goal of advertising is to *distinguish* a product—that is, to impart a unique identity to a product that is essentially the same as its competitors.<sup>143</sup> The problem is not one of creating demand (which, as Arjun Appadurai points out, is more of a “mechanical response to social manipulation”<sup>144</sup>)—rather, it’s a problem of creating *desire*.

One marketer at the 2004 DTC National began his presentation with the following slide: “If you are going to educate, *talk to me with emotion*.”<sup>145</sup> This appeal to emotion is part of a collection of marketing claims about the evolution of the relationship between “health information” and consumer engagement. For instance: “[A]lthough [healthcare] data is mandatory in a detail, there is a more complex and sophisticated approach required to engage consumers. To build a substantial bond between brand and consumer we need to engage that consumer on an emotional level.”<sup>146</sup> In DTC advertising ‘mere’ facts about illness are not enough; in order for consumers to act on healthcare ‘information,’ it is necessary that they be emotionally invested in a pharmaceutical brand. Indeed, ‘educating with emotion’ means bonding with the brand. Drug marketing has come to depend on this division between emotional messaging and

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<sup>142</sup> E.g. Steven Seget, Pharmaceutical Branding Strategies: Thought Leader Perspectives on Brand Building, Effective Communication and Future Brand Models (Business Insights Ltd., 2006).

<sup>143</sup> Jean Baudrillard, The System of Objects (London ; New York: Verso, 1996), Arvidsson, Brands : Meaning and Value in Media Culture.

<sup>144</sup> Arjun Appadurai, The Social Life of Things: Commodities in Cultural Perspective. (Cambridge: Cambridge University Press, 1988). (p. 29)

<sup>145</sup> Lee Weinblatt, CEO of the marketing company PreTesting. (Emphasis in original.)

<sup>146</sup> Rogers, "Dtc Creative: An Emerging Sophistication?." (p. 74)

information/education. Drug marketers separate them, and claim that DTC does both (i.e. educate and create emotional bonds with brands).

### Storied science

In the age of managed health care and DTC advertising, marketing literature commonly describes branded competition in the pharmaceutical market with modifiers like “hyper” and “fierce” and “harsh.” Brand positioning is similarly described as needing to be “strategic” and “defensive.” Scientific fact has its own unique circulation in this marketing environment. This section explores how marketers have evolved their own methods of presenting science to doctors, with ramifications for how patients come to understand illness.

One marketer sets up the challenge of drug marketing in terms of whether a doctor’s professionalism and technical expertise make him or her immune to perception management:

“So, do the observations of [marketing gurus] Trout & Ries [i.e. that ‘perception is reality’] hold firm in pharmaceuticals? After all, your doctor is the same person who decides on your medication and then decides on which car, washing powder or beer to buy.”<sup>147</sup>

The marketer answers himself by making the question rhetorical: *Of course* doctors have perceptions that can be manipulated. At the same time, the question persists in its very asking, and the underlying anxiety reveals itself: Doctors *are* unique consumers;

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<sup>147</sup> The full quote from Trout & Ries is “Perception is reality ... there is no objective reality. There are no facts. There are no best products ... all that exists in the world of marketing are perceptions in the minds of our customers ... the perception is the reality.” From Michael Paling, “The Role of Advertising in Branding Pharmaceuticals,” *Brand Medicine : The Role of Branding in the Pharmaceutical Industry*, eds. Tom Blackett and Rebecca Robins (New York: Palgrave, 2001). (p. 119)

pharmaceuticals *are* unique commodities. Both must be managed in the context of medical authority and scientific expertise.

Richard Vanderveer is a consumer psychologist who specializes in pharmaceutical product positioning. His work is widely cited in drug marketing literature, where he has been celebrated as a “doctor of persuasion.”<sup>148</sup> His writing represents contemporary changes in pharmaceutical marketing strategies, and it has provided me with evocative material to analyze and theorize the social and epistemological configurations that such marketing has brought about the doctor-patient relationship.

Vanderveer proposes “message engineering” as a concrete strategy of doctor persuasion in a marketing environment of “hyper-competition.” Rather than “simple messages,” like branded sound bytes (e.g. Nike’s “Just Do It”), engineered messages are ways to *storyboard* a brand’s positioning statement. Message engineering is based on cognitive psychology theories of memory and recall, which claim that people most readily retain information when it’s presented as some sort of narrative. Thus, Vanderveer argues, the optimal way to persuade is to turn facts into a story. He gives the following example, in which a typical positioning statement for a drug gets reengineered as a story about that drug:<sup>149</sup>

THE TYPICAL ‘POSITIONING’ STATEMENT

“Unmatched in its class, Cizplam provides effective pain relief, safely and without side effects. Cizplam really is the pain reliever that works.”

THE ‘ENGINEERED MESSAGE’ FOR POSITIONING CIZPLAM

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<sup>148</sup> *Medical Marketing & Media*, July 2004, 39(4):32

<sup>149</sup> From Richard B. Vanderveer and Noah M. Pines, “A Marketer’s Cure for Attention Deficit Disorder,” *Medical Marketing & Media* 38.5 (2003).

“Effective on pain and fast-acting, Cizplam, because of its unique mechanism of action, can also treat headaches, is easy on the stomach, beneficial to physical functioning, and does not result in any increase in cancer or cardiovascular risk.”

Vanderveer notes that, in this ‘story,’ the drug mechanism of action functions as the primary “reason to believe.” In message engineering, “credibility is preserved through the reasons to believe, which validate the benefits and proactively address the physician’s concerns or doubts.”<sup>150</sup> In marketing, scientific facts and clinical data do not speak ‘on their own,’ as it were; they must be told as stories.

Marketers like Vanderveer propose to segment doctors based on their engagement with science—or their “desire to understand a product’s science.”<sup>151</sup> Specifically, marketers want to know which doctors are more likely to request clinical trial information from a drug company, and which might perform their own analyses and assessments of such results. Likewise, they want to know which doctors act more like “traditionalists”—doctors whose prescribing decisions are based on habit, and who are least likely to be familiar with the latest pharmacology. Vanderveer claims that “traditionalists” are most swayed by pharmaceutical promotion, and they are most likely to have adopted for themselves “terminology developed by pharma companies [to] describe diseases and medications.”<sup>152</sup>

Marketers are obviously concerned with optimizing their efforts by carving up their target segments in the right way, but at the same time these marketers are drawing out a theory about persuasion in American health care—one that puts scientific fact right in the center. Indeed, as the above cases suggest, drug marketers are active participants in

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<sup>150</sup> Ibid. (p. 67)

<sup>151</sup> J. Breitstein, “The Psychology of Physicians,” *Pharmaceutical Executive* 23.3 (2003).

<sup>152</sup> Op Cit.

the social construction of scientific fact, which is not ‘simply’ circulated, but which must be *storied*.<sup>153</sup>

On the one hand, message engineering and storied facts are part of the de Certeau frame of belief, in which the modality of the assertion trumps its content. On the other hand, storied facts are not always enough. Sometimes they need to be blended with feelings. Following his original proposals of message engineering, Vanderveer writes:

“With pharmaceuticals, unlike shampoos, cars, cereals, and so on, feelings are not typically the primary driver of a product’s positioning. In this highly regulated industry, facts form the backbone of a product’s story. But feelings ... often interpret and contextualize facts, and help shape a story for physicians, patients, and other stakeholders.”<sup>154</sup>

In her work studying rehabilitation therapy, Cheryl Mattingly (1998) describes how therapists<sup>155</sup> devise clinical stories and reshape their plots to make sense of patient experiences, and to plan patient treatments. Such “therapeutic emplotment,” as she calls it, is a form of interactive clinical reasoning in which the therapist and the patient co-construct healing narratives. Mattingly writes: “This ... involves understanding enough about the meaning of the disability from the patient’s perspective to develop a shared account of what ‘fixing’ the problem could amount to in their lives.”<sup>156</sup> I argue that the marketing of emotional, ‘storied facts’ to doctors is also a form of therapeutic

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<sup>153</sup> For broader historical context see also Lears (1994), who writes about how nineteenth-century U.S. patent medicine advertising, with all its deliberate language of “secret formulas,” incorporated an image of science as “mysterious,” and the scientist as “magus.” However, after the development of legislation that mandated drug labeling, scientific language became “an idiom for stabilizing the sorcery of the market, rather than for intensifying it” (p. 174). In medicinal advertising, “science” and “scientists” were invoked as seemingly independent of marketplace competition—as Lears puts it, “with science talking, rather than the advertiser.” Lears, *Fables of Abundance: A Cultural History of Advertising in America*.

<sup>154</sup> Vanderveer, “Position, Position, Position ...”

<sup>155</sup> Mattingly’s example is occupational therapists:

<sup>156</sup> Cheryl Mattingly, *Healing Dramas and Clinical Plots: The Narrative Structure of Experience* (Cambridge University Press, 1998). (p. 74)

employment. Just like ‘being a good nurse’ means being differently sensitive and receptive to patient’s own accounts of why they are ill and what getting better might look like, ‘being a good marketer’ means knowing how to differently leverage scientific facts to groups of doctors who have different modes of engaging with medical literature and providing scientific explanations to patients.

### **Science in the service of branded differentiation**

Freud referred to “the narcissism of small differences” to characterize the aggressive impulses that we might feel towards someone else who closely resembles ourselves. This notion applies to pharmaceutical brand differentiation, and to the *particularity* of individual relationships to drugs as brands. Clinical researchers refer to the phenomena of “the least patentable difference” and “me-too drugs” to characterize the practice of developing drugs that are chemically distinct enough to be granted separate patents, but which are not necessarily more efficacious than existing drugs. Drug companies have relied on brand identity to create meaningful differences between such drugs, claiming that the pharmaceutical brand “provides protection from products with similar profiles – sustainable differentiation.”<sup>157</sup> As another marketer put it with respect to antidepressants specifically, “With little to separate Zoloft, Prozac and Paxil in terms of efficacy, the onus has been on branding.”<sup>158</sup>

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<sup>157</sup> Maclennan, Brand Planning for the Pharmaceutical Industry. (p. 2)

<sup>158</sup> Jennifer Coe, The Lifestyle Drugs Outlook to 2008: Unlocking New Value in Well-Being (Business Insights Ltd., 2003). (p. 81)



Marketers have turned to the science behind the pharmaceuticals they are trying to sell to help create brand differentiation. At the 2004 Pharmaceutical Marketing Congress, Stan Bernard (Director of Persistency and Compliance at Biogen) urged fellow marketers to “learn the science [of pharmacology],” claiming that there is “an obligation to understand it ... to understand why your product is fundamentally different.” I am struck by the language of “obligated,” which puts us back in the realm of ethics. On the one hand, Bernard’s comments are about professional identity, situating him in a historical lineage with pharmaceutical detailing, which, since its emergence as a professional field in the 1940s, developed its own professional literature that increasingly emphasized a “scientific” approach to marketing medicines, including learning some of the pharmacological science of the medicines they were selling. The ultimate goal of the ‘detail man’ was to cast himself not as a salesman, but as a “service professional” whose task was to disseminate scientific information to the medical community—a community that detail men tried to identify with more and more.<sup>159</sup> On the other hand, Bernard is proposing a methodological strategy for pharmaceutical marketing, but one that depends on the ontological argument that the pharmacology of drugs is where “fundamental difference” inheres. Here ontology meets up with ethics: Science is where *real* difference lies, so you fellow marketers better learn the science to make meaningful brand differentiation responsibly.

In an advertising environment where science is grounds for brand differentiation, drug marketers are developing “education programs” that “focus on how pharmaceutical

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<sup>159</sup> Greene, “Attention to ‘Details’: Etiquette and the Pharmaceutical Salesman in Postwar American.”

products work, including a product's mechanism of action."<sup>160</sup> As 'me-too' drug competition intensifies, marketers are turning to descriptions of pharmacology to help create brand differentiation. Part of this strategy includes an evolving conception of the consumer as increasingly sophisticated about the kinds of information they need to make consumer decisions in their own health care. As part of the DTC rhetoric of "consumer empowerment," marketers have argued that:

"Consumers are more prepared than ever to get a more sophisticated level of education to help them understand how a drug works. This need for education will grow in importance as marketers try to distinguish prescription medicines from one another, from generics, and from over-the-counter medicines."<sup>161</sup>

As this quote suggests, it is this "need for education" that arises from a more pressing burden on marketers to make meaningful differences among clinically similar drugs.

As part of this turn towards pharmacological difference as its own selling point, marketers not only claim that the language scientific knowledge should be leveraged in DTC advertising, but that objective facts about a drug should be in play with

"nonrational" terms. Vanderveer (2006) claims that:

"By synergistically leveraging both clinical/rational arguments for choosing the new product and also more subtle, nonrational appeals, one can maximize perceived differentiation and use intent, as well as establish the bases for long-term brand loyalty."

There is quick blurring of clinical/rational and subtle/nonrational that leads to *perceived* difference. Vanderveer proposes putting the rational and nonrational in a synergistic (not oppositional) relationship with each other. He elaborates:

"[Pharmaceutical product branding should strive to] create a unique brand identity that transcends the objective, clinical performance and pharmacology of that

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<sup>160</sup> "Dtc Takes a Back Seat."

<sup>161</sup> Ibid.

product ... brand crafting to imbue the product with appeals that go beyond objective performance to create a sense of bonding and positive differentiation and relationship at a more nonrational level.”

There is almost an inversion of Lévi-Strauss’s effectiveness of symbols<sup>162</sup> here: For Vanderveer it’s not a question of giving people the right language or myth to structure their emotions; it’s a question of giving people the right emotions to ground scientific explanations. Or perhaps it’s both: facts get storied, and stories get emotional.

Chapter 2, “Psychopharmaceutical Promises,” picks up from here. It explores how drug marketing participates in social debates over what is scientifically known about mental illness. It also explores how the popular circulation of neuroscientific facts plays into the relationship between psychopharmaceuticals, pleasure, and identity.

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<sup>162</sup> Claude Lévi-Strauss, “The Effectiveness of Symbols,” Structural Anthropology. (New York: Basic Books, 1976 [1963]).

## CHAPTER 2: Psychopharmaceutical Promises

“Psychopharmaceutical promises” has double meaning: On the one hand, it refers to the promise of a sound science of psychopharmacology; on the other hand it refers to the brand promises made in direct-to-consumer (DTC) advertisements for psychopharmaceuticals (pain relief, better living, fuller enjoyment of life). Illicit vs. licit; pleasure vs. illness-healing; changing-self vs. real-self: These are all distinctions that the pharmaceutical marketing and regulatory environment demand, as well as expressions of a deep social ambivalence about wanting drugs and fearing they will change the self. As Courtwright shows, when drugs are found to be pleasurable and consumed popularly their “political status” changes.<sup>163</sup> In the U.S., historically this has involved a regulatory regime—a “continuum of legal access” as Courtwright calls it, from universal access in the free market (e.g. caffeinated drinks, aspirin) to zero access and no politically-sanctioned market (e.g. heroin). Prescription drugs lie in the middle—they have legal markets, but their access is restricted by way of medical authority (e.g. the prescription).

It is not incidental that pharmaceutical advertising in the U.S. was the first form of advertising to become regulated by the government. Historically, false advertising had to do with lying about ingredients, a question of *what a drug contains*. Advertising claims about *what a drug does* weren’t regulated until much later.

But in DTC, where psychopharmacology is recruited simultaneously as an explanation of drug *and* illness, the antidepressant brand promises neuroscience as the

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<sup>163</sup> David T. Courtwright, *Forces of Habit: Drugs and the Making of the Modern World* (Cambridge, Mass.: Harvard University Press, 2001). (pp. 3-4)

truth of depression. As the following sections will explore, it is through DTC marketing—with all its mechanisms of promising, imputing, and suggesting neuroscience—that the *possibilities* for the relationship between depression and its science get splayed out. Following Courtwright’s historical analysis of the social relationships between drug-taking and government regulation, I suggest that the social ambivalence towards drugs in the age of DTC takes the form of *constant demand for more promises* about the relationship between illness and science, versus the equally impossible attempt to regulate those promises to conform to science. Indeed, psychopharmacological science ‘itself’ has become so embrangled with its own marketing claims that it, too, is founded on promise.

### **Promises and boundaries**

In 2003 I arranged for Peter Kramer (author of *Listening to Prozac*) to participate in a colloquium at the Harvard Mind/Brain/Behavior Institute, where he planned to speak about his most recent publication, a work of fiction. However, a number of participants were more interested to have him revisit the questions he had famously developed about Prozac and the possibilities of ‘cosmetic psychopharmacology.’ Kramer deflected the line of questioning by claiming that, “Prozac in the book really stood for a drug that is better than Prozac.” But in an important sense, this is precisely what drug marketing accomplishes through the brand promise.

When the FDA challenged the marketing claims of Celebrex, it said the company “*overpromised*” what the drug could do. The language of “overpromising” is important to distinguish from the language of “falsely promising”—the latter is a counterfeit relationship to truth; the former is an excessive relationship to truth. Indeed, the age of surplus health, the truth of illness is a question of drawing the right line. There is a certain notion that there is a ‘core’ of an illness that fits properly medical treatment, but which is often surrounded by a symptomological penumbra—a sociomedical gray area (cf. Kramer 1993). One effect of DTC is to play with that line. Often this is met with criticism, for instance one article in *The Nation* criticized that, “Doctors find themselves compelled to respond to ad-driven questions rather than those of fundamental medical importance.”<sup>164</sup> This criticism pairs perfectly with Marcia Angell’s claim about the development of drugs, namely that it’s the NIH that does the truly innovative drug research, and that pharmaceutical companies then “exploit” these discoveries.<sup>165</sup> It’s surplus health enacted twice: once as exploited scientific labor (‘me-too’ drugs), once again as advertised overpromises.

Edgy ethics is also about skillful perception management: the pharmaceutical industry wants steady growth—but not the perception of *overgrowth*. One strategy has been not only to market a drug, but to market a scientific explanation of the illness the drug is supposed to treat. The logic is that, if an illness around which there’s a growing market can be shown—literally depicted—to be *real* in the sense of biologically

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<sup>164</sup> Marc Siegel, “Fighting the Drug (Ad) Wars,” *The Nation* June 17 2002.

<sup>165</sup> Angell is the former editor-in-chief of *The New England Journal of Medicine*. She has claimed that 77 percent of the new drugs marketed between 1998 and 2002 were not demonstrably more effective than other drugs already on the market. Marcia Angell, *The Truth About the Drug Companies : How They Deceive Us and What to Do About It*, Rev. and updated. ed. (New York: Random House Trade Paperbacks, 2005). (p. 75)

identifiable, then social criticism of that growing market should be reigned in. This is essentially the drug/illness lock-and-key model that critics from Healy to SCI have decried as a cultural seduction. Indeed, from the propaganda/culture industry side, belief in the “chemical imbalance” is something akin to false consciousness or ideology. However, from the will-to-believe side, it is something else, perhaps fantasy of the real of one’s suffering.

In the middle is the drug marketer:

“Unless and until society provides an acceptable alternative to the physician dealing with personal problems, as long as people continue to seek relief from this source, it is unrealistic to expect the physician to turn them away because they have a problem with which he or she should not deal. Society has medicalized human problems, it appears. Medicine has perhaps been an accessory, and the pharmaceutical industry, certainly, has provided both with the means. To expect either of the latter parties to do, or to have done, otherwise bespeaks a considerable naïveté.”<sup>166</sup>

In this passage, drug marketing expert Mickey Smith posits a world in which medicalization is flipped on its head: it is not Medicine that medicalizes; it is society. On one hand, there is a certain continuity here to the “it’s just capitalism” defense (Chapter 1), insofar as the marketer perceives him/herself to just be ‘along for the ride,’ as it were. On the other hand, Smith’s comments pair well with Kramer’s acknowledgement-lament that the Prozac of *Listening to Prozac* turned out to represent an idealized version of its ‘real’ self: Both are examples of a will to believe that things could be better through a form of pharmaceutical fantasy.

Society may have medicalized human problems, but the marketer has his own understanding of how to operationalize it. Smith references psychologist Abraham

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<sup>166</sup> Mickey C. Smith, Pharmaceutical Marketing: Principles, Environment, and Practice (New York: Pharmaceutical Products Press, 2002). (p. 38)

Maslow's "hierarchy of needs"<sup>167</sup> to help define potential pharmaceutical markets, arguing that, especially following the advent of so-called "lifestyle drugs" (like the erectile dysfunction drug Viagra), marketers must be increasingly attentive to the ways in which pharmaceuticals might meet the 'higher' needs of consumers:

"At first glance it would seem that pharmaceuticals solve only the physiologic needs. New developments in prescription drugs, however, meet more and more of the other needs ... Philosophers and theologians have argued about the meaning of life for centuries, and we surely do not want to join that argument. Yet an important, unanswered question remains: What do people do when they have satisfied their physical safety, belonging, and status needs? What do they pursue *then*? The answer is often, but disappointingly not always, self-actualization, the complete fulfillment of all their human capacities. This means enlarging and enhancing themselves. It means extending their personal identities, their individuality, their uniqueness" (ibid.).

Just as he preempted the question of medicalization, here Smith sidesteps the question of what kind of needs pharmaceuticals *should* meet ("we surely do not want to join that argument"). All the same, Smith makes an eloquent case for pharmaceutical marketing thinking in terms of "*What then?*" – when physical needs are met, *what then?* Smith makes it clear that this kind of reflection should be extended to all kinds of drug categories, and not just the putatively 'lifestyle' drugs. Smith sees a natural extension from medical needs to self-actualization. This is one of the keys to promising: Smith claims one must move beyond (one must *promise*).

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<sup>167</sup> The hierarchy of needs is as follows: Physiologic → Safety → Belongingness / Love → Esteem → Self-Actualization



## Contested neuroscience and truths of depression

At the level of the brand, credibility means making good on what marketers call “the brand promise” (Chapter 1). But what if the brand promise is science? This is part of what makes the advertising for psychopharmaceuticals so fascinating: no other drug class features scientific explanations of illness and drug action so prominently.<sup>168</sup> Cartoon animations of neurochemical transmission, virtual reality tours of the brain, short informational films that can be downloaded from drug company website—these are key components of pharmaceutical ‘educational’ campaigns on depression and antidepressants. Just as patient groups in the 1980s like NAMI gave biological studies of schizophrenia a certain credibility by advocating for their capacity to destigmatize mental illness (“chemistry, not character”), so too does the pharmaceutical industry tout the ‘chemical imbalance’ as a way to destigmatize depression.

Yet the science of antidepressants is contentious. This section will present three critiques of antidepressants, represented by three figures: David Healy, Elliot Valenstein, and Peter Breggin. These individuals have written popular books that have critiqued the relationship between the marketing of antidepressants and the science of psychopharmacology, but they each make different arguments about this relationship. These critiques, as popular accounts, have helped define the debates over drug marketing and drug science. Together, they map out major terrain on which credibility battles get fought; and at the same time they show how authority in these matters has gone

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<sup>168</sup> This observation is based on a content analysis of 60 print advertisements and 22 broadcast advertisements, collected between 2002 and 2006.

missing.<sup>169</sup> The critiques are about the growing presence of psychopharmaceuticals in everyday life, but they proceed by attacking (and therefore participating in) the grounds of the production and dissemination of scientific fact.

HEALY:

David Healy has offered a sustained critique of “rational drug design,” based on assumptions about the nature of illness and molecular-level studies of psychopharmacology. Healy claims that competing neuroscientific theories of mental illness have been adjudicated on the basis of their marketability – literally, the extent to which pharmaceutical companies could mobilize certain theories at the expense of other equally or even more plausible theories to sell drugs. For Healy, neurochemical receptor theories—with their basic key-and-lock metaphors—were never more scientifically sound than alternative theories to explain mental illness.<sup>170</sup> But the FDA’s requirement that drugs get approved according to a disease model of illness (specific drug for well-defined, medically established illness) led to marketing claims about the scientific relationship of antidepressants and depression.

If the ideas of the receptor and ‘chemical imbalances’ became culturally reified through marketing slogans, they became scientifically reinforced with an armature of means to speed along clinical trials and rapidly disseminate scientific articles. One such

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<sup>169</sup> The subtitle of Valenstein’s book is the capitalized pronouncement “The TRUTH About Drugs and Mental Health”; Breggin has a book called “The Antidepressant Fact Book.”

<sup>170</sup> Healy reminds us that this is not a new critique. Rather, it represents a forgotten position in early debates over the relationship between the efficacy of chlorpromazine and the etiology of schizophrenia, in which a number of prominent researchers argued that it is simply logically erroneous to deduce the abnormality of dopamine receptors themselves from the fact that therapeutically valuable drugs can be shown to act on them specifically. It took the historical pressures of antipsychiatric sentiments in the 1970s and the growing financial and political wherewithal of the pharmaceutical industry in the 1980s and beyond for the *idea* of the receptor to feed back into—and subsequently transform—the research paradigms of cellular neuroscience and psychopharmacology.

method that Healy has criticized is the publication in major medical journals of articles that are ghostwritten by pharmaceutical companies,<sup>171</sup> which exemplifies a collision between the speed of science and the appearance of credibility. The entanglement of DTC marketing and medical ghostwriting is constantly perverting the scientific fact that must end up ultimately as a “statement with no trace of authorship” (Latour 1987).

Healy’s critiques boil down to claims about the production of scientific fact: The psychopharmacology that comes out of Big Pharma is *different* than the psychopharmacology that is produced elsewhere, like the NIH. Indeed, between the ubiquitous ghostwriting of pharmacology articles and the strict protection of clinical trial data,<sup>172</sup> there is no ‘science itself’ here; the clinical trial data are always-already-immediately interpreted as marketing claims about illness. If the wrapping of DTC is easy to tear off, the black box underneath is nearly impossible to open. As I read Healy, he claims that ghostwriting and nondisclosure of clinical trial data is a challenge to the pharmaceutical industry’s capacity to produce truth. It’s not even a question of good science getting distorted, inflated, spun in drug advertising; it’s a question of the credibility of the science in the first place. The *credibility* of the science is called into question, so the *truth* of the ‘chemical imbalance’ is threatened.

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<sup>171</sup> Such ghostwritten articles are typically published under the names of prestigious scientists, whose roles are often not more than reviewing final drafts of articles already penned by pharmaceutical companies or healthcare communications companies.

<sup>172</sup> Healy, a British psychiatrist and clinical researcher (as well as an historian of medicine), was called as an expert witness in a 2001 legal case against GlaxoSmithKline, who makes Seroxat/Paxil (Tobin v. SmithKline). Healy obtained a court order to gain access to the pharmaceutical company’s clinical trial data, and decried the fact that the data itself is so inaccessible, even after drugs are sold: “Not only can you not see what I’ve seen [from the clinical trial archives], but I’ve made notes on those as well and you can’t even see my notes, and it seems extraordinary to me that really that the only way anyone can get to see things like this is through a legal case, and not even a legal case happening here in the U.K. but one that happens over in the U.S. It’s difficult to call it scientific and it’s hard to see how it can be good for patients” (in Troyna 2002).

VALENSTEIN:

Elliot Valenstein's critique represents a related, but different critique of psychopharmaceuticals, namely that the 'chemical imbalance' is a product of cultural imagination, which cannot be scientifically substantiated. One year after the FDA approved DTC, Valenstein (1998) wrote, "It may surprise you to learn that there is no convincing evidence that most mental patients have any chemical imbalance, despite the reality that there are no tests available for assessing the chemical status of a living person's brain" (p. 4).<sup>173</sup> "It may surprise" us because at the time Valenstein was writing the notion of the chemical imbalance had already taken on a cultural life of its own—not only through DTC but through popular magazine articles in major publications like *Time* and *Newsweek*.

As I read Valenstein, he is trying to preserve (a perhaps ideal) independence between marketing and science. He is not claiming that there is a corruption of science that jeopardizes marketing claims about drugs and mental illness; rather he suggests that there is not sufficient scientific evidence to support those marketing claims. Similarly, Valenstein claims that, while it is true that psychopharmaceuticals are becoming increasingly specific in terms of their action on neurotransmitter systems, this does not necessarily mean they will be any more efficacious than older drugs—something implied in drug advertising. In his words, pharmacological specificity is "true, but misleading" (p. 225). *Misleading truth* articulates the problem of credibility at the level of the marketing claims, not the science.

If Healy worries about science founded on promises, Valenstein worries about promises founded on science. In both cases, however, it is the marketing that invites the

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<sup>173</sup> Valenstein, *Blaming the Brain : The Truth About Drugs and Mental Health*.

critical attention to science in the first place. DTC marketing—as possibility, hype, promise, fantasy—is the epistemological doppelganger of psychopharmacology.

BREGGIN:

Peter Breggin stands apart from both Healy and Valenstein. Rather than making a critique of science and its relation to the promise (as either promissory science or promissory marketing), Breggin sees the marketing claims as a mirror of the scientific claims, whose assertions about what antidepressants do to neurons are just wrong. In his book *Talking Back to Prozac* (1994),<sup>174</sup> Breggin claimed that licit SSRI antidepressants work on the brain in a way similar to illicit Ecstasy. He argues that the discourse of brain-damage that surrounds neuroscientific studies of illicit drug use is systematically kept out of public discussion of the long-term physical effects of licit (prescription) psychopharmaceuticals. Breggin has since mounted his own counter-science campaign, by arguing for instance that, “evidence is mounting that all drugs that stimulate serotonergic neurotransmission can cause lasting anatomical abnormalities.”<sup>175</sup> Breggin contests the social (mis)uses of antidepressants by making an ontological argument about their pharmacology—for instance, by arguing that there are “morphological abnormalities” in serotonergic neurons that have been exposed to Prozac or Zoloft.<sup>176,177</sup>

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<sup>174</sup> Peter Roger Breggin and Ginger Ross Breggin, *Talking Back to Prozac : What Doctors Won't Tell You About Today's Most Controversial Drug*, 1st ed. (New York: St. Martin's Press, 1994).

<sup>175</sup> Peter Breggin, "From Prozac to Ecstasy: The Implication of New Evidence for Drug-Induced Brain Damage," *Ethical Human Sciences and Services* 3.1 (2001).

<sup>176</sup> *Op. cit.*, p. 4

<sup>177</sup> Breggin, too, has made more general criticisms about the medical-industrial complex, including excoriating the pharmaceutical industry for covering up clinical trial data on suicide risks. But, for the purposes of this chapter, I am more interested in his counter-science.

In all three cases (Healy, Valenstein, Breggin), we see a reaction against the way that *marketing* participates in the construction of scientific knowledge of psychopharmaceuticals. In all three cases the marketing claims of the pharmaceutical industry are turned against itself. I disarticulate these critiques to show the range of ways in which, in turning industry claims against itself, the terms with which to fight about the social value of antidepressants get defined. Healy, Valenstein, and Breggin are struggling with the abstraction, absorption, and appropriation of psychopharmacological research into marketing, and at some point each of them confronts the ways in which science has been made into propaganda. At the same time, their critiques show that marketing can't be denied its ability to offer promises of science that, while they might be challenged, nonetheless get accepted as *possibilities*.

In Healy's latest book, he claims that, "[a] huge gap has opened up between what is scientifically demonstrable and what people believe, pointing to a cultural phenomenon that lies well beyond the 'medicalization' so worrying to sociologists and bioethicists."<sup>178</sup> I take Healy to mean is that, while medicalization works by making dubious identifications of everyday life that can be subjected to biomedical instrumental rationality, it *works reasonably*: the science is intact, it makes sense, it is credible—despite whether or not we object to it as a fundamentalist explanation for mundane facets of the human condition. In the case of psychopharmacology, however, as Healy would have it, we are in the realm of *belief beyond science*. Healy wants desperately to preserve the idea that the cultural imaginaries of psychopharmacology can

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<sup>178</sup> David Healy, Let Them Eat Prozac: The Unhealthy Relationship between the Pharmaceutical Industry and Depression. (New York: New York University Press, 2004). (p. xiv)

be reigned in by what is “scientifically demonstrable.”<sup>179</sup> This is a far different concern that, say, the one Ralph Nader voiced about ‘emotional information’ making an unethical leap past science (Chapter 1).

Contestations of the relationship between marketing and psychopharmacology happen in more popular contexts, too. One 2003 article in *Time Magazine* described the antidepressant Lexapro as “the perfect answer for anxiety all right, provided you’re willing to overlook the fact that it does its work by artificially manipulating the very chemicals responsible for feeling and thought.”<sup>180</sup> This statement doesn’t challenge the state of our knowledge about the relationship between pharmacology and clinical benefits; rather, like Breggin’s critique, it borrows from the discourse of illicit drugs to claim that Lexapro *artificially* manipulates neurochemicals. Lexapro works, but artificially so.

Or the following, written by a health care reporter:

“Many Americans have seen the television ad for Pfizer’s prescription antidepressant Zoloft. It’s the one with a listless ovoid creature moping about as a voice-over explains that depression may be due to a chemical imbalance in the brain, and that ‘Zoloft works to correct this imbalance.’ Statements like these have been repeated so often in direct-to-consumer ad campaigns for selective serotonin reuptake inhibitor (SSRI) depressants that critics say they now have the ring of scientific truth.” (Mundell 2006)

The logic here—similar to Valenstein’s critique—is propagandistic: Mere repetition of statements like “Zoloft works to correct this imbalance” can generate a public perception of scientific truth. Indeed, this resonates with the Marcuse’s argument that repetition of

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<sup>179</sup> One take on Healy 2004 is that the chemical imbalance has finally come too close to propaganda that socially sustains itself without the State Apparatus.

<sup>180</sup> Jeffrey Kluger, “Medicating Young Minds,” *Time* November 3 2003.

advertised messages can lead to “false familiarity,” which in turn can lead to “false demand.”<sup>181</sup>

Moreover, I would make the case that such recent critiques about psychopharmacology should be read as a reaction to something that is fundamentally *threatening*. On the one hand, the notion of ‘chemical imbalance’ would indeed seem to simplify, reify, and overreach all at the same time—it is worth critiquing and even criticizing. On the other hand, the fact that the notion of the chemical imbalance has been so thoroughly called into question also suggests that it is uniquely threatening. While the chemical imbalance is a threat to the authoritative authorship of scientific knowledge, it would seem that it is also a threat to ... what exactly? Healy is not so much worried about ‘mere’ propagandistic repetition; he’s worried about something more pernicious—towards a seemingly Freudian explanation of the bondage of repetition, in which one gets unconsciously trapped in ‘finding themselves in’ abusive situations.<sup>182</sup>

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<sup>181</sup> The Frankfurt School in particular was deeply committed to the disconnect between media (ideology) and everyday praxis (the Real), and they worried about media repetition as one such mechanism of social control. Marcuse, for instance, critiqued repetition as “a well-known technique of the advertising industry, where it is methodically used for ‘establishing an image’ that sticks to the mind and to the product, and helps to sell the man and the goods.” From Herbert Marcuse, One-Dimensional Man: Studies in the Ideology of Advanced Industrial Society (Boston,: Beacon Press, 1964).

<sup>182</sup> There is indeed a Freudian-cum-Lacanian analysis of the chemical imbalance to be had here—perhaps the Zoloft cartoon is a symbol of an absence? An *objet petit a* to the Big Void? (The relationship between psychoanalytic notions of desire and psychopharmaceutical consumption will be explored more directly in Chapter 3.) Lacan proposed the “objet petit *a*” as an “object cause of desire”—that is, an ineffable quality of an object that stands in for what we ‘really’ desire (i.e. how we fantasize *beyond* the object at hand), but which is otherwise fundamentally unattainable. Pfizer has recently launched an opt-on consumer education program for Zoloft called “Knowing More®” (2005), which includes an emailed link to an animated video of neurochemical imbalances. The text above the link reads: “What causes depression and anxiety disorders? No one knows for sure. But a chemical called serotonin may be a big part of the story. What is it? What does it do?” Now, in the most recent versions of DTC, it is precisely *lack of knowledge* that is promoted as a way of interpellating people as subjects of the chemical imbalance.



## Overpromises

As we saw in Chapter 1, persuading consumers to take and to stay on drugs means helping them understand their relationship with their pharmaceuticals as an ethical one. If the pharmaceutical relationship is an effortful one that requires persistency, then the ethical terrain is rocky. The pharmaceutical relationship often starts in DTC mass marketing, which produces the messages to consumers to both ‘find themselves’ and ‘live life to the fullest.’ The pharmaceutical relationship is that a person is encouraged to have is with himself or herself: Are you the kind of person who is getting *all they can* out of life? In DTC, the conservative message of ‘return to self’ is expressed as the flip side of a quite excessive and superlative message of ‘living life to its fullest.’ But it is the pharmaceutical that mediates the ethical relationship that the consumer is supposed to have with himself or herself as an individual who is encouraged to live life in its surplus enjoyment. This pharmaceutical mediation of surplus living has been spoofed by Comedy Central’s *The Daily Show*: “Everyone knows that Nexium cuts down on acid reflux, Plavix helps you garden with your grandkids, and Cialis helps you have unplanned, impromptu antique bathroom sex.” The joke depends on moving quickly from symptoms to advertisement depictions of life enjoyment.

Marketing pharmaceuticals in such ‘creative’ ways has defined new boundaries between the FDA and the pharmaceutical industry. For instance, early DTC commercials for the anti-arthritis drug Celebrex included the tag line, “Do what you want to do,” which the FDA objected to because it “overstated the efficacy of the drug.”<sup>183</sup> Marketers have begun worrying about how the pharmaceutical brand promise might be regulated.

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<sup>183</sup> Quoted in Hawthorne, *The Merck Druggernaut: The inside Story of a Pharmaceutical Giant*. (p. 153)

One warned that, in an environment of increased regulatory scrutiny, “ad agencies have to be more creative than ever to create truly effective communications that are also responsible and do not overpromise.”<sup>184</sup> The notion of a pharmaceutical brand that *overpromises* what it supposed to do is fascinating, since it points to a kind of boundary work at play in DTC marketing. Taken together, these quotes suggest that the brand ‘overpromise’ might mean “overstating the efficacy” of a drug, or promoting the drug in a way that suggests it can ‘treat’ anything other than legitimate clinical symptoms—that is, as a means towards a kind of pleasure that *exceeds* the regulatory boundaries around prescription drug taking.<sup>185</sup>

It is not part of official medical discourse that we take medications to be ‘new’ selves; rather, we take medications to restore old selves. Medicine, as a social institution, cannot transgress social norms.<sup>186</sup> Drugs, however, *can* transgress social norms. Indeed, drawing the line between licit and illicit substances establishes the relationship between pleasure and law.<sup>187</sup> A key example is benzodiazepines (like Valium and Miltown), which were introduced in the mid-1960s as so-called “minor tranquilizers” to treat depression and anxiety, and which were the first psychiatric drugs in the U.S. to be consumed ‘recreationally.’ In the 1970s benzodiazepines had become the most prescribed

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<sup>184</sup> *Med Ad News*, May 1, 2006

<sup>185</sup> Cf. Mike Fortun’s work on the promise of forward-looking statements in company SEC filings, and the corresponding attempts to regulate these promises.

<sup>186</sup> Cf. Herbert Marcuse, *Eros and Civilization; a Philosophical Inquiry into Freud* (Boston,: Beacon Press, 1966)., who made a similar observation [quote]

<sup>187</sup> “Not until drugs began to be widely used in nonmedical contexts did they generate public controversy and state intervention. The story of the reception of new plant drugs, as well as the creation of wholly synthetic ones, is that of the sorcerer’s apprentice [a phrase later taken up by David Healy]. Again and again, promising new drug therapies slipped the bonds of medical discourse and control. They escaped into a larger realm of popular pleasure and mischief, prompting responses by national and international authorities” (Courtwright 2001:69).

class of drugs in the world, but by the 1980s the U.S. Drug Enforcement Agency (DEA) ended up rescheduling this class of drugs in order to restrict access to them. It was during this time that clinical studies of their long-term use claimed that benzodiazepines were addictive and could lead to serious withdrawal symptoms,<sup>188</sup> a scientific finding that was immediately picked up by mainstream news coverage,<sup>189</sup> which had previously also raised the question of whether the drug was being overprescribed.<sup>190</sup> The pharmaceutical industry has since been deeply invested in the legal distinction between licit and illicit drugs, with its accompanying discourses of health and normality versus pleasure and dependency. For instance one of the first DTC pamphlets for Prozac claimed that, “Prozac doesn’t artificially alter your mood and it is not addictive. It can only make you feel more like yourself by treating the imbalance that causes depression.” The grammar of “it can only” is rigid, perhaps paranoid, but that’s precisely the point. The stakes are high.

Prozac is part of a newer generation of antidepressants and anti-anxiety medications, which have been promoted as distinct from benzodiazepines and the idea of addiction or dependence, and typically promoted to restore a mood-regulating chemical, like serotonin. Indeed, it was touted as a *safe* alternative to benzodiazepines. However, in the summer of 2004, the British government held hearings to address reports that a number of such Selective Serotonin Reuptake Inhibitor (SSRI) antidepressants (specifically Zoloft and Seroxat—“Paxil” in the U.S.) increased suicidal behavior in

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<sup>188</sup> K. Rickels, W. G. Case, R. W. Downing and A. Winokur, “Long-Term Diazepam Therapy and Clinical Outcome,” *Jama* 250.6 (1983).

<sup>189</sup> E.g. P.M. Boffey, “Withdrawal a Problem for 43% after Prolonged Use,” *The New York Times* August 12 1983. (p. A9)

<sup>190</sup> E.g. B.D. Colen, “America’s Psychic Aspirin; Valium: Problems with America’s ‘Perfect’ Drug,” *The Washington Post* January 21 1980. (p. A1)

adolescents. Britain subsequently forbid the prescription of these drugs to children under sixteen.<sup>191</sup> It was during this time, too, that the BBC aired a documentary on Seroxat/Paxil, which also drew attention to the fact that people were experiencing dramatic withdrawal symptoms while trying to come off the drug.<sup>192</sup> The BBC documentary indicted DTC advertising in the U.S. in particular: “If Seroxat is big here [in the U.K.], it’s massive in the States. There it’s called Paxil and, unlike in Britain, it can be advertised direct to the public.”

During the following summer the FDA, while not outright restricting the prescription of SSRIs, issued its own warning that adults, too, may be at an increased risk for suicidal behavior while on antidepressants. The FDA also required that prominent warnings about the link between antidepressant use and increased suicidal behavior in adolescents—so-called “black box warnings”—be placed in SSRI package inserts.<sup>193</sup> Since 2005 the website for Paxil has included the following message: “Is Paxil addictive? No. Paxil is not a controlled substance. Paxil belongs to a class of medications called SSRIs, which have not been shown to be associated with addiction. However, you may have symptoms on stopping Paxil.”<sup>194</sup> The grammar here is remarkable: The Paxil website makes the literalist claim that Paxil is non-habit-forming because it has not been legally categorized as a controlled substance by the DEA—despite acknowledging that people might very well “have symptoms on stopping Paxil.” Indeed, the pharmaceutical industry has gone out of its way to divorce antidepressants from the language of

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<sup>191</sup> It was also determined that GlaxoSmithKline had systematically covered up clinical trial data that already would have suggested these risks, long before the drugs became publicly available.

<sup>192</sup> Gerry Troyna, “Panorama: The Secrets of Seroxat,” (BBC, 2002), vol., ed. Ed Harriman.

<sup>193</sup> The full text of the black-box warning is available through the FDA’s website:

[http://www.fda.gov/CDER/DRUG/antidepressants/PI\\_template.pdf](http://www.fda.gov/CDER/DRUG/antidepressants/PI_template.pdf)

<sup>194</sup> [www.paxil.com](http://www.paxil.com)

“addiction,” “withdrawal,” or “dependence” when explaining the side-effects of SSRIs or the negative experiences that people have reported after having stopped taking them.<sup>195</sup>

Deciding on the right language to talk about side-effects of antidepressants has implications for deciding the relationship between antidepressants and depression. In 2004, psychiatrist Joseph Glenmullen wrote a popular book advising people how to safely come off of SSRIs.<sup>196</sup> The book argued that the withdrawal symptoms of stopping SSRIs are often mistaken as reoccurring symptoms of depression, which has led to a perversely backwards rationale for patients staying on those drugs.

As of 2005, pharmaceutical companies no longer deny a possible link between antidepressant use and increased suicidal behavior, but they have opted for language like “discontinuation symptoms” and “discontinuation syndrome” to characterize this and other negative consequences for stopping one’s medication. Likewise, there is a rise in other phrases like “treatment resistant” to describe patients who don’t respond positively to antidepressants. Here the locus of addiction is shifted from the drug to depression itself, and to the depressed person—that is, from Medicine to the subject whose ethical obligations include understanding oneself as chemically imbalanced, and the dutiful and persistent consumption of medication.<sup>197</sup>

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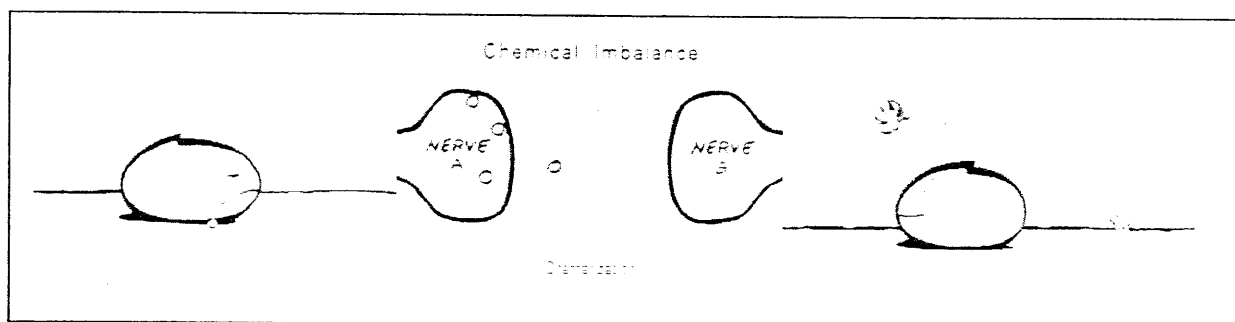
<sup>195</sup> Medawar and Hardon, Medicines out of Control? Antidepressants and the Conspiracy of Goodwill.

<sup>196</sup> Joseph Glenmullen, The Antidepressant Solution : The Only Step-by-Step Guide to Safely Overcoming Antidepressant Withdrawal, Dependence, And "Addiction" (New York: Free Press, 2005).

<sup>197</sup> An added benefit of the language of “discontinuation” for the pharmaceutical industry is that it can easily be reframed as *noncompliance*, which then becomes a legitimate problem of *marketing* (discussed later).

## Science and selfhood

In 2002, the tagline for Paxil DTC advertisements was, “With the help of Paxil you can see someone you haven’t seen in awhile – yourself. Hey, I remember you.” In almost every direct-to-consumer advertising campaign for antidepressants, the “return to self” is depicted as a subjective experience, but one that is grounded in ‘real’ neurochemical processes. The following visual is a series of stills taken from a television advertisement for the antidepressant Zoloft:



In this commercial, the act of consuming Zoloft is presented as a matter of neurochemical transmission rather than subjective experience; the abstract depiction of the drug’s actions on brain chemistry implies that it is not the person who consumes Zoloft, but rather the brain, which is cast as a scientific object on which drugs work simply and directly, bypassing the subjective being of the consumer and disconnecting psychopharmacology from the domain of direct experience. To date, pharmaceutical advertising has never shown the bodily consumption of pills—a striking contrast to advertising for other commodities, which are typically shown to be consumed—and shown to be pleasurable (e.g. food, cars, clothing).

DTC marketing claims about drug mechanisms are situated in a larger discourse about ethical self-transformations, epitomized in the landmark book *Listening to Prozac*, in which Peter Kramer (1993) noted “[a]n important quality of Prozac—namely, that it often surprises us. Sometimes it will change only one trait in the person under treatment; but often it goes far beyond a single intended effect. You take it to treat a symptom, and it transforms your sense of self” (p. 267).<sup>198</sup> Shortly after Kramer’s book was published, popular magazines picked up and sensationalized this language of transforming the self. For instance, one *Newsweek* cover read, “Shy? Forgetful? Anxious? Fearful? Obsessed? How Science Will Let You Change Your Personality With a Pill.”<sup>199</sup> It would seem that the pharmaceutical industry has responded to the popularization of the notion that antidepressants can affect one’s sense of self. For marketers, antidepressants should not be perceived as “happy pills” that *enhance* or *change* experience, but rather they should be perceived as properly medical technologies that *restore* a normative state of health. Similarly, Pfizer’s *zoloft.com* poses the question, “Will my personality change while I’m taking Zoloft?” and answers, “No, taking Zoloft won’t change who you are as a person. Zoloft treats your depression and certain types of anxiety disorders.”<sup>200</sup> This is a remarkable claim in light of the ubiquitous “return to self” language of DTC advertising, in which pharmaceuticals will return your ‘self changed by illness’ to the real (unchanged) self. In DTC advertising the drugs would seem to remember you ... the drug finds your *real* self, it does not generate an artificial one. Foucault (1984) defined the “ethical subject” as “the kind of relationship you ought to have with yourself ... which

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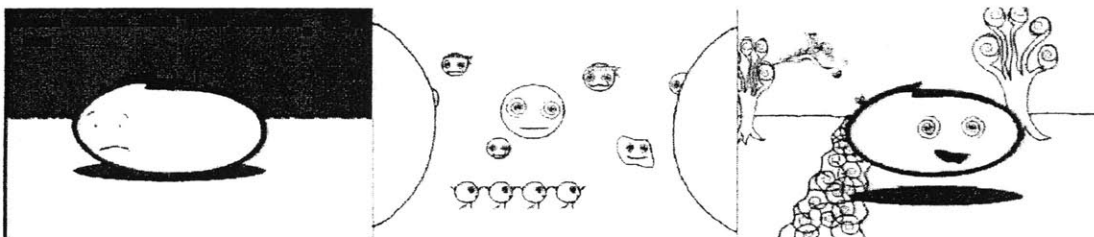
<sup>198</sup> Kramer, *Listening to Prozac*.

<sup>199</sup> February 7, 1994

<sup>200</sup> [http://www.zoloft.com/zoloft/zoloft.portal?\\_nfpb=true&\\_pageLabel=common\\_questions](http://www.zoloft.com/zoloft/zoloft.portal?_nfpb=true&_pageLabel=common_questions) (accessed April 2006)

determines how the individual is supposed to constitute himself as a moral subject of his own actions” (p. 352). In the context of the Zoloft commercial and the Prozac pamphlet, objective-self fashioning of oneself as a chemically imbalanced brain that must be returned to normality becomes an ethical consumer act.

In the wake of the DTC campaign for Zoloft, a number of parodies were developed whose humor also depends on blurring these distinctions between health/normality and pleasure/dependency. One example is a mock advertisement that was featured on the comedy show *MadTV* (2003); it used the same aesthetic and logic of the Zoloft commercial to advertise the street drug Ecstasy. The middle image is a close-up of neurotransmission, with the accompanying voiceover: “Ecstasy works by releasing a series of chemicals into your system—endorphins and serotonin.” The anthropomorphized neurotransmitter in the foreground then says, “Heehee – party, dude! I can feel my skin, I think it’s moving!”



The parody depends on the logic of the Zoloft ad transferring seamlessly to the logic of how Ecstasy works, including its appropriateness to manage depressive symptoms and make one more sociable. It signifies that the pharmaceutical logic has been normalized.



The pharmaceutical industry's efforts to construct SSRIs as properly medical technologies not only involves distinguishing them from benzodiazepines as non-addictive substances, but also distinguishing them from illicit drugs as non-self-enhancing substances. MadTV's choice to compare Zoloft to Ecstasy is perhaps not accidental—underlying that parody is the parallel and complementary social histories of SSRIs and Ecstasy: Both were developed around the same time, both primarily affect serotonergic neurons in the brain, and both have been used to treat depression. However, over time neuroscience has been differently recruited by government, patient advocacy groups, and the pharmaceutical industry to help make social arguments about the kinds of ethical relationships that consumers should have with both of these drugs.

Indeed, the sociopolitical tension between licit and illicit drugs has been taken up in the very neuroscience of psychopharmaceuticals, where competing discourses of drug use, addiction and pleasure also circulate. One prominent psychopharmacology textbook describes the brain as having its own “pharmacy of naturally occurring substances,” pairing brain neurotransmitters with their drug metaphors, including “the brain's own heroin” (endorphins), “marijuana” (anandamide), “nicotine” (acetylcholine), and “cocaine” (dopamine) (Stahl 2000).<sup>201</sup> At the same time, this textbook talks about “a natural high with the brain's natural system,” to describe how people can experience non-pharmacologically-induced states of euphoria:

“Since the brain already uses neurotransmitters that resemble drugs of abuse, it is not necessary to earn one's reward naturally, since a much more intense reward can be obtained in the short run and on demand from a drug of abuse than from a natural high with the brain's natural system” (p. 504).

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<sup>201</sup> Stephen M. Stahl, Essential Psychopharmacology : Neuroscientific Basis and Practical Applications (Cambridge University Press, 2000).

This passage naturalizes pharmaceutical reasoning about selfhood and normality, precisely by explicating the brain in terms of a drug-dispensing system. This psychopharmacology textbook also defines depression as “caused by neurotransmitter deficiency,” the remedy ‘naturally’ being properly psychopharmaceutical intervention to correct such deficiency. In an important sense, then, this textbook defines depression as a chemical withdrawal from pharmaceuticals that one hasn’t started taking yet. This has had important ramifications for psychopharmaceutical marketing. For instance, from the first DTC brochure for Prozac, which was distributed at doctors’ offices: “How Prozac Works: Many physicians believe that Prozac helps to correct the imbalance of serotonin ... by increasing the brain’s own supply of serotonin.” So, unlike the diabetes model of drug-taking in which the drug is a direct replacement of what your body lacks (or the Ecstasy model in which the brain gets “flooded” with its own chemicals), this Prozac marketing model makes the drug out to be a mechanism for letting the brain *replenish itself*, which naturalizes the consumer’s relationship with the psychopharmaceutical.

The psychopharmacology textbook introduces a section on the action of antidepressants with the statement, “The reality is that depression is an illness, not a choice” (p. 139). Without debating the truth of the statement, we can ask: What is such a sentence doing in a textbook? Why should such a statement precede scientific explanations of neurochemical action? If science can seemingly proceed independently of such disputation, why does this psychopharmacology textbook go to great lengths to argue that depression is a biologically real disorder—before explicating the psychopharmacological theories of depression?

## Negotiated neuroscience

Debates about the veracity of psychopharmacology get played out at the level of patient activism as well. For instance, there are numerous patient-run websites dedicated to informing people about the dangers of Paxil specifically. One is called “paxilprogress.com,” which says, “We know about Paxil. We know about Paxil withdrawal. Do you?”<sup>202</sup> The site is not for muckraking as much as it is for patients to share experiences with each others, yet the *raison d’être* of the site is that Paxil leads to various addiction and withdrawal problems, language that is in striking contrast to that of pharmaceutical company websites that speak of adherence and discontinuation symptoms. Indeed, the paxilprogress website’s language of “we know” suggests what sociologist Steven Epstein has referred to as a “negotiation of credibility,” in which different social groups vie to manage and resolve scientific uncertainty (1994:333). In this case, it is a sociopolitical negotiation over the right language to talk about patient experiences with a prescription antidepressant.<sup>203</sup>

Another patient advocacy website, called “prozactruth.com,” quotes and interprets the DSM-IV<sup>204</sup> to offer the following counter-reading of the role of neuroscience in depression:<sup>205</sup>

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<sup>202</sup> Website accessed April 2004.

<sup>203</sup> Another such website, antidepressantsfacts.com, begins with the following Shopenhauer quote: “All Truth passes through Three Stages: First, it is Ridiculed; Second, it is Violently Opposed; Third, it is Accepted as being Self-Evident.”

<sup>204</sup> American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (1994).

<sup>205</sup> <http://www.prozactruth.com/depression.htm>

But now that we've seen how the DSM defines depression disorder, what do they say about what causes it?

*Searching for Physical Causes*

For the answer, let's go back to the DSM. The only information given there as to physical causes of depression is:

Neurotransmitters implicated in the pathophysiology [study of the physical effects of a disease] of a Major Depressive Episode include norepinephrine, serotonin, acetylcholine, dopamine, and gamma-aminobutyric acid.

What does all that mean? Here's a simple explanation.

A *neurotransmitter* is a chemical that helps transmit nerve impulses through the nervous system. There are many different neurotransmitters used by the body. What the DSM definition is saying is that, by some method, the neurotransmitter chemicals known as norepinephrine, serotonin, acetylcholine, dopamine, and gamma-aminobutyric acid seemed to be lower in some depressed people, or higher in non-depressed people.

**Note** carefully the use of the word *implicated* in the DSM definition, however. And therein is the first clue, for it has *never been clinically proven that depression is based in neurotransmitters*. We repeat: *Never*. And believe it or not, there is not a doctor on Earth that will disagree with that statement.

Which leads to the conclusion that a physical cause for depression has never been isolated. How, then, did an entire industry become fixated on neurotransmitters as a cause of depression?

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The above excerpt from prozactruth.com negotiates for scientific credibility by borrowing and challenging pharmaceutical companies' own mode of disseminating scientific facts about neuroscience and depression. The website quotes the DSM, and draws careful attention to its claim that neurotransmitters are *implicated* in depression, arguing that this kind of indefinite language does not warrant the widely disseminated and confidently made claims of the pharmaceutical industry, namely that depression simply *is* the result of a chemical imbalance.

Another advocacy group, called MindFreedom Support Coalition International (SCI), accused Pfizer of making “fraudulent” claims about the links between chemical imbalances and depression in their DTC campaign for Zoloft. In December 2003, in addition to sending a letter of complaint to the FDA, FCC and FTC, SCI sent a letter to Pfizer, which was signed by the organization’s own scientific panel, comprised of thirteen psychiatrists and psychologists. SCI’s specific allegation was that, “there is no scientific evidence for such a chemical imbalance. For example, there is no reliable diagnostic lab test for any alleged chemical imbalance for any mental disorder.”<sup>206</sup> The organization demanded that Pfizer produce incontrovertible evidence of the putative chemical imbalance, or else withdraw the Zoloft advertising campaign.

Pfizer responded with its own letter, which defended the Zoloft campaign by appealing to general medical understanding about the connection between serotonin and depression:

“It is generally accepted and understood by the medical community that SSRIs work by binding to the serotonin transporter in the brain which consequently regulates the neurochemical disruptions that are the biological substrate of Major Depressive Disorder. Therefore, we disagree with MindFreedom’s assertion that this is a harmful and deceptive statement.”

The Pfizer letter also included a reference to a chapter in a psychiatric textbook of psychopharmacology.

The SCI-Pfizer letter exchange, too, quickly became a fight about science and credibility. For instance, SCI challenged Pfizer’s scientific reference on the grounds that the psychopharmacology textbook was partially funded by the pharmaceutical industry and, moreover, that it was not held to the same standards as a peer-reviewed journal

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<sup>206</sup> The entire exchange of letters is available at <http://www.mindfreedom.org/mindfreedom/pfizerlies.shtml>

article. Pfizer responded by citing a peer-reviewed article, and quoting the following statement: “Powerful evidence of an imbalance in serotonin neurotransmission in major depression comes from the observation that the symptoms of this disorder are relieved by repeated treatment with drugs that block the reuptake or metabolism of serotonin.”<sup>207</sup> SCI countered:

“The use of the word ‘imbalance’ in that quote is a breach of scientific protocol in that it exaggerates and misrepresents what was actually demonstrated by the research reported in the article. The research merely demonstrated that a psychotropic drug had an effect on the reuptake and metabolism of serotonin. To say that is evidence of ‘an imbalance in serotonin neurotransmission’ is erroneous because nobody has demonstrated what the balance of serotonin transmission is in the healthy human brain.”

SCI accuses Pfizer of making scientifically unsubstantiated claims about the relationship between brain chemistry and depression. Pfizer responds by citing scientific articles, which SCI deconstructs as bad science. Here, science becomes the grounds for debating the ethics of drug-taking, but scientific claims never seem to definitely settle the debate. More specifically, the promises of neuroscience in journal articles and textbooks become weapons that are volleyed across different social groups who have stakes in the current inability to find the promise in the brain.

### **“Nothing sells like verisimilitude”**

The idea that neuroscience offers the truth of depression is split between claims that the science is known and that it is unknown. In the middle is a rhetorical gray area of

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<sup>207</sup> C. A. Stockmeier, "Neurobiology of Serotonin in Depression and Suicide," Ann N Y Acad Sci 836 (1997).

imputation, suggestion, and belief on the part of scientists, psychiatrists, and consumer-patients. In this middle comes the ability to market the unknown to the FDA and to the public, to repeat the possibility of neuroscience so that it becomes common sense—so that it becomes a promise. And as we saw in Chapter 1, the strategic cultivation of belief is how marketers have framed their own role in the development of scientific promises. In an industry magazine editorial, Kathy Jenkins (one of the drug marketing experts quoted in Chapter 1) urged fellow drug marketers to:

“Tell the truth. Seriously, nothing sells like verisimilitude. Precise language and specific visuals, such as those that show the size of the pill, the mechanism of action or the genuine outcome of faithful compliance help create a reasonable semblance of ‘truth’.”<sup>208</sup>

This quote is fascinating, since it immediately moves from an exhortation to “tell the truth” to a series of specific strategies for marketers to “help create *a reasonable semblance* of truth,” including the visual depiction of pharmacological mechanisms (of which the Zoloft cartoon is a perfect example). This slippage would suggest that ‘truth’ and ‘verisimilitude’ are interchangeable concepts for this drug marketer. On the other hand it is precisely in between truth and verisimilitude where the brand promise and belief-in-the-product can be defined. To push this, social critiques of advertising often go after the fact that marketers are trying to sell *an ideal image* (e.g. the fashion model), which the consumer is then supposed to live up to. The ideal image turns out to be unattainable, *and it therefore* perpetuates the consumeristic impulse.<sup>209</sup> In the case of the

<sup>208</sup> *DTC Perspectives*, March-April 2002:16

<sup>209</sup> E.g. Kalle Lasn, *Culture Jam: The Uncooling of America*, 1st ed. (New York: Eagle Brook, 1999): “And they [the controlling media elite] have done it subtly, feeding our insecurities a little at a time” (p. 75).

Zoloft commercial, the cartoon depiction of neurotransmission is the (perhaps unattainable) ideal image—truth that slips into verisimilitude for the sake of consumerism.

On the other hand, in the landscape of contemporary advertising we are surrounded by an evolving semiology of images, which themselves are often without real-life referents. As Sturken & Cartwright (2001) point out, this is actually an important part of how contemporary advertising functions—namely to entice consumer audiences by displaying ideal images that “in fact, have no basis in reality” (p. 141).<sup>210</sup> The Zoloft advertisement would seem to make the same enticement, and we’ve seen through the above sociomedical critiques just how tricky it is to establish to what extent a cartoon of neurotransmission has a ‘real life referent.’ For one, the Zoloft cartoon of the chemical imbalance has the caption “Dramatization” beneath it. We should ask why this is, since it betrays the obvious. Perhaps ironically, by calling the viewer’s attention to the obvious fact that the cartoon is not real, it actually creates a stronger suggestion that the cartoon does indeed have a real world referent. The cartoon is not fiction; rather, it dramatizes the real. Slavoj Žižek (1997) made a similar analysis of the obsessional neurotic, who “uses factual accuracy to dissimulate the truth of his desire.” Žižek explained that the obsessional neurotic engages in the following kind of strategic act of truth-telling:

“When my enemy has a car accident because of a brake malfunction, I go to great lengths to explain to everyone that I was never near his car and am therefore not responsible for the malfunction. While this is true, this ‘truth’ is propagated by me to conceal the fact that the accident realized my desire.”<sup>211</sup>

This helps explain the particular mode of truth-telling in the Zoloft commercial: Perhaps the ‘truth’ of the Zoloft ad is that the neurotransmission cartoon is dramatized, but the

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<sup>210</sup> Marita Sturken and Lisa Cartwright, *Practices of Looking: An Introduction to Visual Culture* (Oxford ; New York: Oxford University Press, 2001).

<sup>211</sup> Slavoj Žižek, “Desire: Drive = Truth: Knowledge,” *Umbr(a) I* (1997).



concealed desire of the ad is that it is not at all a dramatization; it is ‘the thing itself’—depression is simply chemical imbalance, which Zoloft corrects simply.

There is a flipside to the truth that conceals, however. Riffing off of Pablo Picasso’s dictum about art, media theorist and semiotician Marshall Blonsky noted that, “an ad is the lie that tells the truth.” I connect this clever observation with Sturken and Cartwright’s discussion of scientific imagery, in which they articulate a tension “between the idea that truth is self-evident in the surface appearance of things, and the contrasting idea that truth lies hidden elsewhere, in internal structures or systems of the body,” and in which they point to a history of “scientific representational techniques [intended to] uncover evidence of these hidden truths” (2001:298). Sturken and Cartwright remind the reader that photography became prominent in a context of positivist science in which visual knowledge was prioritized and valued as self-evident.<sup>212</sup> At the same time, “the meaning of a photograph is derived from the belief that it has a referent in the real” (p. 140). It is this entanglement of belief in the apparently self-evident and belief in a hidden truth that characterizes psychopharmaceutical marketing.

Indeed, perhaps in psychopharmaceutical marketing the ‘dramatization’ of science steers too close to Baudrillardian simulation or “mere simulacra” that can only induce nostalgia for the real or authentic.<sup>213</sup> (This is much closer to Healy and

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<sup>212</sup> This is helpful to think about the late-nineteenth-century physician Charcot, who directed the Salpêtrière, the largest mental asylum for women in France. Charcot was an early example of the use of photography on patients to illustrate clinical symptoms. The subjects of his photographs were often staged, and the photographs themselves were nearly always touched up with paint, although Charcot famously declared, “I’m just a photographer.”

<sup>213</sup> Baudrillard emphasizes “simulation” to characterize how the images of advertising especially are removed from anything real, arguing that, as forced participants in a capitalist culture, our lives are constituted by an arbitrary system of symbols—“mere simulacra” that can only induce nostalgia for the real or authentic. Baudrillard critiques advertising as a key mode of presenting what is seemingly personal and intimate, but which really constitutes a kind of sham relationship between a consumer and a commodity. For instance, he closely analyzes the ways in which we are constantly surrounded carefully orchestrated

Valenstein's critiques). Dumit (2002) compares a cartoon with that of a PET scan image: "The difference between a fictional cartoon and a brain image is that the realm of the latter is science, and its concepts subtend rather than extend our everyday identification" (p. 145). However the cartoon in the Zolof commercial would seem to accomplish both—it is both the 'empty shell' that can be inhabited and fantasized with, and it is in the realm of science; it offers a persuasive logic and a fantasy of science.

But we don't have to go far to find deep use of neuroscientific cartoons in more properly pedagogic contexts. For instance, Stephen Stahl's bestselling introductory textbook to psychopharmacology (mentioned above) emphasizes "visual learning," and features numerous graphics that depict drug action on neurons. In the book's introduction, Stahl teaches the novice psychopharmacologist how to read the book strategically through the graphics:

"[I]t is suggested that novices first approach this text by going through it from beginning to end, reviewing only the color graphics and the legends for these graphics ... This approach to using the materials will create a certain amount of programmed learning by incorporating the elements of repetition as well as interaction with visual learning through graphics" (p. viii).

What for Stahl is a heuristic method of "programmed learning," is for marketers a way to simultaneously simplify and engage a broad consumer audience. Touting the use of cartoons in advertising, one drug marketer referenced the 1970s PSA "Schoolhouse Rocks" as a mass media educational tool:

"Why was it so successful? Because it took the same stuff that bored the crap out of kids and served it up in an engaging way, in a format that was acceptable to them. You didn't have an outcry against turning education into cartoons. It was accepted, because it delivered information to the audience in an engaging way. We're dealing with an audience that is confused by complex health topics and, at

the end of the day, we hope to drive them to have that discussion with someone who has a lot more education than they do. The question is how you pave that path.”<sup>214</sup>

Similar to how other drug marketers have advocated ‘headline’-based advertising as a way to spontaneously capture a potential consumer audience (see Chapter 1), this marketer sees the cartoon as a way to engage DTC consumers. But the marketer also suggests that one dimension of that kind of engagement is a reduction of “confusion,” a reduction of the complexity of health topics. This has become a point of contention from a regulatory standpoint. Speaking about the Zoloft commercials specifically, a former FDA regulatory reviewer claimed that explanations of the biological cause of depression “are used in an attempt to describe the putative mechanisms of neurotransmitter action to the fraction of the public that functions at no higher than a 6th grade reading level.”<sup>215</sup> These quotes define a key tension in the use of neuroscience theory in antidepressant advertising: On the one hand persuasive engagement, and on the other hand seductive simplicity.

### **Counter-Advertising**

The MadTV Zoloft parody above is a good example of what de Certeau (1984) and Jenkins (1992) have called “textual poaching,” or the act of taking well-known texts or images and jiggling them for alternative effects.<sup>216</sup> Textual poachers are not mere passive

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<sup>214</sup> Andrew Schirmer, EVP and managing director for McCann HumanCare, quoted in *Medical Marketing & Media*, 41 (4): 38, April 2006

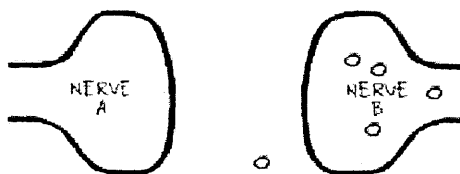
<sup>215</sup> Lisa Stockbridge, quoted in Mundell (2006)

<sup>216</sup> Certeau, *The Practice of Everyday Life*. Henry Jenkins, *Textual Poachers: Television Fans & Participatory Culture*, Studies in Culture and Communication (New York: Routledge, 1992).

spectators who simply and fully assimilate intended meaning; rather, they are actors in a participatory media culture who struggle with and often reframe the meaning they borrow from cultural materials. The cartoon form of the Zoloft commercials has proved to be an especially adaptable and flexible form for personal and popular response to the antidepressant campaign. In addition to the MadTV spoof, I have been collecting a number of additional parodies that have been circulating on the Internet. I have been particularly struck by how these ‘counter-commercials’ made use of the neuroscientific theory presented in the original Zoloft ads. For instance, the following sequence of stills is taken from an advertisement for a fictional antidepressant called “Proloxil”:<sup>217</sup>

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See, in a normal brain, happy little serotonin bubbles fly around, having a great time. This prevents you from sinking into a bottomless pit of despair and anguish because the emptiness and futility of modern life is destroying your soul.



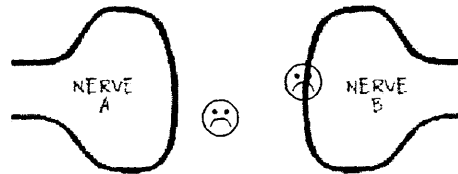
This is how your brain works

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<sup>217</sup> [http://www.astonishedhead.com/images/OVOID\\_123.swf](http://www.astonishedhead.com/images/OVOID_123.swf)

**"But you don't have a normal brain:"**

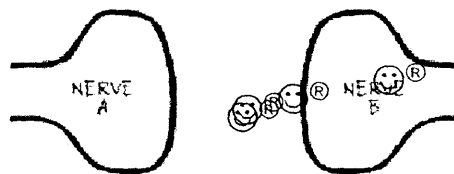
You've got a pathetic mutant brain full of flaccid nerves that are no good for anything.



This is how your brain works



Proloxil® works by completely replacing your naturally miserable serotonin with happy little Proloxil® molecules.



This is how your brain works

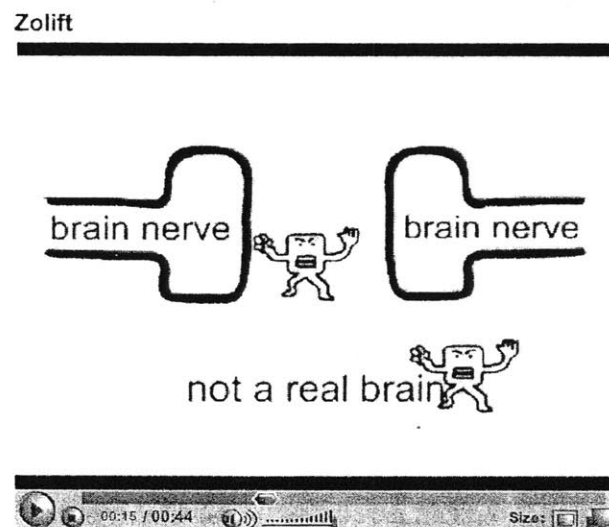


Textual poachers fill in meaning.<sup>218</sup> In this case, the antidepressant *completely replaces* one's own serotonin. Like the MadTV parody, the neurotransmitters here are anthropomorphized, and the drug itself is described as "happy little Proloxil®"

<sup>218</sup> Henry Jenkins explores the example of fan-fiction, in which audience members will create their own storylines to 'fill in' gaps that they identify in the narratives of their favorite television shows and movies. It is a case of bringing one's own unique meaning-making capacity to help *complete* a media experience.

molecules”—a direct and complete replacement for one’s “naturally miserable serotonin.” This challenges the DTC claims for Prozac and Zoloft, which emphasize how the SSRI mechanism of action is precisely not that of *replacing* neurochemicals, but is that of enabling one’s brain to generate *its own natural* neurochemicals. Moreover, each of the new, happy chemicals carries its own restricted symbol, which suggests fabrication and ownership.

As a final example, the following image—a still taken from a Zoloft parody commercial (for a fictional drug called “Zolift”) was posted to the video streaming website youtube.com:



This part of the commercial parody had the accompanying voiceover, “This is a diagram of cells bouncing off of brain nerves. Your brain is very complicated, so we won’t try to explain anything here.” Here the original caption “Dramatization” is replaced with the much more stark—much more constraining—“not a real brain.” This counter-ad mocks

the outright simplicity of the original cartoon of neurochemical transmission as an insulting non-explanation.

Textual poachers respond to unfulfilled promises of neuroscience, in part by repeating, assimilating, and then modifying those promises. Indeed, these Zolift counter-ads demonstrate a kind of cultural competency and visual literacy, and along the way they make critical interpretations of how drug marketing makes use of neuroscientific theory. Often this is accomplished through a cynical form humor, which, as Freud argued, is always partly about anxiety or fear. Certainly we can identify a kind of fear and loathing have surfaced in a broader social contest over the use of neuroscientific theory in drug advertising, for instance in the way people have reframed the scientific claims about Paxil and withdrawal symptoms and increased suicidal behavior. Indeed, the “Zolift” parody listed some side effects at the end of the commercial, which included “nervousness, dry mouth, and an itchy trigger finger.”

There are frequent examples of counter-advertising for DTC, just as there are a growing number of more serious critiques like Healy, Valenstein, and Breggin (see above). The counter-ads come from a rather incredulous spectatorship, but whose attempts to challenge the claims of DTC require participating in them. Here I share iek’s interest in cynical forms of reasoning, which characterizes many of the counter-ad parodies, and perhaps which reveals the ideological flipside of textual poaching and participatory viewership. For iek, “the cynical subject is quite aware of the distance between the ideological mask and the social reality, but he nonetheless still insists upon

the mask.”<sup>219</sup> Indeed, the DTC chemical imbalance has been popularized in an era of ‘reality television’ where the knowledge that such programs are ‘actually fake’ never seems to trump the desire to be a voyeur. Similarly, perhaps pointing out and insisting on the ridiculousness of the DTC chemical imbalance is also a fetishistic disavowal of the reality that it is this very representation—in all its (over)simplicity—that has come to define the terms in which we debate antidepressants. In any case, we are witness to cynicism on all sides of the debate—cynicism as response to cynicism in the wake of unfulfilled promises by neuroscience.

### **Map my symptoms!**

Through the Internet, DTC advertising of antidepressants has provided a medium that goes beyond ‘mere’ representation of neuroscience, towards an interactive engagement with neuroscience. On the one hand this happens through textual poaching of commercials; on the other hand it happens through increasingly interactive websites sponsored by pharmaceutical companies. I have been tracking the evolution of psychopharmaceutical websites between 2001 and 2006. As part of the shift from a mass marketing paradigm to a relationship marketing paradigm,<sup>220</sup> one technologically-facilitated change in these websites has been increased interactivity with scientific representation of illness. One example of this change is the website for the antidepressant

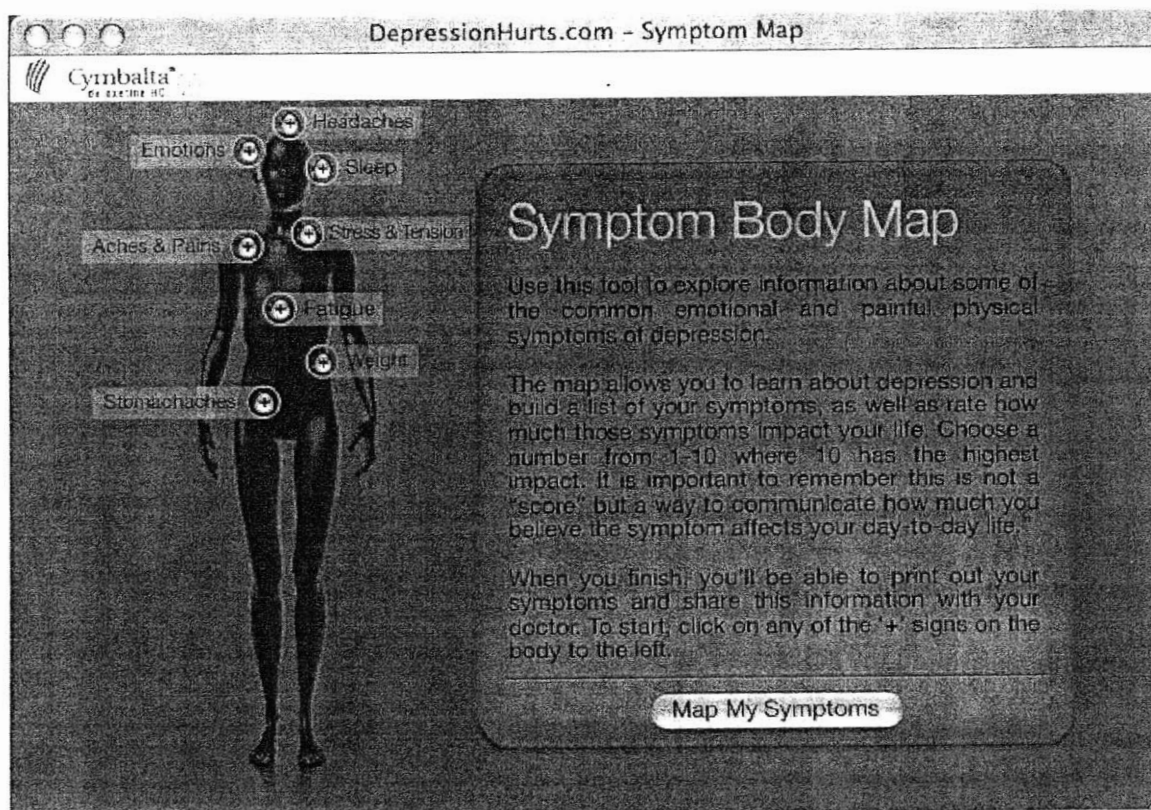
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<sup>219</sup> Slavoj Žižek, *The Sublime Object of Ideology* (London ; New York: Verso, 1989). (p. 29)

<sup>220</sup> See the Introduction and Chapter 1 for a full discussion of the differences between these two marketing paradigms.



Cymbalta, which features an interactive, virtual reality body tour, where the user is invited to “Map My Symptoms”:



The user is encouraged to identify and print out their symptoms, and present the information to their doctor. Mapping symptoms is not a way to communicate how much symptoms affect everyday living—rather, it is a way to communicate *how much one believes* symptoms affect everyday life: “It is important to remember this is not a ‘score’ but a way to communicate how much you believe the symptom affects your day-to-day life.” The website is working with the consumer’s belief as “yours,” but ‘yours’ given by the interactivity of the website. It is a remarkable play of control since, in addition to sundry somatic symptoms (like headaches and stomach pain), the symptoms that the user

gets to “map” are simply those from the DSM depression checklist, which are listed on every prescription antidepressant website. l a k coined the term “interpassivity” to denote how one’s apparently active mastery over media content is also a displacement of the ability to experience something passively.<sup>221</sup> In this sense, websites like [cymbalta.com](http://www.cymbalta.com) exemplify interpassive processes, insofar as the website—in its very interactivity—actually ends up doing part the work of desire for the subject.

One prerequisite of pharmaceutical interpassivity is the presentation of neuroscientific facts in the subjunctive. [Cymbalta.com](http://www.cymbalta.com) urges: “Watch how chemicals in the body may affect how you feel emotionally and physically.” Psychopharmaceutical websites are always presenting neuroscientific facts as *definite possibilities*: You get to watch and interact with the possible. In an important sense, this process obviates the uncertainties around the science of antidepressants, precisely by turning hypothetical versions of that science into ways for consumers to engage their own fantasies about the biological instantiation of their mental suffering. Such websites are part of the infrastructure of the promise of neuroscience, as it were; they help the consumer believe what they supposedly already want to believe about their bodies as neuroscientific objects, and their minds as neuroscientific subjects. Interpassivity is part of edgy ethics, too: Such websites invite one to learn about, and participate in their own fantasies, and present them back to the doctor as health communication.

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<sup>221</sup> l a k writes: “Is the necessary obverse of my interacting with the object instead of just passively following the show, not the situation in which the object itself takes from me, deprives me of, my own passive reaction of satisfaction (or mourning or laughter), so that it is the object itself which ‘enjoys the show’ instead of me, relieving me of the superego duty to enjoy myself?” (The entire essay has been made available on-line at <http://www.lacan.com/interpass.htm>)

## Ecstasy

Ecstasy had never been substantially linked to social problems or health problems, and its first application happened in psychotherapeutic contexts. However, in the early 1980s its growing popularity alone drew attention to the DEA. In 1984, especially in response to the open sales of Ecstasy in the Dallas bar scene, Texas Senator Lloyd Bentsen requested that the DEA prohibit free access to the drug. Despite the ensuing hearings on how to regulate MDMA,<sup>222</sup> a single study<sup>223</sup> arguing that a related chemical (MDA<sup>224</sup>) had caused changes in rat brains was enough for the DEA, in 1985, to use its “emergency controls” to make MDMA outright illegal as a Schedule I substance—the most prohibitive category available (used for substances like heroin and LSD). Schedule I drugs are determined to have “a high potential for abuse,” and “no accepted medical use.” Less than a year later, the DEA referenced this same study to overturn the eventual outcome of the hearings: a recommendation that Ecstasy be made a Schedule III drug—that is, a legal drug acknowledged to have medical benefit, but also recognized to have some potential for abuse, and made available only through a doctor’s prescription. But the DEA discounted the findings of the hearings, and left MDMA as a Schedule I drug.<sup>225</sup> Despite becoming illegal, the drug’s popularity never waned; it went from the bar scene to an underground rave culture.

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<sup>222</sup> The common acronym for Ecstasy’s chemical name: 3,4-methylenedioxymethamphetamine.

<sup>223</sup> G. Ricaurte, G. Bryan, L. Strauss, L. Seiden and C. Schuster, “Hallucinogenic Amphetamine Selectively Destroys Brain Serotonin Nerve Terminals,” *Science* 229.4717 (1985).

<sup>224</sup> 3,4-methylenedioxyamphetamine

<sup>225</sup> The specific statement: “Of immediate concern to DEA is terms of hazard to public safety is a very recent research finding which suggests that MDMA has neurotoxic properties. A paper entitled ‘Hallucinogenic Amphetamine Selectively Destroys Brain Serotonin Nerve Terminals: Neurochemical and Anatomical Evidence’ by G. Ricaurte, G. Bryan, L. Straus, L. Seiden and C. Schuster, describes studies which show that single or multiple doses of MDA selectively destroy serotonergic nerve terminals in the rat

The DEA's involvement in the social adjudication of MDMA happened right at the beginning of the Reagan administration's "Drug Free America" initiative (epitomized by the ubiquitous slogan "Just Say No"). This legacy could be found a decade later as a major government-sponsored public campaign against MDMA, in which the National Institute on Drug Abuse (NIDA) launched a "Your Brain on Ecstasy" campaign. The campaign was based primarily on the NIDA-sponsored research of Johns Hopkins neuroscientist George Ricaurte (the primary author of the very study that the DEA originally cited to justify the exercise of its emergency powers to make Ecstasy illegal), and it featured colorful brain images whose visual features were enhanced and exaggerated to support the general claim that Ecstasy causes "brain damage."<sup>226</sup> Alan Lesher, director of NIDA, led the campaign:

"I did the brain on Ecstasy campaign. I believed that if you could show young people a concrete example of something that that substance does to a critical organ in your body, that they would then do the cost-benefit analysis in a more sophisticated way, and they might decide not to try this drug, or not to use the drug repeatedly."<sup>227</sup>

Not only was the NIDA campaign based on graphical manipulations of the original brain scans, but Ricaurte's original data behind his claim that Ecstasy use led to irreversible impairment of serotonergic neurons became a source of controversy, and were

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brain... Experts have concluded that because of the neurotoxic effects of closely related structural analogs of MDMA (MDA, amphetamine and methamphetamine) and because both MDA and MDMA cause the release of endogenous serotonin, it is likely that MDMA will produce similar neurotoxic [sic] effects to those of MDA." (50 Fed. Reg. 23118-23119, May 31, 1985.)

<sup>226</sup> For a discussion of how the NIDA images were distorted variations of the original brain images, published in a 1998 *Lancet* article by Ricaurte, see Joseph Dumit, Picturing Personhood: Brain Scans and Biomedical Identity, In-Formation Series (Princeton, N.J.: Princeton University Press, 2004). (pp. 148-150).

<sup>227</sup> ABC documentary: "Ecstasy Rising." Peter Jennings, Senior Editor. First aired Thursday, April 1, 2004.

subsequently challenged by a number of equally prominent neuroscientists.<sup>228,229</sup> For instance, in one television interview Stephen Kish (Center for Addiction and Mental Health, University of Toronto) agreed that Ricaurte's study was "bad science." Similarly, a 2003 *L.A. Weekly News* article covering the controversy was sarcastically entitled, "Your Brain on Bad Science."<sup>230</sup>

However, even today, NIDA still draws attention to its judicious use of scientific fact, claiming that its very mission is "to lead the Nation in bringing the power of science to bear on drug abuse and addiction."<sup>231</sup> There is power in speed, apparently, since NIDA elaborates this mission as:

"[ensuring] the rapid and effective transfer of scientific data to policy makers, drug abuse practitioners, other health care practitioners, and the general public ... The scientific knowledge that is generated through NIDA research is a critical element to improving the overall health of the Nation. Our goal is to ensure that science, not ideology or anecdote, forms the foundation for all of our Nation's drug abuse reduction efforts."<sup>232</sup>

In this bit of public relations, NIDA opposes science and ideology. However, commenting on the disconnect between the typical user's experiences and the NIDA propaganda about Ecstasy use and catastrophic and irreversible brain damage, Rick Doblin (founder and president of the Multidisciplinary Association for Psychedelic Studies) noted, "Somehow in our culture we've developed this belief in science so much so that we ignore the evidence in front of our own eyes." On the other hand, Doblin

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<sup>228</sup> See especially R. Buchert, R. Thomasius, B. Nebeling, K. Petersen, J. Obrocki, L. Jenicke, F. Wilke, L. Wartberg, P. Zapletalova and M. Clausen, "Long-Term Effects Of "Ecstasy" Use on Serotonin Transporters of the Brain Investigated by Pet," *J Nucl Med* 44.3 (2003).

<sup>229</sup> Ricaurte also ended up retracting a 2002 *Science* article, which claimed that a single use of MDMA use was associated with Parkinsonian symptoms. Ricaurte claimed that he erroneously used methamphetamine, not MDMA, because of a labeling error.

<sup>230</sup> Judith Lewis, "Your Brain on Bad Science : Leading Ecstasy Researcher Retracts Critical Study," *L.A. Weekly News* September 11 2003.

<sup>231</sup> [http://www.nida.nih.gov/about/welcome/mission/NIDA\\_Movie1.html](http://www.nida.nih.gov/about/welcome/mission/NIDA_Movie1.html) (accessed August 2006)

<sup>232</sup> *Ibid.*

commented on how the brain-on-Ecstasy campaign could actually backfire, creating *disbelievers* of science:

“Young people don’t believe ... that MDMA causes holes in your brain and will profoundly inhibit your ability to be a student, or reduce your capacity for emotional expression, because they don’t *see that* directly. So, I think that that kind of exaggeration of risk is harmful in and of itself—more so even than the drugs, because it causes people to believe *nothing* that they are told.”

Here, Doblin argues that everyday experiences of the safety and lack of long-term effects of Ecstasy will trump scientific explanations to the contrary; at the same time, government anti-drug propaganda that (mis)uses science might turn people into general skeptics of scientific explanations of drugs.

NIDA’s anti-Ecstasy campaign and pharmaceutical DTC advertising both use images of brain function to persuade the public that they should have certain ethical relationships with drugs. Ecstasy and SSRIs both affect serotonin regulation specifically, and their respective sciences are beginning to blur. In 2001 a front-page *San Francisco Chronicle* story quoted a Bellevue Hospital psychiatrist who advocated for MDMA as a potentially useful alternative to Prozac, claiming that “[MDMA] is a potent, immediate-acting antidepressant, and there is no such thing right now in psychiatry.”<sup>233</sup> And in that same year the Multidisciplinary Association for Psychedelic Studies (MAPS) received FDA approval to begin a five-year study on the uses of MDMA to treat trauma victims.

As researchers are finding therapeutic uses for Ecstasy, others are worrying about non-therapeutic uses for SSRIs. For instance, a 2003 report by the President’s Council on Bioethics (whose members include Leon Cass and Francis Fukuyama) was entitled

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<sup>233</sup> Julie Holland, quoted in Ulysses Torassa, “Illegal Drug Ecstasy Seen as Potential Prozac Alternative,” *The San Francisco Chronicle* February 2 2001. (p. A1)

“Beyond Therapy: Biotechnology and the Pursuit of Happiness.”<sup>234</sup> The task of the President’s Council was to produce an ethical treatise on technologies of personal enhancement, including licit prescription antidepressants. The report spends a number of pages outlining the effects of SSRIs on serotonergic neurons, despite acknowledging that, “even if we knew more about brain chemistry and its functional significance, it is not clear that such knowledge would be of a sort to help ethical inquiry” (p. 244). The report also that SSRIs already seemed to be used as technologies of enhancement,<sup>235</sup> and it made multiple comparisons between SSRIs and Ecstasy, including the following:

“MDMA functions differently from SSRIs: Rather than inhibiting serotonin reuptake, it increases serotonin production, causing massive dumps of serotonin into the synapses. Yet to the receiving neuron, more serotonin is available either way. Whether the difference between SSRIs and MDMA is one of degree or of kind, and what the example of one means for the others is not clear.”

Perhaps ironically, the contemporary pharmaceutical marketer’s vision for growing a drug market resonates with early efforts to explore non-medical uses of benzodiazepines like Valium. In 1961, psychiatrist Nathan Kline co-founded the “American College of Neuropsychopharmacology” as a response to the growing use of minor tranquilizers to treat ‘everyday’ symptoms of depression or anxiety. In the group’s manifesto, Kline recognizes and acknowledges the importance of the “non-psychiatric” use of psychiatric medication:

“[The Study Group] recognized that normal humans have used drugs as analgesics, diet reducing compounds, sleeping pills, mood elevators, pep pills, and for recreational purposes since the beginning of man. Therefore, we conclude

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<sup>234</sup> Leon R. Kass, Elizabeth H. Blackburn, Rebecca S. Dresser, Daniel Foster, W., Francis Fukuyama, Janet D. Rowley, Michael J. Sandel and James Q. Wilson, Beyond Therapy: Biotechnology and the Pursuit of Happiness. A Report by the President's Council on Bioethics. (2003).

<sup>235</sup> “Curing mental illness and pursuing happiness ... appearing to be converging, because of the development of medicines so effective that their use overshoots the illness for which they were developed and because they aid or seem to aid the realization of ordinary human desires for happier souls” (2003:241-242).

that this type of usage, i.e. nonpsychiatric, is a legitimate subarea of study in the field of mind-altering drugs. The Study Group was not formed initially to consider the problems of drug misuse. Rather, in its origin, it conceived its mission as a consideration of the possibility of enhancing the quality of human life by chemicals when prescribed to the nonpsychotic, and possibly nonneurotic, patient treated in a general outpatient clinic or by a private practitioner.”<sup>236</sup>

The question of *enhancing normal persons* was part of this research agenda from the outset, and Kline’s group saw enhancement as part of a scientific continuum. However, such a framework is now entirely absent from the rationales of clinical trials (in which specific drugs must be connected with specific illnesses). Indeed, Stahl’s 2002 psychopharmacology textbook never refers to psychopharmaceuticals as “mind-altering substances.” Discourses of pleasure and enhancement are now sociopolitically threatening to the pharmaceutical industry, and are understood as abuses or illusions of science.

But as the Celebrex example shows, DTC advertising has changed questions about what counts as an illness. The FDA regulates the product claim—a particular drug can only be advertised for the treatment of a particular illness, for which it has been tested and approved by the FDA—but in DTC, illnesses are *represented* in popular images, narratives, and slogans. Mickey Smith claims that the push towards ‘creative’ marketing was all the more necessary for pharmaceutical products because of their “undesirability,” and that the goals of drug marketing include not only making pharmaceuticals *comparatively* desirable, but *inherently* desirable.<sup>237</sup> Smith proposes a

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<sup>236</sup> Wayne O. Evans, Nathan S. Kline and Study Group for the Effects of Psychotropic Drugs on Normal Humans., *Psychotropic Drugs in the Year 2000; Use by Normal Humans* (Springfield, Ill.,: Thomas, 1971). (p. xii)

<sup>237</sup> “One of the many unique characteristics of the drug industry is the undesirability of its products; that is, with few exceptions, patients would prefer not to purchase a prescription” (2002:11). This offers another level to the idea that, at heart, DTC marketing is less about getting people to buy specific pharmaceuticals,



detailed list of consumer needs, which he then pairs with “related pharmaceutical goods and services.” The following is one section in which the antidepressant market was defined to meet the consumer need of “diversion”:

**“Consumer Needs and Pharmaceutical Markets”** (From Smith et al. 2002:26)

Need	Description	Product/Service
Diversion	Play; have fun; be entertained; break from the routine; relax and abandon one’s cares; be amused	Alcohol, antidepressants, minor tranquilizers

Here Smith is teaching marketers how to broaden a market for antidepressants. This table illustrates how, even though there is a regulatory line that dictates that antidepressants be exclusively marketed for a legitimate medical disorder called “depression,” there is a marketing logic that dictates that antidepressants can be connected with non-medical experiences, like “diversion.”<sup>238</sup> Note, too, that Smith is thinking in terms of everyday uses of drugs, and he collapses the social distinctions between antidepressants, minor tranquilizers, and non-medical substances (alcohol)—distinctions that we’ve seen in other regulatory and advocacy contexts have been hard-fought.

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but getting people to *buy in* to the idea that pharmaceuticals can enable and sustain everyday life (Chapter 1).

<sup>238</sup> Indeed, Smith claims that, “by examining the different needs and the kinds of consumer goods most often used to meet them, one can identify the most appropriate needs on which to base a promotional strategy for a particular product or service” (2002:26). But Smith is not unique here. Another example comes from Dimitris Dogramatzis, Pharmaceutical Marketing : A Practical Guide (Denver, Colo.: IHS Health Group, 2002). Dogramatzis includes a table that pairs pharmaceutical “product characteristics” (like “efficacy”) with “patient benefits” (like “no fever ... *independence*”) (p. 54; emphasis added).

“Branding is not advertising; it’s production,” says Naomi Klein (author of *No Logo*), “and very successful corporations do not produce products; they produce brand meaning. The dissemination of the idea of themselves is their act of production.”<sup>239</sup> At times, it is through its own public relations that the pharmaceutical brand promise can explode the licit/illicit, real self/changed self boundaries. One week after 9-11, Pfizer aired a PR spot on the American news station CNN. The ad, which showed a montage of rescue efforts and grieving at Ground Zero, explained that Pfizer had donated millions of dollars to relief efforts in New York. But the ad also expressed a desire to help medically, which was perhaps rather shocking:

“At Pfizer we discover and develop medicines. We wish we could make a medicine that could take away the heartache. Until we can, we will continue to do everything we can to help. We have donated more than ten million dollars to help our fellow New Yorkers and others affected by this tragedy. We urge you to help however you can.”<sup>240</sup>

It would seem that, in the rush to broadcast a touching bit of PR immediately after the World Trade Center attacks, Pfizer said what it wanted to say (we make medicines, we perform acts of social good), and it ended up *promising* much, much more (we will make drugs that cure heartache). The pharmaceutical vision of goodwill here is that of a company who eradicates the collective emotional response to a national tragedy. But not just a vision—a *promise*: “Until we can ...” Juxtaposed with this, an earlier claim about pharmaceutical marketing (quoted in Chapter 1) seems much less mundane: “We don’t sell drugs; we sell information on how to use them.”

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<sup>239</sup> Quoted in March Achbar, Jennifer Abbott and Joel Bakan, “The Corporation,” (Zeitgeist Films Ltd., 2004), vol.

<sup>240</sup> [on screen: contact info for United Way, American Red Cross, and the Twin Towers Fund ... LOGO: “Pfizer: Life is our life’s work”]

Although I had the good fortune of obtaining a digital copy of it,<sup>241</sup> I never saw this Pfizer PR spot on television again. But a mere two weeks later, DTC advertisements for anti-anxiety drugs would seem to have made good on the promise of curing 9-11 heartache. One ad for Paxil, which aired in October 2001, featured individuals who looked at the viewer and talked about their anxiety:

- "I'm always thinking something terrible's going to happen. I can't handle it."
- "You know your worst fears. You know, the 'what if's.' And I can't control it, and I'm always worrying about everything."
- "It's like a tape in my mind that just goes over and over and over."

There is strategy in the irony of choosing the looping playback to analogize anxiety in an immediately post-9-11 America whose media repeatedly replayed airplanes slamming into the World Trade Center. And, at the end of the ad (after a list of side-effects which concluded with the now contentious "Paxil is not habit-forming"), a smiling woman on a park bench declared with obvious relief, "I'm not bogged down by worry anymore. I feel like me again. I feel like myself."

Shortly after these spots were aired, the product director for Paxil was quoted in an industry journal saying, "Every marketer's dream is to find an unidentified or unknown market and develop it. That's what we were able to do with social anxiety disorder."<sup>242</sup> Here the marketer's dream realizes the company's vision, and the pharmaceutical promise of the 'unmet need' emerges culturally as empathetic advertising about anxiety.

All this returns us to the difficult and strange question of what it means to change the self through psychopharmaceuticals. In an era of direct-to-consumer advertising,

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<sup>241</sup> Courtesy of Joe Dumit and his Tivo.

<sup>242</sup> Quoted in Shankar Vedantam, "Drug Ads Hying Anxiety Make Some Uneasy," The Washington Post July 16 2001.

psychopharmaceuticals are experienced in multiple ways: as licit pleasures that change or manipulate the self like illicit drugs (SSRIs acting like Ecstasy); as chemicals that heal or find the real self—as, strangely enough, changed from what it has always appeared to be (Zoloft and Paxil knowing/remembering the real you); as medicalized expansions of suffering that change the self for the worse through side-effects (scandalized Paxil); as social responses to social challenges (Smith's take on pharmaceutical marketing); and as personal fantasy (interactive virtual realities of neuroscience).

In the midst of this evolving cultural topology of psychopharmaceuticals, people come to experience themselves as possibly in need of drugs, and come to identify with depression, medication, and scientific theories. The following Interlude will explore psychopharmaceutical promises in these terms, as one ethnographic account of the contemporary social ambivalence of antidepressants.

## INTERLUDE: SARAH

While science produces truth-claims about what's real (and material reconfigurations of the real), this is always discursive and taken up subjectively. I especially like Joe Dumit's formulation of, "the objects of scientific facts ... are also subjects, and can therefore incorporate these facts into their lives and sense of self."<sup>243</sup> Dumit, following Foucault, is interested in how we presume to speak about certain things—i.e. the social mechanisms and psychological realization of the authority of speech: Who or what gives us the right to speak about *x*? Science is a special domain of knowledge because it can transform the desire for power into normative, positivist objects (e.g. social categories of people the seemingly objective rationalizations that we intuit to defend them).<sup>244</sup> Foucault was specifically interested in psychiatry, whose history he characterizes as once overtly moral tactics having been overlaid with "myths of positivism." The passage I have in mind, from *Madness & Civilization* (1965), is worth quoting at length:

"If we want to analyze the profound structures of objectivity in the knowledge and practice of nineteenth-century psychiatry from Pinel to Freud, we should have to show in fact that such objectivity was from the start a reification of a magical nature, which could only be accomplished with the complicity of the patient

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<sup>243</sup> "How to do things with science: Facts as forces in an uncertain world." Manuscript.

<sup>244</sup> For Foucault, concentrate on the notion of the "docile body," which he introduces in *Discipline and Punish* (and which later becomes exemplary of "biopower"—of disciplinary power that sought to understand the body for the sake of controlling it – hence diacritics like "knowledge/power"). What's crucial here is the connection between the production of scientific, objective knowledge about the body as a seemingly natural object in the world, and the political goals of an evolving society (specifically the rise of capitalism, industrialism, bureaucracy). In a quite real sense, knowledge makes the human controllable (in critical distinction to Enlightenment discourses of scientific knowledge being liberatory). The political structures that developed during this time (increasingly complex administrative apparatuses) required knowledge of human subjects "that was concrete, specific, and measurable in order to operate effectively" Hubert L. Dreyfus and Paul Rabinow, *Michel Foucault, Beyond Structuralism and Hermeneutics* (Chicago: University of Chicago Press, 1982). (p.137). The idea here is that biopower is a uniquely modern form of power, which developed alongside of expanding populations and their governing bureaucratic organizations.

himself, and beginning from a transparent and clear moral practice, gradually forgotten as positivism imposed its myths of scientific objectivity” (p. 276).

Foucault makes the case that, if you go back in history to the emergence of the asylum, there is no psychiatric science—only the tactics of dividing and managing the behavior of the insane, and inculcating in them a sense of moral obligation to act according to the wishes of the asylum director. This is the ‘archaeology’ of the positivist science of psychiatry, as well as its ‘history of the present.’

We can read Healy and Valenstein as variations of Foucault’s argument—except the moral tactics that they critique are not at the level of psychiatry, but at the level of pharmaceutical capitalism. Indeed, the idea of the chemical imbalance (along with its accompanying cartoon images) would seem to present its own “myth of scientific objectivity.” Whereas Healy and others worry about the representation of science in DTC as ideological in its capacity to alienate people from a ‘real’ relationship with science, we can also follow Foucault and Dumit to understand how these representations are ‘subjectivized’ as fully rational relationships that people come to have with scientific fact. Indeed, anthropologically, I am interested in how individuals encounter, live with, and negotiate scientific fact for themselves.

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I met Sarah<sup>245</sup> through my MIT Rx-ID research.<sup>246</sup> Sarah holds a Ph.D. in neuroscience but she decided to leave the field after receiving her degree. She described herself as

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<sup>245</sup> “Sarah” is a pseudonym.

<sup>246</sup> See the Introduction for a description of the Rx-ID research group.

someone who has spent her entire adult life struggling with depression, as well as struggling with the decision to take antidepressants. I present Sarah's story to show how the social issues around the ethics and science of antidepressant consumption that were developed in Chapter 2 can be confronted and negotiated by an individual who struggles to make the professional pursuit of neuroscience meaningful.

In 1989, while she was a junior in high school, Sarah saw a therapist who recommended that she take antidepressants. Sarah said she “battled” with the therapist over this idea, and in fact she recalled that much their relationship was defined by this debate. She talked about her reluctance to take antidepressants in terms of “risk.” Sarah was an artist, and she had worried about the risk that antidepressants might “dull” her, that they might interfere in her abilities to “experience things that are spiritual, like art.” She also worried about whether the drugs would induce permanent changes in her. In many respects Sarah's concerns foreshadowed the tensions of illicit vs. licit, changing self vs. real self that would come to define broader public debates over the nature of antidepressant use in the age of DTC—debates which ended up recruiting scientific explanations in strategic ways. Indeed, for Sarah, the pharmaceutical risks of self-fashioning were exacerbated by her worry about “not knowing how they [the antidepressants] work.” Moreover, her very decision of whether to take antidepressants became dependent on receiving a satisfactory scientific explanation of exactly how they worked. Sarah recalls that her therapist referred her to a psychiatrist, trying to persuade her with the following reasoning: “I'm just a psychologist but he's a psychiatrist, so he'll explain the mechanisms.” Of course, the psychologist was restricted from prescribing

antidepressants (since he did not hold a medical degree)—Sarah would have had to see a psychiatrist for medication anyway. But Sarah turned the very question of her taking an antidepressant into a scientific one, and her psychologist ended up deferring to someone with greater scientific expertise.

However, Sarah discovered that the psychiatrist's explanations—which she said often took the form of “well, molecularly that's what happens”—weren't convincing. Sarah said she hadn't challenged the idea of a molecular explanation per se, but rather the simplistic ways in which her psychiatrist explained the neuroscience to her. Sarah said she'd respond to non-explanations like “it just works – that's how it works” with questions like, “Well how does that work *chemically?*” Apparently the psychiatrist once drew a graph for Sarah—not of any neurochemical processes, but of emotional “peaks and valleys,” and they would get “smoothed out” over time by a drug like Prozac. Sarah's relationship with the psychiatrist (which was short-lived) quickly became a sort of intellectual sparring; and together their exploration of Sarah's depression was often bracketed as a contest over scientific explanations. She never accepted the prescription.

While critics of drug marketing worry that the simplicity of the chemical imbalance will seduce people into taking antidepressants, in Sarah's case simplistic biological explanations repelled her from taking antidepressants. Of course, Sarah first saw the psychiatrist in 1989, nearly a decade before DTC and the popularization of the idea of the chemical imbalance. Indeed, it would seem that neither she nor the psychiatrist had any storied science<sup>247</sup> (key images or pithy descriptions of chemical

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<sup>247</sup> The phrase “storied science” was introduced in Chapter 1 to describe how marketers strategize the presentation of scientific information in drug advertisements.



processes) at the ready. At the same time, Sarah commented, “It’s disturbing that I even wanted an answer. Nothing he could have said would have made sense to me.”

In college, Sarah saw two more therapists, but she expressed similar ambivalence over her experiences with both of them. Once again, her resistance to taking antidepressants became a central source of tension. Sarah felt challenged and belittled by the therapists’ seemingly dismissive attitude towards her concerns about how the drugs worked, and how they would affect her. Neither relationship with the therapist lasted long.

In the meantime, Sarah became interested in—and got quite good at—biology, and she developed an interest in localist theories of neuroscience. She mentions neurosurgery in particular—especially the very idea that, if you ablate a specific part of the brain, you affect a correspondingly specific cognitive function or behavior. Sarah said that she was figuring out a biology-related career path right when *Listening to Prozac* was published (1993, in Sarah’s junior year). A friend recommended the book to her, which Sarah found particularly exciting because it balanced a nuanced discussion of the ethics of self-fashioning through antidepressants with a satisfying, *seemingly right* story about the connection between neuroscience and mind. Sarah outlined that story for me as follows:

“It was that some sort of life trauma would lead to neuronal downregulation, which would lead to a decrease in serotonin levels. Over time the neuroreceptors would start to upregulate in response to the decreased levels of serotonin, and they would become super-sensitive. You give the person Prozac, which floods [the synapses] again, and the receptors start downregulating back to where they were.”

*Listening to Prozac* didn’t quite allay Sarah’s concerns about taking antidepressants herself, but the book turned out to be a key source of inspiration for her to learn as much

as she could about exactly how antidepressants work. As she put it, “I had great faith that, by understanding their mechanisms, we could understand their effects.” After college, Sarah went on to study “the mechanisms of antidepressants and antipsychotics” in graduate school, eventually obtaining a Ph.D. in neuroscience from a prestigious university.

Sarah explains that her reasons to go into neuroscience were based on the assumption that scientific laboratories were a place of philosophical reflection. She said, “neuroscience and philosophy aren’t incompatible ... you need to do a lot of philosophy when you’re gathering data to correlate [serotonin levels with emotional ones].” She elaborated:

“What is clinical depression? What does it mean if it’s caused by a physical abnormality? I guess I was looking for different tools to think about these phenomena ... possible ways to think about these experiences, and connect them to bigger questions about the Good, difference, what makes someone a good person, morality.”

Sarah began her graduate work in a laboratory that was researching the genetic basis of bipolar disorder and schizophrenia. But Sarah found out quickly that the lab just didn’t have time for such philosophical reflection: “They made the serotonin equals happiness equation and tried to get results really fast.” At some point, the philosophical disengagement of the scientists she worked with, along with the monotony of the everyday work of neuroscience (she mentioned pipetting as one example), frustrated Sarah’s expectations that neuroscience would be the best place to explore philosophical questions about drugs and selfhood. “The questions I wanted to ask in neuroscience were: What’s it like? What are the implications? What are the best ways to feel better? What kind of self should there be? I guess these were moral questions, essentially. But I felt

more and more like they weren't going to get answered." Sarah boiled it down by claiming that, especially after she began volunteering in the local hospital psychiatric unit, "I realized I didn't want to be thinking about a protein for the rest of my life."

Sarah's realization happened early on in graduate school, sometime between her first and second years: "I knew it wasn't going to be for me. The reason why wasn't totally clear-cut, but there was something wrong about me doing neuroscience." However, Sarah felt temporarily rejuvenated about the potential to use neuroscience as a means of philosophical reflection after she wrote an interdisciplinary qualifying paper, in which she got to make a set of theoretical hypotheses about how molecular genetics could help explain emotional disorders. But although she felt hopeful and redeemed by this opportunity to put science in dialogue with philosophy and ethics, eventually Sarah felt increasingly alienated from her own work. She characterized her lab experience as being "the worst combination of boring and mundane, and time-consuming and stressful. I felt like it wasn't intellectually challenging at all ... I mean, now all those experiments are done by robots." Moreover, Sarah also thought she had picked up on other lab members' disaffection for her more philosophically-minded interests:

"There was this mentality that I wasn't a 'true scientist,' just because I didn't want to spend 80 hours a week in the lab. I also took that as a sign that maybe I couldn't compete. But I was also painting and volunteering in the hospital where, you know, people were living lives and having experiences. Whatever – even if I couldn't compete, I still couldn't even ask philosophical questions [in the lab]. I mean, my colleagues weren't taking about philosophy; they didn't even understand."

Sarah began feeling there was a real disconnect between the science she was doing and the illnesses it was supposed to eventually explain, and she started volunteering in a local hospital psychiatry unit. As a result of her experiences in the

psych ward, Sarah came to think about mental illness as “mysterious,” asking with renewed energy, “It’s just ... *What does it mean?* Are these phenomena really diseases? ... The fact that people had so many different experiences was really interesting, and I didn’t have space to think about that in the lab.” Sarah told an ironic story about her interactions with a psychiatrist who worked in the hospital where she volunteered, but whom she first met through the lab, where he was also affiliated:

“I told him about my wanting to volunteer in the hospital ... and he *just didn’t get it*. I mean—he didn’t even get it! At one point he actually said, ‘Oh, you mean you want to see the phenotype?’ I can’t believe he said that! It was like something straight out of *The Onion!*”

Sarah was incredulous of the fact that the psychiatrist described his own patients as mere phenotypical expressions of an underlying, endotypical biological reality. But the psychiatrist was thinking like a scientist, trying to understand why a budding neuroscientist—whose culture inculcated beliefs about the archetypal graduate student spending their every waking hour immersed in research—would want to spend any time volunteering in a psychiatric unit.

I was especially curious about how Sarah’s understanding of her own depression (including her resistance to taking antidepressants) related to her work as a neuroscientist, from which she had grown increasingly alienated. After all, she had identified as a sufferer of depression, but would not take antidepressants for fear that they would make fundamental and permanent changes in her personality and perhaps also her ability to see the world meaningfully through suffering. In one of our conversations I asked why someone with such a staunch stance against taking antidepressants would become a

neuroscientist whose work might ultimately go towards making better pharmaceuticals.

Sarah responded:

“Well, I was definitely interested in the connections between serotonin and depression. I thought it was important to understand this connection *and* help people by making better drugs. Plus I really did like biology. But, yes, I was very concerned about the ethical questions that Kramer raised. I guess some of the neuroscience was a rationalization. In an ideal world, I wouldn’t want people to take antidepressants. I remember feeling that I didn’t want to promote antidepressants as a first line of therapy.”

This response is fascinating, since it moves succinctly and seamlessly from Sarah’s intellectual curiosity (connections between serotonin and depression), to her split ethical concerns (on the one hand, helping to make better drugs; on the other hand, coming to terms with illness treatment vs. self-enhancement), to the admission that her pursuit of neuroscience might very well have been a “rationalization.” When I asked Sarah if she could say more about neuroscience-as-rationalization, she continued:

“Well, look, science can tell us a lot about the world. But depression is *meaningful*. At least my view of the world expanded because I was depressed. For instance, time gets so fucked up when you’re depressed, when you find yourself forced to be so introspective. *That’s* the contrast to ‘Oh, it’s just serotonin.’ I’m very threatened by scientific explanations.”

In psychoanalytic terms, a rationalization is a defense against one’s own motives—it works as an explanation of one’s actions that masks the otherwise threatening motives behind those actions. This seems to be precisely how Sarah has come to analyze her own experiences as a neuroscientist. Indeed, following Sarah’s train of thought, her own participation in science became a rationalization of her own resistance to antidepressants (insofar as incomplete and unsatisfactory science became a means to defer her decision to take antidepressants), just as well as it became a means to bring under control her own

existential fears about being ‘just’ a phenotype. To the point, Sarah also mentioned a line from a poem by Robert Lowell, which she paraphrased as “All this poetry is just too much salt in my brain.”<sup>248</sup> She commented, “That message is just so sad and empty. It seemed like he was saying poetry isn’t meaningful. But it is! I don’t know, having serotonin be the answer to big questions just doesn’t make sense to me. It’s such a statement of reduction.”

At one point Sarah said she felt “embarrassed” about believing that neuroscience would have the right answers for her. She said she didn’t remember quite when those feelings had set in, but she did recall seeing a magazine or newspaper article whose headline declared that scientists had found “love in the brain.” The article reported the use of brain-scanning technology to image how certain parts of the brain would ‘light up’ when a subject was shown pictures of loved ones. Sarah recalled that the article featured contrasting brain images with simplistic captions like “in love” and “not in love.” She exclaimed, “What does that mean—‘love in the brain’? That doesn’t mean *anything!* How could I ever believe that?” I responded by saying that those images were of course popularized extrapolations, whose simplicity I’d imagine most neuroscientists would take issue with. Sarah agreed, but quickly made the qualification that it was still a scientific explanation and that, even if neuroscientists would challenge its simplicity, it nonetheless characterized their “philosophical mentality.”

Part of the tedium of Sarah’s lab work involved going through chromosomes to look for genetic markers that might later be able to be statistically correlated with bipolar

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<sup>248</sup> The actual line from the poem is: “It’s terrible ... to think that all I’ve suffered and all the suffering I’ve caused might have arisen from the lack of a little salt in my brain.”

disorder or schizophrenia. At one point her lab acquired a certain technology that would allow them to scan the chromosomes more efficiently for trinucleotide repeats—a chromosomal formation associated with genetic disorders like Huntington’s. Sarah said she was “really tempted” to try the technology out on her own DNA. Apparently she came close to drawing her own blood and performing the assay, but she “decided I wouldn’t want to know, after all.” She elaborated:

“I guess it was the whole self-diagnosis thing. I don’t know what that story means exactly ... I also wanted to get my brain scanned, you know, to see what my hippocampus looked like. It’s supposed to be something like 15% smaller in depressed people. But I never followed through with that, either.”

Neuroscience, for Sarah, was a remarkably circuitous form of self-exploration. Sarah wouldn’t consume antidepressants, but she spent nearly a decade of her life figuring out how they work and what the biological substrate of mental illness might be. And I am struck by how Sarah continually sought out scientific and technological opportunities for self-diagnosis (DNA testing, brain imaging), but she repeatedly avoided carrying them through.

Sarah’s story shows how individual lives and science can emplot each other.<sup>249</sup>

Sarah’s engagement with antidepressants happened in a culture that was already listening to Prozac; her early encounters with therapists and psychiatrists were shaped by her own reflexivity about psychopharmaceuticals and identity. Sarah’s experiences exemplify how one might have a transference relationship, not to antidepressants—she never took them—*but to their science*. Sarah’s early encounters with therapists and psychiatrists were largely defined by debates over whether she should take antidepressants, which

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<sup>249</sup> Cf. Fischer (1996) on scientist autobiographies, which explores how scientists mutually emplot their lives with the cultural forms of their sciences; See also M-J Good (1996) on the role that narratives of hope have in biomedicine (especially oncology).

themselves took shape as debates over how antidepressants work. Sarah's own identity was at stake every step of the way. Looking back, she narrates her reasons for leaving neuroscience: "But I found out pretty quickly that it's more a philosophical issue, less a neuroscientific one ... I was a little embarrassed that I bought what the psychiatrist [from high school] said – that serotonin equals happiness. That correlation was just no longer satisfying." Of course, Sarah never really bought what the psychiatrist said—she challenged him on this point. Rather, her retrospective "embarrassment" is about buying in to the idea that she could satisfy her curiosity about antidepressants and selfhood by doing neuroscience. Moreover, Sarah did not just 'do neuroscience'—she was on her way to becoming a neuroscientist.<sup>250</sup> In this way Sarah's original struggle with a personal decision about taking an antidepressant was sublimated into the professional identity of one who uncovers the truth of depression.

It is significant that Sarah's search for the 'right' biological story of depression happened against the backdrop of her own depression, and within the context of a number of strenuous relationships (first with her therapists and psychiatrists, and then with her neuroscience colleagues). In an important sense, Sarah's search for scientific certainty was dependent upon being engaged with individuals who she thought understood and respected her. It was within these evolving relationships that her own relationship to scientific explanations went from feeling excited to feeling threatened. As Chapter 3 will explore, in psychoanalytic therapy it is precisely *the relationship* between individuals that

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<sup>250</sup> There are a number of popular books about mental illness written by sufferers-cum-scientists/psychologists, including Lauren Slater's *Prozac Diaries*, and Kay Redfield Jamison's *An Unquiet Mind*.



enables (or disables) self-understanding, including how one might find scientific facts about antidepressants compelling, persuasive, and therapeutic.

### CHAPTER 3: Fantasies of Illness, Desires of Science

“What in us really wants truth?”

- Nietzsche (from *Beyond Good and Evil*)

In 1921 Ivy Lee, a preeminent corporate public relations expert, explained to the *New York Evening Post* that “I have found the Freudian theories concerning the psychology of the subconscious mind of great interest ... Publicity is essentially a matter of mass psychology. We must remember that people are guided more by sentiment than by mind.”<sup>251</sup> Among pharmaceutical marketers, I have found a remarkable continuity with Lee’s admission, although the specifically Freudian references have disappeared. But still, these marketers discuss building pharmaceutical brand recognition in terms of forging “emotional links” with the consumer, and in the psychological language of “powerfully building a brand in the mind of the consumer.” And yet, while marketing literature is full of claims about appealing to consumers at an emotional level, antidepressant advertisements themselves would seem to deny that a person can wrestle with the drugs psychologically, focusing instead on “real medical treatments” for “chemical imbalances.” But as one marketer put it, “creating an emotional link is not about rational presentation of data—it’s about couching your message inside a personal emotive experience, one that relates to the condition and the consumer.”<sup>252</sup> The mode of DTC here is perhaps ironical, since it uses nonrational tactics to persuade people of supposedly rational facts about health, illness and treatment. On the other hand, we’ve

<sup>251</sup> Quoted in Stuart Ewen, *Pr! : A Social History of Spin*, 1st ed. (New York: Basic Books, 1996). (p. 132)

<sup>252</sup> Rogers, “Dtc Creative: An Emerging Sophistication?.” (p. 74)

see that this is a perfectly strategic use of the scientific promise, to get consumers to believe in the pharmaceutical.

Sarah's story (from the previous Interlude) powerfully evokes how individuals can become emotionally invested in neuroscientific promises. Her narratives of her experiences points to the need to examine the intersection of psychoanalysis and pharmaceuticals. Indeed, drug companies use emotion to get consumers to embrace a kind of scientific rationality. This is not lost on dynamic psychiatrists, who have referred to "the fantasy of an organic etiology" as a culturally robust zeitgeist that has permeated the doctor-patient relationship and which must be factored into the interpersonal ramifications of prescribing antidepressants. Glen Gabbard (Director of the Baylor Psychiatric Clinic<sup>253</sup>) explained to me that the very notion of "chemical imbalances" can become part of a patient's defensive armature against the psychological work required of talk therapy, precisely by strengthening pathogenic fantasies they may entertain about themselves. Moreover, dynamic psychiatrists have described how, while antidepressants may have "real biochemical effects," there's no guarantee that people won't resist, amplify, or invent these effects to meet psychological needs—a much different notion than that of the lock-and-key model of antidepressant action and psychological relief that pharmaceutical companies promote in their advertising for antidepressants, in which the transition from depression to normality is mediated solely by a biological mechanism.

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<sup>253</sup> Gabbard is a prolific and well-known figure in American psychiatry. He is Joint Editor-in-Chief of the *International Journal of Psychoanalysis* and Associate Editor of the *American Journal of Psychiatry*.

## Neuroscience at the crossroads of professional identity

Scientific explanations of antidepressants are part of a broader social history of psychiatry in which biological explanations for mental illness have been promulgated as socially exculpatory. This notion took sway over the psychiatric community in the 1970s, especially in the face of pressures from antipsychiatry social movements that were specifically opposed to psychoanalytic theories about how mental illness invariably had familial explanations (e.g. the schizophrenogenic mother theory). Indeed, in the late 1970s, psychiatrist Gerald Klerman drafted a manifesto to help define psychiatry as a properly medical discipline that dealt with real illnesses, which included his pronouncement that “The focus of psychiatric physicians should be particularly on the biological aspects of mental illness.”<sup>254,255</sup> This legacy continues today, for instance the way in which the advocacy group The National Alliance for the Mentally Ill (NAMI) discusses depression: “Whatever the specific causes of depression, scientific research has firmly established that major depression is a biological brain disorder.”<sup>256</sup>

But both the scientific and popular coverage of the first generation of psychiatric drugs expressed an ambivalence about the causal relationship between mind and brain. For example, a 1956 *New York Times* article on the rise of drug therapy for mental illness stated that, “The striking effects of the drugs on the personality ... have convinced many psychiatrists that mental disorder must *involve* disturbances in the chemistry of the

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<sup>254</sup> G. L. Klerman, “The Evolution of a Scientific Nosology,” *Schizophrenia: Science and Practice*, ed. J.C. Shershow (Cambridge: Harvard University Press, 1978).

<sup>255</sup> In the late nineteenth-century, when the germ theory of disease became paradigmatic for medicine, German psychiatrist Theodor Meynert made the following assertion, which anticipated Klerman’s manifesto: “The more that psychiatry seeks, and finds, its scientific basis in a deep and finely grained understanding of the anatomical structure [of the brain], the more it elevates itself to the status of a science that deals with causes” (Meynert 1890:v).

<sup>256</sup> <http://www.nami.org/helpline/depress.htm> (accessed December 2002)

brain.”<sup>257</sup> Significantly, it was the nature of this “involvement” that was left as a question. This mindset continued through to the second wave of psychiatric drugs (the minor tranquilizers) in the mid to late 1960s. For instance a 1969 *New York Times* article stated that, “The doctors [research psychiatrists] are not even certain whether chemical changes induce depression, whether depression induces chemical changes, or whether it works both ways.”<sup>258</sup> While acknowledging “chemical changes” are likely part of a scientific picture of clinical depression, this article also emphasized that not even the direction of causality can be assumed.

This was part of a more ambivalent and compromising relationship between biological psychiatry and psychodynamic explanations of mental distress, suggested in the following 1956 *New York Times* coverage of a presentation on the antipsychotic medication chlorpromazine at a meeting of the American Psychoanalytic Association:

“An unusual meeting of the minds on the mind was witnessed here yesterday my members of the American Psychoanalytic Association. It was a harmonious presentation by two often unharmonious elements, a psychoanalyst and a physiologist. ¶ Even with many in the audience feeling that the two still would not mix, Dr. Mortimer Ostow, the analyst, and Dr. Nathan S. Kline, a research psychiatrist, told how their combined research in the use of reserpine and chlorpromazine had led them to agree on the thesis of the paper: ¶ That the two most powerful of the tranquilizing drugs reduces psychic energy by action on a certain portion of the brain—the globus pallidus. They feel the finding is important, because, if proved true, it may permit the measurement of the currently hypothetical quantity known as libido or psychic energy.”<sup>259</sup>

This excerpt is striking, because it makes scientific sense of the physiological actions of psychiatric drugs within a psychoanalytic framework. Specifically, reserpine and chlorpromazine (the first so-called ‘antipsychotic’ medication in the U.S.) were theorized

<sup>257</sup> Leonard Engel, “New Approach to Mental Illness,” *New York Times* January 8 1956. (emphasis added)

<sup>258</sup> Nancy Hicks, “Drugs to Fight Depression,” *New York Times* December 14 1969.

<sup>259</sup> Emma Harrison, “Psychic Energy Reduced by Drug,” *New York Times* December 8 1956.

in terms of libido and psychic energy. This is in remarkable contrast this with contemporary claims about the scientific relationship between biology and mental function in pharmaceutical advertising. For instance, the following claim is from zoloft.com: “Today, it’s widely understood that depression is a serious medical condition. Scientists believe that it could be linked with an imbalance of a chemical in the brain called serotonin. If this imbalance happens, it can affect the way people feel.”<sup>260</sup> In this framework, chemical imbalances “happen” to a passive person, who subsequently feels differently—a notion gets played out in both the Zoloft commercial, and in the clinical trial.

The emergence of psychopharmacology happened in the U.S. at a time when psychiatry was intellectually and professionally dominated by psychoanalysis. When pharmaceutical companies first began to advertise psychiatric medication in medical journals they emphasized the doctor-patient relationship, specifically the notion that psychiatric medication would enable stronger rapport, and therefore facilitate talk therapy. For instance, one 1964 advertisement for Deprol (meprobamate, Wallace Laboratories) in the *American Journal of Psychiatry* claimed that the drug “helps the patient work with you”:

“During sessions: In neurotic depressive reactions, ‘Deprol’ encourages positive rapport. It helps reduce self-hostility, facilitates channeling of the patient’s aggressions into more acceptable patterns. It is also valuable in reducing anxiety to manageable levels, and in promoting restful sleep. Thus, during sessions, ‘Deprol’ may enhance the patient’s ability to work with you towards emotional and social readjustments.”<sup>261</sup>

<sup>260</sup> [http://www.zoloft.com/zoloft/zoloft.portal?\\_nfpb=true&\\_pageLabel=depr\\_causes](http://www.zoloft.com/zoloft/zoloft.portal?_nfpb=true&_pageLabel=depr_causes) (accessed April 2006)

<sup>261</sup> *American Journal of Psychiatry* 120 (1964): xxx-xxxi. Jonathan Metzl, *Prozac on the Couch*. (Durham, NC: Duke University Press, 2003). (p. 44)

Such advertisements during this time did not describe the drug's pharmacology to the doctor. Indeed, this early physician-directed advertising did not emphasize any particular biological model of mental illness as a selling point for the drugs. Instead, the drug's actions were described in predominantly psychological language (reducing self-hostility, channeling aggressions). Such language was part of a discourse dually shaped by a certain ambivalence of the psychopharmacology of the time (for instance, leaving open the question of whether the drug works primarily on the libido), and by the professional hegemony of psychoanalytic psychotherapy in America during the 1960s.

### **Neurotic neuroscience**

Just as drug taking has diverse meanings across different cultures and healer-patient relationships, so there are different cultures of psychiatric medicine in the U.S., across which drug taking likewise has diverse meanings.<sup>262</sup> Psychoanalysts, for instance, might analyze someone's medication compliance in terms of patient resistance, focusing on how psychologically invested people can be in their own misery—often at the expense of pharmacological treatments. This is a different model of antidepressant action and psychological relief than the one that pharmaceutical companies promote in their advertising for antidepressants. Indeed, the very idea of that a person's psychological needs might make them resilient against pharmacological intervention (the success of which they might experience as a narcissistic injury, or as an undeserved improvement) is in many ways antithetical to the disease model of mental illness. The visual logic of the

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<sup>262</sup> Luhrmann, *Of Two Minds : The Growing Disorder in American Psychiatry*.

Zoloft television commercial (Chapter 2)—in which the transition from depression to happiness is *solely* mediated by a biological mechanism—does not allow for such subjective psychological maneuvering around what antidepressants are ‘supposed to’ do, or how they are supposed to work.

Years before the advent of DTC advertising, analytically-oriented psychiatrists expressed concern over the popular circulation of strictly biological accounts of mental illness.<sup>263</sup> They wondered specifically about how such scientific language—with all its concrete and reductionist implications—would be taken up psychologically by patients. In an interesting counterpoint to the 1980s discourse of destigmatization of mental illness—which made deliberate and strategic use of biological accounts of mental illness—these analysts were concerned about the ways in which such biological accounts could actually precipitate neurotic traits in patients. For instance, writing about psychiatry in the growing context of biomedicine, Gutheil (1982) referred to “the delusion of precision” to describe the belief that “medication [has] the virtues of concreteness, specificity, precision, and straightforwardness.”<sup>264</sup> Nevins (1990) later warned about the ramifications of such a belief in the context of psychotherapy:

“These hypotheses [that antidepressants ‘correct disturbances in brain chemistry’] are replete with phrases such as ‘chemicals going across spaces,’ ‘finding their way to receptors where keys fit,’ ‘blocking of reuptake,’ or with analogies to disturbances in metabolism such as a diabetic individual’s need for insulin. These explanations may stimulate a patient’s unconscious fantasies or confirm pathogenic beliefs of personal defectiveness, deficit, or vulnerability.”

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<sup>263</sup> E.g. G. O. Gabbard, "Psychodynamic Psychiatry in The "Decade of the Brain", " *Am J Psychiatry* 149.8 (1992), D. B. Nevins, "Psychoanalytic Perspectives on the Use of Medication for Mental Illness," *Bull Menninger Clin* 54.3 (1990), E. M. Thompson and H. K. Brodie, "The Psychodynamics of Drug Therapy," *Curr Psychiatr Ther* 20 (1981).

<sup>264</sup> T. G. Gutheil, "The Psychology of Psychopharmacology," *Bull Menninger Clin* 46.4 (1982). (p. 322)



Fantasy and pathogenic belief are ways to buy into the verisimilitudinal truth of advertised depictions of drug mechanisms of action. Here we see how the promised neuroscience of DTC might be taken up as the fantastical science we produce for ourselves as identity-confirming. Dumit (2004) argues that people are interpellated,<sup>265</sup> or persuaded, by scientific, objective facts—that is, people come to experience the rightness of a scientific claim about biology (Dumit’s example is the PET scan image with its accompanying cultural logics about personal identity and social difference) as being intuitively correct.<sup>266</sup> Dumit is making a cultural argument about the circulation of scientific facts, which helps us to frame the psychoanalytic context in which neuroscientific facts become evocative material for narrating one’s suffering and one’s own distance from it.

Indeed, antidepressant advertising interpellates consumers and doctors alike to respond ‘It’s me!’ to their encounters with neuroscience. As we’ve seen, advertising and public relations (PR) are directly about persuasion. One PR pundit, quoted in Michael Levine’s *Guerrilla PR* said of his company, “We don’t persuade people. We simply offer them reasons to persuade themselves.”<sup>267</sup> Writing about his first interactions with a doctor prescribing him an antidepressant, author Joshua Wolf Shenk narrates one moment of biochemical persuasion:

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<sup>265</sup> Louis Althusser has written about how ideology is always working at the self-evident, ‘it’s me!’ level, exploring how individuals express that they are political subjects when they have automatic, knee-jerk identifications with how authority ‘interpellates’ them (his example is that of a police officer yelling ‘Hey you!’ and someone whipping around and thinking ‘yes, it’s me!’). Althusser claims that self-evidence or “obviousness” (e.g. the sense of ‘of course this is me we’re talking about’) is the “elementary ideological effect.” Louis Althusser, “Ideology Interpellates Individuals as Subjects,” *Identity: A Reader*, ed. Paul du Gay (Thousand Oaks, CA: Sage, 2000). (p. 32) This is a framework that Joe Dumit draws off of to talk about how people accept scientific facts about brains and mental illness, with his notion of objective-self fashioning, in that it is “the rightness of facts [that] seem to emerge from our own experience” (2003:37).

<sup>266</sup> Dumit, *Picturing Personhood: Brain Scans and Biomedical Identity*.

<sup>267</sup> Michael Levine, *Guerrilla Pr* (New York: HarperCollins, 1993). (p. 5)

“When my doctor suggested I take Prozac, it was with a casual tone. Although the idea of ‘altering my brain chemistry’ unsettled me at first, I soon absorbed his attitude ... I asked him how such drugs worked. He drew a crude map of a synapse, or the junction between nerve cells ...”<sup>268</sup>

In this case, the neuroscientific theory of depression—which appears in the Zoloft advertisement (Chapter 2) as the theory of how the drug works pharmacologically—is meant to ground consumer experiences of depression, as well as their experiences of antidepressants. In other words, the cartoon in the Zoloft commercial tells us: “*This* is what is going on—*this* is what you’re really feeling.” These are attempts to get people to experience themselves in terms of neuroscientific theory, which, indeed, have been leading to new ways for people to articulate their own hermeneutics of self. For example, I am struck by the following quote from a *Time Magazine* article on antidepressants, written immediately after the introduction of direct-to-consumer advertising (DTC) in the U.S: “Like a headache one doesn’t know he has until it’s gone away, my serotonin deficiency revealed itself only once a drug had filled it in.”<sup>269</sup> Michel Pêcheux’s elaboration of the psychosemiotic machinery of interpellation is helpful here: As Pêcheux would have it, interpellation has a retroactive effect insofar as, at its moment, the individual realizes not only that *of course* something is true about himself, but also that he was “always already a subject.”<sup>270</sup> In this case, the moment of interpellation as a subject of psychopharmacology includes the realization of *always having had* a serotonin

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<sup>268</sup> Shenk, “America’s Altered States : When Does Legal Relief of Pain Become Illegal Pursuit of Pleasure?.” *Harper’s Magazine*, May 1999 (p. 39)

<sup>269</sup> Walter Kirn, “Living the Pharmaceutical Life,” *Time* September 29 1997.

<sup>270</sup> Michel Pecheux, *Language, Semantics, and Ideology* (New York: St. Martin’s Press, 1982). (p. 106)

deficiency.<sup>271</sup> Not just, ‘I am now this new kind of person,’ but ‘I have always been this new kind of person.’<sup>272</sup>

Indeed, in DTC, it is through the psychopharmaceutical that we can *find our (new) selves again*. It is in this reciprocal context of the brand promise and ‘returning to self’ that science becomes a means of self-knowledge. At the same time, in a psychodynamic framework, biochemical explanations of mental illness are ultimately *interpretations* of suffering that must be reckoned with psychologically. For instance, one psychoanalyst noted that, even if such ‘interpretations’ are *correct*—that is, even if they accurately describe a patient’s “biochemical status” (his expression), such interpretations could strengthen patient fantasies of “being deficient.”<sup>273</sup> For this psychoanalyst, the truth of neuroscience is largely irrelevant to its psychological life as fantasy.

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Through literature reviews, interviews with psychoanalysts, attendance of psychoanalysis conferences, and coursework and participant-observation of the presentation of case studies at the Boston Psychoanalytic Society and Institute (BPSI) and the annual meetings of the American Psychoanalytic Association (APsaA), I have been studying how psychodynamically-trained psychiatrists use medication, and how they

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<sup>271</sup> Pêcheux elaborates: “A meaning effect does not pre-exist the discursive formation in which it is constituted. The production of meaning is an integral part of the interpellation of the individual as a subject, insofar as, amongst other determinations, the subject is ‘produced as cause of himself’ in the subject-form of discourse, under the influence of interdiscourse” (1982:187).

<sup>272</sup> This is a kind of self that Foucault never encountered in his exploration of the self of Greek and Roman antiquity (see *The Hermeneutics of the Subject* lectures) [MORE]

<sup>273</sup> M. H. Swoislin, “Psychoanalysis and Medication: Is Real Integration Possible?,” *Bull Menninger Clin* 65.2 (2001). (p. 145)

understand its role in the psychotherapeutic process. Much of this chapter will center on my interviews with Glen Gabbard, who directs the Baylor College of Medicine Psychiatry Clinic, and who holds one of the only endowed chairs in psychoanalysis in the United States. Gabbard has been one of the most visible proponents of incorporating psychoanalytic insights into more mainstream psychiatric treatment regimens, including psychopharmacology. He has been an important ethnographic source for me, especially since he represents a new voice in psychiatry. Gabbard doesn't simply push back against the hegemony of biopsychiatry, but he advocates for a broader understanding of the psychoanalytic implications of the prescription and consumption of psychiatric medication.

Gabbard explained to me that, "it's not an either/or situation with respect to psychotropics and talk therapy; [rather] it's both/and."<sup>274</sup> However, in contrast to primary care doctors or those more biopsychiatric-leaning psychiatrists for whom drug prescribing is often the default treatment, Gabbard explained that psychodynamic psychiatry privileges two things: the uniqueness of subjective experience, and the fundamentally interpersonal nature of mental suffering. Dynamic psychiatrists are interested in what makes one patient differ from another, and they associate healing with an exploration of the patient's own "inner world" and his or her unique "life story." While strictly descriptive tools like a diagnostic guide may be of initial help orient both the psychiatrist and patient, in the end it is the long-term exploration of the unique

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<sup>274</sup> See also H. Azim and S. Duncan, "Psychoanalytic Psychotherapy and Psychopharmacology: Toward an Integration.," *Psychoanalysis and Psychotherapy* 8 (1990), Bernard D. Beitman and Gerald L. Klerman, *Integrating Pharmacotherapy and Psychotherapy*, 1st ed. (Washington, DC: American Psychiatric Press, 1991), Fredric N. Busch and Barnet D. Malin, "Combining Psychopharmacology, Psychotherapy and Psychoanalysis.," *Psychiatric Times* 15.5 (1998), D. L. Cabaniss, "Beyond Dualism: Psychoanalysis and Medication in the 21st Century," *Bull Menninger Clin* 65.2 (2001), G. O. Gabbard, "Dynamic Therapy in the Decade of the Brain," *Conn Med* 61.9 (1997), G. O. Gabbard and J. Kay, "The Fate of Integrated Treatment: Whatever Happened to the Biopsychosocial Psychiatrist?," *Am J Psychiatry* 158.12 (2001).

qualities and origins of one's suffering—self-knowledge gained through the context of the doctor-patient relationship—that is the basis for psychodynamic psychiatry.

Gabbard discussed the example of depression, describing how people often experience their depression as isolating and as taking place in a vacuum, as it were (“nobody to blame but themselves”). But in a psychodynamic understanding, depression is a fundamentally interpersonal phenomenon. In this framework even the very experience of depression as isolating can be interpreted as a form of resistance to identifying the history of one's pathological relationships, which might be part of the depression's psychogenetic etiology. To this end, psychodynamic praxis involves attending to the doctor-patient dynamics over time, to reveal the fundamentally interpersonal nature of the depression.

Psychodynamic psychiatrists emphasize the *therapeutic alliance* as crucial to the treatment of depression.<sup>275</sup> If it was a bad relationship that got somebody into illness, it is the good relationship that will show them the way out. It is in this context that psychodynamically-trained psychiatrists use medication more strategically than the primary care physician: The acts of prescribing and the experiences of consuming medication are never without meaning in the psychodynamic relationship and, at the same time, the effects of the drugs are not taken for granted, since they might have multiple interpretations for both the psychiatrist and patient.

In this sense, pharmaceutical relationships that happen in psychodynamic doctor-patient contexts often subvert scientific objective-self fashioning. For the dynamic

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<sup>275</sup> J. L. Krupnick, S. M. Sotsky, S. Simmens, J. Moyer, I. Elkin, J. Watkins and P. A. Pilkonis, “The Role of the Therapeutic Alliance in Psychotherapy and Pharmacotherapy Outcome: Findings in the National Institute of Mental Health Treatment of Depression Collaborative Research Program,” *J Consult Clin Psychol* 64.3 (1996).

psychiatrist, the operative question is not, ‘is this person chemically imbalanced?’ but rather, ‘why is it important to this person to think of himself as chemically imbalanced?’

In a psychoanalytic context, the chemical imbalance can operate as a *fantasy*—a script that one creates for oneself to express wish-fulfillment—an imaginary satisfaction.<sup>276</sup>

Fantasy is motivated by unsatisfied wishes; it is how we teach ourselves to desire; and it is where the real of one’s suffering gets named.

Gabbard claimed that the biological fantasy often starts with naming—as a concretization and reification of the illness itself. He asked me:

“Are you familiar with the expression, ‘The Principle of Rumpelstiltskin’? There is magic in naming. And one of things you see in clinical work is, even in a first interview, if you name something, there are certain patients whose eyes light up and say, ‘Ah! That’s what I have! That’s what I am!’ And so the name has a magical connotation, because it has an illusion of mastery over a complicated situation. ‘What you have is depression.’ ‘Depression? Ah, that’s what it is!’ And they’ll go read all about it.”

In this scenario, the label ‘depression’ becomes an opportunity for objective-self fashioning, albeit one that Gabbard sees as potentially challenging to the kind of self-exploration that he understands to be at the core of a psychotherapeutic engagement.

Gabbard uses language like “magical connotation” and “illusion of mastery” to describe what can happen to a patient upon getting a diagnosis. And the line between fantasy and delusion here is thin: ‘going to read all about’ one’s newly discovered illness can double as turning away from the context of talk therapy, where the real work of healing is done. Of course, in the relationship model of DTC, going off to research one’s suffering (whose name, perhaps, was just given in a drug advertisement) is precisely what’s expected and encouraged.

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<sup>276</sup> In psychoanalysis fantasy is distinguished from delusion, which is properly about false notions.

Yet Gabbard does not simply discourage a patient from learning his or her diagnosis outside of the context of talk therapy; rather he worries about the ways in which such diagnostic research can become defenses against the work of talk therapy—both as a fetishistic concretization and intellectualization *against* one's suffering, and against true self-understanding: “[DTC] went against the idea that people have depth and substance, and replaced it with flashy surfaces. So I think the idea of the flashy pill taking care of your brain has that appeal to it—that that way you won't have to spend time getting to know yourself.” He continued:

“I try to get my patients to have a sense of an internal world... to help them mentalize themselves as someone who, based on their own unique experiences, has a subjectivity that causes them to understand themselves in a certain way, including the view of themselves as a brain only. There's a great article in *Science* about people looking at images of brains as though that's who they are! There is that sort of thing that's going around, so I try to get people to think about themselves more reflexively, and that's often a big challenge, because often they just want a quick fix.”

For Gabbard, objective-self fashioning can be an obstacle to getting to know oneself by being reflexive. Moreover, putatively objective knowledge about oneself has frustrating implications for one's health care. As Gabbard put it, thinking of oneself as just a brain that is chemically imbalanced, might very well lead to a search for an elusive “quick fix.”

## The pharmaceutical ethics of knowing oneself

My conversations with Gabbard pushed me to think about what kind of self-knowledge is presented in DTC advertising. In Gabbard's language, how do DTC ads get consumer-patients to "mentalize themselves"? What kinds of "subjectivities" are consumer-patients encouraged to identify in themselves? Indeed, there is a particular grammar of knowing oneself in psychopharmaceutical advertising. It starts with a mode of interpellation that proceeds independently of the 'return to self' (see Chapter 2), one that depends dually on and one's own capacity to recognize that they suffer, and the brand's capacity to know and name that suffering. The television commercials from the Zoloft campaign have three key moments of self-knowledge:

1. "You know when you're not feeling like yourself."  
[followed by list of symptoms]
2. "Now here's something you may not know."  
[Depression is a medical condition, and "a chemical imbalance may be to blame ... Zoloft helps to correct this imbalance"]
3. "When you know more about what's wrong, you can help make it right."

In many ways, this is based on a Health Belief Model (HBM), in which an individual's beliefs about his or her own health (including the likelihood that a specific treatment would help) are measured and altered, with the end goal of eliciting action or changed behavior. In DTC, increased self-knowledge should lead to action (taking medication), and it invokes an action-oriented, cognitive-behavioral psychology: You already know yourself (self-knowledge as consumer empowerment); here's what you may not know



about yourself (changing cognition); now you know more about yourself, and you can act decisively (changing behavior). Repeating Gabbard's "Rumpelstiltskin" scenario: " 'Depression? Ah, that's what it is!' And [the patients will] go read all about it."

Health Belief Models are not only part of the narratives of DTC ads, but they also constitute larger pharmaceutical marketing strategies. At the 2004 Pharmaceutical Marketing Congress, Rick Berard (Director of Persistence and Compliance at Biogen) laid out an HBM as a way to understand the "psychology of adherence." In the model, belief leads to behavior—and Berard encouraged pharmaceutical companies to use the model as a way to predict "health-seeking behavior." Good (1994) has argued that HBMs can be understood as "quite explicit theories of culture," and he critiques them as "narrow and classically empiricist theor[ies] of culture as health beliefs" (p. 42).<sup>277</sup> Good references Marshall Sahlins's notion of "subjective utilitarianism" to describe how HBMs assume a 'homo economicus,' utilitarian model of 'health-seeking behavior' in which individuals perform a sort of rational calculus of beliefs, which they then act on in a predictable way.<sup>278</sup> However, in the recent shift towards relationship marketing I have found a novel twist on the HBM subjective utilitarianism, one added a new focus on emotions and self-expression to the more deterministic conception of health beliefs.

In 2004, I participated in a closed workshop on DTC marketing, which involved one of the largest advertising firms in the U.S.<sup>279</sup> The workshop was sponsored by the

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<sup>277</sup> Byron Good, *Medicine, Rationality, and Experience: An Anthropological Perspective*, The Lewis Henry Morgan Lectures; 1990 (Cambridge; New York: Cambridge University Press, 1994).

<sup>278</sup> HBMs were developed in the 1950s by social psychologists (especially Godfrey Hochbaum, Stephen Kegels, and Irwin Rosenstock, all of whom worked for the U.S. Public Health Service) to help explain why free tuberculosis screening programs had failed. E.g. G. M. Hochbaum, "Why People Seek Diagnostic X-Rays," *Public Health Rep* 71.4 (1956), I. M. Rosenstock, M. Derryberry and B. K. Carriger, "Why People Fail to Seek Poliomyelitis Vaccination," *Public Health Rep* 74.2 (1959).

<sup>279</sup> Because of the proprietary nature of the firm's materials, I signed a non-disclosure agreement in which I agreed not to reveal the firm's identity, its clients (specific brands), or its consumer data.

MIT Industrial Liaison Program (ILP), whose own history includes representing one of the earliest efforts in the postwar U.S. to encourage and facilitate formal relationships between academic and industry research. This workshop turned out to be a valuable opportunity for participant observation in pharmaceutical brand development. The firm's team shared with me their own proprietary HBMs, which they called "behavioral pathway" models, and which took the form of pyramid-shaped diagrams that illustrated the psychological steps that consumers would ideally take to get from "brand awareness" to "brand compliance." These behavior pathway models emphasized various emotional stages, including "emotional arousal" (which was accompanied by the explanation "prompting self-reevaluation"), and "emotional relevance" (which was exemplified by the ideal consumer reaction "is for someone like me").

Through relationship marketing, pharmaceutical companies also communicate with patients in a mode that is overtly psychological. Zoloft.com, for instances, offers "tips for managing depression," which includes "pace yourself ... turn to your friends and family ... keep yourself busy ... think positively."<sup>280</sup> These tips, too, are largely cognitive-behavioral: They aim to challenge and change 'thinking patterns,' so that people will behave differently. They are decidedly not psychodynamic. Gabbard writes:

"Perhaps the most common error both of family members and of beginning mental health professionals is to try to cheer up the patient by focusing on the positive ... [but] 'cheerleading' comments are experienced by many depressed patients as profound failures of empathy, which may lead patients to feel more misunderstood and alone ..."<sup>281</sup>

Drug marketing and psychoanalysis alike conceive of the individual's psychological relationship to the pharmaceutical as a path to health. But whereas

<sup>280</sup> [http://www.zoloft.com:80/zoloft/zoloft.portal?\\_nfpb=true&\\_pageLabel=mang\\_plan\\_depr](http://www.zoloft.com:80/zoloft/zoloft.portal?_nfpb=true&_pageLabel=mang_plan_depr)

<sup>281</sup> Op. cit. (p. 230)

marketers see the relationship as a problem of *belief*, analysts see the relationship as a problem of *fantasy*. The difference is not trivial. Belief involves coming under the conviction that something is true. Fantasy, on the other hand, involves an expression of “wish-fulfillment,” or an imaginary satisfaction of unsatisfied wishes. In psychoanalysis, the patient’s fantasy, over time, is supposed to reveal itself to the patient *as fantasy* (i.e. the realization and understanding of the desire beneath the fantasy). For marketing, however, the patient’s belief is supposed to be managed as perception in the pharmaceutical relationship.

In both psychoanalytic and marketing psychology frameworks, patients often don’t know their own motives; they are neurotics who don’t know what they want. And, in both cases, patients are taught to see how they don’t know that they (actually) know what they want: In the case of pharmaceutical marketing, an individual’s knowledge is filled in by the advertisement, and they are invited to act (to “tell your doctor,” etc.). But in the case of psychoanalysis, it is the analyst’s role—not to implant desire or impart knowledge—but to *stand in for* one ‘who is supposed to know’ what the patient really desires. In this sense, the transference relationship is essentially a question of projecting desire that one doesn’t know one has, onto an individual that one supposes would know.<sup>282</sup>

I argue that this is often how DTC addresses the consumer—not as the patient per se, but as *the analyst*. Indeed, DTC posits the consumer as the one who would know—not only as the one who would know himself, but as the one *who would know the drug*. Recall Pfizer’s “Knowing More®” email for Zoloft, which admits “no one knows for

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<sup>282</sup> See John Rajchman, *Truth and Eros : Foucault, Lacan, and the Question of Ethics* (New York: Routledge, 1991).

sure” what causes depression, but then asks about serotonin, “What is it? What does it do?” The answer, of course, is dramatized in the cartoons of neurotransmission; but even those are part of a relationship marketing campaign in which consumers are addressed as unique individuals. It’s not “one knows”; it’s *you know*.

DTC addresses an individual who is seemingly based on a Western metaphysical ideal, namely the “person as a largely coherent, rational, conscious and self-directed being.”<sup>283</sup> Indeed, DTC promotes a real, authentic self – a fixed, only-waiting-to-be-discovered identity – a fully biologically substantiated one at that. The subject of contemporary pharmaceutical advertising is addressed as fully rational. For instance, the voiceover in a television commercial for Zoloft begins as follows: “You know when you’re not feeling like yourself.” As consumers, the DTC audience is pandered to as fully rational in an apparent shift from medical paternalism to consumer empowerment.

The primary means to wellness in psychoanalysis is also self-knowledge. But the knowledge of the self that is arrived at through psychodynamic therapy does not make clear how one is supposed to act. As psychoanalytic theory would have it, this is largely because our psychological constitution is fundamentally conflicted: We are simultaneously possessed of both a drive to know ourselves, and an opposing force that perceives any real self-knowledge to be threatening and hence protects us through a host of defensive mechanisms (e.g. denial and rationalization). Yet it is precisely in this respect that the supposition that one’s desire is fundamentally unknowable can also constitute the ground for an *ethical* relationship that one is supposed to have with oneself through their pharmaceuticals. I find John Rajchman’s clear formulation much to the

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<sup>283</sup> Paul Du Gay, *Consumption and Identity at Work* (London ; Thousand Oaks, Calif.: SAGE Publications, 1996). (p. 51)

point: “Psychoanalysis ... introduces the problem of a new kind of responsibility—the responsibility for our own desire.”<sup>284</sup> As Rajchman argues, the ultimate purpose of an analysis is actually to “deliver us from it”—that is, the analysis should ultimately expose as false the supposition that one’s self or one’s desire can ‘really’ be known. Indeed, it is the ‘knowability’ of oneself which can constitute an ethical framework for the doctor-patient relationship, and for the possible range of actions one might take on behalf of their path to health.

### **Neurochemical flights**

Recall Sarah from the Interlude. Her professional trajectory was shaped by the promises of neuroscience. But her search for the ‘right’ biological story of depression turned on her desire to understand herself (her depression) as ‘really’ a chemical imbalance. Sarah ended up being consumed by an ethical quandary over whether and how she should come to know herself. For instance, in addition to wrestling with whether she should take antidepressants, she kept flirting with the idea of subjecting herself to biogenetic and brain imaging technologies, as a way to diagnose herself and know herself as a new kind of ill person. Sarah’s responsibility for her own desires took the form of not (or no longer) acting on them. Sarah never underwent any diagnostic tests, and she never consumed antidepressants. While she confronted the possibility of taking antidepressants, she never had to negotiate their effects.

In one sense, psychoanalytic understandings of antidepressants obviate debates about the biological ‘reality’ of mental illness since, *irrespective* of its biological

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<sup>284</sup> Rajchman, *Truth and Eros : Foucault, Lacan, and the Question of Ethics*. (p. 42)

instantiation, mental illness will always be in part characterized by “neurotic disturbances” that will have wily interactions with the effects of antidepressants. Medication never has the final say in psychodynamic contexts; their effects are always overdetermined as psychological. When I first met Gabbard at the 2005 meetings of the American Psychoanalytic Association, I asked him whether he thought patients might be able to resist the effects of antidepressants. He responded, “Oh, definitely! It happens all the time. People resist the biochemical effects of antidepressants for all sorts of psychological reasons. Often those reasons aren’t immediately clear, however, which is where a psychoanalytic understanding can be really helpful.”

As Freud’s analysis of conversion hysteria showed, we can ‘think’ with our bodies;<sup>285</sup> and, as contemporary psychodynamic understandings of medication would have it (Gabbard is exemplary here), we can similarly ‘think’ with our antidepressants that make bodily interventions. In this framework, their effects are wily not only because they act on the objectivized body of pharmacological science (where symptoms express the underlying objective deficit); but also because they also act on a *libidinal* body of desire (where otherwise unexpressed psychological conflict can get somaticized).

Indeed, although antidepressants are regularly used in therapy, psychodynamic psychiatrists often worry that they will quell symptoms rather than determining and undoing the psychogenetic causes of which the symptoms are expressions. The effects of these medications—positive or negative—are always made subjective. However, as iek argues, it is never obvious how or in what direction “the chemical solution” will be subjectivized. If the drug ‘works,’ it might lead to an undecidable situation: the removal

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<sup>285</sup> See also Elizabeth Wilson, “Somatic Compliance -- Feminism, Biology and Science,” Australian Feminist Studies 14.29 (1999), Elizabeth A. Wilson, Psychosomatic : Feminism and the Neurological Body (Durham: Duke University Press, 2004).

of the symptom either compels the patient to think the symptoms was therefore meaningless; or the seemingly erased symptom returns “at a more fundamental level”—e.g. the experience of being powerless against some external master whose form just happens to be that of a technological intervention.<sup>286</sup> Either way, the ‘real’ effects of drugs are fantastic, partly because the symptoms they interact with are already overdetermined as symbolic wishes.

In my coursework and library research at the Boston Psychoanalytic Society & Institute (BPSI) I had the opportunity to trace some of the historical underpinnings of the subjectivity of psychopharmaceuticals. Freud (1905) argued that neurotic symptoms are often ways for an individual to relieve himself or herself of unbearable psychological conflict. He referred to such (perfectly reasonable) turning away from reality with the remarkable phrase “flights into illness.” The following fascinating quote is where that phrase first appeared. In it, Freud advises that the doctor should not be the impulsive interventionalist, but sometimes should sit back and let symptoms be expressed without interference, as it were:

“Indeed there are cases in which even the physician must admit that for a conflict to end in neurosis is the most harmless and socially tolerable solution. You must not be surprised to hear that even the physician may occasionally take the side of the illness he is combating. It is not his business to restrict himself in every situation in life to being a fanatic in favor of health. He knows that there is not only neurotic misery in the world but real, irremovable suffering as well, that necessity may even require a person to sacrifice his health; and he learns that a sacrifice of this kind made by a single person can prevent immeasurable unhappiness for many others. If we may say, then, that whenever a neurotic is faced by a conflict he takes flight into illness, yet we must allow that in some

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<sup>286</sup> Slavoj Žižek, “Bring Me My Philips Mental Jacket: The Philosopher Welcomes the Prospect of Biogenetic Intervention,” *London Review of Books* May 22 2003.

cases that flight is fully justified, and a physician who recognizes how the situation lies will silently and solicitously withdraw.”<sup>287</sup>

Freud dissuades physicians from being “fanatics in favor of health,” by which he is referring to the (again, perfectly reasonable) compulsion to keep patients from suffering. For Freud, somatic symptoms can be a means to express bodily what might be too dangerous (socially taboo) to express verbally.<sup>288</sup>

There is a contemporary legacy of this viewpoint, which comes into play in therapeutic milieus where antidepressants are prescribed. One dynamic psychiatrist, who talked at the MIT Rx-ID research group about some of his clinical experiences, recently described his own practice:

“Psychotropic medicine may or may not be employed, but generally plays a minor role, because the goal of analysis is not so much to suppress symptoms as to understand them, and because, as their meanings become clear, symptoms tend spontaneously to resolve.”<sup>289</sup>

In psychoanalytic frameworks, symptoms often have ‘aboutness’ to them—that is, they are not pain or suffering per se, but rather bodily or emotional expressions or stand-ins for something else (unconscious wishes, perhaps). The problem is figuring out this something else; it is always a question of the patient’s not knowing what their anxiety or depression is about.<sup>290</sup> In this model, medication might work on the symptoms of an illness, but not on its underlying structure.

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<sup>287</sup> From Sigmund Freud and James Strachey, *Introductory Lectures on Psychoanalysis* (New York: Norton, 1977).

<sup>288</sup> See especially Josef Breuer and Sigmund Freud, *Freud & Breuer: Studies in Hysteria* ([New York,: Avon Books, 1966).

<sup>289</sup> Cambridge, MA psychiatrist and psychoanalyst David Mann:  
<http://www.mannpsych.com/psychAn.html> (accessed December 2005)

<sup>290</sup> See especially Sigmund Freud, *Inhibitions, Symptoms and Anxiety*, Rev. / ed. (New York: Norton, 1977).



On the one hand, antidepressants may squelch symptoms, making it harder to understand their psychosocial origins. On the other hand, antidepressants might be experienced as having an exaggerated capacity to heal. Glen Gabbard commented, “The privileged perspective of psychoanalysis is meaning ... this is exploited by pharmaceutical companies to not only get people to buy [the drug], but also to enhance the effectiveness of the drug.”<sup>291</sup> I interpret Gabbard to mean that the clarity of meaning resolves symptoms, but the exploitation of meaning suppresses them. This is not a simple opposition of drug/suppression versus talk therapy/resolution, however. Gabbard doesn’t seem to be worried about effectiveness, but rather enhanced effectiveness—an overpromise. The FDA worries about the pharmaceutical overpromise in terms of the surplus health of a population; the psychodynamic psychiatrist might worry about the pharmaceutical overpromise in terms of the surplus health of the individual. As we saw in Chapter 2, the social ambivalence towards drugs in the age of DTC can be realized as the constant demand for more promises about the relationship between illness and science (versus the equally impossible attempt to regulate those promises to conform to science). Here we see the pharmaceutical promise expressed in a new, psychoanalytic idiom in which pharmaceutical companies can enhance a drug’s effect by offering their own pharmaceutical fantasy of health.

Gabbard worries that the pharmaceutical promise might be overdetermined as fantasy. Writing about the use of antidepressants in the treatment of generalized anxiety, for example, he claims that, in the short term, medication might very well be a helpful adjunct to talk therapy, but is unlikely offer permanent benefit:

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<sup>291</sup> This is certainly not lost on drug marketers, who often speak about “perceived efficacy” to characterize the consumer’s evolving relationship to a branded pharmaceutical.

“Medication may at times be a crucial short-term adjunct to psychotherapeutic interventions for GAD [Generalized Anxiety Disorder]. However, it must not be oversold to patients as a definitive treatment for anxiety. Patients need to learn to tolerate anxiety as a meaningful signal in the course of psychotherapy. Those with reasonably good ego strength come to view anxiety as a window into the unconscious.”<sup>292</sup>

I have found that this position is prevalent among psychodynamically-oriented psychiatrists, who wonder about the ego’s strength to tolerate anxiety and depression; it is through the toleration of symptoms that their sources can be revealed and explored. However, as Gabbard suggests, it is part of the process of psychodynamic therapy that a patient must *learn* to tolerate suffering; they must learn to strengthen their ego. Medication might very well flatten out that learning curve.

I discussed the Zoloft campaign with Gabbard, who suggested that the pharmaceutical promises of those ads can thwart the patient’s experience of an antidepressant:

“Most people don’t have that kind of response portrayed in the Zoloft commercial. And then [the patients’] expectations are biased. And they either think that they’re more sick than they’re supposed to be, or that something else is wrong with them. I think that’s another problem with the biological reductionism—it raises their expectations.”

Whereas Healy and Valenstein (Chapter 2) worry about the cultural fanaticism of the chemical imbalance driving up unnecessary (and potentially dangerous) consumption of antidepressants, I understand Gabbard to worry about the “raised expectations” of individual patients once they have already started taking the drugs. Gabbard foreshadows potential therapeutic challenges to come out of the failure of the patient’s experiences on the drug to match up with their fantasy given by DTC.

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<sup>292</sup> G. O. Gabbard, Psychodynamic Psychiatry in Clinical Practice, Fourth Edition (Arlington, VA: American Psychiatric Publishing, 2005). (p. 275).

In the literature reviews I was able to conduct at BPSI, I have found that psychoanalysts generally offer fascinating and ironic two-way traffic between drugs and neuroses, in which one can replace the other. As one analyst put it, “Pharmacotherapy interventions may obscure the differentiation between direct effects of medication on patients and neurotic conflicts in patients.”<sup>293</sup> Just like the placebo effect in the clinical trial, the ‘direct effects’ of antidepressants in psychotherapy is a question of signal detection.<sup>294</sup> Another analyst elaborated on this slippage between “direct effects” and “neurotic conflict” in terms of how those effects which are perceived bodily can actually reinforce psychological fantasies about oneself, including the very idea that what one suffers from is only a physical defect:

“In that case [of a ‘drug-induced improvement in symptoms’], the affective, cognitive, and physical changes *caused* by the medication could, with even greater power, strengthen the patient’s belief that organic factors explain his symptoms ... We can see how a range of pathogenic fantasies could be formidably strengthened by the use of medication because the fantasies would then be joined to *perceptible* affective, cognitive, and physical changes caused by the medication.”<sup>295</sup>

This scenario flips stigmatization on its head, since the antidepressant ‘working’ does not get someone off the hook: Feeling better might very well be a *flight into health*, in which bodily changes given by the antidepressant make one’s fantasy of being ‘really only’ organically ill *even more plausible*.<sup>296</sup> In DTC, the interpellation to take psychopharmaceuticals is often an invitation to capitulate to the discourse of “it’s not

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<sup>293</sup> Nevins, "Psychoanalytic Perspectives on the Use of Medication for Mental Illness." (p. 323)

<sup>294</sup> This understanding of the placebo effect (Lakoff 2001) will be addressed more fully in a following section.

<sup>295</sup> Swoislin, "Psychoanalysis and Medication: Is Real Integration Possible?." (p. 146-147)

<sup>296</sup> In the article, this explanation is contextualized in terms of Freud’s discussion of ego splitting: “through the presence of a physical object ... a perceptible sensory experience is then joined to the wishful fantasy. In other words, the presence of a concrete, perceptible object makes an otherwise untenable fantasy much more plausible” (2001:147-148). Here, bodily experiences are not exempt from subjective interpretation.

your fault.” Why do you take an antidepressant? Because you are not weak, because depression is not your fault, because you are empowered to take medication to treat yourself. But in the psychoanalytic framework, bodies can get psychologically hijacked for flights into health just as well as they can for flights into illness. Indeed, analysts are often suspicious of sudden or spontaneous mental health in neurotic patients—even if it is seemingly brought about through medication.

The psychoanalytic literature has helped me elaborate on Gabbard’s claim that patients don’t often get ‘full’ responses from antidepressants. Gabbard theorizes that when patients do seem to get dramatic responses—when patients are all of a sudden so much better—a red flag should go up to signal a possible resistance to talk therapy:

“Most people get a partial response to an antidepressant, not a complete return to baseline. And if somebody did [get a ‘full’ response], that’s what we’d call a ‘flight into health’—a manic defense in which you say, ‘I don’t need to look at myself any more. I’m out of here.’ And, as a therapist, you try to help them see that there might be a resistance to the therapy process.”

Here Gabbard challenges the assumption that antidepressants have stable and simply interpretable effects. This assumption has enabled various ethical debates around medicating a widening range of depressive symptoms. For instance, in *Listening to Prozac*, Peter Kramer claimed that “[U]nlike marijuana or LSD or even alcohol, [Prozac frees people to enjoy activities that are social and productive] without being experienced as pleasurable in itself.”<sup>297</sup> In a more recent interview, Kramer distinguishes between “drugs that give pleasure directly” and “drugs that give people the ability to function in society, which can indirectly lead to pleasure,” making the ethical argument that, “If the medication can make you work well or parent well, and then through your work or

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<sup>297</sup> Kramer, *Listening to Prozac*. (p. 265)

parenting you get pleasure, that's fine. But if the drug gives you pleasure by taking it directly, that's not a legitimate use."<sup>298</sup> But the psychodynamic framework blurs the distinction between illicit drugs that give pleasure directly and licit drugs that give pleasure indirectly. Indeed, licit antidepressants might very well provide immediate pleasure and a means to 'escape'—even if the authenticity of such a reaction is called into question.

At the same time, Gabbard noted that patients sometimes exhibit resistance that goes in the opposite direction, as a defense *against* the potentially salutary effects of antidepressants:

“A person who has a conviction that they are the worst sinner that ever lived, that they don't deserve to have a good life to feel good, could override the effect of an antidepressant (whatever the biochemical effect is) by having negative expectations: 'This won't work. God won't let it work. God thinks I need to be punished for my terrible misdeeds, and I'll be damned if it's going to work.’”

Here the drug might very well have its intended effects; the patient does not preempt them or amplify them. Rather, the patient *overrides* the effects—she *thwarts* them, out of the sheer guilt of feeling better. The patient's experience of herself splits, as the still-suffering observing ego that looks down disapprovingly at the undeserving hedonist, escapist self—the medicated self whose healing can be undone.

Here the pharmaceutical promise works against one's experience of a drug. And just like Sarah carved out her own ethics of antidepressant consumption in the face of the pharmaceutical promise (i.e. non-consumption), the patient with a “worst sinner” complex carves out her own ethics of pharmaceutical consumption, one in which the very

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<sup>298</sup> Shenk, "America's Altered States : When Does Legal Relief of Pain Become Illegal Pursuit of Pleasure?."

promise of feeling better threatens the patient's desire to know and experience herself as staidly miserable.

### **Pharmaceuticals as the intersubjective third**

In 1953, sociologist Howard Becker showed how first-time marijuana users actually need to be taught by their peers how to experience its effects as pleasurable – ‘being high’ isn’t intuitive or obvious.<sup>299</sup> The idea that drug effects are not always obvious, but that we need to be socialized to experience them, is crucial to understanding how pharmaceutical companies and doctors alike convey messages of illness, science, and drug persistency; as well as to understanding how those messages are consumed and experienced by patient-consumers. ‘Being high’ on a drug or ‘tolerating’ it—both turn out to be social configurations. Indeed, it is in the context of the interpersonal or social relationship that the effects of a drug become fathomable.<sup>300</sup>

I asked Glen Gabbard about how psychoanalytic understandings of antidepressants could contribute to psychopharmacology. He responded:

“One contribution that psychoanalytic thought can make is that the therapeutic relationship of prescriber to patient is more powerful in terms of its effect on outcome than the treatment itself. So, you know, there’s no prescribing apart from an interpersonal relationship.”

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<sup>299</sup> Howard S. Becker, "Becoming a Marijuana User," Meetings of the Midwest Sociological Society (Omaha, NB: 1953), vol.

<sup>300</sup> In addition to Becker's work, there is an interesting but neglected literature from the 1960s on the subtle effects of marijuana, which offers a fruitful comparison for contemporary psychopharmaceuticals. For instance, from Zinberg & Weil (1969): "Apparently, getting high on marijuana is a much more subtle experience than getting high on alcohol: perhaps it is something that must be learned, so that most persons who take the drug for the first-time can not recognize the changes it causes in their consciousness." Norman E. Zinberg and Andrew T. Weil, "The Effects of Marijuana on Human Beings," New York Times May 11 1969.

Psychodynamic psychiatry puts the doctor-patient relationship at the center of its praxis. A core concept is *transference*, or, the way in which a patient experiences the doctor as a stand-in for a past relationship.<sup>301</sup> In psychodynamic psychiatry, transference is both a concept and a practice; the notion of transference has entire professional literatures devoted it, but the transference relationship is always unique to a specific doctor-patient dyad. Psychodynamic psychiatrists have noted that transference can be acted out around medication,<sup>302</sup> including the notion of the “chemical imbalance.”<sup>303</sup>

The centrality of the relationship to psychotherapy is certainly not lost on drug marketers, who now encourage consumers to have relationships with the branded drug. For the marketer, the consumer’s ideal relationship with the pharmaceutical will eventuate in trust and belief in the brand. Marketers have come to speak about this relationship in terms of the brand’s capacity to develop a “personality,” and its ability to project “charisma.” In his book *Emotional Branding*, Gobé (2001) elaborates on the notion of brand personality, introducing it as a key contemporary marketing concept that must be distinguished from the more basic notion of brand identity: “Identity is about recognition. Personality is about character and charisma! Identity is descriptive ... brand

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<sup>301</sup> Transference is based on reenacting (experiencing emotions, acting out) rather than just remembering. Transference relationships are not solely ‘retroactive,’ though—patients constantly toggle between experiencing the doctor as an old object (repetition) and a new object (correction).

<sup>302</sup> R. Brockman, “Medication and Transference in Psychoanalytically Oriented Psychotherapy of the Borderline Patient,” *Psychiatric Clinics of North America* (1990), F. N. Busch and E. Gould, “Treatment by a Psychotherapist and a Psychopharmacologist: Transference and Countertransference Issues,” *Hospital and Community Psychiatry* 44.8 (1993), R. J. Waldinger and A. F. Frank, “Transference and the Vicissitudes of Medication Use by Borderline Patients,” *Psychiatry* 52.4 (1989).

<sup>303</sup> S.N. Lurie, “Psychological Issues in Treatment of The “Chemical Imbalance,”” *American Journal of Psychotherapy* 45.3 (1991).

personalities ... provoke an emotional response” (p. xxx).<sup>304</sup> Similarly, when asked about the use of celebrity endorsements, one panelist at the 2004 Pharmaceutical Marketing Conference remarked that “there is a risk that your brand can become identified with the personality of the celebrity *instead of the brand’s own personality*.”

Just as Sherry Turkle characterizes “relational artifacts” as “not so much inviting projection as demanding engagement,” brand personalities are the basis for *active* relationships with consumers, in distinction to brand identity. For Gobé and other contemporary marketers, relationship marketing is the new model for branding, one that must engage the consumer emotionally, and know him intimately: “Emotional branding is a means of creating a *personal dialogue* with consumers. *Consumers today expect their brands to know them—intimately and individually—*with a solid understanding of their needs and cultural orientation” (p. xxiii).

DTC advertisements for Paxil demonstrate how a pharmaceutical brand is offered as intimately knowing one’s suffering. One television advertisement<sup>305</sup> depicted three social situations from a first-person point of view. Each situation was presented twice—once to depict the distorted perceptions of someone suffering from social anxiety, and once again to depict the undistorted reality of each situation. Here is the voiceover for the beginning of the commercial (the bracketed text appeared on screen during the voiceovers):

What it is [Friday staff meeting]	→	What it feels like [fear]
What it is [college chemistry class]	→	What it feels like [criticism]

<sup>304</sup> Gobé, Emotional Branding : the New Paradigm for Connecting Brands to People. (p. xxiii) See also Daryl Travis, Emotional Branding : How Successful Brands Gain the Irrational Edge (Roseville, Calif.: Prima Venture, 2000).

<sup>305</sup> Recorded in 2002.



What it is [Carl and Veronica's wedding] → What it feels like [avoidance]

We know what social anxiety can feel like, and Paxil can help ... A chemical imbalance could be to blame. Paxil, the only medication proven effective for Social Anxiety Disorder, works to correct this imbalance ...

Here it's not *you know* but rather *we know* (both we at GlaxoSmithKline, and the 'royal we' of the Paxil brand). Here, Paxil's 'personality' is that of a brand that knows your suffering—which has seemingly *experienced* it (hence the first-person enactments of social anxiety), and which can help to relieve that suffering. Thus GlaxoSmithKline is seeding the future transference relationship to the drug, before it's even consumed.

Epistemological uncertainties about the effects of pharmaceuticals can also be undone through the charismatic resolutions of the brand personality who already knows you. Indeed, brand loyalty is also solution to problems of uncertainty, insofar as it "holds problems at bay," as one marketer noted about pharmaceuticals in particular:

"Big brands can project a kind of 'charisma' which offers to resolve problems. Belief in the brand can magically hold problems or difficulties at bay, big brands involve an act of faith that allows the consumer to get on with their lives without worry ... At their highest level truly profound brands shape the way that people see the world and charismatically 'resolve' issues of doubt and uncertainty in everyday life."<sup>306</sup>

Just as Gabbard noted that there is "magic in naming" through which one's illness identity is reified ("aha, that's what I have!"), this marketer claims that there is magic in belief in the drug brand, through which one's relationship with a pharmaceutical is crystallized.

In the age of relationship marketing, advertising literature abounds with the notion that a brand can *know who you are*. As Gobé points out, this is a new terrain for the

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<sup>306</sup> Mike Owen and Jon Chandler, "Pharmaceuticals : The New Brand Arena," International Journal of Market Research 44.4 (2002).

brand, whose development and relationship to consumers has hitherto been defined in terms of *identity*, or what the brand ‘stands for.’ But now, through the brand, the pharmaceutical relationship comes to be about *time* and *persistence*, and less so about identity. It is an invitation to divert the misery of chronic illness as a place for working through, for developing the ‘good relationship’—a lasting, hopefully lifelong relationship—with one’s pharmaceutical. As psychoanalyst Adam Phillips writes, “‘Good’ relationships become those in which people can tolerate a lot of frustration.”<sup>307</sup> Indeed, relationships don’t just *comply*; they *persist*. Even the very language of brand *loyalty* is evocative of ‘the good relationship’ in Phillips’ sense—loyalty implies persistence through difficulty. And persistence is effortful, as one drug marketer notes:

“Patients will have their own unique obstacles, depending on the severity of their condition, the number of medications being taken simultaneously, and their health insurance status. Various tactical strategies apply according to the particular challenge at hand. For example, helping patients set appropriate expectations and deal with any initial side effects is often critical.”<sup>308</sup>

Indeed, as we saw in Chapter 1, marketing is no longer just about convincing people to take drugs; it has evolved to be about teaching people how to tolerate staying on them. And as the above quote suggests, this process simultaneously involves a here-and-now, day-to-day engagement with one’s body (“dealing with side-effects”) and a psychological orientation to a promised future (“setting appropriate expectations”).

To the point, the Zoloft website explains “what to expect on Zoloft” that urges you to stay the course with Zoloft, emphasizing *your uniqueness* (you might get side-effects, you might not), and even offering branded care-of-the-self tips like, “For people taking Zoloft: Try relaxing with some deep breathing exercises. They can create an inner

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<sup>307</sup> Adam Phillips, *On Flirtation* (Cambridge, Mass.: Harvard University Press, 1994). (p. xviii)

<sup>308</sup> Op. Cit.

calm and a defense against stress.”<sup>309</sup> At the same time, websites like this illustrate that, in the age of relationship marketing, the pharmaceutical brand is not simply charismatic, and consumer engagement with the pharmaceutical brand is not blindly faithful; the consumer must *work with* the brand at the level of identity (what kind of unique relationship can *I* have with Zoloft), and *be worked on* at the level of governmentality (being taught to stay the course through side-effects). Transference and self-knowledge collide in contemporary DTC since it is in the context of relationship marketing that the brand that will know us.

Psychoanalysts refer to “the intersubjective analytic third” to describe how the analyst and the patient unconsciously create an unsaid, third subject/presence that “takes on a life of its own” within the doctor-patient relationship.<sup>310</sup> The analytic third is “more verb than noun”<sup>311</sup> in that ‘it’ dynamically structures the otherwise dyadic relationship. The antidepressant can function in just this respect, acting as a third presence whose wily effects can both reflect and alter the therapeutic alliance.

For example, pills themselves can become transitional objects for patients; they can ‘stand in’ for the physician, whose relationship with the patient can then be acted out and negotiated.<sup>312</sup> One analyst gives the example of not taking medication or not filling prescriptions (non-adherence) as a means of acting out against one’s doctor:

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<sup>309</sup> [http://www.zoloft.com:80/zoloft/zoloft.portal?\\_nfpb=true&\\_pageLabel=what\\_to\\_expect](http://www.zoloft.com:80/zoloft/zoloft.portal?_nfpb=true&_pageLabel=what_to_expect)

<sup>310</sup> See especially T. H. Ogden, “The Analytic Third: Working with Intersubjective Clinical Facts,” *Int J Psychoanal* 75 ( Pt 1) (1994), T. H. Ogden, “The Analytic Third: Implications for Psychoanalytic Theory and Technique,” *Psychoanal Q* 73.1 (2004).

<sup>311</sup> T. H. Ogden, “The Analytic Third: An Overview,” *fort da* 5.1 (1999).

<sup>312</sup> S.A. Adelman, “Pills as Transitional Objects: A Dynamic Understanding of the Use of Medication in Psychotherapy,” *Psychiatry* 48.3 (1985), R. Hausner, “Medication and Transitional Phenomena,” *Int J Psychoanal Psychother* 11 (1985).

“Medications and prescriptions can be kept instead of swallowed, allowing the patient to keep the provider in effigy ... Problems with adherence may be understood as ways for the patient to keep, consume, or discard a transitional object instead of the provider they represent, thus removing the danger of object loss.”<sup>313</sup>

Gabbard similarly makes reference to “manipulative help-rejecters” who “systematically defeat every treatment intervention, pharmacological or otherwise.”<sup>314</sup> Such patients will typically have gone through a large number of psychotropic medications without benefit. Gabbard presents one case study in which a depressed person’s resistance to extensive and multiple drug treatments was finally understood as the external repetition of “internal object relations.”<sup>315</sup> Whereas members of the hospital treatment team were repeatedly frustrated in their seemingly good-intentioned attempts to modify the treatment plan, the patient—in his very role as “help-rejecting complainer”—was caught in a reenactment of internal object relations in which he found himself surrounded by people incapable of helping him.

In Gabbard’s analysis, this case “illustrates how a severe depression that is refractory to conventional somatic treatments may be related to formidable characterological resistances that cause the patient to become ‘stuck’ in an unresolved self-object relationship.”<sup>316</sup> In the psychodynamic context, such resistance to the medication itself is a stand-in for resistance to *the therapist’s help*. Prescription medication is necessarily tethered to the doctor, through whose (perhaps symbolically parental) authority offers material help in the form of drugs. It is in this sense that

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<sup>313</sup> S.N. Wilson, “The Meanings of Medicating: Pills and Play,” *American Journal of Psychotherapy* 59.1 (2005). (p. 21)

<sup>314</sup> Gabbard, *Psychodynamic Psychiatry in Clinical Practice, Fourth Edition*. (p. 145)

<sup>315</sup> In psychoanalytic theory, “object relations” refers to how an individual internalizes and represents interpersonal relationships to him/herself. It is not so much a person who is internalized, but one’s own relationship with that person that is internalized.

<sup>316</sup> *Ibid.* (p. 234)

medication can function as an introject of the prescribing psychiatrist, its effects struggled with and worked through as an extension of the analyst. Gabbard suggests that in such cases an exploration of the doctor-patient transference dynamics can reveal how the somatic and psychological resistance of antidepressants is actually an acting-out against parent figures, whom the patient perhaps perceives as never having been loving enough. The antidepressant becomes a thoroughly social and interpersonal object, one whose putative biological factors are experienced and interpreted as expressing a (perhaps unsaid) feature of the doctor-patient relationship.

### **Pharmaceutical seduction**

Through DTC advertising of antidepressants (which never mention psychiatry or psychiatrists, only “medicine” and “doctors”), pharmaceutical companies have encouraged a shift towards the primary care physician as the main prescriber of psychiatric medication, to help grow sales. It has worked; antidepressants are now the third largest selling category of drugs in the world, next to cholesterol and heartburn medication.<sup>317</sup> As we saw in Chapter 1, this is also part of a larger shift in healthcare in which doctors see more patients, but spend less time with each. Pharmaceutical marketers have seen this as a key opportunity to shape primary care physician’s knowledge of specialty medications, including antidepressants.<sup>318</sup> Glen Gabbard commented on this as

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<sup>317</sup> Denise Grady and Gardiner Harris, “Overprescribing Prompted Warning on Antidepressants,” New York Times March 24 2004.

<sup>318</sup> Jill Balderson, “More Education, Less Promotion : Patient Materials Should Teach Rather Than Tell,” Pharmaceutical Executive March (2006).

the phenomenon of “interchangeable health care providers, where the relationship [between doctor and patient] is insignificant”:

“You know my favorite story—this is true—is that one of my buddies (he’s a psychiatrist) joined one of these managed care panels, and he got instructions on how to do his job. And one of the instructions was ‘Don’t let the patient get attached to you.’ Good advice, you know? But this is the thinking: You’re just a functionary who hands out a prescription—but don’t get attached, because I don’t want to see you any more. I don’t want to talk to you and use more of your time, because that won’t be cost-effective. It sounds like a joke, but it’s true.”

Gabbard is reacting with a sort of comic disbelief to the very idea that the basic role of a psychiatrist is to prescribe medication. For Gabbard, it is precisely the doctor-patient relationship—with all its one-on-one transference and counter-transference—that is the basis for reliable psychotherapy. But as George from InfoMedics (Chapter 1) claimed, it is largely because of the restrictions brought about by managed care that pharmaceutical marketing has assumed such a central and mediating role in the doctor-patient relationship. George sees great potential for patient-communications programs and brand development to “fill in the gap” that managed care has left in the doctor-patient relationship, but, for Gabbard, there is nothing that can substitute for the relationship itself.

Gabbard’s concerns about the way in which managed care threatens the doctor-patient relationship can be also understood as part of a contentious history between pharmaceutical companies and American psychiatry, whose own disciplinary tensions between biopsychiatrists and more psychodynamically-oriented psychiatrists had to account for the new presence of psychopharmaceuticals. For instance psychiatrist Mortimer Ostow warned in 1961 that, after the advent of the so-called major and minor tranquilizers:

“[T]he development of the newer drugs has profound implications for the practice of psychotherapy ... there is the omnipresent danger of unwise use. The easy promise of relief may seduce the physician and cause him [sic] to lose interest in the psychological aspect of mental illness and to minimize the problems of the internal personality.”<sup>319</sup>

Ostow was writing amidst institutional tensions between psychoanalysis (which emphasized psychological etiologies for mental illness) and an emerging biopsychiatry (which advocated a model of symptom relief, albeit one that, in 1961, was promoted primarily as a way to facilitate doctor-patient rapport in the therapeutic context of talk therapy). And a few years later a *New York Times* article on Nathan Kline reported that, “[s]ome psychoanalysts claim that the over-publicizing of drug therapy has even retarded the progress of psychiatry by luring younger doctors away from the analytic field.”<sup>320</sup> Once again we see the language of “over-“ to express concern: “Over-“ does not imply that something is fundamentally or inherently or essentially problematic; rather it implies that something has *exceeded* a certain social threshold.

Writing ten years later about some of the unintended medical and social fallout of the widespread use of antipsychotic drugs (especially long-term physical side-effects and the problems of deinstitutionalization), psychiatrist George Crane seemed to confirm Ostow’s worry:

“Less published is the [psychiatric] patient’s dependence on drugs. The medical staff gains a feeling of accomplishment from the patient’s adherence to a prescribed regime, while the nursing personnel and relatives, who are in more direct contact with the patient, derive a spurious feeling of security when the doctor’s orders are carried out. Thus, the prescribing of drugs has in many cases become a ritual in which patients, family members, and physicians participate. Mystification ... plays a central role in the contemporary practice of

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<sup>319</sup> Mortimer Ostow, “The New Drugs,” *Atlantic Monthly* 1961. (p. 96)

<sup>320</sup> Thomas Fleming, “The Computer and the Psychiatrist,” *New York Times* April 6 1969.

psychopharmacology, inasmuch as neuroleptics are often used for solving psychological, social, administrative, and other nonmedical problems.”<sup>321</sup>

Ostow and Crane both used the language of “seduction” and “mystification,” respectively, to characterize physicians’ own relationships with the advent of psychopharmaceuticals. This very language has been picked up in contemporary debates over the use of neuroscientific theory in DTC advertising for psychopharmaceuticals. For instance, from a *HealthDay News* article: “if you hear though that it’s [depression is] really nothing more than a ‘chemical imbalance’—that that’s why you have these feelings—it makes it all very simple and seductive.”<sup>322</sup>

The language of seduction here should not be overlooked. Seduction implies mystery and hiding, and it depends fundamentally on *withholding* what is desired. Seduction is the play of revealing and concealing. The history of psychopharmacology repeatedly shows psychiatrists worried not just that pharmaceuticals are overrated or overused or misused, but that they were *seductive*—that they (and all their advertising claims) pandered to the desire that mental illness could be treated simply and definitively, but in so doing led psychiatrists astray. This history turned out to anticipate contemporary criticism that pharmaceutical companies can seduce psychiatrists into overprescribing antidepressants and overemphasize the efficacy of antidepressants. Later in this chapter we will see how the question of the appropriateness of antidepressants in the psychiatrist’s office got revisited as a question of the placebo effect in the clinical trial.

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<sup>321</sup> George E. Crane, “Clinical Psychopharmacology in Its 20th Year : Late, Unanticipated Effects of Neuroleptics May Limit Their Use in Psychiatry,” *Science* 181 (1971). (p. 125)

<sup>322</sup> Quoted in E.J. Mundell, “Debate Simmers over Popular Antidepressant Ad Claims,” *HealthDay* (2006).



As Montagne (1998) has noted, pharmaceuticals have become “visible sign[s] of the physician’s power to heal, and ... is a symbol of the power of modern technology.”<sup>323</sup> Along these lines, in a guest lecture for a Harvard history of psychiatry class that I assisted Leon Eisenberg<sup>324</sup> claimed that, “one of the reasons why psychiatrists have glommed onto drugs is because it makes them look respectable. I mean, they [the drugs] are good, but not that good.”<sup>325</sup> Eisenberg was commenting on the disconnect between the less-than-spectacular overall efficacy of psychiatric medication and the robust cultural salience—among both doctors and patients—of the very idea that psychiatric drugs could cure mental illnesses. Eisenberg’s comments about psychiatrists glomming onto drugs for reasons of professional alignment with internal medicine (“because it made them look good”) is reminiscent of Freud’s discussion of “wild analysis”—a phrase he coined to describe the practice of over-zealous and often self-gratifying psychoanalysts who would offer their patients their own full interpretations of their symptoms, to no real clinical benefit. As psychoanalyst Fred Busch writes, “[t]he primary technical error Freud cites is the belief that the patient suffers from a type of ignorance, and that by informing the patient one will have cured the neurosis.”<sup>326</sup> Of course, this is in marked contrast to the consumer empowerment discourse of DTC advertising, with all its language of providing healthcare information. For instance, one Pfizer-sponsored publication (released in 2001) was entitled, “Prescription Drug Advertising: Empowering Consumers Through Information.” Freud’s English translator and fellow analyst James Strachey reflected on

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<sup>323</sup> Michael Montagne, “The Metaphorical Nature of Drugs and Drug Taking,” *Social Science and Medicine* 26 (1988).

<sup>324</sup> The Maude and Lillian Presley Professor of Social Medicine, Emeritus, Harvard Medical School

<sup>325</sup> October 8, 2003. Guest lecturer for Harvard University course HS177.

<sup>326</sup> F. Busch, ““In the Neighborhood”: Aspects of a Good Interpretation and A “Developmental Lag” In Ego Psychology,” *J Am Psychoanal Assoc* 41.1 (1993). (p. 156)

this potentially dangerous role of interpretation in the doctor-patient relationship, this time from the patient's side, noting that patients would sometimes "spend hours at a time in providing correct interpretations of their own—often ingenious, illuminating, correct. Others, again, derive libidinal gratification from being given interpretations and may even develop something parallel to a drug-addiction to them."<sup>327</sup> In light of this Strachey referred to interpretation and its "remarkable efficacy as a weapon." Indeed, as we saw with the critiques of pharmaceutical marketing (Chapter 2), the very idea that information is curative can be deeply threatening.

In this sense DTC offers *interpretations* when it hails individuals to pharmaceutical self-knowledge. It performs (really bad) psychoanalysis, insofar as psychoanalysts have understood biomedical hegemony in American psychiatry in terms of countertransference in the doctor-patient relationship. Anthropologist Tanya Luhrmann describes a "central feature of the psychiatric scientist" as "that the personhood of neither the psychiatrist nor the patient is relevant to the efficacy of psychiatric treatment."<sup>328</sup> Luhrmann quotes one of these psychiatric scientists, who chose his profession over psychoanalysis:

"I was trying to do psychoanalytic research, which was completely obsessional and now, I think, pretty meaningless, trying to define undefined terms and at the same time getting pretty angry at some these psychodynamic diagnoses which let you claim victimhood. But then in residency I started out on a largely biomedical unit, and it was a completely unanticipated delight. Patients were getting better. If the first medication didn't work, you tried another, and there was always a

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<sup>327</sup> James Strachey, "The Nature of the Therapeutic Action of Psycho-Analysis," *International Journal of Psychoanalysis* 15 (1934). (p. 141)

<sup>328</sup> She elaborates: "By 'personhood,' I mean the idiosyncratic features that make someone who he [sic] is: how and when he gets angry, what he fears, how he raises his eyebrow, whether he is abrupt or rude or gentle. Those features (unless they are diagnostic) simply aren't salient to whether the psychiatrist has chosen the right medication or whether the medication will work. The independence of personhood and the things that count repeats itself through most aspects of psychiatric science" (p. 127)

solution to a problem. And you felt so powerful and effective because you were actually doing this action.”<sup>329</sup>

Here it is through prescribing drugs that *the doctor* becomes effective. I find Evelyn Fox Keller’s claim about the practice of science and its relationship to objectivity helpful here: “The scientist is not the purely dispassionate observer he idealizes, but a sentient being for whom the very ambition for objectivity carries with it a wealth of subjective meaning.”<sup>330</sup> This “psychosociology of scientific knowledge” can be realized on two levels: On the one hand, some analysts have characterized the very act of prescribing antidepressants as an “inexact interpretation,” namely the reinforcement of a patient’s own conscious or unconscious fantasy that their symptoms must be explained biologically.<sup>331</sup> On the other hand, the physician’s sense of his own effectiveness can be manifested as countertransference, as Glen Gabbard narrates:

“One common manifestation of countertransference is overprescription. It is not uncommon for a patient to arrive at a hospital or an emergency department with a brown paper bag full of psychoactive agents. One such patient was taking three antipsychotics, two antidepressants, lithium carbonate, and two benzodiazepines. After a few days in the hospital, it was apparent that this patient evoked intense feelings of impotence and anger in treaters. The excessive amounts of medication reflected the countertransference despair of the attending psychiatrist.”<sup>332</sup>

Countertransference doesn’t only have to be manifested as *over*prescription, however. In my reviews of psychoanalytic literature I found cases to complement the overprescription scenario that Gabbard outlines. For instance, in one such case study an analyst wonders whether his decision to prescribe Zoloft might really have led to “an iatrogenic

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<sup>329</sup> Ibid. (p. 175)

<sup>330</sup> Evelyn Fox Keller, Reflections on Gender and Science (New Haven: Yale University Press, 1985). (p. 96)

<sup>331</sup> E.g. Nevins (1990)

<sup>332</sup> 2005:146

perversion,” in which—in the very act of prescribing an antidepressant—he was complicit in reinforcing his patient’s fantasy that she did not need to do the work of psychotherapy, and that she was fine but ‘only needed medication’: “Perhaps I was, through the effects of the medication, convincing K that she is indeed as independent, powerful, and intact as she wishfully imagine.”<sup>333</sup>

Both of these examples echo Crane’s warning in 1971 about the potential misuses of psychiatric medication as a means to “derive a spurious feeling of security” on the part of the doctor. And both point to an alternative ethics of the pharmaceutical relationship, one that privileges not only the patient’s subjectivity, but the psychiatrist’s subjectivity. Psychoanalyst Owen Renik writes:

“It seems to me that ...we are always completely personally involved in our judgments and decisions, and it is precisely at those moments when we believe that we are able to be objective-as-opposed-to-subjective that we are in the greatest danger of self-deception and departure from sound methodology.”<sup>334</sup>

### **Specifically real**

Leon Eisenberg similarly spoke of a surge among physicians of a zealous attitude towards psychiatric drugs in the 1970s, one that corresponded with a shift from understanding psychiatric illness on a more dimensional basis to a more categorical one.<sup>335</sup> In a recent guest lecture for a Harvard history of psychiatry course for which I

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<sup>333</sup> Swoislin, "Psychoanalysis and Medication: Is Real Integration Possible?." (p. 156)

<sup>334</sup> O. Renik, "Analytic Interaction: Conceptualizing Technique in Light of the Analyst's Irreducible Subjectivity," *Psychoanal Q* 62.4 (1993). (p. 562)

<sup>335</sup> Cf. Joel Braslow’s article on how the new biological discourse for General Paralysis of the Insane (GPI) and malaria fever therapy changed how doctors would interact with patients: J. T. Braslow, "The Influence of a Biological Therapy on Physicians' Narratives and Interrogations: The Case of General Paralysis of the Insane and Malaria Fever Therapy, 1910-1950," *Bull Hist Med* 70.4 (1996).

was the head teaching assistant, former director of the National Institutes of Health (NIMH) Steven Hyman characterized this as “medicine envy” on the part of psychiatry and psychology: “that is, medicine has ‘real’ diseases with ‘real’ treatments.” He continued:

“One dominant model [of mental disorders] that came from Freud and psychoanalysis was that there was a normal development continuum and, depending on where your normal development was interrupted by some trauma ... that would determine your symptoms. And Robins and Guze<sup>336</sup> and others at Washington University basically said, ‘that doesn’t make any sense – we think these disorders are different from each other. Depression isn’t on a continuum with schizophrenia, and that’s not on a continuum with panic disorder, and we’re going to have *real* medical disorders, and the way we’re going to get there is just like real medicine, which is where we’re going to see which symptoms cluster together.”

Hyman characterized Robins and Guze as “splitters” who wanted “clear separations between disorders,” and that this approach was operationalized in 1980 by Robert Spitzer, who led the development of the DSM-III—the first psychiatric diagnostic guide to more or less abandon psychodynamic and dimensional models of mental disorders in favor of categorical ones. But, Hyman emphasized, the symptom clusters—or syndromes—in the DSM-III might have been made reliable, but they were not necessarily valid: “Reliability is that people will agree on the same diagnosis for the same patient, whereas validity is about picking out natural kinds—something in the real world.”

David Healy (Chapter 2) has called this shift from validity to reliability “putting a premium on the medical model [of mental illness,]”<sup>337</sup> arguing that the FDA has locked the pharmaceutical industry into developing drugs for medical diseases rather than for

<sup>336</sup> Their key article was: E. Robins and S. B. Guze, “Establishment of Diagnostic Validity in Psychiatric Illness: Its Application to Schizophrenia,” *Am J Psychiatry* 126.7 (1970).

<sup>337</sup> Healy, *The Antidepressant Era*. (p. 257)

broader indications such as the “reduction of tension” or the “provision of a tonic”—more dimensional notions of drug action that hark back to the early applications of minor tranquilizers in psychotherapeutic contexts. But connecting specific psychopharmaceuticals with specific DSM disorders has meant devising and fine-tuning the notion of chemical specificity. For instance, the first physician-directed advertising campaign for Prozac began: “There is considerable evidence that serotonergic function may be reduced in the brains of depressed patients,” and introduced Prozac as “a *specifically*-different antidepressant ... chemically related to all other available antidepressants ... Its distinctive chemistry means greater specificity” (emphasis in original). The advertisement never claims that Prozac is any more efficacious than any other antidepressant.<sup>338</sup> Rather, the ad emphasizes how the drug’s chemical make-up distinguishes it from other drugs: Prozac is “chemically unrelated to all other available antidepressants,” and “its distinctive chemistry means greater specificity”—both claims are true by definition, and have no obvious connection to efficacy. This campaign set the stage for the ‘me-too’ drug phenomenon with antidepressants, in which Freud’s “narcissism of small differences” would come to define how pharmaceutical companies would make neuroscientific promises.

Indeed, just how ‘fine-grained’ the cultural imaginary of drug specificity can become is still up for grabs: A 2005 physician-directed ad for the antipsychotic medication Remeron asked “What’s the difference between SSRIs and Remeron?”<sup>339</sup> The answer:

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<sup>338</sup> A claim not permitted by the FDA, because the drug was compared to placebo, not to another antidepressant (see Chapter 1 on the relationship between clinical trials and product claims in pharmaceutical advertising).

<sup>339</sup> From *The American Journal of Psychiatry* (2005).

**SSRIs... Somewhat Selective**

SSRIs block serotonin reuptake.

Serotonin stimulates 5-HT<sub>1</sub>, 5-HT<sub>2</sub>, and 5-HT<sub>3</sub> receptors.

Stimulation of 5-HT<sub>1</sub> and 5-HT<sub>2</sub> receptors has been associated with common serotonergic side effects.

Concomitant use with a monoamine oxidase inhibitor (MAOI) or use within 14 days of initiating or discontinuing therapy with an MAOI is not recommended. (See WARNINGS.)

In premarketing clinical trials, two out of 2796 patients developed agranulocytosis and a third patient developed severe neutropenia. All patients recovered after discontinuation of therapy. (See WARNINGS.)

**REMERON... Downright Picky**

Mirtazapine is a novel noradrenergic and serotonergic pharmacological agent.

Provides effective relief of depression and has a favorable effect on anxiety and sleep disturbances associated with depression.

Minimal incidence of common serotonergic side effects such as nausea, nervousness, insomnia, and diarrhea. Normal electrocardiogram.

In US 6-week controlled trials, the most commonly reported adverse events associated with REMERON therapy were somnolence (54%), increased appetite (7%), weight gain (17%), and dizziness (7%).

ONCE-A-DAY  
**REMERON**  
(mirtazapine) Tablets  
Downright Effective... Downright Different

This ad for Remeron still capitalizes on the ‘magic bullet’ image of the SSRI, showing how mirtazapine binds to a single subtype of the serotonin receptor. Like its predecessor Prozac ad, this ad does not promise greater efficacy, but rather more exact science.

This refining of chemical specificity in the marketing of antidepressants happens in DTC, too. For instance the website for Lexapro, under the heading “How it works,” offers an animated video that depicts and explains the pharmacology its active chemical escitalopram.<sup>340</sup> The video’s voiceover introduction begins in the following way:

“From the riches of Louis Pasteur’s laboratory came the discovery of chirality—the handedness of chemistry. Now, over a century and a half later, the

<sup>340</sup> [http://www.lexapro.com/english/about\\_lexapro/isomer\\_animation.aspx](http://www.lexapro.com/english/about_lexapro/isomer_animation.aspx) (accessed July 4, 2006)

fruits of Pasteur's discoveries are the basis for one of today's most compelling pharmaceutical advances—single isomer isolation. Only recently have new techniques emerged which makes the separation of isomers possible. A novel SSRI, Lexapro, has been developed using this technology to isolate the therapeutically active component of the highly successful antidepressant Celexa.”

The video and voiceover continue, spending nearly five minutes to describe the science of chemical chirality and stereoisomers. Importantly, this science is discussed in terms of brand names. “Celexa” and “Lexapro” are referred to much more frequently than “citalopram” and “escitalopram”, and thus it is the brands themselves that are said to be possessed of certain chemical properties.<sup>341</sup> Like Prilosec and Nexium (Chapter 1), Celexa and Lexapro are examples of ‘me-too’ competitor drugs, manufactured and marketed by the same company.<sup>342</sup> Lexapro was introduced in 2002, at the same time that Celexa's patent was due to expire, and when the drug would first face competition from its generic equivalents. Although the clinical differences between Celexa and Lexapro are negligible, their chemical differences were enough to warrant a separate patent for Lexapro. As one marketer noted, “From a clinical perspective, any differentiation [between Celexa and Lexapro] is ambiguous; however, Forest's<sup>343</sup> marketing strength will ensure the switch strategy is effectively implemented.”<sup>344</sup> The “switch strategy” refers to getting patients who are taking Celexa to switch to Lexapro. Indeed, now [celexa.com](http://celexa.com) opens with the following message: “From Forest Laboratories ... The next

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<sup>341</sup> As Nikolas Rose has suggested, we are “becoming neurochemical selves,” insofar as we understand sadness as a sign of depression and depression as caused by chemical imbalances (2002, Unpublished Manuscript). But as the Lexapro website suggests, this very notion of “chemical imbalance” has become too general; contemporary DTC advertising for antidepressants shows the ways in which people are *differently* chemically imbalanced.

<sup>342</sup> See Chapter 1 for a discussion of me-too drugs.

<sup>343</sup> Forest Laboratories, the company that makes both antidepressants.

<sup>344</sup> Quoted in *Med Ad News* (2002). “Tough act to follow: Lexapro is the follow-on compound to the highly successful antidepressant Celexa.” 11(30).



generation of Celexa is available: LEXAPRO—the fastest growing SSRI in the U.S.” Again, the pharmaceutical promise is not one of greater efficacy, but better science.

Drug marketers talk about “the brand promise” as a way to connect perceived health with specific brands. The brand promise “more effectively *establish[es] brand expectations that will be fulfilled in the brand experience.*”<sup>345</sup> One pharmaceutical marketer described this in terms of the “functional values” of a brand, or “What the brand *does* for me.” He gave the following example: “For Nurofen these values might ‘fast,’ ‘effective’ and ‘no side effects’.”<sup>346</sup> Here it is *the brand* that would seem to act medically; it’s Nurofen the brand that is “fast” and “effective,” and it is precisely the imparting of medical functioning to brand names (not chemical names) that drug marketers strive for. Similarly, the director of the marketing firm that came up with the name Prozac explained the rationale for the name: “It’s short and aggressive, the ‘Pro’ is positive, and the Z indicates efficacy.”<sup>347,348</sup> As marketing psychologist Richard Vanderveer recently put it, “a product is more than the chemical entity, incorporating all the claims and expectations the company attaches to it in the marketing process” (2006). As we’ve seen, in the case of antidepressants it is the neuroscientific promise that is ‘more than the chemical entity.’ We’ve also seen how the neuroscientific promise also constitutes the

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<sup>345</sup> Seget (2006:103); emphasis in original

<sup>346</sup> Tom Blackett and Rebecca Robins, Brand Medicine : The Role of Branding in the Pharmaceutical Industry (New York: Palgrave, 2001). pp. 16-17

<sup>347</sup> Quoted in Shenk (1999:49n)

<sup>348</sup> Another description: “One of the most successful drugs in recent decades has been the antidepressant fluoxetine, much better known as Prozac. The name has nothing to do with the drug’s chemical makeup or how it is used. It has other things going for it. It begins with the positive associations of pro- and, just as importantly, with a punchy plosive. Having built up force, it links to z, evoking speed (except for ‘zzzz,’ of course, though that, too, may be an element in the drug’s success) and pops out another plosive, k, at the end. The drug plainly sounds as if it would work” “The Making of a Name,” Advertising Age (2005). (March 1, p. 3).

expectations that patients and psychiatrists alike must wrestle with as part of the ethical plateau of the pharmaceutical in the age of DTC.

### **Wily subjects and the placebo effect**

Drug marketer Mickey Smith (Chapters 1 & 2) makes specific reference to the placebo effect to drive home the point that marketers need to learn to work with a consumer-patient's belief to create a truly successful marketing campaign:

“Past and present beliefs (whether based in facts or not) ... have an important and complex influence on consumer behavior. Believing is an important component of successful medical treatment. It is the basis for the placebo response and the reason for double-blind clinical trials.”<sup>349</sup>

It is striking that the clinical trial—which is what the FDA demands of pharmaceutical companies to connect their drugs to specific illness and to prove that their drugs work as advertised—does not account for marketing itself. Clinical trial participants are not told brand names, and they are not provided any story about how the drug will work.

However, clinical trial managers do worry about the placebo effect as a particular kind of psychological problematic.

Irving Kirsch argued in his meta-analysis of antidepressant trial data (see Introduction) that just-barely efficacy in the clinical trial setting surely becomes meaningless in real-world settings. Similarly, in an interview about the relevance of psychodynamic approaches in a biomedical world, Glen Gabbard claimed that, “the altar at which randomized controlled studies have been worshipped is beginning to crumble.

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<sup>349</sup> Smith, *Pharmaceutical Marketing : Principles, Environment, and Practice*. (p. 339)

There is growing recognition that these studies measure an artificial treatment in an artificial setting.”<sup>350,351</sup> For Gabbard and Kirsch, people’s experiences with psychiatric medication in particular are defined by the relationships they have with them. In this framework, it would seem that the problem of determining a drug’s efficacy in the clinical trial turns out to be a problem of fantasy—both in terms of the subject’s capacity to generate a placebo effect; and in terms of the trial manager and drug company’s desire to isolate an antidepressant’s true effects.

Indeed, one implication of the placebo effect that has continued to trouble the drug industry is that side-effects are not entirely properties of drugs themselves but are produced by the subjects who consume them. As one study notes:

“[O]f those who respond while taking medication, at least half do so for reasons other than *direct pharmacological effects*. Although this result may be acceptable in treatment settings, it presents a unique challenge to clinical trial design and analysis in which a clear difference between true drug response and placebo response must be demonstrated.”<sup>352</sup>

The pharmaceutical promise is at play here too, since the pervasiveness of the placebo effect is taken—not as evidence that the paradigm of the double-blind clinical trial might need to be challenged in antidepressant trials—but as evidence that clinical trials need to be better equipped to parse out the “true drug responses.”

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<sup>350</sup> On-line interview, available at: <http://eseries.ipa.org.uk/prev/newsletter/99-2/E3.htm> (accessed April 2006)

<sup>351</sup> There is remarkable continuity between Gabbard and Kirsch’s arguments about the validity of the clinical trial, and critiques of illicit drug research, made in the late 1960s: “The curious problem of the experimentalist ... is that as he [sic] controls the laboratory environment more and more carefully, so as to maximize his confidence in ascribing observed effects to known causes, his laboratory becomes less and less like the real world, which is what he set out to study. Indeed, control can proceed to the point that the experimental results are scientifically impeccable, but their relevance to anything in the real world is lost. Then, if someone comes along and says, ‘So what?’—as happens all too infrequently in science—the experimentalist will be stuck for an answer ... It would seem that the marijuana researcher must steer a middle course between his [sic] desire for scientific accuracy and his obligation to make his findings relevant to the world beyond his [sic] laboratory” (Zinberg & Weil 1969).

<sup>352</sup> T Womack, J. Pothoff and C. Udell, Placebo Response in Clinical Trials: What We Can Learn from Antidepressant Trials. (Raleigh, NC: INC Research, 2001). (emphasis added)

The placebo response rate in clinical trials for antidepressants has been increasing in recent years, for unknown reasons. High rates of placebo responses are obviously frustrating to drug developers, since the higher the placebo response, the harder it is to demonstrate the drug's efficacy. The placebo effect is an uncertainty that clinical trial managers have to manage, one that Lakoff (2001) has referred to as "signal detection": The drugs are already assumed to be efficacious (i.e. have a signal to transmit), and the task of the drug trial is to discover how to detect that signal.<sup>353</sup> If the trial fails, it is not necessarily that the drug didn't work, but rather that "noise has crept into the signal detection process." Clinical trial managers talk about the placebo effect as the most difficult source of noise.

Conceptually, the placebo response frustrates a key pharmaceutical promise, namely the biomedical paradigm of drug action in which there is a sick body on which a drug acts—regardless of the person who inhabits the body. The placebo effect is thus also a problem of personhood, since clinical trial designers are asking about in terms of the kinds of people who are susceptible to it. This plague of personhood in the technoscience of the clinical trial has resulted in a new category of clinical trials subject—the "placebo responders"—a group that, once identified in the clinical trial, is cast out of the trial altogether (the "placebo washout" phase).<sup>354</sup>

So-called "placebo responders" are very much part of the historical legacy of "susceptibility," the notion that certain minds or dispositions are inherently weaker than

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<sup>353</sup> Andrew Lakoff, "Signal and Noise : Managing the Placebo Effect in Anti-Depressant Trials," *Annual Meetings, Society for the Social Studies of Science* (Cambridge, MA: 2001), vol.

<sup>354</sup> The placebo washout phase typically works by creating a baseline for all trial subjects (often by using the Hamilton depression rating scale, which consists of a list of symptoms that each get scored 0 - absent; 1 - mild; 2 - moderate; 3 - severe; 4 - incapacitating), keeping all subjects on a placebo for some period of time, and discarding any subject whose HAM-D score is lowered past a predetermined threshold score.

others (e.g. mesmerism, hypnosis). “Susceptibility” was never conceived in terms of the imagination’s creative ways of interpreting experience (i.e. producing new subjective experiences), but rather was always conceived in terms of one’s capacity to be duped.

Psychodynamic psychiatry, however, emphasizes the uniqueness of subjective experience, often at the expense of symptom checklist approaches to classifying patients and determining the best treatment courses. Such ‘descriptive’ approaches focus on patient similarities, whereas psychodynamic approaches focus on patient differences. Gabbard explained it to me in terms of how pharmacotherapy had to be uniquely tailored to each and every patient:

“And going back to your original question – ‘What does psychoanalysis have to contribute [to the development of antidepressants]?’ – it’s that each person is unique, so that you’re always tailoring treatments to an understanding of the individual. And that goes completely against the psychopharmacological way of looking at – everybody we hang into groups, and we’ll give them the same treatment because they all have the same diagnosis.”

Indeed, as we’ve seen, in psychodynamic psychiatry it is the subjective experience that filters what is biologically determinant. There is no ‘true drug response,’ which is what the clinical trial demands, and which is what the marketer promises. But in the psychodynamic framework, we are *all* placebo responders.

On the other hand, drug marketers have started to leverage a similar conception of the healthcare consumer—one that encourages not that the placebo effect be reigned in, but that it be cultivated through marketing. A recent article (March 2006) in the Public Library of Science (PLoS) discouraged any future ban of DTC advertising by arguing that DTC depictions of pharmaceutical health could be harnessed as the placebo effect.<sup>355</sup>

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<sup>355</sup> E.A. Almasi, R.S. Stafford, R. L. Kravitz and P.R. Mansfield, “What Are the Public Health Effects of Direct-to-Consumer Drug Advertising?,” *PLoS Med* 3.3 (2006).

“Commercials for conditions such as high cholesterol and osteoporosis first assert that widely prevalent minor symptoms or unassessed biological parameters can have grave implications. Then the promoted drug is introduced as the solution, and the relief associated with the drug is depicted in the advertisement, teaching the viewer what to expect. ¶ These advertising strategies not only create consumer demand for the advertised products, but may also create the emotionally conditioned responses and expectancies instrumental to enhancing a placebo effect that occurs when the medication is taken. This conditioned response may increase the effectiveness of medications beyond that which is expected from their purely biological mechanisms.”

The edgy ethics here is that the placebo effect in DTC could actually help patient adherence, and strengthen the doctor-patient relationship. As we’ve already seen, drug marketers understand compliance *and* efficacy in terms of brand loyalty and the consumer’s ability to have a meaningful personal relationship with a pharmaceutical as a storied, emotional object with its own personality. There is a profound disconnect between such emphasis on the branded relationship and the blinded randomized control trial, whose modus operandi is the exact opposite—i.e. not the presentation of storied knowledge and “health education,” but the maintenance of ignorance, all in the service of preserving the pharmaceutical promise of the ‘true’ drug effect.

**INTERLUDE: TERRY**

“[T]he appropriation of bodiliness, in all its aspects, from sexuality and reproductive capacities to sensory powers and physical health, strength, and appearance, is the fundamental matrix, the material infrastructure, so to speak, of the production of personhood and social identity. What is at stake in the struggle for control of the body, in short, is control of the social relations of personal production.”

- Victor Turner<sup>356</sup>

Terry is a legal assistant who works in central Massachusetts. She is in her mid-30s. Terry had been attending local meetings for the support group Recovery, Inc., where I had been given permission to distribute Rx-ID flyers. I interviewed her three times over a span of eight months. During the course of that time, Terry’s somatic and emotional experiences of her antidepressant changed in myriad ways over her course of treatment, depending on how her disorder was diagnosed at different times by different physicians. Her story illustrates the complicated relationship between the experience of psychopharmaceuticals and the expectations that derive from neuroscientific promises.

I first asked Terry how she came to understand her experiences as being part of a medical diagnosis:

“Oh, I’ve had it all my life. I’m bipolar. I always knew something wasn’t right with me because I’d have severe mood swings. And I’d see psychologists. Started in 1994 ... I saw my first psychologist, although I saw some in childhood, but can’t remember that that well. And then by the time I hit my third psychologist, I only went to her once because she didn’t impress me, so I never went back. That was in ‘98. At that point I thought they were all crazy so I wasn’t going to bother

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<sup>356</sup> Victor Witter Turner, *The Ritual Process: Structure and Anti-Structure*, The Lewis Henry Morgan Lectures; 1966 (New York: Aldine de Gruyter, 1995). (p. 28)

with them. And then in '99 I went back to a psychologist, to try it again. I remember my first reaction was 'I don't want to be on medication; I want to try and do this on my own.' But this is before I was diagnosed with bipolar."

Terry's exclamation "Oh, I've had it all my life. I'm bipolar" was said with the force of 'I have been bipolar my whole life,' a diagnosis she had been given only six months before our first meeting. The story she then tells of going through psychologists is told from the perspective of a bipolar who has yet to discover that she is bipolar.<sup>357</sup> For Terry, part of becoming bipolar meant having to take medication (Zoloft) and no longer "do this on my own." It was the naming of her suffering that challenged her resistance to taking antidepressants.

"It's actually—it was a relief to know what my roller coaster has been; I can actually put a name to it. I mean, I think what's worse is when you don't know ... and I didn't know. If I knew then what I know now, my life could have been a lot better. I mean, the disappointments wouldn't have been so extreme or so bad. I mean, we all have disappointments, but to a depressed person or a nervous person, they're just worse. I would have probably done a lot better. I probably would have taken the right medications, done the right things."

As Terry looks back at her life, she fantasizes that just *knowing* she was bipolar would have helped her manage disappointment and, in a moment of fantasy that would seem to go past a Foucauldian care-for-the-self kind of reflexivity, she posits that the real-Terry-that-she-had-never-known would have been a different ethical self ("I probably would have taken the right medications, done the right things.") Indeed, after being diagnosed, Terry began reading about the disorder avidly, and began attending a number of support

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<sup>357</sup> This mode of self-telling is, I think, fairly representative of Terry's language throughout the first interview. She inhabits the diagnosis retrospectively, building manic-depression into her identity before being diagnosed. This is different than self-diagnosis; at no point in the interview did Terry speak about bipolar disorder as something she always knew she had (and, say, just took awhile to go through the formal steps of seeing a mental health professional).



groups, including Recovery, Inc. Being bipolar meant not only having a new way to speak about herself, but it also meant having a new set of activities to order her life.

On the one hand, this is precisely the kind of ‘ah ha, that’s what I have, and now I’m going to go research it’ reaction that Glen Gabbard cautions about, as a spurious defense against real self-discovery. Indeed, Terry’s immersion in popular psychology needs to be considered carefully alongside of the way she embraces the diagnosis. Terry sometimes speaks in terms of unique, personal experiences; but more often she speaks of herself as a category of person (bipolar or manic-depressive), constantly referencing self-help literature and other popular sources on depressive disorders. This way of speaking seems to serve the dual purpose of generalizing herself to what she sees as a well-defined category of personhood, as well as to make this category personal—with epistemological implications for her relationship with antidepressants:

“Well I think for me, I can actually feel when my moods are changing, I know when I’m being manic, and I have to monitor that, and that’s why—for manic depressives—they’re not supposed to be on as high doses of antidepressants. Because that can push us into a manic state. And I’ve discussed this with my nurse practitioner, because who knows my body better than me? And when I start to get manic, I would cut down to 25 milligrams of my antidepressant, or I’d just cut it out completely.”

There is a fascinating grammatical slippage between first-person singular, third-person plural, and first-person plural in this quote. Terry’s description of herself flickers between the personal and the categorical.

Throughout our first exchanges, Terry developed a particular vocabulary to describe what Zolofit was doing to her: it “regulated my mood swings.” She described to me in some detail how she would titrate her doses depending on whether she was feeling

“more depressed” or “more manic,” and how she would enroll her nurse practitioner more directly in figuring out the right dosage when she felt “mixed.” She told me: “I can actually feel the moods coming, and I use the Zoloft to deal with them.” In this manner of speaking, Zoloft functioned as a means to gain control of affect.

“I tried Zoloft back in ... I think it was '96. I wasn't on it very long, my medical doctor gave it to me and at that time I thought, 'well, okay I'm doing better and I won't be on it,' you know? I didn't know I was bipolar and needed to be on a medication for the rest of my life. But then I found out last November when I went to a new psychiatrist that I was bipolar, and he prescribed mood stabilizers and antidepressants, and that's when I went back on antidepressants.”

Terry's attitude towards antidepressants changes alongside of her changing diagnosis. While her attitude toward Zoloft is initially ambivalent, becoming bipolar—in the sense of coming to live under the description—put her in a new relationship with antidepressants, one that she characterizes as inevitably life-long. Indeed, Terry's new illness identity helps her to make sense of Zoloft. Zoloft becomes significant to Terry—regardless of its experienced effects—because being bipolar means taking it.

Terry's experience of her antidepressant also depended on which of her health care providers was helping her to manage the medication. She did not have entirely positive experiences with the medical doctors: “All doctors want to do is medicate us. You know, none of them told me about the support groups, like Recovery [Inc.], where people all had the same problems.” Terry had come to associate doctors with thoughtless prescribing practices and as a result spoke pejoratively about “being medicated” as a draconian alternative to the kind of self-empowerment she was able to discover through depression support groups. On the other hand, Terry had developed a good relationship with her nurse practitioner, with whom she actively negotiated how she should take

Zoloft: “We talk about it [taking Zoloft]. And I told her, “You know, I feel myself getting manic, so I’m down to 25 milligrams,” because I couldn’t get a hold of her that weekend. And she says, “You know what? I *want* you to do that. If you think it’s going to help you, you do it.”

Terry’s feelings of self-empowerment and control over her antidepressants also expressed themselves as opinions about how clinical trials are conducted—similarly enabled by positively experienced conversations with her nurse practitioner:

“At first I wasn’t sure [about going back on antidepressants]. But she [the nurse practitioner] had talked with me and told me how certain antidepressants can affect one person differently. I do know that antidepressants aren’t tested on women in their trial stages, they’re tested on men, which I think that they need to start doing. I really think that in order for them to be able to treat women more effectively—and this is something I’d like to research on if I go to grad school. They need to start developing better trials for women because, I mean, how can you just give it to a man and tell a woman to take it, when we have hormones, you know?”

Over the past decade or so, there has been an increasing number of popular books on mental illness and psychopharmaceuticals, as well as growing number of support groups for people suffering from mental illnesses. These represent ways in which how people come to know and manage their mental anguish has changed, and also how the doctor-patient relationship is becoming more flexible and less central to mental health care in the U.S. Like Sarah from the previous Interlude, Terry’s engagement with popular literature helps her to understand herself as a social category with its own science, in which she one day hopes to intervene (my questions and responses are in brackets):

[Have you and your doctor talked about a ‘master patient plan’? Is the goal to eventually get off the drugs, or is it to figure out how they should be tailored to you?]

“Most likely how I should tailor them to me, because with manic depression you have to be on drugs pretty much for the rest of your life. Unless they ever figure out that human genome project, and locate the gene that causes it, um ... are you familiar with the Human Genome Project?”

[A little bit.]

“Oh, I’ve been reading a lot of books, and a real good book on bipolar that’s called *An Unquiet Mind*, by Kay Redfield Jamison. Are you familiar with her?”

[Yes. I know the book.]

“Oh, okay, because in the book she mentions it. Her husband is actually the lead researcher on that project. It gave me great inspiration when I read it, like, ‘okay, she’s a psychologist, and I could do that.’ ... There’s a few books I’ve read. I’ve read *In the Mouth of Madness*, but I forget who wrote that. It’s a woman’s encounters with her son, dealing with his manic depression. I’ve been reading my—this is my DA [Depressed Anonymous] book. [Terry shows me the book she has with her] Oh, another one is *The Depression Workbook*, by Mary Ellen Copeland. It’s a good book to read. So I’ve been reading a couple of those books.”

Verta Taylor argues that self-help offers women an opportunity to actively construct illnesses for themselves.<sup>358</sup> Like Taylor, I am interested in how “experiential knowledge” intersects with “increasingly technical [and] impersonal knowledges of science” to produce new sociomedical agendas and illness identities.<sup>359</sup> At the same time, I have become newly mindful of the psychodynamic perspective that warns against certain modes of receiving scientific facts about illness and identity.

Terry experiences her antidepressant differently depending on whether it is administered in what she perceived to be a supportive and empowering relationship with the prescriber, versus a dismissive one. She appreciated the control that her nurse practitioner gave her over taking her medications, and she spoke differently about what

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<sup>358</sup> Verta A. Taylor, *Rock-a-by Baby : Feminism, Self Help, and Postpartum Depression* (New York: Routledge, 1996).

<sup>359</sup> *Ibid.* (p. 19)

she thought the medications are doing in the contexts of speaking with her (versus speaking with her primary care physician). In this interpersonal context, Terry also described her body “working with” Zoloft, and being in a kind of “balance” with it:

“I think the medications help me sleep, they help calm me. Like when I start to get my twinges of the depression they’re not like they used to be, y’know? I may have a twinge but it doesn’t fester all day, or, y’know, all night. But in general I can feel my body working with the Zoloft, sort of balancing each other out, I guess.”

She told me that she envisioned an antidepressant that could detect and prevent symptoms before they could be felt, and she fantasized about being part of the research team that would develop such a drug.

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After three interviews over the course of a few weeks, eight months passed before I met with Terry again. In the intervening time, she was diagnosed with a thyroid disorder and was informed that she was probably not bipolar, after all. I asked her what it was like to receive such news:

“I’ve actually felt calmer, less hyper, in fact my thyroid did a 360 from hyper to hypo, so I take a synthetic thyroid now. So I’m even questioning if I could have been manic-depressive. I mean, there’s a possibility I could be, but I’ve been reading another book on thyroid disease since now I have it called *The Thyroid Solution*. And reading this book shows that a lot of people who might have manic depression could have an underlying thyroid disease, which could be actually causing similar symptoms to having manic depression.”

When I met with Terry, she was about to begin thyroid hormone supplementation therapy, but was instructed to remain on the Zoloft until that time. She was no longer

trying out different dosages and ‘negotiating’ between the drug and her body, and she had newfound mixed feelings towards it. For example, she told me, “So I took my Zoloft today and I kind of feel a little bit more hyper than usual, and I have a feeling it’s the medication doing it to me.” Statements like these were typical of my next interviews with Terry. She no longer experienced the Zoloft as *regulating* her moods, but *producing* them. That is, the Zoloft was no longer an agent that could control her mania, but was rather the cause of being hyper. Rather than actively using the drug to negotiate how she’s feeling, Terry experienced herself as passive to Zoloft’s effects. At the same time, she expressed a new uncertainty about these effects: “You know, I’m not really sure *what* the Zoloft is doing, if anything. But it doesn’t really matter anymore.”

Terry’s psychological and bodily relationship with Zoloft changed when she was told that the biological source of her depressive symptoms was no longer her brain, but her thyroid. Neuroscientific promises were no longer relevant, and Terry was able to split her experience of the same drug by experiencing it through two different illnesses, with two different scientific stories. In many ways, of course, this is precisely how DTC advertising interpellates the consumer: the dual brand promise of symptom relief and neuroscientific explanation is connected to a specific diagnostic understanding of those symptoms.

Chapter 4 will explore branding as a mechanism to accomplish the same splitting of illness experiences that Terry brought about for herself. Recall the MIT student from the Introduction who was unable to consume Sarafem, the chemical equivalent of Prozac but which had been marketed as a treatment for premenstrual dysphoric disorder. In the

previous Interlude we saw how Sarah had profound angst about the changes that Prozac might have on her identity as a sometimes suffering artist. Similarly, the MIT student expressed great reluctance over the personal implications of taking a drug that had been marketed for a quintessentially form of female suffering. In both cases it is an ethical dilemma of treating illness versus of changing oneself. However, in the case of Sarafem the dilemma involves the non-medical brand promise of gender.

## CHAPTER 4: DEP@SSION and CONSUM\_TION

The Pharmaceutical Research and Manufacturers of America (“PhRMA”), the big industry trade group, supports DTC, contending that it encourages competition among products, and that DTC is a public health service, in the sense that the ads can foster new doctor-patient conversations about prescription drug treatments, and can help viewers identify symptoms and new treatments. It is within this public relations model that women’s health education has become a principal target for DTC marketing, which has tended to concentrate on socially contentious illnesses, like premenstrual syndrome (PMS) and postpartum depression (PDD), for which psychopharmaceuticals are typically prescribed. Historically, women’s life experiences have been characterized in terms of emotions and moods, and have come under the institutional purview of psychiatry and psychology.<sup>360</sup> And now, recent figures reveal that, in the U.S., antidepressants are prescribed to women three times as often as they are prescribed to men,<sup>361</sup> and recent studies have attributed this trend to a widening range of female life experiences that have come under biomedical purview, like menstruation, menopause and postpartum depression.<sup>362</sup> As women’s health becomes newly public with the changing cultural messages of DTC marketing, it deserves a new interdisciplinary mode of social analysis.

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<sup>360</sup> J. T. Richardson, “The Premenstrual Syndrome: A Brief History,” *Soc Sci Med* 41.6 (1995).

<sup>361</sup> D.H. Kreling, David A. Mott and Joseph B. Wiederholt, *Prescription Drug Trends : A Chartbook Update* (Washington, D.C.: Kaiser Family Foundation, 2001). [[also 2006 reference]]

<sup>362</sup> S. Franklin and H. Ragone, *Reproducing Reproduction: Kinship, Power, and Technological Innovation*. (Philadelphia: University of Pennsylvania Press, 1998), Janet Lee and Jennifer Sasser-Coen, *Blood Stories: Menarche and the Politics of the Female Body in Contemporary U.S. Society*. (New York: Routledge, 1996), Janet Stoppard, *Understanding Depression: Feminist Social Constructionist Approaches*. (London: Routledge, 2000).



## Listening to Sarafem: Ethnography and antidepressants

*When I was taking the Sarafem this morning I did stop and think about the fact that it's purple. I mean, the pill itself is purple. Like, I'm starting to think a little about the packaging. I mean, I already knew that it was pre-packaged because people didn't want to say, 'oh, it's 10 milligrams of Prozac.' But in the world that I live in, I tell people: 'Yeah, it's Sarafem. It's 10 milligrams of Prozac.' ... But [Sarafem] is part of my life now. And my life's sort of 'out there,' and there's very little I'm not going to tell someone. So I got involved with someone new recently, and it's just, like, part of the casual conversation: 'This is where I am medically and, oh yeah, I'm taking the antidepressant Sarafem, which is basically 10 milligrams of Prozac.' Because, you know what Prozac is, you know 10 milligrams doesn't sound like a lot (so I'm not, like, way off the deep end), and you know that it's Sarafem because it's related to Depo-Provera, which is related to PCOS [Polycystic Ovarian Syndrome]. That's why it's significant that it's Sarafem—to me. Because if it was Prozac, then it would feel like it had to do with some other thing. So I'm just trying to draw the line—they're all lined up together in my head, but I'm not trying to hide behind the packaging because the packaging doesn't say to me what I guess other people would want it to say. It doesn't work for me in that same way. But it was a lifesaver.*

This person (who will be properly introduced at the end of the chapter) has a rich and curious relationship to the prescription drug Sarafem. This person wonders about its color, its relationship to Prozac, its amount, what to tell people about it, its role in a lifestyle, and whether it 'belongs' to certain illnesses. This relationship allows us a way into the political economy of medicine and marketing that pharmaceuticals are challenging us to consider. This quote comes from one of the interviews I conducted through Rx-ID. I will return to it at the end of the chapter, putting it in dialogue with the following social analysis of Prozac/Sarafem, as well as with additional interview material.

I opened Chapter 4 with a quote from Robbie, in order to present the richness and even the oddness of the statements that patient-consumers are now producing about pharmaceutical products, and to set up questions about the kind of social, political, and institutional arrangements it has taken for such statements to be producible. This last section will explore Robbie's experience with Sarafem in greater depth, presenting her as a new kind of medical citizen. Robbie is a complicated person who gets tossed around by different drugs, and different brands. Her experiences getting to and consuming Sarafem reveal a deep relationship to medicine as identity, and to brands as a means to connect gender, sexuality, identity, and sanity. I present these experiences to show how, by attending to the different ways that people learn about mental illness and its treatments, we gain an understanding of how scientific theory and corporate practices becomes discursive, and can act as a social forces.

Markens (1996) has pointed out that “[w]omen who menstruate have always had premenstrual experiences, but the meaning of those experiences has changed with the legitimation of PMS as a medical phenomenon.”<sup>363</sup> Indeed, there is a crucial but often overlooked relationship between how women interpret their premenstrual experiences and what kinds of biomedical research make sense to carry out on the menstrual cycle. My work complements sociological investigations of the relationships between women's health movements and biomedical research<sup>364</sup> with anthropological explorations of the meanings that women generate about their illnesses, their pharmaceuticals, and their

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<sup>363</sup> Susan Markens, "The Problematic Of "Experience": A Political and Cultural Critique of Pms.," Gender and Society 10.1 (1996).

<sup>364</sup> Auerbach and Figert, "Women's Health Research; Public Policy and Sociology.", Steven Epstein, Impure Science: Aids, Activism, and the Politics of Knowledge. (Berkeley: University of California Press, 1996), Hamilton, "Women and Health Policy: On the Inclusion of Females in Clinical Trials.."

relationships to medical institutions.<sup>365</sup> This work fits with that of recent feminist scholars who have broadened the arenas in which social contest can take place, e.g. from policy to personal and group identity.<sup>366</sup>

For years Robbie had been wrestling with ways to best express her sexuality, including participating in a number of gay and bisexual groups and moving from Long Island to Boston to find communities that she could most identify with. Robbie explained to me that she has been trying to convey a certain kind of gender ambiguity,<sup>367</sup> and that her experience of gender is now importantly caught up in how she is perceived by other people:

*I've realized that gender is more of an interactive thing, and with me in particular it feels very interactive. Because pronoun-wise it's up to how you read me; I don't have a huge preference, and I'm more interested in how people read me than in digging my heels into an identity. Some people always use 'she' with me (because they've known me my whole life) and other people who've just met me might use 'he' because it makes them feel more comfortable, because in their world if I'm 'he' then it makes their identity stronger. ... But in allowing [my gender identity] to be fluid I'm not really owning a single identity – I'm more interacting with people to see how I'm being perceived. Because my gender expression is really about perception. I mean, I'm expressing something, but are you getting it?—That's different from than if I came to you and said, 'from now on you have to call me Robbie and you have to use 'he.'*<sup>368</sup>

A couple of years ago Robbie's participation in her own health care became a new way to come at, confront, and question her gender identity. It was then that she was diagnosed

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<sup>365</sup> Emily Martin, *The Woman in the Body: A Cultural Analysis of Reproduction*. (Boston: Beacon Press, 1987), Rayna Rapp, *Testing Women, Testing the Fetus: The Social Impact of Amniocentesis in America*. (New York: Routledge, 1999).

<sup>366</sup> Epstein, *Impure Science: Aids, Activism, and the Politics of Knowledge*, Verta Taylor, *Rock-a-by Baby: Feminism, Self Help, and Postpartum Depression*. (New York: Routledge, 1996).

<sup>367</sup> She had recently changed her first name from "Alana" to the gender-ambiguous "Robbie," to—as she put it—"help strive for the gray area."

<sup>368</sup> For the sake of readability, I'll be using "she" and "her."

with polycystic ovarian syndrome (PCOS), and her gynecologist started administering DepoProvera, the brand name of a drug containing the hormone progesterone, which has been primarily marketed and administered as a female contraceptive.

*I think that was the first time I really had to deal with the 'wow, you're female and you now have female problems.' I had never dealt with, like, emotional crisis or PMS or GYN's. I mean, I go to a GYN now four times a year (because I get these [DepoProvera] shots), but in the culture that I really was in, you just didn't go to doctors. I mean there was a barrier to receiving medical benefits in the lesbian community, because most of them don't speak honestly to doctors ... And I called [my girlfriend] up, and I was like, 'I am going through the most gender-fucked moment of my entire life – I'm going to have to go on birth control.'*

Robbie's own gender identity in an important way implicated certain health care systems (like whether she felt comfortable speaking with physicians), and health care products. For instance birth control was a key issue for second-wave feminism, which emphasized the body as a political object and which problematized gender identity in these terms, depicting female contraception as a civil liberty and one means for women to re-appropriate control of their bodies. But Robbie, who identifies birth control with the lived experience of being female, saw it as a rupture in how she had begun to experience her own gender identity. The shock of *going on* birth control was the anxiety of knowing that, through this medical technology, she would be in a new and uncertain relationship with her body. And the shock of *being on* birth control later led her to characterize it as "fucking hormonally with my system," complicating the bodily experience of how she identified as gender-ambiguous—as "X." But Robbie also explained how DepoProvera ended up helping her to lose weight, which actually enabled her to build her body as more "male," with "wide shoulders and a thin waist." Robbie was able to attain a more

masculine gender expression she was striving for, and she was quite explicit that in this sense the DepoProvera ended up “influencing my gender expression greatly.”

For instance, DepoProvera became a way for her to draw out tensions in her own identity, and having a story of what this substance was doing to her body took on a new urgency. During our interview she repeatedly talked about hormones as agents of personhood, referring especially to people she knew in transsexual communities who were deliberately undergoing hormone therapies to change how they could experience their own bodies. In fact, Robbie herself had been debating whether, in the future, she might undergo some sort of testosterone therapy to further experiment with her own gender expression, and her narrative about what PCOS and DepoProvera were doing to her own body drew off of these deliberate uses of hormone therapy:

*What's at issue, though, is that with PCOS I'm taking Depo because it stops the ovaries from functioning, and if the ovaries stop functioning then the cysts go away. And one of the things the cysts cause is that the cysts produce testosterone ... the excess of testosterone in the body. So in a weird way I just turned off the extra testosterone that I've had since puberty and at the same time I'm having this internal debate about one day being on testosterone.*

Alongside of ideas in medical anthropology about illness and narrative, Emily Martin has written that how people understand themselves as social actors can involve using medical concepts as generatively metaphoric.<sup>369</sup> There's a self-definition going on in the above quote that is tethered to statements about drugs, hormones and bodies. For Robbie, seeing sexuality as hormones allows for a new set of metaphors to explore her gender and gender expression. She discusses her gender identity in terms of what amounts of

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<sup>369</sup> Emily Martin, *Flexible Bodies : Tracking Immunity in American Culture from the Days of Polio to the Age of Aids* (Boston: Beacon Press, 1994).

different hormones her body has ‘already been’ equipped with, and how current and future hormone therapies might alter this. The very idea of “turning off” hormones is a way for Robbie to imagine a new kind of agency that she might have to intervene in her own sexuality.

Robbie’s gynecologist ended up prescribing Sarafem. Robbie depicted the long-term actions of DepoProvera as putting her sense of self into a new and uneven motion, and depicted Sarafem both as a medicine to treat symptoms and as a technology of self to help her regain a sense of control:

*And that’s where Sarafem came in ... I had never been a PMS kind of person ... She [my GYN] gave me Sarafem, and when handing it to me she said, ‘Just to let you know, if you read the insert, this is Prozac.’ And [she] kind of waited for that reaction from me, but I was like, ‘okay.’ And she said, ‘it’s the lowest dosage, it’s only prescribed for PMDD, it sounds like it would really help you, here’s a sample packet, try it and come back to me and let me know.’ And I was, like, I’m willing to try absolutely anything at this point. And I’ve been taking it since then, and I kind of wonder at what point I’m not going to take it. It’s not something I see myself being on forever. I was learning how to cope with life differently at the time. I think in these last few months ... it’s helped me have that sense of balance—that net so I don’t drop as far down, and then I get to choose my reactions to life a little bit more than having them chosen for me.*

Robbie says she had never been “a PMS kind of person.” She alternately characterizes Sarafem as a way to treat undesirable emotions and mood swings, and as a way to not be that kind of person. So, while the discourse of PMDD in Sarafem commercials is that “it’s not you, [return to your sense of self]” for Robbie it’s “it was *never* me.” Robbie also talks about being on Sarafem only temporarily; she doesn’t want to incorporate its effects into a long-term identity. This attitude towards Sarafem is simultaneously a reflection on having PMDD, which for Robbie is as dependent on DepoProvera as it is on

herself. She even tells me about certain clinical trials she's heard about, in which non-hormone-based therapies are used to treat PCOS: "And if I went that way then maybe the hormone levels wouldn't be affected as much and I wouldn't need Sarafem." Robbie's identity with PMDD is thus a fragile one, despite that she acknowledges its role in her struggles with gender expression. Along these lines, it's revealing that Robbie also ended up characterizing the non-hormonal therapies as "having nothing to do with gender." The ambiguity of whether "gender" here refers to the effects of being on synthetic hormones, or to her own gender expression, highlights the interrelatedness of both when she wonders about her illness and its possible treatments.

In her ethnographic work on women, Emily Martin points to a disconnect between women's frequent descriptions of PMS as "feeling possessed" and the sociomedical discourses of women's malfunctioning bodies. (1988:294) Robbie offers us an additional vantage point, since the disconnect for her is not between her emotions and a dominant societal logic about female bodies, but between knowing she's a certain way and feeling that her body is (rather suddenly) otherwise. But when reflecting on being on Sarafem, Robbie's ideas about bodies and hormones end up coalescing with an emergent sense of gender identity.

*So it was interesting to be identifying in lots of ways more a boy and more emotional at the same time [while on DepoProvera]... But [being on Sarafem] is like finding a new sense of balance and not feeling like I have to adhere to some new gender paradigm.*

For Robbie, there was a tension between identifying as a boy and feeling more emotional – a tension that, if not resolved, she thought might require devising a new gender identity.

How Robbie feels on Sarafem, however, is that very resolution. Untreated PMDD in DTC advertising and untreated PMDD in Robbie's case thus turn out to be quite different creatures. In DTC, Sarafem enables a woman to return to a personal and social sense of normality, a sense of womanhood that was always there, just buried under symptoms. In Robbie's life, Sarafem preempted a personal search for "some new gender paradigm." Both represent returns to normality, although the specifically female normality that is presupposed in the marketing of Sarafem is entirely absent in Robbie's discussion of herself. In an interesting twist, Sarafem's significance to Robbie subverts Sarafem's answer to the feminist call.

*And in all of this, I've had a better sense of myself, just because I had to deal with things instead of letting them slide, like whether medical or gender or health or emotions. It's been part of a whole journey: the Sarafem, the gender stuff, all of it has just been about me finding a new sense of self.*

I have given particular attention to the statements Robbie produces about herself and her drugs to put scientific and popular claims about the effects and appropriateness of antidepressants into situated and comparative contexts. Robbie's relationship to DepoProvera and Sarafem evokes a profound sense of how experiential knowledge both uses and breaks with explanatory structures, like the promotional material someone might have encountered for their antidepressant.<sup>370</sup> In this contemporary, biomedical U.S., there are new and complex relationships between medicine, psychiatry, the pharmaceutical industry, government, and health and consumer advocacy groups. Robbie's relationships to DepoProvera and Sarafem offer us a path into these relationships, giving us a way to

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<sup>370</sup> Fischer (2000) called this "situated feedback." Michael M.J. Fischer, "Calling the Future(S) with Ethnographic and Historiographic Legacy Disciplines: Sts @ the Turn[2000.Mit.Edu," Late Editions 8 : Zeroing in on the Year 2000, ed. George Marcus (Chicago: University of Chicago Press, 2000).



think about just what kind of person is produced at their intersection; at the same time, her experiences offer a path out of these relationships, giving us a way to think about just what a person can produce at that intersection as well.

Fluoxetine hydrochloride, under the brand of Prozac, is white and green, and was introduced as an antidepressant; fluoxetine hydrochloride, under the brand of Sarafem, is pink and lavender, and is offered to women as a treatment for premenstrual dysphoric disorder (PMDD). Both are developed, manufactured and marketed by the drug company Eli Lilly. “Sarafem” is homophonic with “seraphim,” the borrowed Hebrew word meaning “angel,” and targeted to *females*. Through this kind of packaging, marketing and targeting, pharmaceutical products take on changing symbolic lives, and represent in new ways a constellation of cultural messages regarding illness.

The circulation of pills as social signifiers happens as part of the evolution of certain psychiatric diagnostic categories. The new social lives of prescription drugs can turn out to be a key dimension to the social histories of mental illnesses. The case of PMDD is particularly illuminating, since its evolution as a diagnosis has been markedly contentious both within and outside of psychiatry, instigating questions of gender and pathology, and has involved issues of professional boundaries, medical expertise and scientific authority. Yet the story of PMDD can't be told without telling the story of Sarafem, whose very availability ended up diffusing authority that formerly had been centered in psychiatry. Indeed, over time, the institutional and public debates over PMDD became debates over Sarafem and Prozac. Accordingly, the production and marketing of Sarafem changed the venues where scientific facts about mental health were being fought

over. Social movements, for instance, started going after the FDA to contest a drug, rather than only going after the American Psychiatric Association to contest a diagnosis. And, when the FDA contested a Sarafem TV ad campaign, actors' depictions of premenstrual symptoms were transformed in a policy space to claims about the clinical reality of mental illness. This chapter will show some of the ways that Sarafem has multiplied accountability for how ideas about mental health are produced, precisely by diversifying how ideas about mental health get consumed.

### **Branded identity and “symbolic mistakes”**

Studies of collective action include Dumit (2006), who introduces the notion of “illness you have to fight to get.”<sup>371</sup> These are socially and politically contested categories, like post-traumatic stress disorder (PTSD) and Gulf War Syndrome, which sufferers have mobilized to make medical and scientific cases for. Similarly, Petryna (2002) explores what she calls “biological citizenship,” in which damaged biologies in the wake of technological disasters (like the Chernobyl population) become grounds for social membership and political action.<sup>372</sup> There is a thematic relationship here to the (largely successful) efforts of the National Alliance for the Mentally Ill (NAMI) in the U.S., a group of mothers of schizophrenic children with a strong history of supporting strictly biological theories of schizophrenia to deflect schizophrenogenic theories of bad mothering (moreover, NAMI has a history of intense lobbying for scientific research in

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<sup>371</sup> Joseph Dumit, “Illnesses You Have to Fight to Get : Facts as Forces in Uncertain, Emergent Illnesses,” *Social Science & Medicine* 62 (2006).

<sup>372</sup> Adriana Petryna, *Life Exposed : Biological Citizens after Chernobyl*, In-Formation Series (Princeton, [N.J.]: Princeton University Press, 2002).

mental illness, and its main sources of financial support have been from the pharmaceutical industry). Social scientists have also studied how socially marginalized groups have organized to resist medical characterization. For instance, Bayer (1981) wrote about how gays and lesbians came together to fight the American Psychological Association on its diagnosis of homosexuality;<sup>373</sup> and Figert (1996) has explored how women fought the American Psychiatric Association on its diagnosis of premenstrual dysphoric disorder (PMDD).<sup>374</sup> In both cases, the medical establishment capitulated and removed or revised their diagnostic categories.

Indeed, social scientists are increasingly interested in questions about illness and agency,<sup>375</sup> that is, about on the one hand using illness and its institutions (medicine, psychiatry, pharmaceutical companies, insurance) to instigate social and political changes, and on the other hand how individuals come to make contested illnesses—illnesses whose ‘realities’ are in question—meaningful for themselves. People fight to be ill (e.g. Vietnam veterans and post-traumatic stress disorder [Young 1995<sup>376</sup>]) and fight not to be ill (e.g. gays and homosexuality as a medical category [Bayer 1981]), and they forge collective identities along the way. Now more than ever these social formations are being complicated by the relationships that people can develop with pharmaceutical products.

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<sup>373</sup> Ronald Bayer, Homosexuality and American Psychiatry : The Politics of Diagnosis (New York: Basic Books, 1981).

<sup>374</sup> Anne E. Figert, Women and the Ownership of Pms : The Structuring of a Psychiatric Disorder, Social Problems and Social Issues (New York: Aldine De Gruyter, 1996).

<sup>375</sup> See J. Dumit, "Drugs for Life," Mol Interv 2.3 (2002), Dumit and Greenslit, "Informed Health and Ethical Identity Management.", Steven Epstein, Impure Science : Aids, Activism, and the Politics of Knowledge, Medicine and Society (Berkeley: University of California Press, 1996).

<sup>376</sup> Allan Young, The Harmony of Illusions : Inventing Post-Traumatic Stress Disorder (Princeton, N.J.: Princeton University Press, 1995).

In addition to collective action around basic health research, women have come to form social movements around specific illness categories. Taylor (1996), for instance, analyzes how women have organized themselves around the shared experiences after childbirth, and how postpartum self-help has become a form political resistance.<sup>377</sup> AIDS patient groups become a newly educated community opening “the black boxes of expertise to become civic issues,” actively challenging and reconstructing the medical ‘facts’ around AIDS [Fischer 2003]. Epstein also argues that it was during the AIDS battles that gays and lesbians sought a political identity for themselves, precisely by working with (and many times working against) the medical establishment over the proper science of the disease. Here it’s crucial to note that how questions of sexual orientation and the public face of illness can instigate negotiations with science and politics for authentic forms of social identity.

On the other hand, some women’s groups have formed to resist medical categories. For instance, feminist scholars and activist groups have critiqued PMS as the medicalization of a natural state of the female body, and they resist the reduction of psychic and emotional complexities to “hormones” or, now, “serotonin” [e.g. Sommer 1989]. Along similar lines, Martin (1987) has proposed a Marxist critique of the creation of PMS, namely that in the late-industrial workplace there was a need for a new vocabulary to describe the cyclic losses in women’s productivity.<sup>378</sup> In this framework, PMS went through medicine to naturalize what was essentially an inequitable social relationship between women and work.

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<sup>377</sup> Taylor, *Rock-a-by Baby : Feminism, Self Help, and Postpartum Depression*.

<sup>378</sup> Emily Martin, "Premenstrual Syndrome, Work Discipline, and Anger in Late Industrial Societies," *Blood Magic : New Perspectives in the Anthropology of Menstruation*, eds. Thomas Buckley and Alma Gottlieb (Berkeley: University of California Press, 1988).

In the case of Sarafem, for instance, people on either side of the fence have made demands in the name of illness that are hard not to respond to:

Has anyone seen the commercial for Sarafem [pink flavored Prozac ;-) ]? The commercial tries to pathologize the mood changes often associated with menstruation: “Think you have PMS? Think again! You may have PMDD, Premenstrual Dysphoric Disorder, a recognized medical condition.” Medical condition my ass, do the words “dysphoria” and “disorder” sound familiar to the community?

- From a listserv for transgendered people [Google: soc.support.transgendered (posted March 15, 2001)]

And:

I’m so glad to hear the good Sarafem is doing. All I can say that it’s about time they’re treating PMS more seriously.

- From an on-line discussion group on depression [From a post at [www.depressionforums.com](http://www.depressionforums.com) (May 31, 2002, translated from ‘e-speak’)]

In the first quote, Sarafem represents a medical/corporate intrusion into the gender politics that have formed around questions of menstruation and pathology; in the second quote Sarafem represents a long-overdue recognition of a medical condition that is uniquely female. Between these sides sits a new factor: the pharmaceutical product’s *identity*. Sarafem and Prozac are chemically identical, but Eli Lilly (the company that manufactures and markets both) justifies the separate branding of Sarafem for PMDD as an ethical response to consumer demand:

We asked women and physicians, and they told us that they wanted a treatment with its own identity. Women do not look at their symptoms as a depression, and

PMDD is not depression but a separate clinical entity. Prozac is one of the more famous pharmaceutical trademarks and is closely associated with depression.<sup>379</sup>

The pharmacology of a prescription drug alone does not provide consumers with new ways to understand what it means to treat illness: it is only in the context of a set of social explanations that the identity of a drug and an illness becomes crystallized. The new logic at work in the quote from Lilly is that the drug's branded identity itself can parse illness into separate and differently experienced diagnoses (here, depression and PMDD).

In his best-selling *Listening to Prozac*, Peter Kramer implies that the varied and growing number of conditions that fluoxetine counteracts (e.g., depression, obsessive-compulsive disorder, dysthymia) might really be part of the same thing—*because* Prozac counteracts them.<sup>380</sup> But here, in the separation of Prozac-treated depression from Sarafem-treated PMDD, fluoxetine participates in a marketing logic that splits, rather than groups, illnesses. Such marketing practices complicate the idea that a person's relationship to a drug is 'really' her/his body's relationship to a chemical compound. There is, of course, a contemporary medical discourse in which people can speak comfortably about "chemical imbalances," but this gets layered by considering how the pharmaceutical industry can become quite concerned about the social—that is, precisely *not* the chemical—effects of their drugs.

At times, these social lives of drugs can generate new anxieties around what it means to be ill:

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<sup>379</sup> Laura Miller, marketing associate for Eli Lilly, quoted in *The Washington Post*, April 2001.

<sup>380</sup> Kramer called this "diagnostic bracket creep."

Last week, I saw 10 patients with PMS that had been prescribed Sarafem. Not one was told that she was taking Prozac. They were shocked and angry.<sup>381</sup>

This quote begs an important question: *Were* these patients taking Prozac? This doctor denies that Sarafem is anything but Prozac, and it's this sense of all of a sudden finding out what some drug is 'for' that demands attention, since it points to the precariousness of keeping illnesses apart when their treatments are the same, and highlights the fragileness of how in this context of rebranding people can experience medical diagnoses.

Rebranding and symbolically recoding drugs is happening in the context of direct-to-consumer advertising (DTC), which, in its current form that includes print and broadcast advertisements and websites, was approved by the FDA in 1997. It's thus relatively recent that pharmaceutical companies are extending and differentiating products in a meaningful way to consumers, and it's within the context of DTC that a number of tactics for representing pills as brands have emerged. For instance, the website for Prozac contains specific sections to learn about *generic* fluoxetine hydrochloride, which nearly collapsed Prozac's share in the selective serotonin reuptake inhibitor ("SSRI") market when it was first introduced (Scott-Levin 2002).<sup>382</sup> Under the heading "Generic or brand name? Are there differences?"

Can I still get brand name Prozac? The answer is 'yes.' ... We think it is important you know that Lilly will not manufacture generic fluoxetine ... Generic fluoxetine is not identical to brand name Prozac in appearance. The generic prescription you pick up at the pharmacy won't look like brand name Prozac.

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<sup>381</sup> Scottsdale physician Joshua Holland, quoted in *The Phoenix Business Journal*: <http://phoenix.bizjournals.com/phoenix/stories/2001/05/28/newscolumn2.html> (accessed October 2001)

<sup>382</sup> Scott-Levin, *Managed Care Formulary Drug Audit*, 2002, Available: [http://www.quintiles.com/products\\_and\\_services/informatics/scott\\_levin/press\\_releases/press\\_release/print\\_friendly/1,1255,359,00.html](http://www.quintiles.com/products_and_services/informatics/scott_levin/press_releases/press_release/print_friendly/1,1255,359,00.html).

Receiving medication with a different color or shape may be unsettling or cause concern.

About 50 years ago most pills were white and round (Hogshire 1999:51).<sup>383</sup> But the language of the Prozac website site suggests that pharmaceutical companies have new struggles over how to represent pills as brands. Clearly Eli Lilly is tapping into and trying to generate anxiety around generic fluoxetine, exemplifying how pharmaceutical developers now carefully consider the sociomedical meanings of what Jean Baudrillard critically referred to as the “inessentials” (e.g., color) of advertised commodities.<sup>384</sup> Baudrillard called certain features inessential to separate them out from functional aspects (you buy a dishwasher because it washes dishes, not because it’s black—although its color sets it apart from a series of dishwashers and will probably play into your decision to purchase it), and argued that in the post-industrial world of consumption, personalization could only be achieved through the emphasis of such inessential aspects of a commodity. In contrast, a recent U.S. Department of Health and Human Services (DHHS) pamphlet on generic drugs included the following question and answer:

“If generic drugs and brand-name drugs have the same active ingredients, why do they look different? Generic drugs look different because certain inactive ingredients, such as colors and flavorings, may be different. These ingredients do not affect the performance, safety or effectiveness of the drug. They look different because trademark laws in the U.S. do not allow a generic drug to look exactly like other drugs already on the market.”<sup>385</sup>

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<sup>383</sup> Jim Hogshire and Skylaire Alfvigren, Pills-a-Go-Go : A Fiendish Investigation into Pill Marketing, Art, History and Consumption, 1st ed. (Venice, Calif.: Feral House ; Distributed by Publishers Group West, 1999).

<sup>384</sup> Baudrillard, The System of Objects.

<sup>385</sup> “You know the questions that go through your mind when you take your generic drug? Here are the answers.” DHHS Publication No. (FDA) 02-3243



Eli Lilly is not unique with this new preoccupation with surface appearances. A professor of drug marketing, quoted in a Boston Globe article, said, “You wouldn’t make a pink Viagra” (May 20, 2001).<sup>386</sup> The article went on to say that “Designers propose colors for a particular medicine and help make sure there are no *symbolic mistakes*” [emphasis added]. Here, a symbolic mistake implies a disconnect between the social implications of particular illnesses (e.g. stigma) and the cultural effects of certain signifiers (e.g. pink vs. masculinity). This statement is evocative precisely because it lays bare the new practices of mobilizing images and texts, and attaching them to pharmaceutical products to create meanings about drugs and health, as well as the range of responses this can generate.

### **Markets, molecules and meanings**

Pharmaceutical companies are trying to convey to consumers that brands matter, but they can’t do so by making direct claims about clinical superiority to other brands, which would be in violation of an FDA guidance on DTC advertising (FDA 2002). But branding and the social coding of drugs are situated within medical contexts: PMDD is different than depression, and so Sarafem ‘belongs’ to it more than Prozac does. As the previous quotes showed us, this has been met with appreciation, and with derision. And, in addition to complicating consumers’ relationships with prescription drugs, this attempt to make brands stick to illnesses invites a whole new set of tensions among pharmaceutical companies, health care providers, and insurance companies. Now that

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<sup>386</sup> Patricia Wen, “Pills That Pop : Prescription Drugs Are Getting the Designer Touch, with a Consumer's Subconscious in Mind,” The Boston Globe May 20 2001.

generic fluoxetine is commercially available, for instance, managed care providers—for whom “therapeutic equivalence”<sup>387</sup> and not brand name is key—typically refuse to cover the cost of Sarafem.<sup>388</sup> This suggests that, within these different institutional settings, the patient-consumer can encounter quite different ideas of how illnesses, bodies and drugs go together.

Similarly, DTC interpellates patients into a relationship with prescription drugs that is different from how physicians are interpellated to prescribe them. The website for Sarafem, for instance, includes separate “physician information” and “patient information” sections, each of which describes in different ways the relationship of Sarafem to Prozac:

Physicians are told:

Fluoxetine was initially developed and marketed as an antidepressant (Prozac®, fluoxetine hydrochloride).<sup>389</sup>

While patients are told:

What is the active ingredient in Sarafem? Sarafem contains fluoxetine hydrochloride, the same active ingredient found in Prozac®.<sup>390</sup>

These two statements are both technically true, but socially they produce very different meanings. The differences in these descriptions are not those of technical expertise; the

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<sup>387</sup> “Drug products evaluated as ‘therapeutically equivalent’ can be expected to have equal effect and no difference when substituted for the brand name product. FDA considers drug products to be substitutable if they meet the criteria of therapeutic equivalence, even though the generic drug may differ in certain other characteristics (e.g., shape, flavor, or preservatives).” [<http://www.fda.gov/cder/about/faq/default.htm#3>] (accessed March 2002)

<sup>388</sup> E.g. Aetna’s coverage policy, which will only cover Sarafem if patients can document contraindications for the generic equivalent [<http://www.aetna.com/products/rx/data/sarafemcpb.html>]. Likewise, Blue Cross/Blue Shield does not cover Sarafem

<sup>389</sup> <http://pi.lilly.com/us/sarafem.pdf>

<sup>390</sup> <http://pi.lilly.com/us/sarafem-ppi.pdf>

patient-directed description is not ‘simpler’ than the physician-directed one. For physicians, the first statement allows that Sarafem and Prozac are the *same drug*, with different packages. The second statement, for patients, conveys that they are *different drugs*, with the same ingredient. And as patient advocacy is increasingly overlapping with consumer advocacy, these differences are not trivial: As some of the previous quotes suggested, we now live in a world where people can be “shocked and angry” that their prescription drug is chemically identical to another, whereas others welcome new brands as an important material-semiotic aspect of their health care.<sup>391</sup>

Sarafem is not an antidepressant—not because of its chemical make-up, but because of its brand. This move to brand illnesses away from antidepressants is new, and occurs in other contexts as well. For instance, “Wellbutrin” is another SSRI marketed by GlaxoSmithKline as an antidepressant. It was later FDA-approved for smoking cessation and rebranded as “Zyban.” The website for Zyban states, “Zyban is a nicotine-free pill. Not a patch. Not a gum.” Under the heading “Zyban: Helping Smokers Quit Neurochemically,” the site claims that “[w]hile it is unclear exactly how Zyban works, it is thought to act on the part of your brain that is addicted to the ingredients in cigarettes.”<sup>392</sup> Here, an explanation of cigarette addiction becomes a description of what Zyban is, and how it works – a description that obviously doesn’t fit with what *Wellbutrin* is, and how *it* works. Also, in this context, a brain on Zyban is different than a

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<sup>391</sup> Drugmakers were up in arms over the first proposed legislation to label all drugs: They resisted the idea of labeling, which they claimed robbed them of the ability to keep trade secrets. And they had broader, more ideological beefs, for instance claiming that this new legislation would effectively “Sovietize” drug sales in America. This kind of resistance met with spoofs. One article in *The Nation* said the following: “This measure frankly challenges the sacred right of freeborn Americans to advertise and sell horse liniment as a remedy for tuberculosis ... [challenges] his God-given right to advertise and sell extract of horsetail weed as a cure for diabetes. This is precisely the sort of constitutional question which stirs men to the very depths of their pocket-books.” [Quoted in Hiltz, p. 82]

<sup>392</sup> “Tell Me About Zyban”: [http://zyban.ibreathe.com/zp\\_1000.shtml](http://zyban.ibreathe.com/zp_1000.shtml) (accessed 2003)

brain on Wellbutrin; here separate brands require separate kinds of brains. Indeed, sometimes part of what it means to rebrand a prescription drug is that the lineage between the new brand and the old illness, and old biologies, get erased. In fact, the only mention of Wellbutrin in prescribing information for Zyban is in the contraindication section: “You should not take Zyban if you are already taking Wellbutrin®, WellbutrinSR®, or any other medicines that contain bupropion hydrochloride [the active ingredient in Zyban].” As was the case with Sarafem and Prozac, the patient-directed information does not allow that Wellbutrin and Zyban are the same drug.

Branding has functioned as a strategy to keep *certain* illnesses apart, but not others. Unlike Prozac becoming Sarafem for PMDD or Wellbutrin becoming Zyban for smoking cessation, Pfizer’s Zoloft, for instance, was originally marketed as an antidepressant, but was *not* rebranded once it was approved to treat post-traumatic stress disorder (PTSD) and obsessive-compulsive disorder (OCD). The distance between depression and PMDD, or between depression and nicotine addiction, may thus be seen as a *symbolic incompatibility*. To rephrase the Lilly quote about Sarafem, some people just don’t want PMDD and depression to be the same thing, which is exactly what might be achieved symbolically if they were treated by the same brand. The lesson here is that the marketing logic of rebranding does not simply dictate the cultural logic of how illnesses relate to each other, even though branding drugs differently can function as a way to sustain the conceptual apartness of certain illnesses.

## Sarafeminism?

Many doctors counter that medicines such as Sarafem help women who suffer severe discomfort, irritability and tension every month. A simple matter of medicine, they say, has been complicated by gender politics, drug marketing and the future of Prozac.

- From a *Washington Post* article on the Sarafem controversy (April 29, 2001)

Sociologists have explored how women's health issues gain public awareness in the U.S., and how they have—or have not—become part of the national health agendas.<sup>393</sup> One aspect of this work has demonstrated how women's health research has always at least implicitly been linked to considerations of their social roles (e.g. as wives or mothers or workers).<sup>394</sup> For instance, early Congressional Acts (including the Social Security Act of 1935) allotted medical research funding related only to maternal and child health services, thus reinforcing the idea that “women's health” is primarily about procreation and child rearing. In more recent years, women's health policy has been formulated in terms of scientific research on women's bodies. Auerbach & Figert (1995) traces the origins of this shift to the success of women's health movements, which pushed women's health issues into public awareness, and which specifically helped lead to a 1985 Public Health Service (PHS) report that “identified the lack of scientific data on women's health as a barrier to understanding women's physical, mental, and social health

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<sup>393</sup> Judith D. Auerbach, *In the Business of Child Care: Employer Initiatives and Working Women*. (New York: Praeger, 1988), M. Bass and J. Howes, "Women's Health: The Making of a Powerful New Public Issue.," *Women's Health Issues* 2.1 (1992), Anne E. Figert, "Women and the Ownership of Pms: The Professional, Gendered and Scientific Structuring of a Psychiatric Disorder.," *Social Problems* 42 (1992), J. Leavitt, ed., *Women and Health in America*. (Madison, WI: University of Wisconsin Press, 1984), T. Skocpol, *Protecting Soldiers and Mothers: The Political Origins of Social Policy in the United States*. (Cambridge, MA: Harvard University Press, 1992).

<sup>394</sup> Nancy Chodorow, *The Reproduction of Mothering*. (Berkeley: University of California Press, 1978), B. Ehrenreich and D. English, *For Her Own Good: 150 Years of the Experts' Advice to Women*. (Garden City, NY: Anchor/Doubleday, 1979).

in the United States.”<sup>395</sup> The main goals of these movements (which included Women’s Health Action Mobilization – WHAM, and Women’s Action Coalition – WAC) were the inclusion of women in clinical trials, better attention to female-specific diseases, greater professional representation of women in medical fields, and in general raising the consciousness of women about their health and bodies to help them be informed consumers.<sup>396</sup>

Since the introduction of DTC in 1997, the pharmaceutical industry has inserted itself into these debates, openly promoting DTC as a new form of medical education, including a special focus on women’s illnesses. I am collecting data on these “educational campaigns,” analyzing the new ways in which pharmaceutical companies are asking women to perceive themselves as potentially ill, with transformed relationships to health care professionals, and medical institutions. My preliminary research suggests that DTC (and thus the pharmaceutical industry) has located itself as a new place of promotion of, and contention over, women’s health policy.

Emily Martin has explored how medical and scientific ideas about menstruation have fit together with the historically contingent requirements of social and economic systems in the U.S. (Martin 1988). Specifically, Martin points out that, after women began entering the workforce at the start of World War II, the periodic changes in energy and mood associated with menstrual cycles became understood in terms of losses of productivity. Working-while-premenstrual became a new sociomedical category; and, the

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<sup>395</sup> Judith D. Auerbach and Anne E. Figert, "Women's Health Research; Public Policy and Sociology," *Journal of Health and Social Behavior* 35 (1995).

<sup>396</sup> C. Dreyfus, *Seizing Our Bodies: The Politics of Women's Health*. (New York: Vintage, 1977), J. Hamilton, "Women and Health Policy: On the Inclusion of Females in Clinical Trials.," *Gender and Health*, eds. C. Sargent and C. Brettell (New York: Prentice-Hall, 1996), S. Wilkinson and C. Kitzinger, eds., *Women and Health: Feminist Perspectives*. (Taylor & Francis, 1994).

premenstrual worker became a new category of person, with an accompanying medical science that was always partly out to answer what happens to women's capacity to work during their periods. Martin gets us to see the contingency of this situation: "Periodic changes in activity in accord with the menstrual cycle are not built into the structure of work in our society" (1988:290), and she uses her ethnographic work on women to show that the premenstrual forms of depression, irritability and anger that we now comfortably refer to in the medical language of "symptoms" might also be understood as implicit, collective reactions to inheriting such a constraining socioeconomic reality. Martin published this work more than a decade before Sarafem was launched, but she anticipated the introduction of drugs specifically made to manage PMS, wondering about the potential losses in personal and social diversity if women's cycles were to be pharmacologically "smoothed out" (1988:297).

It's interesting to read Martin (1988) alongside of *Listening to Prozac* (1993), where Peter Kramer claims that, to the extent that antidepressants can put women in a position to be more motivated and active, "[t]here is a sense in which antidepressants are feminist drugs, liberating and empowering" (1993:40). This seems to be exactly what Eli Lilly *wants* to say about Sarafem, but obviously is not in the right subject position to do so. The language of DTC advertising, however, is precisely about women "taking control" of their symptoms (the very opposite of the retrospective discourses of women and benzodiazepines—the "mother's little helpers" of the 1950's and 1960's, like Miltown and Valium—in which antidepressants and anti-anxiety drugs helped keep women 'in their places'). For instance, the following is the voiceover from a Lilly TV

commercial for PMDD, during a scene in which a woman was trying to find lost keys, growing increasingly frustrated:

Think it's PMS? It could be PMDD, premenstrual dysphoric disorder. You know, those intense mood and physical symptoms the week before your period. Sound familiar? Call to get free information about PMDD and a treatment your doctor has to relieve its symptoms. Why put up with this another month?

The subtext here is that severe premenstrual symptoms get in the way of a woman's personal and social functioning, and that it is the woman's responsibility for treating them – which in itself is a self-empowering act. The altered text from the following print advertisement for Sarafem also says this through a different logic:



What's conveyed graphically in this ad is that “ability” is embedded in the symptom of “irritability,” and that deriving one from the other—i.e. treating PMDD with Sarafem—is a feminist act. Whereas Martin posed the question of whether menstrual capacities themselves could be seen “as powers, not liabilities” (1988:292), the message of the



Sarafem ads is that power resides in the act of treating them.

This message is also significant given the uneasy history of women in pharmaceutical ads.<sup>397</sup> One concern that has been repeatedly is the over-representation of women in advertisements for antidepressants geared towards health care professionals. For instance, a 1971 article in the journal *Mental Hygiene* argued that “[a]ttitudes towards [women] can be influenced by an inordinate use (quantitatively) of pictures of them as ‘sick’ or disturbed. One can create the image of women as not only the weaker sex but the sicker sex.”<sup>398</sup> The theme of “quantitative” over-representation was picked up in later studies, including a 1995 study published in *Women and Therapy*, which showed that between 1986 and 1989 the ratio of females to males depicted in antidepressant ads was 5:1 in the *American Journal of Psychiatry* and 10:0 in *American Family Physician*, despite the fact that during this time the national diagnosis rates for depression was 2:1.<sup>399</sup> The authors framed the implications of their study in terms of the cultural stereotypes that physicians might carry, suggesting that diagnoses of mental illness might operate unequally across genders. Other articles published around this time drew out the ‘qualitative’ aspects of gendered representations in DTC print advertising, including a 1995 article in *Health Care for Women* arguing that drug ads depicted women as victims of depression, downplayed the “social problems and situational stresses” of depression by emphasizing its biological nature.<sup>400</sup> Similarly, Georges Canguilhem has written about “sickness without a sick person”: “Hence it is no longer pain or functional incapacity and

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<sup>397</sup> E.g. Jonathan Metzl, *Prozac on the Couch : Prescribing Gender in the Era of Wonder Drugs* (Durham: Duke University Press, 2003).

<sup>398</sup> R. Seidenberg, "Drug Advertising and Perception of Mental Illness," *Mental Hygiene* 55.1 (1971).

<sup>399</sup> F.J. Hansen and D. Osborne, "Portrayal of Women and Elderly Patients in Psychotropic Drug Advertisements," *Women in Therapy* 16 (1995).

<sup>400</sup> A.G. Nikelly, "Drug Advertisements and the Medicalization of Unipolar Depression in Women," *Health Care Women International* 16.3 (1995).

social infirmity which makes disease, but rather anatomical alteration or physiological disturbance” (1966:92).<sup>401</sup> In the case of women and depression, one concern is that the tendency towards making things somatic unfairly reduces the range of treatment options for depression, effectively disempowering women from making their own choices.

Similarly, medical sociologists have recently argued that the rise in antidepressant use among women is not simply correlated with an expanding number of uniquely female syndromes, but that it is also influenced by how cultural assumptions about gender have shaped the ways in which popular media have reported on those syndromes. For instance, Metzl & Angel (2003) have analyzed popular representations of women’s mental health since the introduction of Prozac.<sup>402</sup> They found that, when specifically referring to women, American newspapers and magazines have tended to describe mood disorders in non-medical, typically emotional terms (e.g. “overwhelmed by sadness,” “crying”); whereas when referring to men, they have described mood disorders in terms of official diagnostic language (e.g. “depressed”). Metzl and Angel also found that, since Prozac, U.S. popular media have increasingly described women’s mental health in terms of social roles (like marriage and mothering), whereas the coverage of men’s mental health has not undergone a corresponding change. They and others argue that cultural notions of gender have interacted with medical ideas about women’s health to produce popular symptomatology of women’s illnesses. My research picks up from medical sociology here, exploring with women their own uses of popular and professional literature, and their own experiences and perspectives on illness and treatment. One of my goals is to understand how these popular representations of mood disorders become incorporated

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<sup>401</sup> Georges Canguilhem, *The Normal and the Pathological* (New York: Zone Books, 1989).

<sup>402</sup> Jonathan M. Metzl and Joni Angel, "Assessing the Impact of Ssri Antidepressants on Popular Notions of Women's Depressive Illness," *Social Science & Medicine* [in press] (2003).

into women's own accounts of their illness identities and their experiences with pharmaceutical treatments.

Sarafem was one of the first prescription drugs to be introduced after the appearance of broadcast direct-to-consumer advertising. It was marketed from the beginning with a large print and broadcast campaign, representing one of the first times a pharmaceutical company had spent more on DTC than physician-directed advertising in the first months of a drug's release. The Sarafem campaign in particular also played into a more general controversy around DTC advertising and its effects on pharmaceutical expenditures, prescription practices, and possible delays in bringing generic drugs to market. In Europe, for instance, DTC is not permitted, and opposition there has cited the Sarafem campaign as an example of the potentially deleterious effects of DTC (like the over-prescription of antidepressants to women).<sup>403</sup> In the U.S., the Sarafem campaign was quickly implicated in debates over advertising as a new space where people encounter ideas about health, illness, drugs, and selves, and DTC became a new site for social movements to instigate health care reforms. For instance, the National Women's Health Network (NWHN – *Our Bodies, Ourselves*) testified at public FDA hearings on DTC advertising, using Sarafem ads to critique more generally the practices of DTC, and suggested that pharmaceutical companies should fund independent consumer-run groups to evaluate drug commercials. The NWHN had then begun its own policy of monitoring DTC ads and contacting the FDA when it deemed them “inaccurate and incomplete.”<sup>404</sup>

For all sides of the debate over DTC, the stake seems to be in establishing the

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<sup>403</sup> “UK consumers reject direct advertising to patients by drug industry” *BMJ* 2002;324:1416; “Providing prescription medicine information to consumers: Is there a role for direct-to-consumer promotion?” Health Action International Europe symposium report, 2002. The full proceedings are available at [http://www.haiweb.org/campaign/DTCA/symposium\\_reports.html](http://www.haiweb.org/campaign/DTCA/symposium_reports.html)

<sup>404</sup> <http://www.womenshealthnetwork.org/advocacy/cpa.htm> (accessed 2001)

gateways for participating in one's own health care. For instance, the pharmaceutical industry has met criticism about DTC with claims that this kind of advertising "empowers" consumers to participate in their own health care, "[r]ather than remaining uninformed and relying entirely on health care professionals."<sup>405</sup> Along these lines, the pharmaceutical industry has also claimed that DTC doubles as "educational campaigns" about illness and treatments, inevitably making healthcare more democratic. It's somewhat ironic that it was the pharmaceutical industry that 'answered the call,' picking up on the very language of empowerment and democracy that women's groups were using to challenge DTC in the first place, especially the question of whether DTC might actually be *limiting* the kinds of ways in which people could learn about illness. (For instance, in pharmaceutical advertising learning about something like depression *can only mean* learning about Prozac or Zoloft—and not, say, psychotherapy.)<sup>406</sup> Either way, the controversy around DTC and the fact that social movements have been inserting themselves into health care policy debates suggest that a new form of medical citizenry has emerged, one in which informed patients must be savvy consumers and political activists, and that these new kinds of medical citizens are emerging at the same time that sites for health care reform are shifting.

The specific question of how women have been represented in

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<sup>405</sup> From the Pharmaceutical Manufacturers of America's web page: <http://www.phrma.org/publications/documents/backgrounders/2000-11-05.189.phtml> (accessed March 2002)

<sup>406</sup> Simultaneously hailing women as sufferers of PMDD and as an empowered consumer demographic has important implications for the evolving relationships between medicine and marketing. For one thing, the kinds of mental illness that the public comes to learn about through DTC in part turns on the kinds of viewerships that are expected to engage in consumerist behavior. There is a large market for antipsychotic drugs, for example, but to date there have been no DTC ads for them. The effectiveness of DTC as a medium for disseminating neuroscientific understandings of mental illness depends in part on the kinds of people pharmaceutical companies expect to be watching their ads. Mental illness turns out to have a demographic complexity, too.

psychopharmaceutical advertisements was enlivened in November 2000 when the FDA sent a warning letter to Lilly over its first DTC advertising campaign for Sarafem. The contested spots featured a frustrated woman trying to extract her shopping cart from others lined up in front of a supermarket, along with the voice-over: “Think it’s PMS? Think again. It could be PMDD.” The FDA claimed that “The imagery and the audio presentation in the advertisement never completely define or accurately illustrate [PMDD], and there is no clear distinction between premenstrual syndrome and PMDD communicated,” and that the Sarafem spots “trivialized the seriousness of PMDD.”<sup>407,408</sup>

But what was it that made possible the language of “trivialization”? How did the line for representing PMDD separately from PMS become so thin, and so contested? It turns out that the FDA’s warning letter about the Sarafem campaign replicated the institutional struggles over PMDD, especially the insistence that PMDD be cleanly separated from PMS. What later became a key tension between the market reach for rebranded Prozac and the FDA’s insistence that PMDD be discontinuous with PMS was originally a tension between psychiatry, gynecology, and women’s advocacy groups over the “ownership” of PMS.<sup>409</sup>

### **PMDD in the making**

In the mid-1980s, the controversy around whether a premenstrual disorder should be included in the DSM-III-R (Diagnostic and Statistic Manual of Mental Disorders, Third Edition, Revised) quickly polarized into two basic sides within the American

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<sup>407</sup> The entire letter is available at <http://www.fda.gov/cder/warn/nov2000/dd9523.pdf>

<sup>408</sup> Lilly complied with the FDA’s request, immediately pulling the contested Sarafem commercials.

<sup>409</sup> This metaphor is taken from *Women and the Ownership of PMS* (Figert 1996).

Psychiatric Association (APA): Some argued that the creation of PMDD would pathologize *all* premenstrual symptoms (and, therefore, in a sense pathologize all women), whereas others embraced the diagnosis as a long-overdue recognition of the uniqueness of female suffering. These positions were complicated by the fact that the DSM-III was supposed to represent a decisive break from previous DSM nosologies that were “less scientific” (i.e. more psychoanalytic<sup>410</sup>), and psychiatrists who supported a premenstrual category in the DSM typically characterized splits over the ethics of a diagnostic category as “politics, not science.”<sup>411</sup>

Attempts to resolve the debates over the inclusion of a premenstrual disorder category in the DSM-III-R drew additional actors into the controversy. For instance, Jean Hamilton was a member of the “Premenstrual Advisory Committee,” and led the opposition against any version of PMDD, eventually recruiting the APA’s Committee on Women and outside women’s health groups (including the National Coalition for Women’s Mental Health and the American *Psychological* Association’s own Committee on Women) to challenge the decision to include a premenstrual disorder in the DSM-III-R. In the end, PMDD (then called “Late Luteal Phase Dysphoric Disorder”) was assigned a code number that placed it under “Other and Unspecified Special Symptoms or Syndromes, Not Elsewhere Classified,” and placed it in a special appendix in the DSM for areas “needing further research,” which was created especially for it.

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<sup>410</sup> Edward Shorter, *A History of Psychiatry : From the Era of the Asylum to the Age of Prozac* (New York: John Wiley & Sons, 1997).

<sup>411</sup> S. Squires, “New Guide to Mental Illness : Diagnostic Manual Takes Scientific Approach,” *The Washington Post* April 12 1994. See also Stuart A. Kirk and Herb Kutchins, *The Selling of Dsm : The Rhetoric of Science in Psychiatry, Social Problems and Social Issues* (New York: A. de Gruyter, 1992)., who criticize the determination of diagnostic categories for mental illness by the APA, arguing that it essentially happens through social arbitration involving contested scientific evidence. The backdrop is the politics of remedicalizing psychiatry and the significant break that DSM-III represented in terms of its alignment with pharmacologic interventions and, in general, biological paradigms and classification systems.

In the early 1990s, when the APA committees reconvened to plan for the next edition of the DSM (the DSM-IV), the question of the appropriateness of a premenstrual category was taken up again. A key figure in this controversy was Paula Caplan (a psychologist and member of the new PMDD Work Group), who renewed the opposition against a premenstrual category within the “science, not politics” framework, charging—and publicizing—that there was only “bad science” around PMS.<sup>412</sup> Caplan’s arguments were part of the shift from a debate about the ethics of a diagnostic category to a debate about a possible science of PMS and psychiatry’s pretensions as a scientific enterprise. And as the rhetorical grounds for fighting over a premenstrual category increasingly became scientific ones, the American Psychiatric Association (and not just the pharmaceutical industry) had an important stake in determining the effects of psychopharmaceuticals on premenstrual symptoms.

Specifically, Prozac became commercially available in 1987—the same year in which the DSM-III-R was published—and added a new dimension to the controversy around a premenstrual category in the DSM-IV. Previously, the inclusion of a premenstrual disorder was contested partly because there were no established treatments for its symptoms; but now, the commercial introduction of Prozac and its off-label usage to treat severe premenstrual symptoms provided a new way for psychiatrists to talk about how to distinguish PMDD from PMS (Figert 1996:166). Proponents of PMDD argued that drugs that specifically targeted mood-based symptoms (and not somatic symptoms, like cramping) allowed for the identification of symptoms that are truly psychiatric.

A separate issue was that a diagnostic code for PMDD would open up the

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<sup>412</sup> Paula J. Caplan, *They Say You're Crazy : How the World's Most Powerful Psychiatrists Decide Who's Normal* (Reading, Mass.: Addison-Wesley, 1995). (p. 146-151)

possibility of third-party reimbursement for drug treatment costs. This represented a new logic that some psychiatrists deployed to defend the inclusion of PMDD in the DSM-IV: If PMDD is not recognized and legitimated as a disorder, then the treatments for what count as its symptoms cannot be reimbursed. This health insurance logic had epistemological implications for the disorder: “If psychiatrists and physicians aren’t knowledgeable about PMDD, women with the disorder won’t be given therapy and / or antidepressants.”<sup>413</sup> The very availability of antidepressants became part of an argument that the reality of PMDD should be disseminated to mental health care professionals and primary care physicians. In the end, PMDD was coded for these purposes, despite remaining in an appendix. But as part of the new DSM-IV coding schema, the reference to PMDD in the main text was changed to “Depressive Disorder, Not Otherwise Specified.”

Of course, the new relevance of psychopharmacology in the PMDD debates did not evacuate the politics around women’s health care. If anything, it demonstrated that science and medicine couldn’t settle issues of inequality. This is illustrated in the following exchange of editorial comments in *The New England Journal of Medicine* after a study on the effects of fluoxetine on PMDD was published in 1995,<sup>414</sup> one year after the DSM-IV was published:

This study provides further evidence that science thinks it must rescue women from their bodies. And it gives more evidence of the negative view this culture holds of women and their physiology.

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<sup>413</sup> Judith Gold, chair of the APA’s PMDD Work Group, quoted in Figert (1996:161).

<sup>414</sup> M. Steiner, S. Steinberg, D. Stewart, D. Carter, C. Berger, R. Reid, D. Grover and D. Streiner, “Fluoxetine in the Treatment of Premenstrual Dysphoria,” *N Engl J Med* 332.23 (1995).



And the response:

To deny these women effective treatment merely because our culture has negative views of female physiology is bad medicine.<sup>415</sup>

This exchange reengages the very terms of debate around the initial inclusion of a premenstrual category in the DSM; but here clinical pharmacology does not seem to offer a new logic to fight within. Still, women's health care here more than ever involved various actors figuring out what counts as good science, and the above quotes reveal two views of science in the world: Both sides make feminist arguments, but have opposing views of science as controlling or liberating. These quotes also refer to the new tension between science and politics in the debates around PMDD, in which opposing sides simultaneously tout science in the name of women, and thus fights over the politics of women's health care become fights over the right kind of science.

These quotes also invoke the relationship between medicine and "culture" in important ways. In the first quote, medicine is complicit with a culture that demeans female physiology; in the second quote, medicine is fighting against such a culture.

### **Symbolic side effects**

Prozac represented one of the so-called "blockbuster drugs"—defined by IMS-Health (a large market intelligence firm for pharmaceutical and healthcare industries) as products with sales of \$500 million or more. Blockbuster drugs have come to change how

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<sup>415</sup> J. C. Prior, K. Gill and Y. M. Vigna, "Fluoxetine for Premenstrual Dysphoria," *N Engl J Med* 333.17 (1995).

pharmaceutical companies think about their markets, specifically in terms of the short-term practicability to segment markets through existing products rather than develop new drug classes. IMS-Health attributes the blockbuster drug phenomenon primarily to increases in FDA approval time, and the bottom-line it takes to actually get a drug to market:

To offset their substantial R&D investments in new drugs, companies increasingly look to the revenue generated by blockbusters. To sustain growth and market share ... they are looking for ways to extend the life of their patents; to receive FDA approval for new indications of existing products; and to create new, improved versions of existing products.<sup>416</sup>

On the one hand, the pharmaceutical is a medical technology with certain scientific resources behind its development and production; on the other hand, the pharmaceutical is a branded commodity, and marketing enters into the picture. Accordingly, the launching of Sarafem was part of a strictly economic move, exemplifying new pressures in U.S. pharmaceutical markets to get drugs approved and marketed for multiple illnesses to extend their patent lives. In this case, as soon as generic fluoxetine was made available, it was added to 91% of managed care drug formularies, half of which immediately dropped their coverage of brand-name Prozac altogether (Scott-Levin 2002). And within a month after generic fluoxetine went public, Prozac lost two-thirds of its prescription volume, a collapse in market share that represented “an all-time speed record” for the pharmaceutical industry.<sup>417</sup> Marketing journals at the time spoke of Sarafem as part of an attempt by Lilly to recoup inevitable losses from Prozac’s patent expiration and the

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<sup>416</sup> “Life After Prozac”: [http://www.imsglobal.com/insight/news\\_story/0009/news\\_story\\_000925.htm](http://www.imsglobal.com/insight/news_story/0009/news_story_000925.htm) (accessed 2000)

<sup>417</sup> Carl Seiden, “Even without Prozac, Lilly Won’t Suffer Depression,” *Medical Marketing & Media* 37.3 (2002).

subsequent availability of generic fluoxetine (by getting FDA approval for an additional use under another brand name), and IMS-Health also anticipated the appearance of Sarafem as a tactic to “combat generic erosion” (IMS-Health 2000).

When Sarafem was launched in 2000, the media picked up on the coincidence of Prozac’s patent expiration. Much of the news coverage referred to PMDD as a “new” illness category, and not infrequently raised the question of whether PMDD was in actuality created for the marketing of Sarafem:

Irritability, sudden mood changes, bloating? Ladies, if you suffer from these nasty symptoms just before your monthly period, you could have Premenstrual Dysphoric Disorder. Sounds serious? Eli Lilly certainly hopes you think so. You may never have heard of PMDD, but the American drug company wants you to take a pill for it.<sup>418</sup>

Anxiety over the creation of consumer demand for Sarafem was predicated on the uneasiness over PMDD as a legitimate illness category—but now the institutional genealogy of PMDD (including its footholds in psychiatry) was largely absent from the new discourses around Sarafem. Women’s healthcare groups, feminist groups, and individuals participating in on-line discussion groups also focused on the timing of Sarafem with the patent expiration of Prozac, using language like “Prozac repackaged” to describe the drug.<sup>419</sup> When PMDD was debated in the American Psychiatric Association, there were publicly expressed concerns about how psychiatry might medicalize premenstrual experiences; when Sarafem came on the market, they were made complex by concerns about the how the pharmaceutical industry might capitalize on premenstrual

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<sup>418</sup> “Marketing Madness,” *The Economist* July 21 2001.

<sup>419</sup> For instance, from a zine on sexuality:

<http://www.theposition.com/coverstories/cover1/00/11/27/pmdd/default.shtm>. The American Psychological Association has adopted this language as well: <http://www.apa.org/monitor/oct02/pmdd.html> (accessed October 2002).

experiences. But within both frameworks, public concerns about PMDD have always been about the extent to which it either reinvented or intruded upon PMS. The following quote, from a news wire service, makes even more complex these new tensions between Sarafem, Prozac, and PMDD:

The popular antidepressant Prozac has just won a new use: to treat women suffering from a severe form of premenstrual tension. But if you use Prozac to treat “premenstrual dysphoric disorder,” don’t call it Prozac – the manufacturer has come up with a new name, Sarafem, to catch women’s attention. It’s the same drug, known chemically as fluoxetine, the U.S. Food and Drug Administration stressed.<sup>420</sup>

Unlike the previous quote, in which consuming Sarafem means consuming PMDD, here it’s assumed that women might already be taking Prozac for PMDD, and that Lilly has simply encouraged them to start calling it Sarafem. The (sarcastic) logic here is that women might instantaneously change their relationship to *the same drug*, rather than being prescribed a different drug, or coming to learn about a new diagnosis through a new drug.

Sarafem rekindled the controversy around PMDD, but also restructured it. For instance, the APA had a marginal role in the public discussions that formed around PMDD after Sarafem was launched. Instead, the pharmaceutical industry and the FDA took center stage, especially after Lilly’s first round of DTC campaigning for Sarafem (the shopping cart ads), which became a target for women’s health groups and, ultimately, the FDA. Also, the launching of Sarafem gave those who had been involved with the DSM working groups on premenstrual disorders a platform to renew (and sometimes subtly redefine) their positions on PMDD. For instance, Darrel Regier, director of the American *Psychological Association’s* division of research, was quoted in

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<sup>420</sup> “Prozac for Pmd,” [The Daily Telegraph](#) July 8 2000.

*The Washington Post* as saying that PMDD was “the first indication for a drug that the FDA has approved for a nonofficial diagnosis.”<sup>421</sup> The language of “nonofficial diagnosis” is noteworthy, since it both allows for the diagnosis and delegitimizes it. Regier’s comment is especially interesting when lined up with Paula Caplan’s own statements about Sarafem and PMDD, for instance that “[t]he decision to accept Lilly’s description of Sarafem as effective for ‘PMDD’ exacerbates the misleading and dangerous assumption that this condition even exists.”<sup>422</sup> Regier’s and Caplan’s statements about Sarafem revealed new grammatical splits among those who were politically aligned against PMDD when it was being debated within the APA: On the one hand, PMDD might exist but is not official (since it does not appear in the main text of the DSM, and might require more compelling evidence to move it there); on the other hand, PMDD simply doesn’t exist (and should never have been placed in the DSM to begin with).

Others welcomed Sarafem. Robert Spitzer (former chair of the work groups to revise the DSM-III and DSM-III-R), for example, defended Sarafem by appealing to women’s suffering: “My own view—and the view of the people who originally proposed the category [of PMDD]—is that there is a small subset of women who suffer from this disorder, and the best thing you can do for these women is to recognize and develop effective treatments for it” (Quoted in an interview with *WebMD*, June 18, 2001). For Spitzer, the development of drug treatments obviated the need for debates about the reality of PMDD. Here there’s a subtle logic that reproduces a key argument supporting

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<sup>421</sup> Shankar Vedantam, “Renamed Prozac Fuels Women’s Health Debate,” *The Washington Post* April 29 2001.

<sup>422</sup> Paula J. Caplan, “Expert Decries Diagnosis for Pathologizing Women,” *Journal of Addiction and Mental Health* 4.5 (2001).

PMDD in the DSM-IV: the development of drug treatments for PMDD *is* simultaneously the decision that PMDD exists. This sentiment was shared by David Rubinow, clinical director at the at the National Institute of Mental Health (NIMH), also quoted in the *Washington Post* as saying that “Concerns over the disorder are about politics, not science. If a woman was in distress and an effective treatment was available, common sense dictated that she should get help.” It’s important to note that both Spitzer and Rubinow speak as if Sarafem was an altogether new treatment, but of course its chemical alter ego Prozac had already been used to treat severe PMS for over a decade. Moreover, it was the ‘sameness’ of Sarafem and Prozac that became a focal point of public controversy around PMDD. Indeed, it was Sarafem—and not Prozac—which received FDA approval to specifically treat PMDD. Thus, it was Sarafem alone that could be talked about as an official treatment, whose very availability legitimated PMDD, and it was Sarafem that was recruited as a new term in the “politics, not science” binary that was wielded throughout the DSM fights. What was never said outright, though, was that “politics, not science” now also translated debates over the marketing of Sarafem.

### **Marketing (and) medical turf: symbolic fall-out**

PMDD and Sarafem have also figured prominently into a turf battle between medical specialties – with ramifications for the epistemology and experience of PMS. A recent survey of fellows of the American College of Obstetricians and Gynecologists suggested that gynecologists consider PMDD to be their one of their primary responsibilities, but that major depressive disorder is not.<sup>423</sup> That gynecologists feel

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<sup>423</sup> L. D. Hill, B. D. Greenberg, G. B. Holzman and J. Schulkin, "Obstetrician-Gynecologists' Attitudes

PMDD is in an important sense theirs, and that a condition like depression isn't, is on the one hand due to the lineage that gynecology has had with premenstrual symptomatology—which have been conceptualized as somatic and hormonal, not mental. But, as we've seen, PMDD is a *psychiatric* category that the American Psychiatric Association had to fight for in important ways. Carving out PMDD from PMS was simultaneously a response to concerns from women's groups about the boundaries between a supposedly psychiatric disorder like PMDD and PMS, and to concerns from gynecologists about the proper boundaries between psychiatry and medicine.

Telling the story of PMDD as a history of interactions between psychiatry and women's medicine adds another layer to the amount of work it took to keep it apart—conceptually, clinically—from PMS. Gynecological authority over PMS generated tensions between the APA and women's medicine over the legitimacy of PMDD, intensifying reasons for it to be conceptualized mostly in terms of mood (whereas PMS was characterized more somatically in terms of fatigue, “bloating,” etc.). This move was complicated by the fact that the DSM-III represented deliberate attempts to align psychiatry with medicine (again, to make the DSM “more scientific”). For instance, one of the main motivations behind the coding system in the DSM-III and subsequent editions was to make it more compatible with international diagnostic systems, especially those of the World Health Organization's *International Classification of Disease* (in 1986, the ICD-9-CM). But the ICD-9-CM included “premenstrual tension syndromes” under the category “Other Disorders of the Female Genital Tract,” so the use of an analogous code number within the DSM would in effect have duplicated a

*gynecological* category within a *psychiatric* nosology. This proposal led to conflict between psychiatrists and gynecologists, and this particular classification for PMDD was eventually rejected (Figert 1996:76-79).

Interpreting the effects of antidepressants on premenstrual symptoms also became part of the work of resolving professional boundary disputes, since some psychiatrists were already using SSRI studies to argue that mood-based premenstrual symptoms could be separated out from somatic ones, and that an institutional division of work was therefore justified. A Medline search of fluoxetine research between 1987 (when Prozac became publicly available) and 1994 (when the DSM-IV was published) turns up studies on “premenstrual syndrome,” “severe premenstrual syndrome,” and “luteal phase dysphoric disorder,” among which the patient criteria differ (from DSM-III-R diagnostic criteria for “late luteal dysphoric disorder” to self-rating reports of feeling premenstrual). Thus psychiatrists could consider a number of studies that successfully demonstrated drug efficacy on a range of premenstrual symptomatology. Of course, what was at issue in the APA debates was just how separate a psychiatric version of PMS could be, and PMS ‘itself’ obviously wasn’t a viable diagnostic entry for future versions of the DSM. In the end, the psychopharmacology research did not speak for itself, as it were; the decision to keep PMDD in the DSM-IV was based more on enabling insurance reimbursement of the newly available psychopharmaceuticals, than on any clear psychopharmacological evidence that PMDD was an entirely different creature than PMS.

But PMDD “needing further research” has largely meant psychopharmacological research and, since the DSM-IV, publications on PMDD have emphasized the



relationship between PMDD and pharmacological treatment. For example, a 1999 article in *The Journal of Women's Health* entitled, "Is premenstrual dysphoric disorder a distinct clinical entity?" claimed that, "PMDD displays a distinct clinical picture that, in the absence of treatment, is remarkably stable from [premenstrual] cycle to cycle and over time."<sup>424</sup> The grammar here crystallizes the idea that the distinctness of PMDD from PMS is predicated on the effects of psychopharmacological treatment, even in its absence.

Once the marketing of Sarafem became the primary vehicle for the public to learn about PMDD, the conceptual distance between PMDD and PMS took on another dimension. While the clinical trials for fluoxetine on PMDD were meant to establish treatment efficacy (what the FDA requires), Lilly's marketing of Sarafem transformed claims about treatment *efficacy* into claims about premenstrual symptom *etiology*. The publicity around Prozac as a treatment for depression played a crucial role in circulating the language of "chemical imbalances," and the marketing for Sarafem—non-Prozac fluoxetine—also incorporated this framework to characterize PMDD. The website that Lilly maintains for information about Sarafem describes PMDD as "believed to be caused by an imbalance of a chemical in the body called serotonin" and that "Sarafem taken daily helps to correct the imbalance of serotonin that many physicians believe contributes to PMDD" (Lilly 2000). This framework locates the causes of PMDD in the brain, and aligns it exactly with the neurobiological discourses for depression and anxiety. This represents a significant shift, because the language of hormones and abnormal menstrual

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<sup>424</sup> J. Endicott, J. Amsterdam, E. Eriksson, E. Frank, E. Freeman, R. Hirschfeld, F. Ling, B. Parry, T. Pearlstein, J. Rosenbaum, D. Rubinow, P. Schmidt, S. Severino, M. Steiner, D.E. Stewart and S. Thys-Jacobs, "Is Premenstrual Dysphoric Disorder a Distinct Clinical Entity?," *Journal of Women's Health and Gender-Based Medicine* 85 (1999).

cycles previously had dominated both scientific and popular discourses of premenstrual symptoms. For example:

[Premenstrual Tension comes from] a malfunction in the production of hormones during the menstrual cycle ... This upsets the normal working of the menstrual cycle and produces the unpleasant symptoms of [PMS]. (Lever 1981, quoted in Martin 1988)

NIMH researchers who co-authored the *Journal of Women's Health* article mentioned above have argued publicly that hormones should be downplayed in discussions of premenstrual symptomatology, characterizing them as “triggers” but not “causes” (*USA Today*, February 18, 2000). But Lilly’s “educational campaign” about PMDD extends this logic one step further, characterizing hormones and hormonal activity as “normal,” effectively moving the pathology of severe premenstrual symptoms *completely* to the brain:

“While PMDD is not fully understood, many doctors believe it is caused by an imbalance of a chemical in the body called serotonin. The normal cyclical changes in female hormones may interact with serotonin, and may result in the mood and physical symptoms of PMDD.” (Lilly 2000)

These statements do not allow that the premenstrual cycle is where PMDD originates. Moreover, these statements are part of the move to link *what fluoxetine does* to *what PMDD is*. The psychiatrist and historian of medicine David Healy has written about this phenomenon more generally, arguing that, historically, neuroscientific theories of drug action have been hijacked as marketing claims about the biological reality of mental illnesses (Healy 2003). A relevant aside: the writer and producer of a number of television spots for Prozac and Sarafem told me that he assumed “Sarafem” alluded to

serotonin, the neurochemical whose activity fluoxetine specifically affects (personal interview, January 23, 2003).

In direct-to-consumer (DTC) advertising generally, mental illness is medical, not mental, and the promotional material for psychopharmaceuticals typically refer consumers to “doctors” or “physicians”—never psychiatry or psychiatrists. Accordingly, the Sarafem website includes a section entitled “treatment options” for PMDD, but there is no mention of psychiatrists or psychologists. Perhaps ironically, the rhetoric of PMDD in contemporary DTC advertising for Sarafem is quite similar to the rhetoric of PMS in mid-1980s ads for over-the-counter drugs. In those ads, psychiatry was not too subtly maligned for making PMS mental: “Premenstrual tension is not a psychological issue. It is a physical condition ... Premenstrual tension is not in your mind. It’s in your body. Use your head – get to the physical source” (from an ad for “PreMysyn PMS,” *People Magazine*, June 30, 1986, cited in Figert 1996). The PreMysyn ad campaign also prominently featured recommendations from “leading OB/GYNS.” This kind of challenge to psychiatry’s claims to PMS resonates with contemporary DTC ads for Sarafem—which is a prescription-only drug for a psychiatric syndrome, but whose promotional materials never actually mention psychiatry. It’s true that DTC ads for Sarafem don’t mention gynecology explicitly, either, but for many women the “talk to your doctor” refrain of this kind of advertising *means* talk to your OB/GYN. This also speaks to the fact that gynecologists feel that PMDD is one their specific responsibilities.

DTC promotion of psychopharmaceuticals has also changed the way health care policy experts weigh in on mental illness:

Perhaps more important than the side effect profile of SSRIs is how they have changed the perception of mental illness ... Depression can be viewed as a treatable medical event much like hypertension or high cholesterol. One needn't visit a psychiatrist to get better; even primary care physicians can help. (Cutler 2002)

The grammar here is that *the drugs themselves* have changed the social reality of mental illness. Indeed, once the pharmaceutical industry got its hands on PMDD, it became medical—in the sense of bodily (but not hormonal)—once again. In a series of complicated moves, the pharmaceutical industry went through psychiatry (mental) to get to the brain (physical) to produce ideas about premenstrual symptoms (which became neither psychiatric nor gynecological).

One implication here is that pharmaceutical products allow psychiatric diagnoses to travel into other medical fields—but not without transformation. In this case, Sarafem helped to redefine who should treat PMDD (any M.D.), and DTC advertising redirects where potential patient populations seek out their psychopharmaceuticals (any M.D.). So, on the one hand, the pharmacotherapy that DTC advocates leads to fewer women seeking specifically psychiatric care for severe PMS; on the other hand, the contested psychiatric diagnosis of PMDD gets legitimated when deployed elsewhere, and informs practitioners in other fields. (The fact that PMDD is still in a special “needs further research” appendix in the DSM-IV doesn't matter when it is touted as a bona fide medical condition in pharmaceutical promotional materials in general practitioners' offices.) Here, one effect of pharmaceutical marketing is to decouple the authority to determine psychiatric categories from the authority to treat these categories.

PMDD is so socially manifold, so intertextual, because it lives in the American Psychiatric Association's DSM-IV; yet gynecologists feel that in an important sense it's

theirs; yet because Eli Lilly was worried both about the stigma of psychiatric disorders and the market reach for Sarafem, for them PMDD is simply “medical.” Likewise, ‘officially’ PMDD is a “Depressive Disorder, Not Otherwise Specified”; yet for the purposes of Eli Lilly’s “educational campaign,” PMDD and depression are symbolically incompatible.

As a final note, consider how the following ad interpellates women to participate in a clinical trial for PMDD treatments at a major Boston psychiatric research center:

Do you feel moody, depressed, or anxious and irritable before your period? Do you suffer from severe PMS or PMDD (premenstrual dysphoric disorder)?  
(Posted in a Boston subway car, February 2003)

Here PMDD bleeds back into PMS: “severe PMS *or* PMDD” identifies separate kinds of premenstrual categories, but only for the purpose of collapsing them in a clinical trial population. “Severe PMS” is not a diagnostic category; on the contrary, it points to the spectrum of PMS that fights in the APA over establishing a diagnostic category were about. So I also want to understand this alongside of the rhetorical question that Eli Lilly asks of its DTC viewership: “Think it’s PMS? It could be PMDD.” This is worth exploring a couple directions: First, the APA and the pharmaceutical industry have tried to make PMDD uncontroversial by arguing that it’s a different creature altogether from PMS, but here’s a clinical trial that solicits women with PMDD *or* with “severe PMS,” as if the differences were *only* grammatical – as if the different grammars didn’t betray anything other than etiological sameness. Second, it’s important to note that we live in a world in which solicitations for clinical trials can function as a form of advertising for a

syndrome that has been called “nonexistent” and “nonofficial.” Here we have a situation in which compensation for participating in a clinical trial is pharmacological treatment for a psychiatric syndrome that is socially contested.

With this in mind, let’s return to where we started, and hear again those voices that are hard not to respond to:

Medical condition my ass, do the words “dysphoria” and “disorder” sound familiar to the community?

And:

I’m so glad to hear the good Sarafem is doing. All I can say that it’s about time they’re treating PMS more seriously.

Now we can understand these statements as being about boundaries, too. On the one hand, PMDD is a medical condition that constrains social communities by rigidly defining them; on the other hand, the perceived commercial success of Sarafem is a way to spread out recognition that *PMS* is no longer a trivial matter. The little word “or” in “PMDD or severe PMS” makes the clinical trial flyer something good to think with. By understanding some of the complicated ways that such an object is historically and socially situated, we can understand how the co-production of illness categories and pharmaceutical treatments can offer up ways for people speak about themselves as medical objects, and experience themselves as subjects of medical discourses.

### **Titration up to identity**

We all know someone who is on Prozac, or think about going on it ourselves, or see it seep into our communities in ways both alarming and amusing. Prozac, for these reasons alone, is a remarkable drug. It is perhaps the only drug to have seeped so far out of its plastic shell, to have been absorbed by the bloodstreams of so very many, even those who have never had any tactile relationship with it. I would go so far as to say we are all “on” Prozac, in that we all must grapple with its presence, its meaning, and its implications for our lives.

- from *Prozac Diary*<sup>425</sup>

Prescription drugs are medical technologies that are taking on new social lives through marketing, and we need to account for how this might be changing the ways people experience and identify with illness. Patient identity can become branded identity, and knowing which brands belong with which illnesses can complicate experiences with medications. For example, if you take Prozac and left your pills at home, would you take your friend’s Sarafem? What about your friend’s generic fluoxetine? How are we interpellated to consume prescription drugs? How do the new ways in which pills are designed and marketed affect our consumption practices and guide our experience of medical diagnoses?

The “identity practices” that I refer to in the title of this chapter turns out to be ambiguous. “Identity practices” refers to how individuals and social movements, including professional organizations, participate and position themselves in sociomedical discourses; but it also refers to the pills themselves, and how marketers and doctors and patients and regulators have come to think about a pharmaceutical product’s

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<sup>425</sup> Lauren Slater, *Prozac Diary*, 1st ed. (New York: Random House, 1998). (Appendix, p.9)

identity—including the illness it is associated with—can be represented in the space of direct-to-consumer advertising. This is part of the power of DTC; these advertisements provide rich and lively material for cultural criticism precisely because their purpose is to represent and act out the symptoms of mental illness in such a way that these illnesses connect with viewers. Advertising, like pharmaceutical products, is about the structure of desire, and, within this context, the phenomenology of the pill itself is intended to be like a therapeutic intervention. So we need to decide whether Baudrillard gets to have the last word. It's getting harder and harder to confidently demarcate the "essential" from "inessential" aspects of psychopharmaceuticals. Chemicals matter; but so do colors.

Indeed, the question of how we experience illness through social categories must simultaneously be a question of how we encounter ideas about illness, drugs and brains in the first place.<sup>426</sup> Especially since the advent of DTC, prescription drugs are being produced, not only as chemicals consumed by bodies, but as texts that have to be consumed socially, culturally, and personally. This isn't to say that pharmaceutical consumption in a postmodern world is any 'more' cultural or social or personal than it has been during any other time in the history of medicine, but rather that, more and more, these are the levels that constitute how consumers, doctors, drug developers and marketers assume, worry about, or get excited over how we (should) relate to our pharmaceuticals. Apropos of that, we could ask what kind of world must exist in order that a science journalist could produce the statement "symbolic mistake" to refer to a not-quite-medical interaction between a drug and an illness. I began exploring the symbolic life of Sarafem with this level of analysis in mind, and was continually surprised. Who would have thought that the color of a prescription drug could be read backwards in time

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<sup>426</sup> Cf. Dumit, "Drugs for Life."



to reveal institutional and social struggles over a diagnosis, and then read forward as a new component of a contemporary technology of self?

## Conclusions:

### New directions for pharmaceutical studies

For Marx, “commodity fetishism” meant mistaking commodity objects and their interchange as relations between things, not as relations between the humans on whose production and circulation the commodities actually depend. When Prozac was rebranded as Sarafem, commodity fetishism intersected with psychoanalytic fetishism. Recall from the Introduction the MIT student who refused to take Sarafem, even though he knew it was ‘really just’ Prozac. The company’s willful illusion that Prozac and Sarafem really are not the same thing collided with the student’s own fetishist denial that they really are the same thing. The tension is remarkable: For the company it was a question of getting the public to suspend disbelief in difference (look, these drugs are really not the same), but for the student it was a question of getting himself to suspend disbelief in sameness (I know they’re really the same, *but ...*). It is the student’s own ‘acting-if’ that subverts commodity fetishism: His refusal to take Sarafem depends on actually knowing the social labor behind how it was produced (i.e. that the same pharmaceutical company produced a single chemical but packaged and marketed it in two different ways). On the other hand, it is the psychoanalytic fetishism that undoes him: The student can’t help but believe that the difference between Prozac and Sarafem is somehow a real stand-in for gender. His good-intentioned political correctness doesn’t help him; he simply won’t take a pink-and-purple pill marketed for premenstrual symptoms.

The Prozac/Sarafem tensions are new, and they go a long way towards characterizing the new social, cultural, and personal challenges and analytics of

pharmaceutical relationships in an age of direct-to-consumer advertising. DTC started more traditionally as advertising with the particular problems of pushing medicine and publicly defining and defending the pharmaceutical industry. But relationship marketing represents a very personal orientation towards pharmaceuticals, one that is shot through with the challenge of psychoanalytic subjectivity.

The drug industry's public relations needs are about how agency creatives tweak, shape, and create culture; but at the same time are about how patients buy in to a series of relational problems. And as we've seen, savvy contemporary American consumers puts us past *The Hidden Persuaders* (where audiences are blindly or simply manipulated) towards consumers who know that to get what they need (psychologically and physically) they need to be players who know the psychopharmacology, know the marketing, and know how the FDA shapes what is publicly said about illness and treatment.

In turn, it is precisely this savvy individual who is the new target of drug marketing. Drug marketers approach market issues as the problem of managing consumer belief, which is the real work of advertising and public relations. And yet, while brands are the lifeblood of pharmaceutical companies, contemporary American citizens are suspicious of brand pushing. Relationship marketing, with its own history as a strategically ethical response to the FDA and critical press, solves two problems at once by taking health consciousness and channeling it through brands, and working to inform drug compliance.

These dynamics point to new directions for pharmaceutical studies that cut across anthropology, sociology, and science and technology studies (STS). I situate this

dissertation with other recent interdisciplinary scholarship on the cultural shifts brought about by pharmaceutical-centered medicine. Lakoff (2006), Petryna et al. (2006) and Sunder-Rajan (2006) all offer ethnographies that document the deep and unexpected relationships between international pharmaceutical regulation, drug research practices, and illness identities. Emily Martin's recent ethnographic work with drug marketers and former pharmaceutical reps (2006) highlights the new ethical subject positions that pharmaceutical salespeople end up inhabiting in the face of widespread public criticism of the drug industry. And Dumit & Greenslit (2006) have recently edited "Pharmaceutical Cultures," a special issue of *Culture, Medicine and Psychiatry* that identifies the interconnected themes of "informed health" and "ethical identity management" in diverse ethnographic and historical scholarship on pharmaceuticals, dietary supplements, contraceptives, and gambling addiction.

"Ethical identity management" refers to how identity in the U.S.—i.e. "one's sense of oneself as a good, conscious, careful person"<sup>427</sup>—has increasingly come to depend on how one chooses to consume pharmaceuticals. Indeed, in the years since Peter Kramer's *Listening to Prozac* the socially provocative dilemma of *whether* one should take pharmaceuticals has been supplanted with the question of *how* one should take pharmaceuticals. In the age of direct-to-consumer marketing, these choices are often negotiations with advertising messages and the symbolic meanings of pills themselves (Greenslit 2006).

"Informed health" names how the very notions of health and illness increasingly depend on external, expert techniques of measurement—in particular the population-

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<sup>427</sup> Dumit & Greenslit (2006:130).

based metrics of clinical trials and pharmacoepidemiology that provide statistical proof of drug effects and disease rates.<sup>428</sup>

This dissertation has examined how, through DTC marketing, informed health can become part of ethical identity management. I have explored how marketers carve out their own ethical niche from which they innovate on ways to persuade consumer audiences with scientific facts that double as public relations. I have given special attention to how individuals encounter and incorporate the putative neuroscience of DTC, to negotiate their personal knowledge of illness, and to manage their identity, everyday practices, and professional pursuits. Within this “pharmaceutical nexus”<sup>429</sup> questions of agency are always at stake. Informed health depends on the standardization and widespread dissemination of seemingly objective statements about illness, bodies, and identities. But ethnographic attention to the diversity of the ways in which individuals experience and account for such facts reveals social contingencies and constant ways in which persons thwart, redirect, or defy standardization—even as they cannot help but be recruited as subjects of pharmaceutical relationships.

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<sup>428</sup> Ibid. (p. 128)

<sup>429</sup> Petryna & Kleinman (2006) coined this phrase to describe the globalization of pharmaceuticals as “a multiscaled movement with political, economic, and ethical dimensions” (p. 20).

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