"DEPRESSION IS A MEDICAL CONDITION": EXPLORING THE MEDICALIZATION OF DEPRESSION ON SSRI WEBSITES

By

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A thesis
presented to the University of Waterloo
in fulfillment of the thesis requirement for the degree of
Master of Arts
in
Sociology
Waterloo, Ontario, Canada, 2007

I hereby declare that I am the sole author of this thesis. This is a true copy of the thesis, including any required final revisions, as accepted by my examiners.

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ABSTRACT

"DEPRESSION IS A MEDICAL CONDITION": EXPLORING THE MEDICALIZATION OF DEPRESSION ON SSRI WEBSITES

Sociologists of medicine have become increasingly interested in mental health over the last two decades (Pilgrim and Rogers, 2005). Known as the "common cold" of mental illness, depression affects millions around the globe. The social understanding of depression has been shaped by a phenomenon known as *medicalization*, where an unusual behavior or state of being is labeled *illness* or *disorder* or *disease*, and addressed through rationalized medical intervention. The medicalization of depression is particularly evident on SSRI websites. SSRIs (Selective Serotonin Reuptake Inhibitors) are a popular class of antidepressants used to treat depression. Pharmaceutical companies who manufacture these medications now advertise their products on the Internet, an increasingly popular source for health information.

This thesis is a critical, empirical investigation of the medicalization of depression on SSRI websites.

Five major research questions guide this study. First, how is depression portrayed on the websites? Second, what are the means used to construct this portrayal? Third, who is the apparent target audience? Fourth, what assumptions are made about this audience? Finally, what is absent from or silent in the websites? These questions are answered using an analytical framework called Critical Discourse Analysis (CDA). This framework is both a theoretical orientation and a methodological process (Fairclough, 1992).

This study reveals that medicalization has a strong impact on the portrayal of depression on the websites, and is the major perspective from which the issue is

approached. The depressed person is seen to be affected by depression in a variety of ways, including being ill with a medical condition and at risk for further difficulty if treatment is not handled properly. A variety of means are used to construct the portrayal of depression, including structural means such as interactional controls, linguistic means such as word choices and meanings, and visual means such as the use of diagrams and caricatures. Embedded in the text are a number of indicators which highlight some apparent assumptions about the targeted audience, such as insurance coverage and general literacy. Absences or silences in the texts include a failure to discuss the prevention of depression. The most significant finding concerns "the symptom/side-effect" problem; this dilemma highlights the lack of clarity around definitions of recovery and mental health as well as the purpose of taking medications. It also reveals that, while the application of the medicalized perspective to depression is certainly useful given the efficacy of antidepressant drugs for many people, it is not infallible and requires careful critical consideration.

DEDICATION

Dedicated to everyone who has been ravaged by the dark and terrible emptiness of depression; in memory of those for whom it all became too much; in celebration of those who have overcome.

May we all find our way home;

Ubi Morbis Ibi Remedium.

ACKNOWLEDGEMENTS

If it is true, as they say, that it takes a village to raise a child, then it is also true that it takes a lot of people to sustain a graduate student. There are many who have assisted the completion of this degree, and they deserve recognition here.

I am very grateful to my three committee members. Thank you to my supervisor Juanne Clarke for your brilliant mentorship and tutelage, for insisting on rigor while allowing for creativity, and for coaching me through the last and painful stages of this process when coaching was so desperately needed. Thank you to Rick Helmes-Hayes for making me love theory, for teaching me how to read like a graduate student, and for your long-standing, invaluable leadership in my academic life. Thank you finally to Lorne Dawson, for kindly agreeing to step into this project so late in the game, and for being as fair and forthright in your feedback as you were in all those undergraduate classes I so enjoyed taking.

Special thanks to my dear colleague Joanna Jacob, without whose confidence and encouragement I would never have had the audacity to apply for September admission to the Master's program at the end of August. Sage advice and a listening ear during 6am runs considerably eased my transition into the graduate world. For that and for your friendship I will always be so grateful. Thank you also to Jen Plaskett for never ever taking me seriously about anything - but for managing anyway to be sensitive and supportive as I muddled through this degree and worried to you about it all.

To my parents: Thank you for setting such a distinguished academic example with your four combined graduate degrees, for your abiding love and sensible advice, and for being stars to this wandering bark as I sorted out my life and myself - I would still be lost if not for you. Thank you to my brother Ben, who brought a little sanity and a lot of levity to two years of graduate seriousness, and who has always known that life without mirth and laughter is no life at all. I should be so lucky to be as wise as that. Thank you most of all to my husband Tim, for patiently enduring papers all over the kitchen table, my office and your desk; for picking up a thousand books from the library; for ignoring me when I said this was all impossible, and doing everything you could to make sure it wasn't. More than this degree or anything else, the moment I am most proud of in my life is the moment I married you. You bridge all of my troubled waters; back there but for the grace of you go I.

***Antonio*: In sooth, I know not why I am so sad;**
It wearies me, you say it wearies you;
But how I caught it, found it or came by it;
What stuff 'tis made of, whereof it is born,
I am to learn;
And such a want-wit sadness makes of me
That I have much ado to know myself.
(Merchant of Venice, I:I)

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***Macbeth*: Cure her of that:**
Canst thou not minister to a mind diseas'd;
Pluck from the memory a rooted sorrow;
Raze out the written troubles of the brain;
And with some sweet oblivious antidote
Cleanse the stuff'd bosom of that perilous stuff
Which weighs upon the heart?

***Doctor*: Therein the patient**
Must minister to himself.
(Macbeth, V:III)

TABLE OF CONTENTS

CHAPTER ONE

INTRODUCTION

1.1 INTRODUCTION

The sociology of mental health has been a growing area of interest since the 1990s (Pilgrim & Rogers, 2005: 317). Once the province of medical personnel and epidemiologists, mental health is now being studied by sociologists who often use qualitative modes of inquiry (Pilgrim & Rogers, 2005: 319). Qualitative investigators of mental health are concerned with the way life stress, social integration and relationships, social roles and cultural systems of meaning are connected to mental health (Horowitz, 2002: 144). Cultural systems of meaning are connected to mental health insofar as they influence the way a culture thinks about, talks about, and deals with mental illness. These systems of meaning can best be understood only through qualitative investigation.

One growing trend with respect to understanding, diagnosing and treating mental illness is the system of meaning known as “medicalization”. Medicalization is defined as “the increasing attachment of medical labels to behavior regarded as socially or morally unacceptable” (Abercrombie, Hill and Turner, 2000: 222). Under medicalization, a behavior is defined as a medical problem such as illness or disorder, and then dealt with using a medical intervention or treatment (Conrad, 2005: 3). The phenomenon of medicalization cannot be properly understood, however, without some explanation of its context and of the history and social processes which granted it such legitimacy as a way to approach human behavior.

According to Max Weber, the modern world has undergone a process of “disenchantment” wherein humanity

> has chased [the gods] away and has rationalized and made calculable and predictable what in an earlier age had seemed governed by chance, but also by feeling, passion and commitment, by personal appeal and personal fealty, by grace and by the ethics of charismatic heroes (Coser, 1971: 232).

Modern scientific rationality disenchanted the traditional world, displacing authority based either on tradition or on charisma (Giddens, 1971: 157). The quest for truth became equated with the pursuit of science, with the application of "such abstract cognitive processes as logical deduction, induction [and] attribution of causality" (Ritzer and Goodman, 2004: 221). There was also a new emphasis on searching for general laws based on consistent, abstract principles (Collins and Makowsky, 2005: 123). Furthermore, those individuals specifically trained to search for truth using scientific tools came to be seen as experts in possession of an important and distinctly modern sort of authority.

The individual holding authority in a rationalized, scientific world has legal-rational authority as an expert, granted to him

> in virtue of impersonal norms which are not the residue of tradition, but which have been consciously established within a context of either purposive or value rationality. Those who are subject to authority obey their superordinate, not because of any personal dependence on him, but because of their acceptance of the impersonal norms which define that authority (Giddens, 1971: 157).

For Weber, the system of 'impersonal norms' which is the hallmark of the modern era is bureaucracy, organized in accordance with rational principles (Coser, 1971: 230). In a bureaucracy

> offices are ranked in a hierarchical order and their operations are characterized by impersonal rules. Incumbents are governed by methodical allocation of areas of jurisdiction and delimited spheres of duty. Appointments are made according to specialized qualifications rather than ascriptive criteria (Coser, 1971: 230).

The institution of modern medicine is a prime example of the application of the principles of rational-legal rationality. Medical doctors have highly specialized qualifications, gleaned from long years of training, and are licensed and granted permission to practice. They are assigned job tasks by virtue of their "areas of jurisdiction" (Coser, 1971: 230) or specializations which they decide on over the course of their training. Their training, which is in turn controlled by other "experts" and rooted in scientific knowledge, is designed to give them a "professional monopoly over technical skill" (Collins, 1979: 138). People do what doctors recommend – follow their direct orders, or grant them what Weber refers to as "authority" – because they are seen as trained experts in possession of rarified, scientific knowledge. As "experts", doctors are accorded prestige in society by virtue of this monopoly.

Medical sociologist Irving Kenneth Zola argues that medical knowledge and the application of medical terminology to various health and social issues has led to a situation in which medical practice is sometimes used as an instrument of social control. First, medical thinking shifted from a commitment to uni-causal models of disease to acceptance of multi-causal explanations. In other words, doctors began to attribute illness to a series of interrelated causes rather than simply to one isolated cause. Because of this shift in thinking, doctors also concluded that more aspects of human life and behavior are "relevant to the good practice of medicine" (Zola, 1972: 492). Second, the medical profession established absolute control over important technical procedures, including surgery and drug prescription (Zola, 1972: 493). Third, medicine retained absolute and almost exclusive access to the most private areas of human mind and body (Zola, 1972: 494). Finally, there came to be expanded notions of "what in medicine is

deemed relevant to the good practice of life" (Zola, 1972: 495). Said another way, medicine came to have an increased role in defining those personal practices and habits which would maintain and sustain a good life. These are the norms which reflect both the bureaucratization of medicine and the way in which it came to garner such social prestige.

Historically, medicine has had a certain level of social prestige. In medieval Europe, for example, medicine along with theology and law, was one of only three subjects taught at the highest levels of university (Collins, 1979: 139). Physicians claimed a "genteel status" in society partly because of their education and because they did not engage in the usual commercial pursuits (Collins, 1979: 139). Elite physicians (as opposed to surgeons and apothecaries) enjoyed the status and wealth they gained from treating wealthy patients, which only served to further enhance their status (Collins, 1979: 140). Medical training was based on 'traditional[1]' thinking and practices, and it was not until scientific advances in France and Germany led to some understanding of disease and infection, the role of antiseptic and proper sanitation that doctors were able to administer curative treatments (Collins, 1979: 139). After 1870, when several social changes increased the resources available to the medical elite and medical science began to develop in Europe, the prestige of medical practice was already well-entrenched. Efforts to represent the profession not only as prestigious but also as "altruistic dedication" (Collins, 1979: 147) only further enhanced its stature.

According to Zola, the prestige of the institution of medicine is so firmly established in contemporary society that information coming from a medical perspective

[1] Weber argued that traditional authority was based either on gerontocracy or on a clear differentiation between the ruler and his subjects (Giddens, 1971: 157).

carries tremendous weight and influence. The use of medical rhetoric or arguments is seen to buttress a large and increasing number of causes (Zola, 1972: 495), and the public takes its cues from "professionals who increasingly have been extending their expertise into the social sphere or have called for such an extension" (Zola, 1972: 495-6). The increasing application of clinical or health-related words such as 'healthy' or 'unhealthy' to the state, the economy and the environment is further evidence of the social regard for medical perspectives (Zola, 1972: 496).

In this context, the importance of a medicalized perspective regarding mental illness is a fruitful area of study. The social regard for the institution of medicine means people are very likely to accept this perspective. Despite its social prestige, medicine in Europe was "based on virtually no valid expertise at all" until well into the nineteenth century (Collins, 1979: 139). While people today are very often justified in their trust of medicine, because it works, they may also still be inclined in part to "go on faith", buoyed by the general stature of medicine. Some people even go so far as to claim that that people taking antidepressants are simply "going on faith", arguing that "there's not a scrap of evidence that there are biological abnormalities in any of the so-called psychiatric diseases" (Warme, 2006: 2). Moreover, it has also been argued that the serotonin theory of depression (on which the alleged utility of the SSRI class of medications is based) has not yet been clinically proven (Healy, 2003). Although these arguments are not common, it is still worth bearing them in mind when considering the popularity of SSRI antidepressants, which has become so widespread that Cohen et al. (2001: 453) call these drugs "blockbuster drugs", and Healy (2003) identifies Prozac as the symbol of a generation.

The popularity of antidepressants is partly attributable to advertising (Cohen et al, 2001: 454). Prior to 1997, pharmaceutical companies were legally prohibited from advertising anywhere other than clinical and academic publications. However, in 1997 the United States Food and Drug Administration relaxed this restriction (Conrad, 2005: 5). Since that date, pharmaceutical companies have been legally permitted to advertise to the lay public in whatever media forum they wish, including the Internet. Spending on drug marketing has skyrocketed $30 billion in 2005 (*The Kitchener-Waterloo Record*, August 21, 2007: A1).

The Internet has become an extraordinarily popular media outlet, and North Americans are increasingly using the Internet for health information. According the United States Food and Drug Administration (FDA), *millions* of consumers now go online for health information (FDA, 2005). In 2005, 58% of Canadian adult Internet users cited searching for medical or health information as a reason for going online (Statistics Canada, 2006).

1.2 PURPOSE

This project explores images of depression on SSRI websites. In particular, it explores the image of depression as a medical condition best treated by medical means – specifically, antidepressant drugs. Moreover, this project seeks to document the way in which the medicalized representation of depression encourages consumers to believe that medication is the best option for treatment. Depression is defined in the fourth edition of the *Diagnostics and Statistics Manual* (DSM-IV)[2] consisting of a 'Major Depressive

[2] The Diagnostics and Statistics Manual, or DSM, is a reference manual disturbed by the American Psychiatric Association which contains information about all known existing mental disorders.

Episode" wherein the individual experiences "at least two weeks of a depressed mood or loss of interest accompanied by at least four additional symptoms of depression" (American Psychiatric Association, 2000: 345). To be depressed, an individual must also have at least four other symptoms, including but not limited to irritability or crankiness, changes in appetite, sleep disturbances, psychomotor disturbances such as agitation, and decreased energy (American Psychiatric Association, 2000: 345-350). Current thinking about the cause of depression has led to the Serotonin Theory of Depression, which posits that clinical depression is caused by a chemical imbalance or deficiency in serotonin. Serotonin is a neurotransmitter found in the brain and is thought to be responsible for several important body processes including sleep and mood. SSRI antidepressants, or Selective Serotonin Reuptake Inhibitors, work by blocking the serotonin receptors in the brain, preventing its reabsorption, and thereby increasing its levels and by extension alleviating depression.

The analysis is structured around five research questions: (a) How is depression portrayed? (b) What means are used to construct this portrayal? (c) Who is the apparent target audience? (d) What assumptions are made about this audience? (e) What is missing from or silent in the websites? The websites for six SSRI antidepressants are analyzed: Celexa, Lexapro, Paxil, Prozac, Sarafem and Zoloft.

1.3 RATIONALE

This study is relevant given the millions of people who suffer from depression and other illnesses. SSRIs are a popular class of drugs, prescribed to millions of people for a variety of mental conditions in addition to depression. The Internet is increasingly being

used as a resource for health information. Direct-to-consumer advertising is increasingly prevalent in marketing pharmaceutical products. As Zola (1972) points out, anything containing medical terminology or based on medical research carries added credibility given the continued prestige of the medical profession. The literature put out by the pharmaceutical companies regarding depression (including disease information such as etiology as well as treatment information) certainly seems to be based in science, and thus people may be predisposed to finding it particularly credible and accurate.

1.4 ORGANIZATION

The thesis is organized as follows. Chapter Two contains a review of several interrelated bodies of literature. The first section provides a more detailed rationale for the project by outlining the social and personal significance of antidepressant medications. The second section attends to the two research questions regarding the portrayal of depression, commenting on the medicalization of deviance and the role of the pharmaceutical industry in representing depression to the public. The third section describes the different audiences targeted by SSRI advertising. The fourth section reviews completed studies of antidepressant medications. My research shows that these studies have largely been done on advertisements found in printed magazines and academic journals. Only one recent study has examined antidepressant advertisements on the web. The fifth section deals with the Internet and its growing use by lay people as a source of health information. The last section discusses an article which emphasizes the need for the critical study of online health information.

In Chapter Three, I discuss the general principles of Critical Discourse Analysis (hereafter, CDA) which serves as an analytical framework for the methodological technique I employ in this thesis. CDA is an analysis of "the relationships between concrete language use and the wider social and cultural structures" (Titscher, Meyer, Wodak & Vetter, 2000:148). The specific methodology is outlined, along with the operationalization of five analytical elements. Each element is discussed in the context of the research question to which it pertains. The data are described and coding procedures are outlined. The chapter concludes with a brief discussion of the limitations of the study. CDA is used because it emphasizes the relationship between power and discourse and also on structural or institutional foundations of power.

Chapter Four is the analysis chapter. This chapter is structured in accordance with the research questions, which are answered in the order they appear above. The first section examines the portrayal of depression on the six SSRI websites. The second section addresses the means used to construct this portrayal, such as visual and graphic means. The third section examines the audience targeted by the websites. The fourth section explores assumptions which have apparently been made about this audience. The fifth and final section address some major gaps or 'absences' in the website material. The websites focus extensively on medication and do not advocate other forms of prevention or treatment, such as faith-based healing. Lastly in this fifth section, I discuss some of the problems with the diagnostic quizzes and checklists that the websites provide as a means of convincing people they may be depressed and would benefit from drug therapy.

Chapter Five is the discussion chapter. The first section concerns anomalies or notable exceptions in the text regarding the representation of depression, and addresses the extensive referencing on the Lexapro site, as well as the uniquely non-clinical rhetoric found in several spots on the Prozac website. Next, I discuss issues regarding the target audience, namely the challenge of establishing accurate statistics, and the challenges of reaching particular subsets of the population such as youth and the elderly, as well as whether all depressed people can possibly be reached. Next, I discuss the logical problem with lifestyle suggestions to address depression, which are often impossible given the presenting symptoms. For example, a consistent suggestion surrounds getting a good night's sleep. Yet a common symptom of depression is insomnia, and therefore getting a good night's sleep would be impossible to accomplish. The last section revisits the issue of power by considering the debate as to whether or not direct-to-consumer information really could change the nature of the doctor-patient relationship as some scholars predict. Chapter Six is the conclusion. Here, I make a few comments by way of generally summarizing the thesis. I also highlight key findings surroundings surrounding symptoms of depression versus side-effects of medication, and also the portrayal of the depressed person. I also return briefly to Weber's theory of rationalization and its role in modern Western societies, and make some speculative comments about the future of medicalization using Weber's phrase the 'iron cage' of rationality.

The major argument overall here is not that medicalization is necessarily a bad thing. In some cases, it can actually serve to reduce the stigma associated with mental illness (Grinker, 2007) which is exacerbated by factors such as unbalanced media coverage. From the medical perspective, mental illness is not madness or insanity, but

instead a set of symptoms stemming at least partly from an organic malfunction or imbalance. Furthermore, according to the medical perspective, these imbalances may be corrected or least managed through the use of medication. And, in fact, data do suggest that millions of people find relief from depression at least in part from the use of antidepressants. What I do find problematic is the strength and dominance of the medical explanations of depression, to the exclusion of other explanations, such as psychological or emotional, which may also be credible and could bring relief from the profound suffering caused by depression.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

The following discussion is a review of multiple literatures pertaining to depression, antidepressants and antidepressant information in society and in the media.

Section 2.2 is a brief commentary on the substantial social and personal importance of antidepressants. As such, this section acts as a rationale for the continued study of the process of selling antidepressant medications. Sections 2.3 and 2.4 explore literature pertinent to the research questions regarding (i) the medical portrayal of depression and (ii) the audience to whom disease and treatment information is directed. In Section 2.3, I examine the role of medicalization in casting deviance as an 'illness', as well as the role of the pharmaceutical industry in distributing disease information alongside pharmaceutical product information. Section 2.4 considers the four major audiences for depression information and treatment marketing: depressed people, healthy people, universities and physicians.

Section 2.5, which reviews past studies done on antidepressant advertisements, provides a context for understanding the findings presented in chapter four. It is important to note that with the exception of Delanie Woodlock's feminist examination of antidepressant websites, all the other studies were conducted on advertisements which appeared in traditional print media. Furthermore, several of these studies were done on material distributed before 1997, the year the U.S. Food and Drug Administration changed its regulations to allow pharmaceutical companies to advertise directly to

consumers (Conrad, 2005: 5)[3]. Prior to that date, drug advertisement materials were distributed directly to physicians or were found only in academic and professional journals (not often accessed by the lay public). Many of these studies discussed how diseases were represented. These representations were embedded within the antidepressant advertisements and were seen as important to the success of marketing the medication. It appears that disease information and advertisements for treatment have often gone hand-in-hand, and this dataset is no exception.

Section 2.6 reviews some of the literature addressing the intersection between the Internet and medicine, and explores the unique importance of the online medium in presenting health information. The Internet is, in some ways, changing the nature of medical practice. For example, some patients look to doctors to confirm diagnoses they already suspect rather than to diagnose symptoms which are a complete mystery. The Internet is making medical information (traditionally the province of medical experts) widely available to the lay public who are then able to be more informed about their own health than they might otherwise have been. This wider dissemination of information is seen as significant by some scholars because it may have the potential to change the balance of power in the doctor-patient relationship. Patients, so the argument goes, are being empowered by this knowledge. As the next chapter shows, consideration of power is a cornerstone of Critical Discourse Analysis. Section 2.7 utilizes Clive Seale's recent summative commentary on critical studies of health information in print media and

[3] The 1997 policy change concerned advertisements to *American* physicians and consumers. While the Internet has an international audience and does not revolve around American regulations, this shift in policy would have made it easier for American pharmaceutical companies to distribute legally product information on the Internet.

studies of internet health information to frame this thesis. It points out a gap in the literature which this project may begin to fill.

2.2 RATIONALE

2.2.1 THE SOCIAL IMPORTANCE OF ANTIDEPRESSANTS

The SSRIs I examine in this study are "psychotropic" or "psychiatric" drugs.[4] Psychotropic drugs are used globally. While the websites studied here are English-language websites published by American companies, psychotropic drugs are used worldwide, and have been used for some time. Riska and Hagglund (1991: p.465) document patterns of benzodiazepine use in Nordic countries such as Sweden, Denmark and Iceland as early as the mid-1970s. Riska and Klaukka (1985) discuss pattern of psychotropic drug use in Finland. More recently, Andrew Lakoff (2004) has examined the increased sales of antidepressant and anti-anxiety medication in Argentina as a result of aggressive campaigning by its national pharmaceutical industry. Ecks (2005) has studied the connection in Indian culture between antidepressants and social marginalization or cohesion.

There is documented evidence of prescription psychotropic drug use (as opposed to illegal use) all over the world. The Chinese have recently begun to make efforts to contain the cost of psychotropic drugs (WHO, 2005). Low-dose benzodiazepines have been available in Brazil since the 1960s, and their sale over-the-counter became a serious public health issue in the 1980s (WHO, 2005). Zimbabwean health workers have been

[4] The terms 'psychoactive' and 'psychotropic' are used throughout the thesis. They are used interchangeably to describe drugs which affect the mind.

interested in promoting access to essential drugs such as psychotropics since the 1980s (WHO, 2005).

Antidepressants are significant globally from an economic perspective. For years, statistics have shown that depression is a major global burden of disease. For example, untreated mental illness puts people at increased risk of developing physical disorders for reasons such as compromised immune function and poor lifestyle behaviors (WHO, 2003). Health officials are concerned that by 2020 disability will account 15% of all the years of life lost (WHO, 2003). The World Health Organization (WHO) notes that

> the current global context of mental health is one of an increasing burden of mental disorders, inadequate resources and funding for mental health, and opportunities to remedy this situation through recent developments (WHO, 2003).

Consequently, the international health community is beginning to mobilize to distribute psychotropic drugs to developing countries which are thought to need them the most. One recent estimate put the annual cost of untreated mental disorders in the United States at 148 billion dollars (WHO, 2003). Untreated mental illness places a huge burden on the economy. Antidepressants have an important role in easing this burden and reducing the costs incurred because they serve to ameliorate or at least moderate the deleterious effects of depression.

Antidepressants are significant vis-à-vis the healthcare system of many countries. Their primary significance is that they do successfully treat many mentally ill individuals who otherwise might require hospitalization, although many people do still seek hospitalization for mood and anxiety disorders. In Canada, women and older adults are more likely to be hospitalized for anxiety disorders, but hospitalization rates for anxiety disorders in general hospitals (as opposed to psychiatric hospitals) have decreased by

49% since 1987. Similarly, hospitalization for mood disorders such as depression has decreased significantly in older adults (CMHA, 1992). The effectiveness of psychoactive medications means that individuals may be treated in the community, partially (though not totally) relieving the healthcare system of a costly burden of care.

However, just as these medications may lift a burden in one area, they may create a problem in another area. Psychoactive medications such as antidepressants solve some health problems but may cause or exacerbate others. People take medications to alter the bio-chemistry of the brain, but psychoactive medications do not only work in isolation; they may have secondary effects or side-effects on the body. These side-effects may become consequential in their own right. A prime example of this is the weight gain associated with certain psychoactive medications; weight gain of course can lead to a host of health issues such as diabetes, heart disease and certain types of cancer. Sharpe and Hills (2003: 705) observe that prolific weight gain in patients prescribed antipsychotic medications has been documented since the 1960s, with "40 -80% of such individuals experiencing such a side-effect". They elaborate on the "clinical dilemma" posed to clinicians when patients experience weight gain despite efforts to prevent it (Sharpe and Hills, 2003: 706). Sometimes a mental health condition serves to exacerbate the problem of weight gain, since many people with psychotic disorders are not very active (Sharpe and Hills, 2003: 706) and thereby susceptible to increased body mass.

Sharpe and Hills are not the only scholars to acknowledge this serious issue. Arthur (2001: 250) laments that "it is always a shame when unwanted problems are found with new 'wonder drugs', and it is especially a shame with [psychoactive drugs] as their benefits are so obvious". Arthur himself acknowledges, however, that many of his

patients gained more than 20 kg in their first three months on the medications and continued to gain weight thereafter (Arthur, 2001: 250). Another related study also finds that patients continue to gain weight while on these medications, a fact which is problematic in and of itself, since many patients on psychoactive medications must be on them for years or even for life (Mahi, Mitchell and Caterson, 2001: 315). Worse, Mahi et al found that many patients who manage to go off these medications also continue to gain weight and may remain overweight for some time (2001: 315).

Weight gain clearly has the potential to cause people on psychoactive drugs to require health care for other related problems, but it is certainly not the only potentially deleterious side-effect. Others include liver problems, increased risk of cardiac arrest and fetal abnormalities when mothers taking the medication during pregnancy. The most famous example of the last mentioned side-effect is perhaps being the Thalidomide tragedy of the 1950s and 1960s (Modrup and Morgall, 2001: 59). Currently, a lawsuit is being mobilized and advertised on television on behalf of mothers who took Paxil during their pregnancies and may have given birth to children with serious cardiac problems. For various reasons, people taking psychoactive medications may need to continue to make use of available health care services and as such continue to have an impact on their national and local health care infrastructures.

2.2.2 THE PERSONAL IMPORTANCE OF ANTIDEPRESSANTS

The use of antidepressants has widespread economic and health consequences. It may also have consequences, however, in the private lives of the individuals who take

them, potentially influencing their general sense of identity and/or, more specifically, their sense of gender.

a) IDENTITY

Identity has been defined as "the sense of self, of personhood, of what kind of person one is" (Abercrombie, Hill and Turner, 2000: 171). Sociologists have often argued that identities are both fluid and malleable, and that one can acquire any number of new identities (Abercrombie, Hill and Turner, 2000: 171). For example, one might define oneself as a parent, as belonging to a particular ethnicity or race, etc.

One of the consequences of becoming mentally ill and of taking antidepressants is that one comes to put "mentally ill" in the string of adjectives one uses to describe oneself. Sense of self then changes to accommodate this new element of illness (Barker, 2002: 294). Garfield, Smith and Francis (2003: 534) highlight the paradox of "taking a medication which increases [ability] to function normally but reduces the inner sense of being normal". This sense of being abnormal is fed by the media which contribute to the stigmatization of being mentally ill and needing medication (Garfield, Smith and Francis, 2003: 521; Sieff, 2003: 260)). For this reason, depressed people may decide to eschew the use of antidepressants. They may also refrain if they have become skeptical about the value of medication in solving their problems (Karp, 1993: 355). Those who feel more positively about taking medication, however, may experience a socialization process which "involves overcoming the initial resistance to drug-taking, negotiating the terms of their treatment, adopting new rhetorics about the cause of depression, [and] experiencing a conversion to medical realities" (Karp, 1993: 355). This conversion to medical reality

incorporates a new sense of identity and involves an acceptance of the medicalized perspective on sadness, outlined below.

b) GENDER

Women tend to be diagnosed with mental illnesses more often than men. In Canada, hospitalization rates for mental illness are one and a half times higher for women than for men (CMHA, 1992), and women are hospitalized nearly twice as often as men for anxiety disorders (CMHA, 1992). The dataset consistently cites higher incidence of depression for women, and since the 1960s women have been consistently show to use psychotropic drugs twice as often as men (Ettore and Riska, 1993: 506).

Perhaps because of the higher rates of depression in women, antidepressants are understood by some scholars to be infused with gender-specific expectations and meanings. Metzl (2003: 5), for instance, observes that "psychotropic medications are imbued with expectation, desire, gender, race, sexuality, power, [and] time". In the 1950s, fathers and sons were seen as the true victims of a mother's psychological distress because the mother/wife would be falling short of fulfilling her domestic responsibilities as a result. Accordingly, so the argument goes, the use of psychotropic medications was socially sanctioned as a way to return the mother to a state where she could resume her family obligations (Metzl, 2003: 232). More recently, Ettore and Riska (1993: 205) found that women view antidepressants as tools which allow them to return to their caring roles. By contrast, men tend to see the need to use antidepressants as representing a loss of independence; they see themselves as dependent on the drugs in order to function optimally. Cooperstock and Lennard (1979: 336) report that women tended to see Valium as "an aid in the maintenance of a nurturing, caring role, and in coping with

any unresolved conflict about gender roles in society (340). Interpreted in this way, antidepressants might be seen as a way of assisting people in conforming with broader social expectations.

2.3 THE PORTRAYAL OF DEPRESSION

2.3.1 DEVIANCE AS CLINICAL ILLNESS

Under medicalization, deviation from the healthy norm is disorder. Depression is not inherently disordered or deviant, but is constructed as such under the medical paradigm. Everyone feels sad from time to time, and sometimes for an extended period of time, for example, following the death of a spouse. Under these circumstances, it would be deviant *not* to feel sad and not to be seen by others as sad. At some point, however, some people are seen as "too sad", or as sad for "too long". Here, depression becomes constructed as deviant.

Szasz has suggested that mental illness is manufactured, nothing more than the summation of social, psychological, ethical and legal standards by which people might be judged (Szasz, 1970 in Cockerham, 2003: 99). Illness is framed here not "as a biological or physical condition, but as the outcome of a social process that involves the definition of social deviance, a social language of labels, and a complex of social interaction" (Conrad, 1976: 4). By this interpretation, it would seem impossible for anyone to ever be objectively ill or deviant. And yet, depression is real, as is all of the pain and suffering which go along with it. The equation of depression with mental illness, then, may be summarized as *partly* (though not entirely) one interpretation or construction of it by the medical establishment.

What follows is a brief consideration of the process of the *medicalization of deviance*. This process may be broken down into four parts: classification, codification, institutionalization, and perpetuation (Conrad, 1976).

Firstly, the medicalization of a deviant behavior involves "defining a deviant behavior as a medical problem [and] especially the labeling of certain behaviors as constituting an illness" (Conrad, 1976: 5). Language is the means by which certain ranges of experiences are grouped together under the label 'mental illness':

> The conditions or behaviors we now call mental distress were not discovered as disease such as diabetes mellitus or myocardial infraction were. Instead, they had formerly been know by other names…or had been accepted as customary and natural and were therefore not designated by special names. In the eighteenth and nineteenth centuries, a host of phenomena – never before conceptualized in medical terms – were renamed or reclassified as illness (Szasz, 1970: 137)

Applying a medical label infuses a condition with an air of legitimacy.

Second, after a label or name for a certain condition has been established, it must be codified as an "accepted part of the official medical and/or legal classification system"[5] (Conrad and Schneider, 1980: 270), such as the *Diagnostics and Statistics Manual*. Inclusion in widely-referenced manuals means that a large number of health professionals will come across it in such texts, and probably also that they will not question it, but rather take it as established fact. This is due in part to the fact that manuals such as the DSM undergo a rigorous assessment process and are vetted by colleagues in the psychiatric community. Taking the conditions included as established fact, doctors will use a given label to diagnose a patient and to then dictate whatever treatment is appropriate, for once something is called an illness, it then becomes "the province of medicine to provide some type of treatment" (Conrad, 1976: 5). Further to

[5] According to Weber, this codification would be an example of legal-rational authority.

this, the third step in the process of medicalizing deviance involves institutionalization i.e. the creation of large bureaucracies that essentially "provide institutional support" to medical practitioners (Conrad and Schneider, 1980: 270). Government bodies, hospitals, and the pharmaceutical industry buttress the illness rhetoric by accepting the idea that mental illnesses have biological or physical causes, and designing biological or physical solutions in the form of pills.

If and when bureaucratic and institutional supports are widespread enough, "medicine becomes a de facto agent of the status quo" (Conrad, 1976: 75). In other words, as suggested above, medicine becomes a cultural authority on what the behavioral status quo is or ought to be and then goes about trying to make that a reality. Insofar as it pursues its own version of the status quo – the good and happy life – medicine becomes an agent of social control (Zola, 1972). Control is firmly established once the medical perspective becomes the dominant way of understanding a certain phenomenon (Conrad and Schneider, 1980: 242).

At the fourth and final stage, medicalization as a form of meaning or way of understanding begins to perpetuate itself. Medicalization starts to become hegemonic as competing definitions of illness are challenged and dismissed (Conrad and Schneider, 1980: 242).

Zola (1972: 487) argues that medicine is becoming a major institution of social control…by 'medicalizing' much of daily living, by making medicine and the labels 'healthy' and 'ill' relevant to an ever increasing part of human existence". The diagnostic process in the clinical encounter is influenced by broad social trends and developments

such as medicalization. The perpetuation of medical notions of mental illness is likely to be

> the product of a social process that includes the publication and revisions of diagnostic manuals themselves, mental health policy such as the shift from inpatient to community care, the discovery of successive generations of psychiatric drugs and the power struggles in psychiatry between biological psychiatry…and psychoanalytic psychiatrists (McPherson and Armstrong, 2006: 51).

An important social process involved in the medicalization of mental illness is the increasing strength of and credibility given to pharmaceutical companies in their portrayal of mental illness such as depression.

2.3.2 WHO IS PORTRAYING DEPRESSION AND WHY?

The pharmaceutical industry now plays a strong role in educating the professional and lay public about new illnesses and diseases. The industry 'markets' diseases, and then sells the very drugs which will treat those diseases (Conrad, 2005: 6). Scholars are increasingly aware that pharmaceutical companies are actively involved in "sponsoring the definition of disease and then promoting it to both prescribers and consumers" (Moynihan, Heath and Henry, 2002: 886). In this regard, Szasz (1970) has accused the psychiatric profession of "manufacturing madness". Today, the pharmaceutical industry which is becoming increasingly involved in this process of "corporate-backed disease mongering" (Moynihan et al, 2002: 886). By this, Moynihan et al mean that a drug company participates directly in the dissemination of information about diseases for which it has the ideal treatment, in convincing people they are sick and need a certain medication. For example, after Paxil was approved for treating Social Anxiety Disorder (SAD) and General Anxiety Disorder (GAD), GlaxoSmithKline launched a massive

campaign about these two conditions about which little was previously known (Conrad, 2005: 6).

Pharmaceutical companies firmly emphasize the biochemical roots of depression (Grow, Park and Han, 2006: 163). They also reinforce the appropriateness of medical jurisdiction over it, in addition to emphasizing the authority of the medical profession when it comes to mental illness:

> Depression is covered in a taken-for-granted manner where – while other definitions and explanations are sidelined – direct comparisons with other, genuinely biological illnesses are made; where medico-scientific language is used to account for lived experience; where agency resides in medical practitioners and politicians rather than members of the public, and where the expertise of medical, research and bureaucratic experts is not questioned but in fact promoted (Rowe, Tilbury, Rapley and O'Farrell, 2003: 693).

2.4 THE TARGET AUDIENCE

2.4.1 DEPRESSED PEOPLE AS PROBABLE CONSUMERS

The World Health Organization reports that 121 million people worldwide are affected by depression (WHO, 2007). Depression is the fourth leading contributor to the global economic burden of disease (WHO, 2007). The American National Institute of Mental Health reports that in 2004, 26.2% of the United States population, or 57.7 million people suffered from a diagnosable mental illness (NIMH, 2007). Both the National Institute of Mental Health and Health Canada report that depression is a leading cause of disability worldwide. The Canadian Mental Health Association notes that mood disorders affect 10% of the Canadian population (CMHA, 1992). According to Statistics Canada, the population of Canada as of January 1, 2007 was 32, 777, 304 (Statistics Canada, 2006); this means that approximately 3 million Canadians are affected. Canadians reported a 3% increase in clinical depression between 1991 and 2001, and a

7% increase of depression in family and friends (CMHA, 1992). The millions of people who have been diagnosed with depression in Canada, the United States and around the globe are a key audience for antidepressant marketing campaigns. These ultimately are the consumers who fill out prescriptions and are therefore the main target of "direct-to-consumer" advertising.

2.4.2 HEALTHY PEOPLE AS POTENTIAL CONSUMERS

Pharmaceutical industries continue to cement their established markets. They also have moved to targeting healthy people who are not ill but are *at risk* for a particular illness. In some cases, perfectly healthy people are advised to begin medication in view of their risk factors and as a preventative measure (Mintzes, 2002; Gotzsche, 2002). Here, bodies that were once seen as normally healthy and only occasionally ill "are now understood as inherently ill and only able to be brought towards health" (Sismundo, 2004: 157). These people are most often reached through popular media channels such as television.

2.4.3 UNIVERSITIES

Pharmaceutical companies have worked to foster relationships with research and academic institutions, and exercise a great deal of control over the product information they distribute. In the "medication marketplace" (Cohen, 2001: 7), the vast majority of information given to physicians about particular drugs comes from their manufacturer rather than from independent research organizations (Cohen, 2001: 11). Further, the question of how 'independent' research organizations really are is a matter of some dispute. More and more academic institutions are entering into partnerships with pharmaceutical companies. This brings much-needed funding into the schools. Drug

companies also provide academic researchers with free meals, luxurious dinners and quasi-social lecture series covering a variety of medical topics (Cohen, 2001: 11). On the darker side of this involvement, however, is the growing concern that pharmaceutical companies slant their research results, publish results unethically, pressure medical centers, intimidate physicians and researchers, and manipulate the FDA (Cohen, 2001: 14).

2.4.4 PHYSICIANS

Pharmaceutical companies continue to distribute selected information designed to market conditions to medical practitioners who, according to Healy, may not even be aware that they are the targets of marketing initiatives (2004: 221). In 1990 for example, Roche developed a medication which it hoped to market for social phobias, and then commissioned the development of an information manual for distribution to clinicians (Healy, 2004: 223). The *Physician's Desk Reference* (PDR) is a highly popular and frequently consulted reference manual (Cohen, 2001: 11). This is a collaborative effort put forth by multiple drug companies, which spend billions of dollars targeting office physicians, interns and residents (Cohen et al, 2001: 11) in order to make sure they are aware of all available drug possibilities.

2.5 PAST STUDIES OF ANTIDEPRESSANT ADVERTISEMENTS

Antidepressant advertisements have long been of interest to scholars. The research explored below covers thirty years and is written by scholars from various disciplines and a range of theoretical traditions. What ties this disparate body of literature together is the quest to understand how or why antidepressant advertisements work, and

what specific steps or tactics are used by advertisers to facilitate their enormous popularity.

For Stimson (1975: 159), this tactic is medicalization, wherein "advertisements for psychotropic drugs – those drugs which affect mood – define and portray certain problems in living in the world as medical problems". He observes that "the message in the ads is that certain life events put people in a position where the prescription of a drug might be appropriate" (Stimson, 1975: 157). Further, Stimson (1975: 159) argues that the solution to a psychiatric problem is represented in psychotropic drug ads as changing or correcting individual bio-chemistry rather than correcting the problems which may have upset the chemistry in the first place, such as prolonged stress contributing to a chemical imbalance.

In 1986, Goldman and Montagne published an analysis of antidepressant advertising and offered the term "mind mechanics" to summarize the unique and slightly manipulative way advertisers communicate to physicians about psychiatric drugs (Goldman and Montagne, 1986: 1047). They highlight features of the ads such as abstract metaphors and other images which produce "as a social side-effect, a reified and medicalized account of psychiatric illness" (1986: 1047) which is also accompanied by a reified notions of psychiatric interventions as the only interventions which truly allow the transcendence of the illness. For Goldman and Montage, medications are sold through various means, including the use of abstract symbols which are so separated from their usual context that readers are free to fill in their own positive meanings (1986: 1056). An image of a solar eclipse, for example, has little meaning when set apart from its wider environmental context.

Riska and Hagglund (1991) also highlight the use of visual tools in antidepressant advertisements. Pharmaceutical companies look to boost previously poor sales by using simple visual cues as a marketing technique (Riska and Hagglund, 1991: 470). They document the then-new addition of photographs of people at their places of work, doing well on the job because of their use of antidepressants. At the time this article was published, men in Sweden and Denmark had been a previously untapped market for antidepressants. Companies attempted to gain access to this market by including photographs of men in a variety of circumstances (Riska and Hagglund, 1991: 470). It is important to note that by the early 1990s, advertisements by foreign drugs companies had found their way into Scandinavian medical journals and made up nearly half the material in each journal (Riska and Hagglund, 1991: 70).

Echoing Riska and Hugglund as well as his own earlier work, Montagne proposes in 2001 that images and symbols in antidepressant drug ads serve to strengthen the notion that pills can easily resolve mental and emotional problems. Montagne finds this somewhat problematic given that clinical research has found that the newest antidepressants are no more effective in treating depression than their predecessors (2001: 1261). However, the general public often looks to advertisements as sources of information (2001: 1263) without properly understanding that they are marketing tools as well. In a departure from other scholars who find continued emphasis in the media on the biological and chemical roots of depression, Montagne (2001: 1266) observes that the media report a variety of personal, psychological and social causes for depression. In the 1990s, people were depicted as being at risk for depression from all these causes, and Prozac was touted as both a wonder drug and a ‘weapon’ in the ‘battle’ against

depression (Montagne, 2001: 1266), making it popular as a means of security and feeling safe.

Currie (2005: 1), too, highlights the popularity of Prozac, calling it "the first blockbuster SSRI". She reports that in Europe and North America, depressed women are twice as likely as their male counterparts to be prescribed antidepressants (Currie, 2005: 8), and speculates that this is due in part to the way antidepressants are portrayed in women's publications. As early as the 1950s and 1960s, women's magazines and advice columns represented antidepressants as an uncomplicated and efficient way to address the complexities of female emotional problems (Currie, 2005: 9). These emotional problems included not only extreme depression and anxiety but also "minor symptoms of distress common to everyday living" (Currie, 2005: 19). Currently, women are being aggressively pursued in education/marketing initiatives around depression. Currie theorizes that this may be one possible reason for the high incidence of SSRI use in the female population (2005: 19).

Like Currie, Woodlock suggests in her analysis that women suffer from mental illness at twice the rate of men, but claims that the pharmaceutical industry is now looking for ways in which female biology is responsible for female mental pain (2005: 304). Antidepressants are marketed by targeting the social group which suffers from depression the most (women) and by pathologizing them. This process of pathologizing is accomplished primarily through the inclusion of higher prevalence statistics for women (Woodlock, 2005: 304). Like the other scholars cited above, Woodlock finds that the use of visual images is a key way that women are targeted (2005: 309). The photographs of women used in pharmaceutical advertising depict whiteness, youth, prosperity and

heterosexuality (Woodlock, 2005: 309) and as such many of the women visiting the sites will be able to personally identify with the images and to see themselves sharing that version of recovery.

Grow, Park and Han (2006) also offer an analysis of antidepressant advertisements. Though they likewise focus on imagery and symbolism, they move beyond observations of particular cases to broader conclusions about the marketing techniques used. In their sample of magazine and newspaper material, a biochemical discussion of depression dominates. Also included, though is a more individualized assessment of depression, which narrows the focus so much that psycho-social causes are all but excluded (Grow, Park and Han, 2006: 178). Depression, in other words, is seen as being caused by something internal to the individual rather than by something in the external social environment. Though social conditions or common life experiences are used as triggers or hooks, it is the individual's biology which is the center of attention (Grow, Park and Han, 2006: 178). Given the framing of depression as both as individual and a biological problem rather than as a psycho-social phenomenon, it becomes very easy to see an individual and chemical intervention as the only solution (Grow, Park and Han: 2006: 178). For these authors, it is not only what is included in the advertisements, but also what is deliberately excluded that is important e.g. acknowledgement of the psycho-social causes of depression.

2.6 HEALTH INFORMATION ONLINE

The Internet is being increasingly studied as an advertising medium (Lei, 2000: 465). Web advertising is anticipated to "become the most important media breakthrough

[for advertisers] since the development of television" (Lei, 2000: 470). The online environment allows a user to sort through vast amounts of text and hone in only on that which is most relevant (Faber, Lee and Nan, 2004: 451) through the use of search engines and the capacity to refine searches and search criteria as one goes along. Perhaps this is one reason why the Internet is increasingly being used to gather health information.

2.6.1 HEALTH, MEDICINE AND THE INTERNET

The term *cybermedicine* has been coined to represent "the science of applying internet and global networking technologies to medicine and public health, of studying the impact of the internet, and of evaluating the opportunities for health care" (Eysenbach, Ryoung and Dipgen, 1999: 1). General practitioners, hospital specialists and nurses from developed countries are utilizing online medical resources (Eysenbach et al, 1999: 1) to assist them in hospital and clinic settings. Consumers may be facilitating this transition by encouraging practitioners to go online for up-to-the-minute medical information (Eysenbach et al, 1999: 3). Consumers may also be interested in their practitioners' use of electronic reference materials since they are able to draw on the same knowledge bases and as such to become increasingly involved in decisions about their own care and also in the pursuit of top-quality care.

There are a number of consequences or outcomes for the online seeker of health information. Information seekers feel better informed, are relieved to find that their experiences are similar to others and that they are on track with treatment decisions. They are likely to retain more of what they have learned since they can revisit the material as needed (Nettleton, Burrows, O'Malley and Watt, 2004: 548). Nettleton et al (2004: 550) caution, however, that information-seeking patterns on the Internet need to

be understood in the context of people's lives, and that not all online quests for health information are the same.

Some groups are more likely than others to employ the Internet in seeking out information about their health. For instance, adolescents are considered to be suffering from a poverty of health information in comparison to adults, and are increasingly going online for health information (Gray, Klein, Noyce, Sesselberg and Cantrill, 2005: 1467). Use of the Internet by elderly populations in being explored (Kiel, 2005) in an effort to move towards reduced health care costs. Certainly there are a large number of websites devoted to geriatric medicine, geriatric psychiatry, and the interface between gerontology, ethics and the law (Madan and Bodagh, 2002: 71).

The particular characteristics of someone's illness are also likely to influence their internet usage patterns. For instance, Ziebland (2004: 1792) notes that people with life-threatening illnesses are likely to relate differently to their doctors and the Internet than people with minor ailments, and that people with chronic conditions are especially likely to use the Internet to develop expertise on their own conditions. Similarly, "significant and consistent patterns of increased internet use among people with stigmatized illness when compared to those with non-stigmatized illness" (Berger, Wagner and Baker, 2005: 1826). Consumers with stigmatized illnesses such as depression, herpes and urinary incontinence may consult the internet in part to maintain their privacy and guard against the embarrassment of public knowledge of their condition (Berger, Wagner and Baker, 2005: 1821). There is still a strong stigma attached to seeking assistance for mental health problems (Wood and Smith, 2001: 101). Berger et al speculate that perhaps

people with “psychiatric stigmatized illness are more likely to turn to the internet for health information than those without psychiatric illness” (2005: 1825).

2.7 TOWARDS THE CRITICAL STUDY OF ONLINE HEALTH INFORMATION

Seale (2005: 515-6) observes that “representations of health and illness in the mass media have been extensively studied by sociologists interested in the role of culture in illness experience”. While traditional print media have been critically studied for their representation of the illness experience, studies of health information on the Internet have tended to be centered on assessing medical accuracy and quality, and on the potential of the electronic medium to transform relations with clients (Seale, 2005: 515). Little work has been done to examine critically representations of health and illness on the Internet. According to Seale, existing methods for text analysis should be applied (and new methods developed where necessary) to the development of a critical perspective on health information on the Internet (2005: 515). This study is a critical analysis of drug information and the qualitative representation of depression on antidepressant websites, and as such is an example of the application of these critical techniques.

CHAPTER THREE

ANALYTICAL FRAMEWORK AND METHODOLOGY

3.1 INTRODUCTION

The purpose of this chapter is to outline my basic analytical framework -- Critical Discourse Analysis or CDA -- and to address the methodological issues important to my study. The first section of this chapter outlines the research questions. The general principles of CDA are outlined next. CDA is primarily a methodological orientation but is infused with its own set of theoretical assumptions and orientations which serve as guiding principles. These principles are fundamental to the specific methodological steps and are discussed below. Next, I provide an operationalization for the key elements from the typology which I have selected. For each element, I identify the research question to which it pertains. The data are then described, and coding procedures outlined. Finally, limitations of this study are acknowledged.

CDA considers text at the level of discourse, which is understood as a "body of language that is unified by common assumptions" (Abercrombie, Hill and Turner, 2000: 89).

3.2 RESEARCH QUESTIONS

The text the SSRI websites is examined to answer the following are the five research questions being asked of the text:

1. How is depression portrayed?
2. What are the means used to construct this portrayal?
3. Who is/are the apparent target audience/s?

4. What assumptions are made about this audience?
5. What is missing from or silent in the websites?

3.3 GENERAL PRINCIPLES OF CRITICAL DISCOURSE ANALYSIS

Scholars have developed a variety of methods for doing discourse analysis (Sinclair & Coulthard, 1975; Labov & Fanshel, 1977; Potter & Wetherell, 1987; Fowler, 1979; Pecheaux, 1982). Fairclough was one of the earliest scholars to offer an extensive statement on *critical* discourse analysis, maintaining a critical focus on the role of power in shaping language and text. Other important contributors in the field have built on his work, such as Hammersley (1997), Wodak (1996; 1997; 2001; 2003) and McKenna (1999; 2004). I chose to use Fairclough's work for three reasons. First, there is a strong critical component in his methodology. Second, he is clearly important to the work of other prominent scholars in the field. Finally, there was an easy fit between the research questions and Fairclough's analytical measures.

Critical discourse analysis (CDA) uses a set of principles which differ from simple discourse analysis. Discourse analysis (DA) is defined as "a method of analyzing the structure of texts or utterances longer than one sentence, taking into account both their linguistic content and their sociolinguistic context" (*Canadian Oxford Dictionary*, 1998: 399). In other words, DA is concerned both with the nature of a particular communication but also "with the structures that undergird ordinary daily activities" (Merrigan and Huston, 2004: 205). Discourse analysts seek to understand "the interpretative work being accomplished by participants in interaction" (Merrigan and Huston, 2004: 205). Discourse analysts are permitted and even encouraged to use as

evidence “prior cultural knowledge of, or experience with, the kinds of conversation [they] are analyzing” (Merrigan and Huston, 2004: 211).

To fully understand discourse, analysts must integrate or account for both the macro-context of discourse (i.e. organizations or institutions) alongside particular time, place and participants (Titscher, Meyer, Wodak and Vetter, 2000: 27). An individual example of discourse is properly understood only against the backdrop of a more macro-sociological context (Titscher et al, 2000: 27). It is “the inclusion of these factors that influence text production and comprehension [which go] beyond the limits of traditional investigations that are based on the analysis of content” (Titscher et al, 2000: 27).

The fundamental assumptions of *critical* discourse analysis are very much in line with DA. However, CDA expands on discourse analysis

> in not just describing discursive practices, but also showing how discourse is shaped by relations of power and ideologies, and the constructive effects discourse has upon social identities, social relations, and systems of knowledge and belief, neither of which is normally apparent to discourse participants (Fairclough, 1998: 35).

In other words, CDA and DA overlap considerably, but are differentiated by CDA’s incorporation of issues of power and ideology alongside social context and the role of discourse in the social construction of identity, relationships, etc.

Below are the essential theoretical components of critical discourse analysis according to Fairclough.

1. The object of analysis in CDA is linguistic text (Fairclough, 1992: 35). CDA understands language to be a form of social practice, and seeks information about the relationship between language and social structure (Itischer, Meyer, Wodak & Vetter, 2000: 147).

2. The relationship different texts have to each other is important i.e. the ways in which they "draw upon, incorporate, recontextualize, and dialogue with other texts as well as those that are left out" (McKenna, 2004: 11).

3. Texts also are understood as products of processual text production and interpretation, and these processes are analyzed (Fairlcough, 1992: 35). In other words, texts themselves reflect processes by which they were produced and the way in which something has been interpreted into language.

4. Text is an interpretation of reality, and analysis is interpretation of the text (Fairclough, 1992: 35). The analyst therefore must be cognizant of and sensitive to their own interpretive habits and the reasons for those habits (Fairclough, 1992: 35).

5. Discourse has a historical context. It shifts with, and reflects, processes of social change (Fairclough, 1992: 35-6). CDA operates on the premise that discourse is historical, embedded in time and space (Titscher et al, 2000: 146).

6. CDA sees discourse and language as socially 'constructive' (Fairlcough, 1992: 36; McKenna, 2004: 12). Language interacts with truth or objective reality to constitute "social subjects, social relations, and systems of knowledge and belief" (Fairclough, 1992: 36). In other words, language interacts with reality to influence people, social relationships and ways of thinking or knowing.

7. CDA is concerned with power. More specifically, it is concerned with power relations within discourse, and the way power struggles act on and change social or institutional discourse practices (Fairclough, 1992: 36). Importantly, it also retains a focus on the structural foundations of power which other theorists such as Foucault are thought not to have satisfactorily accounted for (McKenna, 2004: 14).

8. CDA is concerned with the relationship discourse has to the perpetuation of ideologies and social practices (Fairclough, 1992: 36). CDA argues that individuals may become agents of ideology (McKenna, 2004: 13) insofar as they engage in thought and social practices which support and 'spread' ideology.

3.4 METHODOLOGY AND OPERATIONALIZATION

3.4.1 METHODOLOGY

Fairclough's analysis has three dimensions: text, discourse, and social practice (1992: 232). For the sake of clear elaboration, he separates them into distinct categories, but grants that this separation is somewhat superficial or artificial, since in reality they overlap considerably (1992: 231). My thesis primarily focuses on the textual/discourse dimension, although social practices are also considered.

Several components from Fairclough's methodology have been excluded. Transitivity (active or passive voice) and cohesion between clauses and sentences, as well as theme and modality were not seen as particularly relevant (1992: 235). These were excluded because they appeared to be very technical features, perhaps more appropriately utilized by a linguist than a sociologist. Fairclough also offers politeness (1992: 235) as a feature of the text to be examined. Since the text is a one-way form of communication and not a dyadic interaction, this has also been excluded. A certain degree of propriety and politeness seems only reasonable to expect of publications put out by major pharmaceutical companies. The five elements that have been selected for application to the data are interactional control, ethos, language, word choices and meanings, and metaphor.

Interactional controls are defined as those measures which "ensure smooth interactional organization – the distribution of turns, selection and change of topics, opening and closing interactions, and so forth" (Fairclough, 1992: 152). For example, if we were to analyze the transcript of a conversation between an employer and an employee, we would see that certain conventions and features of the conversation regulate these patterns in accordance with the power discrepancy between them. Interactional control may be collaborative to some extent, but the degree of control between various participants can vary (Fairclough, 1992: 152). When analyzing interactional control, the following issues are addressed: introduction, development and establishment of the topic, the (a)symmetry of topic control, who sets interactional agendas and how they are set, the extent to which the participants formulate the interaction, and the function or purpose of interactional formulations for the participants (Fairclough, 1992: 234-5).

By *ethos*, Fairclough refers to the ways in which the text contributes to the construction of *private* self and identity. Though "the self" may always be social to some extent, the ethos addresses one's most personal opinions and feelings about oneself.

Next, Fairclough turns his focus to *language*, which is also connected with identity and in addition with relationship and 'ideation'. In contrast to the understanding of private sensibility or identity pertaining to ethos, this understanding of identity is more social. Fairclough focuses here on the way *social* identities are set up within the discourse (Fairclough, 1992: 64). Though both reflect aspects of identity, the former is the way in which one arrives at a private sense of self, while the latter is about the ways in which one comes to understand oneself as part of a social group. Language serves a

relationship function insofar as it helps to enact and negotiate social relationships between discourse participants (Fairclough, 1992: 64). By 'ideation' and the 'ideational' function of language, Fairclough means "the ways in which texts signify the world and its processes, entities and relations" (1992: 64).

Fourth, Fairclough also addresses *word choice* and *meaning.* He offers them as distinct categories but, given that they are quite closely aligned, I decided to consider them together. Word selections are important since they may represent a contrast or lack of fit between the way texts are actually worded and "the interpretive perspective that underlies this wording" (Fairclough, 1992: 237). For example, medicalization as an interpretive perspective labels depression as "disorder". The meaning of words is also significant here, especially "key words which are of general or more local cultural significance; [words] whose meanings are variable and changing…and [the] potential meaning of a word…as a mode of hegemony and a focus of struggle" (Fairclough, 1992: 236).

Finally, the analysis looks at *metaphor*. Seen conventionally as the province of creative literature, metaphor is defined in the *Canadian Oxford Dictionary* as "the application of a name or descriptive term or phrase to an objection or action to which it is imaginatively but not literally applicable" (1998: 911). Fairclough agrees with this definition but builds on it by arguing that

> when we signify things through one metaphor rather than another, we are constructing our reality in one way rather than another. Metaphors structure the way we think and the way we act, and our systems of knowledge and belief, in a pervasive and fundamental way (Fairclough, 1992: 194).

What is important here is the connection between metaphor and reality; metaphor not only represents reality but also structures it, and influences the way we think about it.

For example, while the expressions ‘sick as a dog’ and ‘under the weather’ are both metaphorical representations of feeling ill, the former is more literal, more concrete and implies a greater degree of sickness rather than the latter, which is less tangible and is connotes a milder problem.

3.4.2 OPERATIONALIZATION

The above remarks are at the level of conceptualization, whereby “fuzzy and imprecise notions [of discourse analysis] are made more specific and precise” (Babbie, 2005: 125). What is needed now is a series of operational definitions, moving Fairclough’s general conceptualizations to specific indicators of what is to be empirically observed in the dataset of this thesis. Each operational definition will be provided under the research question it has been used to answer.

1. How is depression portrayed?

The linguistic element of what Fairclough calls *ideation* refers to “processes, entities and relations” (1992: 64). For this project, the specific portrayal of depression is found in text concerning the *process* of depression, the disease *entity*, and the bio-chemical *relations* between serotonin and the SSRIs.

The portrayal of depression is also found in the way the depressed person is represented. Here is where *ethos*, the more private dimension of identity as a depressed self, is discussed. The portrayal of the depressed self is very important because people only become patients seeking antidepressant medication once they have come to identify themselves as depressed. This is a broad category which subsumes many diverse features of the text.

2. What means are used to construct this portrayal?

The three elements in the portrayal of depression are the structural aspect of interactional control, the linguistic dimension of word choices and meanings, and also the visual or graphic features of the web pages.

Interactional controls are understood here to be a) the system of links and menu options found on the websites, b) repetition of text and c) circularity within the text. These structure a user's interaction with the website material and also regulate the order in which the information is accessed. Control is especially evident when text is repeated, since the user does not know in advance of clicking on a link that they will be viewing particular information a second (or third or fourth) time. The navigation system and patterns in place on the website reflect the agenda of the pharmaceutical company advertising its product and are also understood to mitigate the degree to which an individual may surf around the websites strictly in accordance with personal preferences.

Word choice and *word meaning* are important because of their potential as sources of either hegemony or struggle. The words *symptom* and *side-effect* are discussed in relation to each other; the word *disorder* is also observed. Here, I am most interested the way the symptom versus side-effect dichotomy and also the promulgation of the term 'disorder' serve to support or reinforce the medicalization of depression and as such may become sources of struggle for those unwilling for some reason to participate in this discourse.

The websites are more than simply text. Visual elements include diagrams, cartoon caricatures and also photographs. Applying Fairclough's argument, I consider diagrams of the disease and treatment processes of depression to be *metaphors,* or representations of reality and also factors which may influence reality. Other scholars

such a Riska & Hagglund (1991) have also considered illustrations of the bio-chemical activity of drugs to be metaphors.

3. Who is the target audience?

Language can be a tool in establishing and fostering *social identity*. Assumptions made in the text about the social characteristics of the audience are explored, such as their social class, as is the way people may learn to identity themselves as members of a group – in this case, all those afflicted with depression

4. What assumptions are made about this audience?

Key assumptions surrounding the social integration of depressed people and also their capacity to enact medical relationships are shown in the text. Fairclough's *relational* aspect of language here addresses the social relations enacted around the depression process, such as family support and seeking medical treatment.

The fifth question regarding any absences or silences in the text can be answered by examining the totality of the results to the other four questions and identifying examples of relevant information which does not appear.

3.5 THE DATA

3.5.1 POPULATION

The study is a cross-sectional observation (Babbie, 2005: 104). The dataset comprises the whole population of online direct-to-consumer advertisement websites for SSRI antidepressants. The units of analysis are the printed textual pages. The whole population of online material pertaining to SSRIs is not known. Any SSRI material not found online, or any online material not published on SSRI product websites has been

excluded from the study. Other nonprobability techniques such as quota and snowball sampling were not considered appropriate. In addition, snowball sampling was not necessary because I was aware of the whole population at the outset of the study and did not need assistance from others in adding to it. Probability sampling techniques were not considered. It would have been difficult to know with any certainty whether the aggregate characteristics of any random sample of the data were truly representative of the data (Babbie, 2005: 195) since the whole population is not known.

3.5.2 GATHERING, ORGANIZING AND CODING

The following websites were used for analysis:

1. Zoloft (www.zoloft.com)
2. Zoloft for PMDD (www.zoloftforpmdd.com)
3. Paxil (www.paxilcr.com)
4. Celexa (www.celexa.com)
5. Lexapro (www.lexapro.com)
6. Prozac (www.prozac.com)
7. Sarafem (www.sarafem.com)

The order in which the websites are listed above follows the order in which they were printed. The order of printing was arbitrary.

To print each website, I began on the homepage and systematically followed each link and menu item, doubling back constantly to be sure previous pages had been printed. Once printed, the pages were organized by website and merged: Zoloft and Zoloft for PMDD were grouped. Paxil stood on its own. Prozac and Sarafem, which are chemically identical but marketed by different companies, were clipped together. The

Cipralex/Celexa/Lexapro pages proved somewhat more complicated, and Cipralex was disregarded in the end[6]. Celexa and Lexapro were grouped together, since they are manufactured by the same company and Lexapro is simply a newer version of Celexa.

Once printed and organized, the pages were numbered. Each website was given its own initial, for example Z1 for Zoloft and CL1 for Celexa and Lexapro. This was done for two reasons. First, should the printed dataset ever be dropped or become very disorganized, this measure ensured that the original order of the pages within each website could be restored with little difficulty. Second, it was important to know how many pages were in each website rather than the number of pages overall (N = 396). As I note, the structure of websites and the system of links and menu items meant that pages were visited and printed more than once. Duplicate pages were retained and numbered but were not analyzed a second time; they were identified as duplicates with large black marker.

Each website was coded from beginning to end and on its own, rather than considering, for instance, the first ten pages of each website, and then the first ten pages of the next website, etc. This was important for continuity, to be able to develop a sense of the overall 'tone' of each website, and to make it easier to observe key features such as inconsistencies or repetition. Textual features such as words and phrases were important, as were visual features such as photographs, diagrams and drawings. Structural features such as menu, links and headings were also germane.

A coding key was created which included a list of Fairclough's five elements and their operationalization for this project. See Appendix A for the coding key which lists

[6] Cipralex is not an SSRI, as originally thought, but rather an ASRI, or Allosteric Serotonin Reuptake Inhibitor (ASRI). Because the project involved SSRI websites only, the website for this medication was excluded from the dataset.

specific indices of each of Fairclough's elements. Instances of any of these indices were either highlighted or marked with an asterisk in colored ink. Key words or phrases which either appeared consistently and constantly throughout, or appeared to have particular importance within the text were also observed. Notes and preliminary theorizing or analyses were recorded on separate pieces of paper and consulted later during the formal analysis process.

The data were gathered over a period of twenty-four hours between January 29, 2007 and January 30, 2007. All of the claims made were based on the websites as they were available online on those two dates; all of the quotations were retrieved during this time period as well. More specific referencing has not been provided, for several reasons. First, the 'pages' I numbered do not correspond to 'pages' online. By this I mean that one cannot go online and straight to Page #Z25, because they are not divided into pages on the websites. Rather, the information/text is continuous. The pagination was created by the printer; it was not a feature of the data. Second, websites are constantly changing, and these sites are no exception. On August 21, 2007, I went online to find the Lexapro, Sarafem and Paxil sites changed considerably. Most notably, entering in http://www.zoloft.com did not bring me to the Zoloft homepage, as it did in January, but instead directly to a PDF download of clinical information regarding safety and proper use of the medication. In this regard, page references from my dataset would be irrelevant, since it is not possible to find online the pages to which I am referring. Finally, the convention with Internet research is either to list the URL or the website's name (e.g. Prozac), along with the date the data was retrieved. Since all data were

retrieved over a short period of two days, it would be redundant to repeat this information throughout the analysis chapter.

3.6 LIMITATIONS

Any methodology has some limitations. First and foremost, the dataset only comes from one source of online information about depression. While the degree of medicalization within the dataset can be observed and discussed, it is not clear how this compares with other online sources of information. The suggestion was floated in the original proposal defense that a comparative study between SSRI websites and some other body of websites pertaining to depression treatment might be useful. However, it was decided that such a comparison would be of a more appropriate scope for a doctoral dissertation.

Second, there is some potential for methodological relativism. Fairclough himself concedes that ultimately "there is no set procedure for doing discourse analysis [and] people approach it in different ways according to the specific nature of the project, as well as their own views on discourse" (1992: 225). He encourages rigorous and constant consultation with the dataset to guard against relativism and cautions that any interpretation must be justified "through text analysis, by showing that your interpretation is compatible with the features of the text, and more compatible than others" (Fairclough, 1992: 232). Please refer again to Appendix A for coding procedures and also the Analysis Chapter where I made every effort to substantiate carefully claims and conclusions with excerpts from the text.

Third, excerpts from the text which are included for legal reasons such as statements about the intended audience for the website, insurance coverage information and identifying other appropriate healthcare professionals, etc. all highlight insurance liability issues. These are not considered for their legal purposes, but are examined in the same manner as all the rest of the text. Identification and examination of certain parts of the text from a legal perspective is beyond the scope of this paper and is not directly relevant to the primary research questions.

Finally, another possible weakness surrounds my personal connection to the subject matter; it would be unprofessional and inappropriate to engage a topic I am profoundly connected to without at least revealing that such a relationship exists. Though I am lucky to have recovered, depression is something I battled with over much of the last ten years. My emotional association with this material poses a risk for the interference of bias. Mindful of this possibility and looking to guard against it, I searched at length for a comprehensive methodology which would tightly structure my interaction with the data. I remain mindful that I must be vigilant in guarding against the interference of my personal history in my interpretation of the data.

CHAPTER FOUR

ANALYSIS

4.1 INTRODUCTION

The analysis is structured in the following way: The research questions are answered in sequence, and each of Fairclough's five elements is integrated in accordance with the questions to which they are most pertinent. The five research questions again are: How is depression portrayed on the websites? What means are used to construct this portrayal? Who is the apparent target audience? What assumptions are made about this audience? What is missing from or silent in the websites? Fairclough's five elements again are interactional controls, ethos, language as pertaining to identity, social relations and ideation (disease process/entity/relation), word choice and meaning, and finally metaphor.

I answer the first research question concerning the portrayal of depression by discussing the textual portrayal of depression as disease entity and process, and the chemical relations of treatment. I also include discussion of the four forms of ethos, or how the depressed person is represented. The second research question concerns the elements of the portrayal of depression; here, I discuss interactional controls, word choices and meanings and the use of visual images or metaphors. The third question addresses the nature of the target audience; the use of language to foster depression as a group identity is discussed. The fourth question concerns the assumptions made about this audience. Key assumptions made concern the level of social integration and the financial capacity to seek medical treatment, but other assumptions are discussed as well.

The fifth and final research question addresses that which is missing from or silent in the websites.

4.2 HOW IS DEPRESSION PORTRAYED?

4.2.1 DEPRESSION AS DISEASE

With the rationalization of society comes the belief in the capacity of science to establish calculable and predictable facts about the world. Medicalization may be understood as the application of medical science to the understanding of human suffering, altering the view of health and disease. Physical and mental conditions are seen to be the consequences of determinable physical (often chemical) causes. Disease, suffering, amelioration, cure – all are calculable and predictable given our scientific understanding of body chemistry. Medicalization is a scientific or "ordered and structured framework within which people see their world" (Abercrombie et al, 2000: 89). The websites medicalize depression. Medicalization infuses the text with a certain set of assumptions which then guide the reader's understanding about depression and treatment.

Depression is portrayed as a medical condition. Depression is understood to have physical or chemical causes which manifest as mental illness. Though a causal connection is sometimes suggested between genetic predisposition or life circumstances and the onset of depression, the argument presented on the websites is that depression is caused by an imbalance of serotonin levels in the brain (See Appendix B for examples of this). The representation of depression as a problem is buttressed by an emphasis on all the ways depression interferes with daily living; for example, it is portrayed as compromising one's ability to perform well on the job. Depression is considered

treatable. However, 'treatable' seems to mean the management of symptoms through prolonged use of medication rather than 'curative'.

The language used by those who construct these websites represents depression as (in Fairclough's terminology) a disease *entity*, as a bio-chemical *process* of disease. It also portrays the chemical *relations* between the neurotransmitter serotonin and the SSRI medications which are put forth as the medical treatment of choice. It is in this light where the 'rationalization of depression' is most evident. Depression is represented as a series of symptoms which are entirely predictable given a particular chemical imbalance in the brain. Further, intervention with medication is represented as having the predictable (even inevitable) outcome of correcting the problematic imbalance. Given the scientific explanation of depression as being the result of an imbalance, it is not surprising that depression is equated with such terms as 'disease' and 'disorder'.

Prozac.com provides information about depression, obsessive-compulsive disorder, bulimia and panic disorder all under the heading 'Disease Information'. Every website makes very frequent use of the term 'disorder':

Page # Z1: "Zoloft is FDA approved to treat depression, social anxiety disorder, posttraumatic stress disorder (PTSD), panic disorder, obsessive-compulsive disorder (OCD), and premenstrual dysphoric disorder (PMDD) in adults over age 18"

Certain emotional states or experiences are also understood to be indicators of disorder:

Page #PCR29: "If you have felt persistent feelings of worthlessness and hopelessness, or have an inability to feel pleasure or take an interest in life, you may have depression. If you have experienced repeated feelings of intense, sudden terror or impending doom, racing or pounding heartbeat or even chest pains, you may have panic disorder.

If you have felt excessive, persistent fear and avoidance of social or performance situations, accompanied by sweating, shaking, tense muscles, or a pounding heart, you may have social anxiety disorder".

Using a variety of means (including providing information about depression as well as checklists to determine if a person is experiencing symptoms of a disorder or if they are experiencing symptoms sufficiently severe to reasonably assume they are ill with this disorder) the text establishes a certain range of experiences as symptoms, or indicators of disease. Checklists, in particular, are a way to 'calculate' the degree of one's depression. After taking the quizzes or reviewing lists of symptoms, the user is then instructed or advised to seek medical help in a timely fashion to obtain a diagnosis:

Page #Z27: "If you think you or someone you know might suffer from depression, fill out a checklist on this site. These answers can help a doctor diagnose depression. Only a doctor or other qualified healthcare professional can diagnose depression".

Having established a particular collection of experiences as a disease entity, explanations of the disease *process* are provided. The disease process is understood to originate with the neurotransmitter serotonin, found in several areas of the body but most significantly in the brain. The connection between optimal levels of serotonin and good mental health is hypothesized and explained. All websites provide some or other variation on this, as shown below. See Appendix B for further examples of the current thinking about serotonin and mental health.

Page #PCR4: "The exact cause of these conditions is not completely understood. Research has shown that depression and panic disorders could be linked to a chemical imbalance in the brain. A family history of these conditions might also play a role in their development".

Page #P7: "While depression is not fully understood, a growing amount of evidence supports the view that people with depression may have an imbalance of the brain's neurotransmitters, the chemicals that allow nerve cells in the brain to communicate with each other. Many scientists believe that an imbalance in serotonin, one of these neurotransmitters, may be an important factor in the development and severity of depression".

Page #CL23: "The brain chemistry of depression and anxiety is not fully understood. However, a growing body of evidence supports the view that people with these disorders have an imbalance of the brain's neurotransmitters. These are chemicals in the brain that allow nerve cells to communicate. One of these neurotransmitters is serotonin. An imbalance in serotonin may be an important factor in the development of depression and anxiety".

An imbalance of serotonin is conceptualized as disease, and as such intervention is required. This intervention is a medical antidote which is expected to address the deficiency of serotonin levels in the brain. The *relations* of treatment are described as follows:

Page # CL24: "Serotonin is released from one nerve cell and passed to the next. In the process, some of the serotonin released is reabsorbed by the first nerve cell. SSRIs block the reabsorption of serotonin into the first nerve cell. It is this blocking action that causes an increased amount of serotonin to become available at the next nerve cell. This is how SSRIs affect the balance of serotonin in the brain".

Page #PCR4: "Paxil CR, a Selective Serotonin Reuptake Inhibitor (SSRI) is commonly used to treat depression and panic disorder . . . . With continued treatment, Paxil CR helps regulate the balance of a chemical called serotonin a natural substance that acts as a "messenger" between nerve cells in the brain".

Page # P53: "PROZAC was the first of a new class of drugs, called Selective Serotonin Reuptake Inhibitors (SSRIs) to be approved for use in the United States. This new type of medication helps patients with depression by increasing the availability of serotonin in the brain. Scientists believe serotonin affects many types of activities in the brain, including the regulation of mood".

Page #Z15: "Over time, Zoloft will help maintain your body's supply of serotonin. Scientists believe that depression could be caused by low levels of serotonin. By maintaining your brain's level of serotonin, Zoloft can help you feel good again…"

4.2.2 ETHOS: THE DEPRESSED PERSON IS….

By 'ethos', Fairclough means to address "the diverse features that go towards constructing 'selves' in the sample" (Fairclough, 1992: p.234). We delve here into the features of the text which facilitate the construction of self as depressed or mentally ill. Fairclough presents the term 'ethos' as a singular entity, but in fact there are four different forms of this ethos which are evident in the text. The depressed person is sick by virtue of his or her medical problem. The depressed person is at risk, in danger of a relapse or of a decline in condition without correct use of medication as dictated by a physician. The depressed person is altered or changed as a result of their condition. The depressed person experiences a reduction in competence as a result of having depression. Depression changes someone from a positive to a negative -- and potentially even destructive -- presence in the lives of family and friends; a great burden of care is placed on significant others by virtue of the condition. This burden may be so severe that these others becomes themselves at risk for becoming depressed. Depression becomes an aspect of someone's personal identity or sense of self.

a) AFFLICTED WITH A MEDICAL PROBLEM

Human experience is a multi-faceted composite of varied activities, thoughts emotions, memories and skills. Most humans experience a wide range of emotions, from rejoicing and jubilation to indifference and apathy to extreme distress, grief and sadness. The medical model places this range of emotion on a quantifiable spectrum, and argues that any experience beyond a certain spot on this spectrum or after a prolong period of time is neither normal nor desirable. Furthermore, certain kinds of distress are considered to be actual 'illness'. Establishing sadness as a medical problem is accomplished by giving it a medical label and discussing it in medical terms, recommending consultation with a medical expert who can administer medical treatment, and explaining the origin or cause of the sadness in a medical way. The websites represent depression as an assessable medical problem.

First, depression is equated with illness:

Page #CL11: Depression is a complicated illness, and each individual case has unique circumstances.

Page #P10: Depression is a medical illness that usually responds well to treatment.

Second, part of medicalizing human suffering involves recommending consultation with a medical expert. Doctors are portrayed as the primary experts on depression, trained as they have been in medical science. Doctors have of course been granted the legal-rational authority to deliver diagnoses, and are represented as the most important support and the most definitive source of treatment throughout the entire dataset. Closely related to this, are recommendations for solutions in the form of 'treatment', and 'medication':

Page # CL11: For this reason, any decisions regarding your depression treatment should be made after a consultation between you and your healthcare professional or doctor. If you think you may be depressed and have not seen a healthcare professional or doctor, you should get a professional evaluation as soon as possible.

Page #P21: Remember: healthy eating and exercise may help you feel better as you recover from depression; however, they are no substitute for PROZAC (or any other medication prescribed for your depression). Continue to take your medication for as long as your doctor advises.

Third, explaining depression and other mood/anxiety disorders as a quantifiable chemical imbalance in the brain more firmly grounds this set of experiences in the clinical realm. There is the occasional concession that the origin of the chemical imbalance may lie in any number of life circumstances (as shown in the first quotation below), but the focus always comes back to a chemical imbalance in the brain as the ultimate cause:

Page #CL38: "There are many reasons or even a combination of reasons why a person might become depressed. These include traumatic life experiences such as the death of a loved one, certain diseases or medicines, substance abuse, hormonal changes, or a family history of depression. Sometimes the cause of depression is unknown. More often it is a combination of genetic, psychological and environmental factors that bring on a depressive episode. Whatever the circumstances, depression is caused by an imbalance of certain chemicals in the brain".

Page # P78: Once the symptoms of depression go away, it is easy to forget that depression may result from a chemical imbalance in the brain. Avoid the danger of relapse. If you doubt that depression could result from a chemical imbalance, try to remember all the times when you tried to "snap out of it" without the help of a doctor and effective treatment".

Page #P9: Major depression is an illness many doctors believe is related to an imbalance of a natural chemical in the body called serotonin.

The use of medical language, the recommendation to seek medical advice and medical care, and the representation of the cause of depression as physical/biochemical all underscore the portrayal of depression as a medical condition.

b) AT RISK OR IN DANGER

All the websites feature a number of warnings and cautionary sets of instructions, ranging from appropriate use of medications to the consequences of its inappropriate use, from who should consider themselves at risk for depression to the imminent danger of relapse upon premature cessation of medication. Risk and danger are presented in four variations: risk of relapse, the depressed person as a danger to him/herself, the danger of not seeking treatment, and the damaging effects of a condition on someone's life.

First, the risk of relapse is seen as a very predictable and likely outcome upon premature cessation of the medication:

Page # CL20: "Depression and anxiety can be lifelong medical conditions that may require continuous long-term treatment. If your symptoms are currently controlled by medicine and then you stop taking it for a few days, you run the risk of a relapse. Like many patients, you may begin to feel relief from your symptoms, such as depressed mood or anxiety, after taking Lexapro for just 1 or 2 weeks. However, it is important to take your medicine as long as your healthcare professional advises, even if you start feeling better; otherwise your depression or anxiety could return or worsen"

PCR #33: "It's important that you do not stop taking your medicine without first talking to your doctor. Doing so could make your symptoms worse and could cause complications in some people. Some people suffer from relapses when they go off their medications before their doctors say they should".

Lexapro is represented here as a buffer protecting patients against future relapse. The phrase "if your symptoms are currently controlled" is significant: symptoms of depression and anxiety disorders are usually thought to become latent or dormant because of control by the medication, but not to disappear altogether. Following this line of thinking, a relapse could well occur upon cessation of the medication, which keeps the symptoms at bay:

Page #P57: "Relapse is one of the 'danger areas' on the road to recovery. Relapse is the reappearance of symptoms of depression before the patient has recovered fully from the original episode of depression (developing a new episode is called recurrence). Patients who discontinue their medication prematurely without consulting with a doctor, because they either feel better or they are annoyed by mild side effects, have a good chance of relapsing. Even if you feel better, to prevent relapse, continue to take your medication. You may feel 'normal' but should take your medication for at least 6-12 months to have the best chance of continuing to feel 'normal'".

Missing from the risk-and-relapse rhetoric is the entertainment of the possibility that the medication user might have healed, and that cessation of medication might bring no catastrophic relapse or return of symptoms.

Second and closely related to this is the depiction of the depressed person as likely to endanger him/herself through unwillingness to continue treatment. Family and friends are warned to expect resistance to treatment:

Page # CL64: "Remind your loved one to keep his or her appointments with a healthcare provider and take prescribed medication. Depressed persons are often tempted to stop their medication as soon as they begin to feel better. It is very important for them to keep taking their medication as directed. This will help prevent a relapse of depression, or the return of symptoms".

Page #P32: "Expect the person to think about stopping his or her medication early. You should know that patients who discontinue antidepressant therapy early are more likely to have a relapse (return of symptoms) and return to previous suffering . . . . Continuing the medication maintains symptom relief and may help prevent recurrence".

Third, the likelihood of depression being a chronic condition and the danger of leaving any mental disorder untreated are emphasized:

Page # P3: "Depression is a recurring illness. If you have one episode, there is a 50% chance you will have another. The chances of recurrence increase to 70% after two episodes and 90% chance after three episodes. Untreated, depression can last up to 6 months or longer. For as many as 10% of people, depression may last much longer. It is estimated that 15% of people with chronic depression commit suicide".

Page # CL56: "Much like diabetes, asthma, or heart disease, depression is a disease that requires medical treatment. Otherwise, depression can last months, or in some cases, years. If left untreated, depression can worsen the symptoms of other illnesses, lead to disability, or increase the risk of suicide. The suicide rate triples for men in midlife, and increases seven times in men over the age of 65".

Finally, the general damage and negative consequence of mental disorder on someone's life is emphasized. Even when not cast as an immediate threat, mental illness is portrayed as something which profoundly and very unpleasantly affects all areas of someone's life:

Page # Z58: "Depression and anxiety disorders are difficult conditions that might affect virtually every part of your life. You might find yourself falling behind at work, school, and life. Often that's the hardest part of your condition.

Page # P5: "Depression is a medical illness that disrupts your life. It involves your whole body. Depression affects your thoughts, emotions, behavior, and the way you feel about yourself. Depression can also change the way you think and feel about other

people, about situations at work or in a social setting, or even about things such as your garden, your house, or your clothing".

The depressed person comes to understand that their illness is a great risk to them in a number of ways, and that they may even be a danger to themselves.

c) LOSING PERSPECTIVE OR NOT FUNCTIONING WELL

The depressed person is often portrayed as less competent and capable than usual given that they are 'depressed'. The depressed person is portrayed as experiencing a loss of perspective and also as having difficulty managing normal life:

Page # P12: "Talking with a licensed therapist, psychiatrist, mental health professional, or counselor, or joining a support group, helps many people see that their feelings aren't abnormal, unusual, or terrible at all. They begin to see that everyone has these feelings from time to time and that depression caused them to lose their natural perspective".

Page #Z94: "A mental illness is a biological illness affecting emotions and behavior. This makes the person not able to manage the ordinary demands and routines of everyday life".

Page #CL40: "In addition to having five or more of the symptoms listed above, in order to lead to the diagnosis of major depressive disorder (MDD), the symptoms must cause significant distress or impair the person's ability to function. This means the symptoms have a negative affects on how the person functions socially, at his or her job, or in some other aspect of their life"

This depiction of the depressed person as less competent is common, but not the only version. The depressed person is also paradoxically admonished to seek help; the very person who is described above as having lost perspective is expected to have the cognitive capacity to recognize symptoms, to self-diagnose and then seek medical

diagnosis and treatment. At the farthest end of this spectrum is the occasional affirmation of the depressed person as having a primary role or significant involvement in treatment:

Page # P11: "Becoming an active partner with the doctor treating your depression is important. The patient can maintain an informed relationship with the physician or therapist by discussing treatment options and voicing concerns".

d) A BURDEN TO FAMILY AND FRIENDS

In varying degrees, all websites include information directed at family and friends of those suffering from depression, anxiety, eating disorders, etc. Ironically, it is usually here, in the sections designed to be helpful and to assist others in care giving, that the depressed person is portrayed most negatively. This negativity often takes the form of declarations and warnings about the toll that caring for a depressed or anxious person takes on the loved one. Furthermore, as in the second quotation below, it is even advised that caring for someone with depression puts the caregiver at risk for a similar illness[7]:

Page #P31: "Never forget, it is also important not to lose sight of your own well being. Living with a person who is suffering from depression can be emotionally stressful for everyone involved. Read our strategies and advice to keep yourself well as you help your loved one get better".

Page #P33: "If you are a relative of the depressed person, you too may be at risk of developing the illness, since depression 'runs in the family'".

[7] By making this observation, I am not disputing that there may be a connection between the burden of caring for a depressed loved one and the onslaught of depression in the caregiver. I am simply noting that the inclusion this information contributes to a more negative representation of the depressed person.

4.3 MEANS USED TO CONTRUCT THE PORTRAYAL

4.3.1 STRUCTURE: INTERACTIONAL CONTROLS

The purpose of this section is to outline the three examples of interactional control found on the websites. Order will be discussed first, followed by menus and links, and finally repetition and circularity. Interactional controls are those features of the websites which direct and shape navigation around it. Though perusing a website may not be an interaction in the conventional sense, it is a way of directing the use of information and as such a form of interaction has taken place.

a) ORDER

The order of the presentation of the information is significant. Certain things must be established and understood before other matters can be discussed. Information seems to have been laid out in accordance with a very scientific interpretation of depression. For example, discussing SSRIs is neither useful nor relevant until a) serotonin has been defined as a neurotransmitter found in the brain, b) a consumer understands that when serotonin falls below a certain level, the deficiency may contribute to various mood and anxiety disorders, and c) the user should be able to make the connection between this deficiency of serotonin and the purpose of an SSRI. Information seems to have been laid out in a certain order to maximize the logical understanding of the medical material and concepts.

b) MENUS AND LINKS

Menus and links organize the content of the websites. These are a form of interactional control insofar as they serve to steer the user around the material in a certain way and in a particular order. The sites are so extensive that it often seems easier to

browse through them in accordance with their inherent structure rather than taking any initiative with the navigation: Paxil.com prints out on 40 pages, Prozac.com on 80, Sarafem on only 9, Zoloft.com on 122 pages, and Celexa/Lexapro on 143 pages. Menus and links are a way for the user to hone in on specific information they are looking for without having to go through each webpage consecutively.

The Paxil menu/link system is among the simpler of the websites, with only three menu options listed horizontally across the top of each page: About Paxil CR, What Paxil CR Treats, and Support & Treatment. Clicking on one of these three options brings up a submenu, with items listed one below the other on the upper left hand side of the page. In contrast to this visual simplicity, Paxil pages are full of links. On the homepage, for example (in addition to the typical links concerning safety information, privacy policies and the like), there are six links to disease or treatment information. Paxil is one of only two sites in this study (Prozac being the other one) which includes a search window so the user can search the site for a particular piece of information. This capacity to search independently grants the user autonomy not found on any of the other websites and mitigates the degree of control enforced by the pre-existing order and structure of the material.

Prozac.com also has three horizontal menu options across the top of each page: Disease Information, How Prozac Can Help, and Next Steps. Clicking on any one of these items brings up another menu extending down the left-hand side of the page, consisting of multiple items and sub-items. Though all websites provide safety information and a guide to proper use and prescription of the medication, Prozac is the

most persistent in directing users toward this information[8]. Only Prozac has two *permanent* boxes on the lower left-hand side of each page, containing a link to Safety Information and another to Medication Guide.

The Zoloft website is very extensive but has the least amount of content per individual page. The Zoloft pages do not have horizontal menus across the top, but rather menus along the left-hand side of each page which expand further to reveal several sub-items. Though the format is different visually from Prozac.com and Paxil.com, which are again different from Sarafem, menu options on this website are similar to the others: About Zoloft, Learning About Depression, Learning About Certain Types of Anxiety Disorders, Learning About PMDD, Managing Your Condition, and Recognizing Depression and Anxiety Symptoms in Others.

The Celexa/Lexapro site has a different example of interactional control yet again. Upon arriving at http://www.celexa.com, one encounters a large box, occupying nearly half the page, which advertises Lexapro. It is possible to move further into the Celexa website, but the size and frequency of advertisements for Lexapro strongly encourage learning about this medication instead. Once on Lexapro's homepage (http://www.lexapro.com), a large picture indicating Lexapro for the treatment of depression and anxiety is captioned by two different sections: one "For New Patients", and the other "For Current Users". While the particular content of the information in these two sections does not vary significantly, the quantity of information does. The site appears to target new patients almost entirely; indeed, there is only one small section

[8] Though I have not done research into why this might be, I would hazard a guess that since Prozac is the oldest member of the SSRI class, its pharmaceutical distributor is well-versed in the legal issues surrounding any medication and to this end takes additional precautionary steps in the hopes that all such information is easily accessible.

(which printed out on two pages of 8.5 x 11in paper) devoted to current users. Interactional control is exercised on this website through the categorization of site visitors as one group or another in addition to the way menus and items are laid out.

c) REPETITION

Two other forms of interactional control found on the websites are repetition and circularity. Repetition is multiple occurrences of identical or almost identical information.

The best example of repetition is found on the Zoloft website. At the bottom of almost every web page the following body of information is included. (This information does not appear on the bottom of symptom checklist pages):

Depression is a serious medical condition, which can lead to suicidal thoughts and behavior. A combined analysis of studies involving 9 antidepressants showed that in people under 18 this risk was 4% for those taking antidepressants compared to 2% for those taking sugar pill. This risk must be balanced with the medical need. Those starting medication should be watched closely for suicidal thoughts, worsening of depression, or unusual changes in behavior. In children and teens, Zoloft is only approved for use in those with obsessive-compulsive disorder.

Zoloft is not for everyone. People taking MAOIs or pimozide shouldn't take Zoloft. Side effects may include dry mouth, insomnia, sexual side effects, diarrhea, nausea and sleepiness. In studies, few people were bothered enough by side effects to stop taking Zoloft.

Zoloft is approved to treat depression, social anxiety disorder, posttraumatic stress disorder (PTSD), panic disorder, obsessive-compulsive disorder (OCD), and premenstrual dysphoric disorder (PMDD) in adults over age 18. It is also approved for OCD in children and adolescents age 6-17 years.

Zoloft is not habit-forming and is not associated with weight gain. So talk to your doctor about how Zoloft might help you. Zoloft comes in 25-mg, 50-mg, and 100-mg tablets. You and your doctor can discuss a dose for you.

In 103 physical pages, the above appears *forty-two* times in identical format. On Zoloft's sister site, http://www.zoloftforpmdd.com, this warning appears sixteen times in eighteen physical pages. Interestingly, the third paragraph above which outlines all conditions Zoloft has been approved to treat, does not appear on the zoloftforpmdd.com website. This evidence points to a concern with liability issues, which would be innumerable if someone were to causally link someone's suicide with the use of Zoloft.

The above excerpt is not the only example of repetition within the data. Recommendations to consult the doctor regarding medication appear very frequently throughout the dataset. Page # Z9 contains four recommendations within two paragraphs to consult a physician about treatment:

Zoloft is available in multiple strengths. Your doctor can decide the right dose for you. Don't stop taking your medication without talking to your doctor first, even if you're feeling better. If you stop taking your medicine, your symptoms could come back. Keep talking to your doctor while you're on treatment. If side effects are bothering you, let your doctor know.

Recommendations to consult the doctor regarding symptoms appear frequently as well. Pages #Z40-Z42 contained the following recommendations:

If you think you or someone you know might suffer from social anxiety disorder, fill out the checklist on this site. Your answers can help your doctor determine if you might have social anxiety disorder. Only a doctor or other qualified healthcare professional can diagnose social anxiety disorder.

If you think you or someone you know might suffer from panic disorder, fill out the checklist on this site. Your answers can help your doctor determine if you might have panic disorder. Only a doctor or other qualified healthcare professional can diagnose panic disorder.

The Prozac website also displays several cases of repetition:

Page # P2: Depression is not a character flaw; it is neither a "mood" nor a personal weakness that you can change at will or by "pulling yourself together".
Page # P31: "It is important for you to accept that depression is a real illness – not a weakness or character defect. Your friend or loved on can't "snap out of it" and it won't go away with time.

Page #P60: You should know that the recommended length of treatment with an antidepressant is 6 to 12 months, because one of the long-term goals of treatment is to keep depression from troubling you again.
Page #P61: The recommended length of treatment with an antidepressant, including PROZAC, is 6 to 12 months. One of the long-term goals of treatment is to keep depression from troubling you again. You should continue as your doctor advises.

Finally, the Celexa/Lexapro website has its own example of repetition. Between Page # CL39 and Page #CL70, the following warning appears seven times:

If you or someone you know has thoughts of suicide, seek professional help immediately through your healthcare professional, or call 411 to get the phone number for the nearest local suicide hotline.

Neither the Sarfem nor the Paxil site have any discernible repetition – perhaps due to the fact that these websites are substantially smaller than the others.

d) CIRCULARITY

Circularity is a harder interactional control to notice and to track. By circularity, I mean that the navigation system of the website directs a user *back* onto a page that has already been visited. I found only a small number of meaningful instances of circularity. The Zoloft site, for example, there are links on page #Z1 to a variety of questions, such as What are the possible side effects [of Zoloft]? And Is it addictive? Because this is the

first page of the site, it does initially lead the online user to new information. But should this user follow through the menu items in a systemic fashion, the user will arrive back onto the Question & Answer page several times.

Repetition and circularity represent interactional control since they influence not only the number of encounters a person has with a particular unit of information but also the order in which those encounters take place. Circling back to the same information over again, or being exposed to it multiple times (perhaps without awareness of this multiplicity of exposures) may serve to highlight or emphasize this information in the mind of the user making it more likely that this information is both retained and acted upon. While this of course could never be proven without specific causal experimentation, it seems logical to infer than one will remember better something read five times than something read only once.

4.3.2. TEXT: WORD CHOICES AND MEANINGS

Fairclough emphasizes the importance of particular word choices and their meanings. He argues that when considering word choice, the goal is to "identify the interpretative perspective that underlies this wording" (Fairclough, 1992: 237). In this text, science is the underlying 'interpretive perspective'. He also observes that when studying word meaning "the emphasis is upon 'key words' which are of general or more local significance; upon words whose meanings are variable and changing; and upon the potential of a word – a particular structuring of its meanings – to become a mode of hegemony and a focus of struggle" (Fairclough, 1992: 236). [Hegemony involves domination through political and ideological means (Abercrombie et al, 2000: 161)][9]. In

[9] For example, in liberal capitalist countries like Canada, the hegemonic or dominant ideology is meritocratic individualism. The liberal capitalist places an emphasis on the rights and freedoms of the

this section, we first consider the symptom versus side-effect dichotomy, exploring the contradiction that different labels are often assigned to the same set of sensations. Secondly, we will consider the word 'disorder' and the way this serves to cement the social and medical construction of mental illness as deviance.

a) SYMPTOM VERSUS SIDE-EFFECT

All the websites provide accounts of disease symptoms and also common side-effects expected to occur when using the medications. The label given to a set of experiences infuses it with a particular significance. Symptoms are represented on the websites as a problem, a sign of disorder and likely to be permanent without treatment. Side-effects, by contrast, are portrayed as mild or benign, not guaranteed to happen but usually temporary if they do. Consider the following examples:

Page #CL77: "Lexapro is well tolerated by most people. But, as with all SSRIs, side-effects have been reported during treatment with Lexapro. Most of the side effects are mild and temporary, and usually do not cause you to stop treatment. . . .And, clinical studies have shown that there were no meaningful weight changes".

Page #Z117: "In these studies for PMDD, most women have to stop taking Zoloft because of side-effects. Some women who take Zoloft for PMDD may not have side-effects. If you do, they should be less of a problem over time"

Page # PCR5: "As with any prescription medication, PaxilCR may cause some side-effects, which are usually mild to moderate and may fade or disappear completely over time".

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individual person. In an open market, the individual is at least theoretically free to pursue any business endeavors, and will be rewarded in accordance with effort and merit. When people try to describe or explain human behavior using terminology, assumptions, etc challenge liberalism, their explanations and assumptions are easily dismissed and discounted by the hegemonic culture.

Page #P65: "Side-effects are similar for Prozac Weekly and Prozac…These tend to go away within a few weeks of starting treatment and, in most cases, aren't serious enough to cause people to stop taking Prozac Weekly or Prozac.

What is ironic is that the precise experience of a given symptoms and the precise experience of a side-effect (such as insomnia, seen below) are often one and the same. This could lead to confusion and cause great difficulty for the depressed person, since a given sensation might be a symptom of the disorder not yet under control or a benign side-effect which will disappear shortly. Consider the following examples from the Lexapro and Paxil sites where symptoms of depression and side-effects caused by the medication directly overlap:

*Page # CL39: "Common symptoms of depression [include]: 1) Depressed or irritable mood most of the day – nearly every day 2**) Loss of interest or pleasure in activities** (such as hobbies, work, **sex** or being with friends) most of the day – nearly every day A sudden change in weight (weight loss without dieting, gaining more than 5% of body weight in 1 month) or a change in appetite 4) **Inability to sleep or sleeping too much nearly every day** 5) Agitation or restlessness (observed by others) nearly every day 6) Constant **fatigue or loss of energy** nearly every day 7) Frequent feelings of worthlessness or inappropriate guilt nearly every day 8) Difficulty concentrating or making decisions nearly every day 9) Frequent thoughts of death or suicide (or a suicide attempt or plan)*

*Page #CL77: The most frequent side effects with Lexapro are nausea**, insomnia**, **sexual side effects**, **drowsiness**, increased sweating and **fatigue**".*

Fatigue, sexual dysfunction and sleep problems are presented on the one hand as symptoms and on the other as side-effects of Lexapro. Paxil.com does the same thing with gastrointestinal issues and sleep disturbances:

Page # PCR11: "*A sad or empty mood lasting for two weeks or more and/or loss of interest or pleasure in most activities you once enjoyed, along with several or all of these*

additional symptoms [may be signs of depression]: 1) Feelings or worthlessness, hopelessness, guilt 2) difficulty concentrating, making decisions ***3) changes in sleep habits (such as insomnia or oversleeping) 4) significant changes in weight or appetite*** *5) fatigue, loss of energy, feeling 'slowed down' 6) agitation 7) frequent thoughts of death or suicide, or suicide attempts"*

Page #PCR1*: "As with many medications, there can be side-effects. Some of the side effects may include infection, injury,* ***nausea****, diarrhea, dry mouth, constipation,* ***decreased appetite****,* ***sleepiness****, dizziness, sexual side effects, nervousness, tremor, yawning, sweating, abnormal vision, weakness or* ***insomnia****."*

A similar overlap between symptoms and side-effects occurs on Zoloft.com with respect to suicidal ideation:

Page #Z27: "The term depression refers to a lasting sad mood and/or loss of interest or pleasure in most activities. Sometimes people experience several or all of these additional symptoms: changes in appetite or weight, changes in sleep patterns, restlessness or decreased activity that others notice, loss of energy or feeling tired all the time, hard time concentrating or making decisions, feelings of worthlessness or guilt, ***repeated thoughts of death or suicide****.*

*Page #Z28: "****Depression is a serious medical condition, which can lead to suicidal thoughts and behavior. A combined analysis of studies involving 9 antidepressants showed that in people under 18 this risk was 4% for those taking antidepressants compared to 2% for those taking a sugar pill****."*

If 2% of people taking a sugar pill demonstrate suicidal tendencies, and this doubles for people on Zoloft, could not one possibility be that Zoloft actually increases the frequency with which people think about suicide?

Recall Fairclough's contention that the meaning of words may be variable and changing. Here, the meaning of a particular physical or emotional aberration is variable: it may be symptom, or it may be a side-effect. In the absence of a definitive blood test or other such diagnostic tool, an irregularity such as a headache or a bout of insomnia is totally subject to the interpretation of the attending physician. Furthermore, words like 'lasting', 'sad mood' and 'interest' or 'pleasure' as found in the Zoloft quotation above, are very ambiguous terms, making judgment of them subjective. Viewed from this vantage point, the diagnostic process of a mental illness such as depression seems much more nebulous and uncertain than diagnosing a physical illness which can be empirically observed or tested for. However, the right to diagnose remains with the physician, who has the legal authority as a practitioner and the rational authority as a trained scientific expert to do so.

The acceptance of side-effects as part and parcel of receiving treatment is rather contradictory in view of the general philosophy on the websites that medications are supposed to eliminate symptoms. An anomaly or idiosyncrasy of physical or emotional sensation might be given any number of labels, of which symptom and side-effect are only two; whatever the label, though, it is still a deviation from the healthy norm. While medications unquestionably work for many people, it seems somehow illogical, at least in the abstract, to take medications which can cause some irregularities while eliminating others, or cause/exacerbate existing irregularities.

This creates some confusion about the reasons for taking medication in the first place. First, if medications take away symptoms but cause side-effects (which may be identical to symptoms) what has been gained? Second, how is the patient to know

whether the headache caused by depression has been replaced with a headache caused by the medication, or whether the headache caused by depression has remained and the medication is not effective? Third, is the presence of side-effects an indicator that the medication is working? In other words, is it a bad thing to experience no side-effects? Lastly, given the medicalization of depression through the application of a scientific perspective on it (which strives for the capacity to calculate and predict), isn't the presence of these 'messy' questions somewhat antithetical or contradictory? The resolution of these dilemmas really depends on whether the person is, overall, better or worse off with medication.

Finally, all the websites include a caveat about side-effects being not very troublesome. For example:

Page #CL77: "The most frequent side effects are mild and temporary, and usually do not cause you to stop treatment. . . . And, clinical studies have shown that there were no meaningful weight changes"

What does it mean to have mild appetite disturbance versus severe appetite disturbance? Who gets to decide this? Is there a difference between clinical and personal significance? Does temporary mean three days, two weeks or six months? What are the small number of patients for whom side-effects never disappear to do? What exactly is a meaningful weight change (versus a non-meaningful weight change?). Arriving at a judgment concerning some of these rather amorphous terms might be somewhat difficult, but here again the physician is in possession of the expertise and authority to issue the ultimate judgment.

b) DISORDER: MENTAL ILLNESS AS DEVIANCE

Disorder is defined as " confusion, disarray; lack of order or regular arrangement; a disturbance or commotion, especially a breach of public order; an ailment or disturbance of the normal state of body…upset [in] the health or proper function of the body or mind" (*Oxford Canadian Dictionary*, 1998: p.402). Deviance is defined as "the recognized violation of cultural norms" (Macionis, Jansson & Benoit, 2005: p.129). Disorder is understood medically to be an upset in proper biological or chemical functioning, where 'proper' means good, correct and healthy. Dis-order is a breach of order, a disturbance, a sign of disarray. The application of medical science to depression grants legitimacy to the conceptualization of it as disorder, even in the absence of absolute proof.

The medical explanation of depression as disorder is seen as the truest or most compelling explanation, issued by scientific experts. I question the *conflation* of the experience of depression with disorder, although not the experience of depression itself. Called disorder, malaise, the blues or anything else, the experience of depression is real and not a matter for dispute. What is unclear is the appropriateness of the title of 'disorder' for the variations in mood and functioning generally taken to connote depression. Just as a respiratory infection may be a cold or serious pneumonia, so may 'depression' be minor or serious and severe. I am not certain whether it is appropriate to term every gradation and variation of mood associated with depression a 'disorder'.

4.3.3 GRAPHIC ELEMENTS

a) DIAGRAMS AS METAPHOR

The term metaphor originates with the Greek *metaphora*, meaning transfer (Sykes, 1976: p.686). A metaphor is defined in the literary sense as "the application of a name, descriptive term, or phrase to an object or action to which it is not literally applicable" (Sykes, 1976: p.686). The use of metaphor, as Fairclough (1992: p.194) observes, is not exclusive to English literature, but is used in other forms of language and discourse as well. He places particular importance on metaphor because "when we signify things through one metaphor rather than another, we are constructing our reality in one way rather than another" (Fairclough, 1992: p.194). He further argues that "how a particular domain of experience is metaphorized is one of the stakes in the struggle within and over discourse practices" (Fairclough, 1992: pp.194-195). In the examination of the pictorial representations of the depression process as provided on the Zoloft and Prozac websites, we can understand them both as metaphorical signifiers of reality. Further, we can understand them as signifiers of the rational, scientific understanding of depression as a chemical imbalance which may be rectified using chemical means.

Both pictures, occurring on pages Z13 and P54 respectively serve as the first frames of an animation sequence. Zoloft.com provides an animation of how Zoloft works in the brain, while Prozac.com offers images of normal, depressed and Prozac-enhanced neurotransmitter receptors (recall that SSRIs work to block the re-absorption of serotonin by binding to the receptors). The pictures here are metaphorical in the sense that they speak only to theorizing and not to definitively proven processes; these are not images of

the cellular HIV process or of a cancerous growth. These visual representations are metaphorical representations scientific theorizing.

Fairclough argues that the application of a metaphor serves to construct reality in one way rather than another. The websites all claim that depression is caused by a chemical imbalance in the brain. The use of the diagram portrays depression and anxiety in a very physical and concrete way. The actual illness experience is much more amorphous and less tangible, as discussed above. Hopelessness, for instance, and anxiety would be hard to quantify in a systematic way.

The use of the diagram also serves to cement the medicalized understanding of depression. As such, the diagram may also represent "one of the stakes in the struggle within and over discourse practices" (Fairclough, 1992: pp.195). The social practice of direct-to-consumer advertising, subsumed within the large meta-discourse of bio-medicine, may be a subject of struggle insofar as the medicalized definition of mental illness is neither accepted nor acted upon by everyone. As a succinct summary of the bio-medical assessment of the depression process (interaction between neuro-receptors in the brain) the picture as metaphor might easily become a stake in the struggle between allopathic discourses and other discourses, such as naturopathy, which understand the etiology of depression and mental illness in other ways.

b) CARICATURES

While the other websites provide actual photographs of seemingly healthy and happy people, Zoloft provides a banner across the top of each page which contains one of a number of images representing life activities: shopping, conversing, working at a computer. What is striking about these images is that they are cartoon figures, little more

than circles with faces drawn into them; neither limbs nor hair characterize any of these sketches. Furthermore, indicators of other characteristics such as age and gender are also completely absent. Woodlock (2005: 309) interprets these figures as “cartoon images of pill shaped characters”.

c) PHOTOGRAPHS

Photographs of human faces are also included on the websites. However, none show the suffering that depression can cause. Instead, the photographs depict people looking well and happy – presumably how they look once taking the proper medication.

4.4 THE TARGET AUDIENCE

The websites are directed toward a Western Anglophone audience. Unlike Hotmail and other websites which provide the option of viewing the content in a number of languages, these websites can be displayed only in English. Further, some websites include the caveat that the site is intended for American visitors only. The websites were directed toward an adult audience, despite acknowledgement on several of them that children and teens can also be affected by mental illness. Because of its complexity, the content of the websites would likely be rather inaccessible to teens and certainly to small children. Children and teens were generally omitted from information such as incidence and prevalence statistics and social support suggestions. The audience members are assumed either to be depressed (judging by frequent use of words like you/your/you’re) or to be connected emotionally with someone who is (as evidenced by through phrases such as “your depressed loved one”).

Assumptions appear to have been made about the general intelligence and literacy of the target audience. As Friedman, Hoffman-Goetz & Arocha (2006: 78) found, health information on the Internet can be at as high a reading level as grades twelve to thirteen. While no formal assessment of readability and reading level was done for this analysis, much of the content appeared to be of a high enough level that it would only be accessible to persons with high literacy skills, and some medical knowledge. Despite the inclusion of very clinical language, the websites generally seem to be directed toward an educated lay audience rather than a medical one.

Generally speaking, the websites are inclusive with respect to gender. Exceptions are Sarfem.com and Zoloftforpmdd.com which understandably are directed towards women suffering from Premenstrual Dysphoric Disorder (PMDD). Several sites seem to make an effort to reach both genders. The first three pages of the Prozac website all featured pictures of men; the caricatures on the Zoloft website do not show gender-specific features. These caricatures are also not engaged in activities associated more frequently with one gender than the other.

Language is used to establish a sense of group identity. This is accomplished by providing statistics regarding both the number of people experiencing depression and the number of people receiving treatment. In both cases, the numbers are estimated to be in the millions. Every website does this at some point:

Page # CL13: "Lexapro has been prescribed to over 15 million patients in the US, where it is the fastest growing medicine of its type".
Page # CL41: "Nineteen million people suffer from depression – a common but serious medical illness.

Page # PCR10: "In the United States, over 14 million people suffer from depression in any given year. Although depression can affect people of all ages, symptoms often appear for the first time in people in their mid 20s. As many as 25 percent of women suffer from depression serious enough to seek treatment at least once in their lifetime. In fact, nearly twice as many women as men suffer from depression every year".

Page # Z25: "More people suffer from depression than you might think. Depression strikes people of all ages, backgrounds and ethnic groups. Depressive disorders affect about 34 million American adults. Nearly twice as many women as men are affected by a depressive illness every year".

Page # P1: "Prozac is the most widely prescribed antidepressant medication in history. Since its introduction in 1986, Prozac has helped over 54 million patients worldwide, including those suffering from depression, obsessive compulsive disorder, bulimia nervosa and panic disorder".

Page # P81: "PMDD is a distinct medical condition…Some think it's part of being a woman or PMS (Premenstrual Syndrome). But for millions it is PMDD.

Though the figures noticeably vary among the websites, all cite incidence, prevalence and treatment statistics. Some go farther and name particular social categories, such as gender and age.

Statements concerning the commonality of depression are included alongside attempts to reduce the stigma or shame surrounding it:

Page #P3: Depression is a common medical illness. More than 18 million Americans suffer from some type of depression, and one in eight people needs treatment for depression during his or her lifetime. Depression is not a character flaw. It is neither a "mood" nor a personal weakness that you can change at will or by "pulling yourself together". . . . The social stigma surrounding depression is still substantial and may prevent people from seeking treatment. The National Institute of Mental Health (NIMH)

estimates that two –thirds of people suffering from depression are without the help they need”.

Depressed people who understand that there are literally millions of others like them, that depression is the ‘common cold’ of mental illness, may be more likely to accept their status and to seek treatment for their concerns.

4.5 ASSUMPTIONS MADE ABOUT THE AUDIENCE

4.5.1 INSURANCE COVERAGE AND FINANCIAL RESOURCES

Assumptions are made about social class and employment of the prospective user. For instance, the Paxil site has two sections called “Working With Your Employer”, and one called “Insurance Coverage”. These two sections are six pages in total, and cover topics such as the [American] Family and Medical Leave Act (FMLA), and the insurance coverage options for different treatments available. It appears to have been taken for granted that the audience would, by virtue of good employment insurance coverage, have the financial wherewithal to purchase medication and therapy. In terms of socio-economic status, the target audience appears to be middle to upper class with disposable income. To state that that cost of treatment should not be a deciding factor is to overlook the fact that for the lower socio-economic classes with little or no disposable income, cost would be a primary factor in considering treatment options. Assumptions regarding class are particularly striking given that poverty is a very strong predictor of mental disorder. Eleven studies done between 1990 and 2003 found a very strong statistical association between the two factors (Patel and Kleinman, 2003: 609).

4.5.2 SOCIAL INTREGRATION

The websites assume a fairly high degree of social integration in the readers. Advice concerning the importance of family and friends, the value of community support groups and the value of social activities provides evidence of this assumption. In addition, social integration is assumed to be a positive thing, where social contacts are generous, willing to help, and also likely to be a constructive, beneficial presence. Audience members are assumed not to be marginalized by any other factors such as a physical disability which would prevent them from getting out and doing social activities.

All websites affirm the importance of social support systems when someone is depressed, with the curious exception of the Prozac website. While Prozac.com provides the most extensive instructions on individual lifestyle changes which can improve symptoms, it does not really advocate seeking support from non-medical others such as friends and community support groups. On the other websites, though, people are strongly encouraged to establish a support network and by implication make their depression more public knowledge. Language is used to facilitate a social identity through its encouragement of social support networks.

In its 'Managing Your Condition' section, for instance, Zoloft.com has two sub-items pertaining to family and friends and to the benefits of support groups. Recommendations for seeking social supports are as follows:

Page # Z74: "Your friends and family members can be the best resources you have during your treatment. As long as they understand the treatment you're on, they can help you every step of the way. . . . Support is important, but remember that each person will react differently to your condition. You can also find support in other people who share your condition".

Page # Z76: "Support groups bring together people with similar problems. As a group, people can give each other emotional and moral support, as well as share practical information".

By encouraging the formation of relationships based primarily on a presenting mental disorder, someone's social status as depressed becomes more firmly entrenched and interaction may come to revolve around this issue. Examples from other websites include similar guidelines:

Page # PCR22: "Many communities have support groups for family and friends of people with depression or anxiety disorders. They can receive emotional support and accurate information about your condition at these group meetings. Participation often leads to better quality of life for you, your family and your friends as you recover".

Page # PCR24: "One of the best places to find personal supporters is in support groups for people with depression or specific anxiety disorders. These are not therapy groups. They are places where people who have the same condition come together for self-help and support. These groups provide the opportunity to be with people who are dealing with the same problems and issues. They provide a place where you don't have to hide your problem. Because group members understand what you you're going through, it's easy to talk with them. Group members can often offer tips for handling problems associated with your condition".

4.5.3 HEADED TO THE DOCTOR'S OFFICE

There seems to be a general assumption that a visit to the doctor will occur. As such, extensive advice and instructions are provided to guide the depressed person through initiating and sustaining this relationship. The patient is advised to move beyond the self-diagnosis made possible by checklists and quizzes on the websites to an official diagnosis from a medical doctor. The patient is advised to maintain the relationship. The doctor is cast as a helpful resource for family and friends seeking to learn about

depression as a medical condition - making them participants in the discourse as well. Finally, relationships with other allopathic healthcare professionals are encouraged and participation in other discourses is discouraged.

First, the patient is advised to confirm the informal, preliminary diagnosis made by him or herself by seeking an official diagnosis from a doctor. These websites are direct-to-consumer advertisements for antidepressants and so the encouragement of this relationship makes sense since doctors are gatekeepers for medications requiring prescriptions:

Page # Z113: "The best way to know if you have PMDD is by visiting your doctor. The way you can get answers about your symptoms, and learn if Zoloft can help. . . . Make a list of any medicines are you are taking. Also write down how much you take of each medicine. Bring these notes along on your doctor visit. It will save time and can also help your doctor…Think about whether any women in your family may have PMDD. If you think they might, let your doctor know".

Page # PCR3: "Please keep in mind that this Web site is not meant to replace a discussion about your condition with your doctor, who knows your medical needs best. If you have questions regarding your condition or treatment, contact your doctor".

Next, the patient is strongly advised to maintain the relationship:

Page # CL1-2: "Be sure to keep follow-up appointments with your doctor or other healthcare professional. They need to know how you are doing and might want to change your treatment plan".

Page #CL35: "Keep follow-up appointments with your healthcare professional. He or she needs to know how your treatment is going, if you're feeling better, and if you're experiencing any side effects. Keep a journal and take it with you to your appointment."

Page #P71: "It is important to communicate with your doctor. Talk to your doctor if you're thinking about stopping your medication because you're feeling better, or if you're having trouble staying on your medication schedule. Your health care professional is your best resource for information on staying well".

Third, family and friends are encouraged to view the doctor as a resource for information and to consult the doctor regarding the illness and its treatment:

Page #PCR32: "Even your closest friends or family members might not completely understand your depression or anxiety disorder. Your doctor can help you here by explaining the course of treatment you've worked out together, as well as giving friends or family members some additional insight into the nature of your medication condition. Your doctor can also explain to your family and friends how they can help you as you recover, as well as how they can be active support partners over the course of treatment".

Finally, the patient is encouraged to stay within the allopathic medical discourse by seeking help from other medical professionals and by refraining from the use of other treatment strategies such as naturopathic medicine:

Page # Z66: "In addition to your regular doctor, you can turn to other doctors or healthcare professionals who can help find a treatment that's right for you. Other professionals who can help are: psychiatrists, nurse practitioners, physician assistants, clinical psychologists, social workers, mental health counselors".

Page # P13: "According to the American Psychiatric Association (APA), "no one who thinks he or she may be depressed should self-medicate with St. John's Wort or any other 'alternative' remedy. Many suitable, clinically approved, and highly effective therapies are already available for the treatment of depression. If you think you may be suffering from depression, it is important to consult with a physician. Symptoms of depression could be caused by another illness or result from other causes, such as substance abuse.

Never self-medicate. The risk of self-harm far outweighs the potential benefits of self-help".

4.6 ABSENCES AND SILENCES

Following is a discussion of six major absences from the website data. Tips regarding how to prevent first onset of depression are not found. Spirituality and faith as potential aids in the fight against depression are not addressed. There are no personal accounts by people who have endured or are currently living with depression. Definitions of "mental health" and "recovery" are not clear and not directly stated. A way to resolve the ambiguity regarding the line between inconvenience or abnormality and disease is not found. Finally, there is no affirmation of psychotherapy as a viable alternative instead of medication, only that it sometimes can be useful alongside it. This list is not meant to be inclusive. These are a few notable absences among what I am certain is many. Those listed here have been included because they support the argument that the medicalized view of depression prevails on SSRI websites.

First, there is virtually no discussion of how to prevent depression (only of how to prevent its resurgence). This is surprising from a public health perspective, given that depression is a health issue affecting millions around the world. Much is written on the websites about healthy lifestyle habits which should accompany medical treatment, yet these are always listed as supplementary measures to combat a presenting illness rather than to prevent its first onset.

Second, spirituality and faith are not mentioned. This is doubtless due to the primacy of the bio-medical understanding of cause, symptomology and treatment. Designers of the websites may have assumed that most audience members would not find spiritual content very compelling. It may also have been an attempt at 'political

correctness', since given the variety of religious and spiritual convictions characterizing the North American audience, it would be impossible to reference everyone's particular beliefs. Despite the plausibility of these explanations, however, this is a surprising omission given the growing recognition that spirituality and/or religion are connected to mental health i.e. religious and spiritual practices may have a positive influence on mental health. Mental health practitioners are increasingly advocating for the integration of religion and spirituality into psychiatric treatment (Gopaul-McNichol, 1997; Dein, 2005; Koenig, 1998). Some researchers have even found that spiritual or religious convictions may influence treatment choices for those with diagnosed mental illnesses (Chiu, Ganesan, Clark and Morrow, 2005). Presumably, findings of this sort would be particularly relevant for pharmaceutical companies, who might be interested in knowing whether religious convictions make patients more or less amenable to the use of psychotropic drugs.

Accounts from people with depression are noticeably absent. Perhaps this is not surprising given the findings of Nairn & Coverdale (2005) that narratives written by psychiatric patients themselves are rarely if ever found in the mass media. The only exception to this is Lexapro.com, which includes the voices of depressed people in two ways. First, boxes sized at approximately one quarter of an 8.5 X 11 in page contained anecdotes such as "Treatment and therapy have made a significant difference in my life" (Page #CL93). Other boxes allow users to view video footage of the patient before and after treatment. These are called 'testimonials', and also include interviews with doctors strongly advocating the use of medication. Second, this site also includes personal memoirs of depression in its list of additional resources.

Fourth, a clear and succinct definition of recovery and mental health are conspicuously absent. The most prevalent understanding of recovery is the absence of symptoms, rather than the presence of health, wellness and happiness. Recovery is associated with remaining on medication to avoid the return of symptoms rather than addressing the problem permanently, thereby eliminating the need for medication altogether. However, if recovery is equated to remaining on medication, but medication has, at least theoretically, the potential to cause long-term or on-going side-effects, what does it mean to be recovered or well? Is it even possible to establish a definition of recovery and mental health that would appeal to or apply to everyone?

Fifth, tools for the patient to assess whether the degree, intensity or frequency of something such as insomnia is a normal variation or a symptom of an illness are missing. Zoloftforpmdd.com lists anger/tension/fatigue, crying and feelings of sadness, arguments with loved ones, concentration difficulties, inability to cope, and cramping/breast tenderness/bloating/food cravings as symptoms. Who does not feel angry, tense or tired sometimes? Who does not experience times of heightened emotionality or pessimism (especially in response to tension and fatigue?) Who does not have times when loved ones are particularly frustrating, when arguments erupt, when concentration and sleep are less than adequate? The above list makes it difficult to clarify the line between annoying idiosyncrasy on the one hand and pathology on the other. Clarity on this issue would be important when making decisions regarding whether or not to seek medical help. I would argue that these tools are useful, but that their scope of utility is somewhat limited.

Finally, while psychotherapy is mentioned on the websites, it does not stand alone as a credible or equally effective counterpart to the medicinal intervention so strongly

advocated. Rather, it is represented as a useful complement or supplement. Neither complementary nor alternative medicine, that take a more holistic approach to health and illness, are offered as useful avenues to pursue.

CHAPTER FIVE

DISCUSSION

5.1 INTRODUCTION

This Discussion chapter is organized as follows. The first section, Anomalies, addresses additional ways of representing depression and the treatment of it. The Analysis chapter answered the research questions concerning the most common portrayal of depression and the means used to construct this portrayal. The Anomalies section highlights departures from this norm. The next section revisits the audience from three vantage points: the challenge of establishing accurate statistics about depression given changing definitions and understandings of the condition, the challenge of reaching specific subsets of the population such as adolescents and the elderly, and the challenges presented by the possibility of a 'digital divide' with respect to accessing health information on the Internet. The third section, entitled Contradictions and Logical Problems, examines the difficulty of abiding by lifestyle advice contained in the websites and also the paradox of alleviating symptoms by taking a medication known to cause side-effects. The fourth section briefly considers medical power as shown in the order and structure of the website material and also adds an argument to the current debate regarding whether or not direct-to-consumer advertising really can change the doctor-patient relationship, particularly given the social and historical context of rationalization and the medical expert as laid out in the Introduction. The final section presents suggestions for future research.

5.2 ANOMALIES: ADDITIONAL WAYS OF REPRESENTING DEPRESSION AND TREATMENT

5.2.1 DEPRESSION: CLINICIAL AND NARRATIVE RESOURCES

Lexapro.com provides academic references at the bottom of many of its sections, drawing on internal documentation and variety of peer-reviewed academic sources. In addition, the Lexapro site also provides a long list of resource materials, such as useful websites and tools for getting the most out of clinical consultations. Most notably, Lexapro.com provides a seven-page list of recommended reading material. This list is broken down into General Information and Self-Help, Family and Friends, and Personal Experience. The list contains some very technical and clinical references, such as *Treating Generalized Anxiety Disorders: Evidence-Based Strategies, Tools and Techniques* (Rygh & Sanderson, 2004), but also memoir titles such as *Willow Weep for Me: A Black Woman's Journey Through Depression* (M N-A-D, 1999) and *On the Edge of Darkness: Conversations About Conquering Depression (*Cronkite, 1995). Lexapro is one of the newer members of the SSRI class of drugs, being far younger than Prozac and Zoloft.

5.2.2 TREATMENT: LIGHTS, ROAD MAPS AND SELF-ESTEEM

The Prozac website is unique in several ways. First, Prozac provides a list of famous people throughout history who are known to have suffered from depression; none of the other websites provides such a list. Second, alongside the clinical/medical rhetoric so typical of this data are statements about healing and light, and also about the journey towards wellness of self-discovery. As I suggested in Chapter 4, discussion of recovery and mental health is largely absent from the texts. The materials on the Prozac website are notable exceptions, more notable still because they are somewhat lyrical or poetic.

This is a marked departure from the tone of the other websites and also from the rest of the Prozac website, which is very clinical and functional by comparison.

Finally, Prozac.com provides a huge section on a number of lifestyle, behavioral and emotional steps anyone can take to enhance health. Spanning twelve pages, this guide offers a wide variety of suggestions and information, including self-esteem and self-care, indicators of stress, dietary information, and the use of writing in the healing process. While all the websites offer lifestyle information and suggestions, it is the breadth and depth of this material on the Prozac site which sets it apart.

5.3 ESTABLISHING THE AUDIENCE AND REACHING THEM

5.3.1 WHO IS DEPRESSED?

Another issue surrounds incidence and prevalence statistics. The websites report 'growing numbers' of people with mood and anxiety disorders. Whether more people actually are depressed, or more depression is being identified and reported, or depression is defined differently or counted differently is not clear. As Roy Richard Grinker (2007: p.3) puts it in his book about autism:

> The increase in the number of those reported to be clinically depressed does not mean that depression is more common today than in the past, but only that our way of defining depression has changed. Fifty years ago, the term was used to describe only the serious, debilitating depression that may have required long-term hospitalizations. Likewise, there exists the logical possibility that the incidence of autism has not increased but that we are defining it differently and counting it differently than in the past. Of course, the fact that some diagnoses become popular or fade away does not mean the conditions they describe are not real…It does mean, however, that what may be called an "epidemic" is really a reflection of a change in the way a culture perceives a condition or disease.

Depression has not always been defined in a medical way, or even known as 'depression'. As Grinker observes, reports of an epidemic may not reflect increasing

rates of depression so much as a change in the *perception* of it which occurs as a result of medicalization. Public health statistics regarding depression may therefore also reflect these perceptual shifts in addition to the actual presence of depression in a given population.

5.3.2 REACHING THE YOUNG AND ELDERLY

There is a certain audience targeted by the SSRI websites. Specific sub-groups of the population, such as adolescents and the elderly, are either excluded (as with the caveat that site visitors must be 18 or older) or more subtly by generally not being mentioned. Both these populations suffer from a variety of mental illnesses: enough teens experience Obsessive-Compulsive Disorder that Zoloft has been approved treating it, and the Lexapro site offers a guide for depression in older adults, saying that 15% of adults will experience a depressive episode during their elderly years. The Internet may represent a unique opportunity to reach these particular sub-groups, especially given the propensity of both to consult the Internet for health information.

One study finds that age has a statistically significant correlation with Internet use, and the average age of Internet-health users is much lower than the age of non-users (Cotton & Gupta, 2004: 1804). Adolescents are very likely to see the Internet as a viable, supplementary source of health information alongside the traditional clinical encounter (Gray et al, 2004: 174). In particular, teens see the Internet as addressing what for them represent impediments to accessing conventional health care services and information, such as inconvenience and lack of anonymity (Grey et al, 2004: 1475). Perhaps both the medical establishment and pharmaceutical companies could capitalize on the credence teens give to electronic health information and design teen-friendly websites specifically

catered to their cognitive capacity to learn, assimilate and digest health information. Given age-appropriate information about illness and treatment options, and given the presentation of this information on a medium which allows anonymity, teens may become both better informed and more able to act in the interests of their own health.

The elderly also suffer from depression. Furthermore, the consequences of untreated depression are different for the elderly and may bring about serious added complications such as disability and increased possibility of premature death (Page #). A large enough proportion of the elderly population now uses the Internet for healthcare information (Campbell & Noffi, 2005) that studies are now being done about creating user-friendly sites, and efforts are being made towards the creation of usability guidelines (Ownby & Czaja, 2003: 1). Medical information regarding geriatric care is available on the Internet (Maddan et al, 2002: 74). Perhaps there is a place in this context for the addition of mental health information, so the elderly population may become informed not only about depression in general but also about the intersection of mental illness and aging, which poses a unique set of treatment challenges. The elderly are likely to act on the information they find online, and continue to favor a physician-centered model of care ultimately (Campbell & Noffi, 2005: 19). The pharmaceutical industry could capitalize on the propensity of elderly adults to consult their physicians and establish a new market with this subset of the population.

5.3.3 LIMITATIONS OF THE AUDIENCE

As this study has shown, the Internet is one forum for pharmaceutical companies to advertise their products in North America. Because of the infinite room in cyberspace, a particular website may expand *ad infinitum* to include an ever greater quantity and

complexity of information. This is in contrast to the direct-to-consumer advertisements found in print media, to which a finite and much smaller amount of space is devoted. To this end, the Internet may be the most comprehensive source of certain types of advertising/information.

This is somewhat problematic though, since not everyone has equal access to the Internet (Cotton & Gupta, 2004: 1804). For example, "social inequalities discriminate between whether or not individuals utilize online or offline venues for health information" (Cotton & Gupta, 2004: 1804). Other factors are also related to Internet use. For example, age has been found to correlate with health-related Internet use, (Cotton & Gupta, 2004: 1804). Education and literacy are also important, particularly given that much of the health information online is published at a Grade twelve reading level or higher (Friedman et al, 2006: 67). Income is also an important factor (Cotton & Gupta, 2004: 1804), and uneven patterns of use and differences in perception of the relevance of e-health information may serve to exacerbate the already wide chasm between rich and poor (Rogers & Mead, 2003: 102). The Internet must be understood then, as a medium which has the potential on one hand to reduce social inequality and on the other to exacerbate it.

5.4 CONTRADICTIONS AND LOGICAL PROBLEMS

5.4.1 WHEN LIFESTYLE STEPS ARE IMPOSSIBLE GIVEN SYMPTOMS

Contradictory or confusing information can be found in several places throughout the dataset. The most striking example occurs on the Zoloft website, where suggestions about lifestyle modifications directly overlap with lists of symptoms. In a tautological

relationship to one another, a certain lifestyle change would take away a symptom but if making this change was possible in the first place, the symptom would not exist; it is the impossibility of making a certain change that is the symptom. For example, Zoloft.com suggests that the *symptoms* of depression include changes in appetite or weight, changes in sleep patterns, and fatigue or loss of energy. In a section called "Importance of Healthy Living", the following *lifestyle* recommendations include keeping active, eating well and getting enough good rest. The lifestyle recommendations do not make much sense when considered in tandem with the list of symptoms: eating well might be difficult given either absence or excess of appetite; exercising might be difficult given lack of energy and generalized fatigue; sleeping adequately might be difficult given that depression (and medication) can cause disruption in sleep patterns.

When appetite, energy and sleep are changed in some way, the change may be a reflection of the presence of an illness e.g. a symptom. If the disruption of these body rhythms is indeed a symptom, these lifestyle recommendations make little sense and would be difficult or impossible to follow.

FROM SYMPTOMS TO SIDE-EFFECTS: TRADING ONE PROBLEM FOR ANOTHER?

The websites all assert that millions of Americans struggle with mental health problems. A high percentage of these millions are taking prescriptions drugs to address their illnesses. As was documented above, depression is an international phenomenon, and psychoactive drugs are used globally in the fight against it. There are social consequences to such widespread use, particularly when the potential for very serious physical side-effects remains, including liver dysfunction and the risk of sudden cardiac

arrest (Bentall & Morrison, 2002: 254). Behavioral issues also continue to be a troubling consequence of psychotropic drug use.

The media has documented and perhaps even sensationalized the connection between violence and mental illness (Thornton & Wahl, 1996; Wahl, 2003). However, there is growing concern that antidepressants may actually have contributed to violent behavior. In 2004, the FDA issued a warning that ten antidepressants might not only deepen depression but might also cause agitation, mania and violent behavior (*The Nation*, 2004). This warning came after several cases such as that of Christopher Pittman who shot his grandparents and then burned their house to the ground three weeks after starting on Zoloft to treat his depression (*Mother Jones*, November 2004). The connection between depression, antidepressants and violent behavior continues to be under investigation. Just as with suicide, however, it is precisely the ambiguity of this connection which makes it such a serious concern. If it is at all possible that antidepressants cause someone to direct violent impulses outward toward others, the administration of psychoactive drug might actually be putting communities in serious jeopardy rather than making them safer places to be. More research needs to be done to determine whether, on balance, antidepressants solve more problems than they cause.

The grey area around suicidal ideation also poses great difficulty. No one could logically dispute that many mental illnesses, including depression, lead to suicidal ideation and behavior; clearly, the impulse to take one's own life is a serious threat to any depressed individual and medications are represented *in some instances* on the websites as being an answer to this. Zoloft.com, however, documents that while only 2% of the population are likely to experience suicidal ideation, this figure doubles to 4% for those

taking Zoloft. The vast and dangerous unknown here is the source of the suicidal ideation: Was the depressed person already suicidal and the medication is not effectively addressing these thinking patterns? Did they use their medication incorrectly or go off it prematurely, thus causing suicidal ideation? Do only those who are so depressed that they are likely to be contemplating suicide decide to take Zoloft in the first place? Or, does Zoloft cause suicidal ideation? Administering medications which simultaneously have the potential to both alleviate and cause suicidal thinking patterns in so many millions of people is a grave public health concern, and graver still because it is as yet impossible to isolate the exact cause of suicidal thinking.

5.5 POWER TO THE PATIENTS?

5.5.1 FIRST THINGS FIRST

The dominance of the medicalized perspective on depression is both reflected in and supported by the structure and order of the website material. All six sites present disease and treatment information first. Deep within the sites is information about healthy lifestyle, social support systems, the value of therapy and additional resources. However, the earliest and most accessible information is the medical discourse around depression as disease and the merit of pharmaceutical intervention. It seems reasonable to think that not every visitor to the site goes to every page, and that the pages that appear first in the system of menus and links are more likely to be accessed by more people than are those at the 'back' or 'bottom' of the websites. The prominent placement of the medical information in comparison to non-medical information demonstrates the credibility given it by the pharmaceutical industry. It is also likely that its place of

prominence would reinforce medicalization because more people would see and act upon the medical understanding of depression and treatment strategies than on the non-medical suggestions.

5.5.2 THE DOCTOR-PATIENT RELATIONSHIP

Some of the literature suggests that direct-to-consumer advertising, particularly as found on the Internet, will transform the doctor-patient relationship. Researchers argue that the social role of patients is shifting, from "passive recipients to active consumers of health information" (Anderson, 2004: 247). In a study of men with prostate cancer, Broom (2005: 342) finds that use of the Internet often provides patients "with a sense of empowerment and greater control over their disease". Empowered patients may become experts on their own conditions, causing a role-reversal wherein they provide medical information to doctors (Hardey, 2001: 338). This may result in a "demystification of medical expertise" (Broom, 2005: 319).

Other scholars, however, are more guarded in their predictions about the changes brought about in the doctor-patient relationship. Kivits (2004: 510) finds that patients "in the end continue to need the services of a medical professional to sort through the information and discern what is most valid or correct" (Kivits, 2004: 525). Patients will also require a doctor's skill in sorting through what is true medical fact and what is "commercially driven promotional information" (Wolfe, 2002: 524). Henwood, Wyatt, Hart & Smith (2003: 589) argue that the 'expert patient' "will not emerge naturally or easily within existing structures and relationships" (Henwood et al., 2003: 605). Further, constraints within the broader communities of both patients and practitioners, and

conventions regarding “space occupied by both in the medical encounter” (Henwood et al., 2003: 605) are neither easily nor quickly changed.

The physician retains legal-rational authority as the primary diagnostician in the clinical situation and retains “the exclusive right to prescribe and thus pronounce on and regulate drugs” (Zola, 1972: 493). In other words, the physician will continue to have a monopoly on these technical procedures (Zola, 1972; Collins, 1979) regardless of how much a patient knows about his or her condition. As such, the doctor will always have more authority than the patient in the clinical environment.

Doctors retain their social status (and by extension, their influence) not only because they are members of a profession which has long been accorded great prestige, but because they are seen as ‘expert’ by virtue of their extensive education. Furthermore, there is a heightened prestige attached to medical education, which “is often taken as the epitome of valid technical education” (Collins, 1979: 138). The degree of medical control is further supported by “our increasingly complex technological bureaucratic system - a system which has led us down the path of reluctant reliance on the expert” (Zola, 1972: 487).

Conrad (1976) also highlights the role of bureaucracy in the process of medicalization. Once a deviant behavior has been given a medical label – classified – it then becomes codified (Conrad, 1976:5). Through being codified, it comes to be a manifestation of the legal-rational form of authority Weber identified. After codification, institutional or bureaucratic supports arise around the medicalized conceptualization of the deviant behavior. And finally, the medicalization of a deviant behavior begins to perpetuate itself (Conrad and Schneider, 1980: 242). Conrad and Zola’s commentaries

on the connection between medicalization and bureaucratization hearken back to comments about Max Weber made in the Introduction. Though Weber writes about bureaucracy and rationality in general rather than about medicalization in particular, his remarks do help to provide an intellectual and historical context about the power and prevalence of bureaucracy, lending credence to Conrad and Zola who place such emphasis on it in their understanding of medicalization. Combining Weber's perspective on modernity with Zola and Conrad's specific commentaries on the process of medicalization lends further support to the argument that the strength of medicalization depends on the degree to which rational social structures have been created around it to support it.

5.6 FUTURE RESEARCH

Much additional research is required. First, as Seale (2005) observes, research on Internet health information has largely been about factual accuracy and quality rather than a critical examination of the material. Though personal accounts from people who suffered from depression were conspicuously absent from this dataset, there are certainly accounts of this kind in other media. There continues, for instance, to be a proliferation of mental illness memoirs, particularly by celebrities such as Anne Heche (*Call Me Crazy)* and Brooke Shields (*Down Came the Rain)* who chronicle their experiences with psychosis and post-partum depression, respectively. Research into representations of illness experience in print media has been done by people like Rowe et al (2003) who investigated the representation of depression in Australian newspapers.

Second, and as a corollary to the above, research is needed about the subjective experiences of antidepressant use. A brief Google search for side-effects brings results

which include clinical information as well as sites created by angry consumers who have been deeply troubled by the negative impact of antidepressants on their lives and bodies and wish to share their stories. An analysis of the discrepancy between these accounts and the clinical/medical information around side-effects would be very useful. Also valuable would be an investigation into how doctors handle patient complaints about antidepressants and what steps are taken in addressing these complaints.

Third, further research into the connection between reading websites and seeking medical treatment for depression in the form of medication would be informative. Is there a causal relationship between visiting an SSRI website and a trip to doctor's office? If yes, how strong is this relationship? And if the relationship between stimulus and response is not a direct one, what other factors intervene? In other words, thorough documentation of the way people process the information and how and why they act on it is needed. A comparison of the care-seeking decisions made by depressed people who consult the Internet versus depressed people who find their information in other media would also be helpful.

Fourth, an analysis of the specific way website visitors analyze and sort through risk information would be very useful. Depressed people are represented on the websites as being a risk to themselves (e.g. suicide) if they leave the disease untreated, a risk to others burdened with the task of care, at risk if incorrect decisions are made around medication, and at risk for side-effects. Weinstein (1999: 15) asks what it means to understand a risk. How do visitors to the websites process this risk information? Is there a difference in the comprehension process between visitors who are depressed and visitors going online on behalf of someone else? Weinstein (1999: 19) argues that

> to assess someone's understanding of a heath hazard is to study the constellation of beliefs that are relevant to decisions and behaviors concerning that hazard. Just as no single question can ascertain a person's understanding of the judicial system or a person's understanding of the human body, scientists much use a variety of questions and approaches to learn what people understand about a risk. A basic set of essential points would include the identity and severity of the potential harm, the likelihood of harm under various circumstances, and then possibility and difficulty of reducing that harm.

These 'essential points' should be operationalized specifically with respect to depression and studied in order to shed some light on the 'constellation of beliefs' which contributes to understanding (or not) a particular health hazard. The actions resulting from this constellation of beliefs should also be studied.

CHAPTER SIX

CONCLUSION

6.1 SUMMATIVE REMARKS

Depression is a serious problem which affects millions in North America and around the globe. Epidemiological statistics of the incidence and prevalence of depression are informative but do not present the whole picture. Qualitative inquiry adds a different dimension to the study of depression, investigating subjective illness experience as well as the representation of depression and treatment in the mass media. Of particular interest in qualitative inquiry are cultural systems of meaning, as well as the system of social relations enacted around a particular social phenomenon, such as the medicalization of "depression" as a kind of "disorder" requiring treatment through the use of antidepressants.

The popularity of antidepressants is partly due to a policy change in the United States Food and Drug Administration. After 1997, drug companies which previously had only been allowed to advertise only to physicians were permitted to market their products directly to consumers, and the phenomenon known as direct-to-consumer advertising – DTC – was born. While pharmaceutical companies advertise in a variety of media, including the newspaper and magazines as well as television, many of these companies have created websites for many of their products. The intersection of this development with the growing popularity of the Internet as a source of health information makes the study of online pharmaceutical information especially timely.

This thesis has investigated SSRI antidepressant websites. The specific purpose of the study was to answer five key questions, which concerned the portrayal of

depression, the elements of this portrayal, the target audience for the websites, assumptions made about this audience, and finally anything which was noticeably absent from the website texts. The dataset consisted of printed pages (N = 396) from SSRI websites. The medications studied were Celexa, Lexapro, Paxil, Prozac, Sarafem and Zoloft. Critical Discourse Analysis was both the analytical framework and the methodology used for this study. CDA was selected for its attention to power and for its compatibility with the primary research questions.

The portrayal of depression was explored in terms of Fairclough's 'ideation', where depression is understood as a disease entity, a disease process, and being solved through the chemical relations of treatment. The portrayal of depression was also examined vis-à-vis the representation of the depressed person's ethos, or the ways in which various aspects of the text might contribute to a private or personal understanding of the depressed self. The elements of the portrayal of depression were structural, textual and visual. Interactional controls such as order of the material and particular word choices and meanings were structural and textual elements. The visual elements, including diagrams, caricatures and photographs, were studied as metaphorical representations of a certain kind of reality. The target audience was inferred through statistics about the millions suffering from depression, which created affliction with depression as a group identity of sorts. Many assumptions seem to have been made about the audience, including that they would act on the information gleaned from the websites and begin a long-term relationship with a medical doctor. To this end, much advice and instruction was provided on the websites regarding how best to carry this out. Finally, notable absences and silences were observed. Though none of Fairclough's analytical

constructs spoke directly to this question, the answering of it revealed much about the dominance of the medical perspective on SSRI websites.

The key finding of this study is the glaring overlap between symptoms of depression and the side-effects caused by the medication. Over and again, the symptoms of depression, to which the medication would supposedly attend, reappeared as side-effects caused by use of the medication. This is a serious concern and raises some grave questions about the overall utility of the medications, particularly with respect to suicidal ideation, which is the most concerning outcropping of depression and also a side-effect of the use, misuse, or premature cessation of antidepressant medication. While it would be folly to deny the positive impact of these medications on the lives of millions, it also seems somewhat illogical to prescribe medications which are known to cause some of the very problems they purport to alleviate.

Another important finding surrounds the depiction of depressed person. This depiction is mostly very negative, with the depressed person being represented as sick with a medical problem, at risk or in danger, of reduced competence, and a burden to family and friends. Conspicuously absent are written personal accounts of the depression experience and also positive representations of people living with mental illness. This echoes the findings of Nairn and Coverdale (2005: 282) who found that of 600-item data set consisting of newspaper articles about mental illness, only 0.8% "offered readers access to thoughts, explanations and depictions provided by people living with a diagnosed mental disorder". In addition, they found a general consensus around media representations of people with mental illness, which focused on times of crisis and chronicle those with mental illness "living well" (Nairn and Coverdale, 2005: 283). A

more balanced representation of depressed people and depression in the media is certainly needed.

6.2 THE 'IRON CAGE' OF MEDICALIZATION?

Medicalization is the system of meaning which this thesis has sought to explore. When applied to depression, medicalization provides a bio-chemical explanation for depression and also advocates for the use of antidepressants as the cornerstone of any course of treatment. The medical perspective is a particularly compelling way to consider any aspect of human behavior and emotion. The profession of medicine is one of the oldest professions, and medical practitioners have long been held in high regard by the public. Because of their specialized training, and because of bureaucratic norms which give doctors a monopoly on certain activities such as diagnosis and prescription, medical professionals are seen as experts on a wide variety of physical, behavioral and emotional issues.

Medicine's bureaucratic structures and the system of industries that have sprung up around it (such as the pharmaceutical industry) are a major part of why the medical perspective has become even more influential. Recall Weber's argument about legal-rational forms of authority being one distinguishing feature of modernity. In medical forums such as the clinical environment, relationships between people are based on rationality and calculability. The websites encourage readers to address depression within existing patterns of structural relationships. Relationships are encouraged between the patients and drug companies, either via the physicians or independently, such as on the Zoloft website where patients may sign up for an information newsletter distributed

by Pfizer Inc., who manufactures the antidepressant. These relationships are based on calculability, this time with respect to profits for the drug companies.

The doctor-patient relationship is based on the calculability of human suffering and the socially-sanctioned (legal-rational) authority of the physician to provide treatment. Zola (1972) highlights the importance of bureaucracy in supporting medicalization and in structuring the relations between doctor and patient. As discussed above, there are scholars who feel that despite the increasing capacity of the patient to know about, and actively participate in decisions pertaining to, his or her condition, the relationship between patient and doctor will essentially remain the same.

There seems to be an emergent argument here regarding the 'iron cage' of medicalization. The 'iron cage' was the image Weber used to capture his sense that bureaucratization was irreversible and inevitable in the modern world and in capitalist economy (Weber, 1921 in Giddens, 1971: 235). The medicalization of depression continues to dominate despite some loopholes which have the potential to undermine it, such as the contentions by people such as Warme and Healy that there is a considerable lack of evidence surrounding the biological basis for mental illnesses, or the symptom/side-effect problem discussed above.

For a variety of reasons, including and especially the fact that medications work for many people, medicalization continues despite some of the problems with it. It is a popular epistemology to apply to illness, is firmly entrenched in society, and remains strongly supported by a series of complex institutional structures. It would seem almost impossible to change. Furthermore, given on the one hand that there are no viable contemporary structural, scientific or intellectual alternatives which might compete

effectively with it, and on the other hand that many people have been helped greatly as a result of it, perhaps it is not reasonable to desire such a change. An acceptance of the iron cage inevitability of medicalization alongside an integration of the clinical perspective on human suffering with other paradigms such as naturopathy and homeopathy might be a more appropriate and more feasible goal to work towards.

APPENDIX A

INDICIES OF FAIRLCOUGH'S ANALYTICAL ELEMENTS

HOW IS DEPRESSION PORTRAYED?

1. Language – disease ideation (entity, process, relations)

Key Words – disorder, symptom, illness, disease, diagnose, condition, chemistry, chemical imbalance, serotonin, nerve call, neurotransmitters, SSRIs, medication

2. Ethos – the private depressed self

Key Words – you/your (representing the depressed person to his or herself), individual, "depression is"

WHAT ARE THE ELEMENTS USED IN THIS PORTRAYAL?

1. Structure – Interactional Controls

a) order – general ordering of the material

b) menus, links and headings

c) repetition – same content or same pages occurring more than once within the website

d) circularity – links or headings on different pages leading back to a page already visited previously

2. Text – Word Choice and Meaning

Key Question – What words appear most often and consistently within each site and across the whole dataset?

Answer – disorder, illness, symptom, side-effect, doctor

3. Visual Elements (Metaphor)

a) diagrams – brain chemistry, what the medication does, etc.

b) caricatures or sketches

c) photographs

WHO IS THE TARGET AUDIENCE?

1. Language – group identity

Key Indicators – statistics about the millions suffering from depression and/or seeking treatment

WHAT ASSUMPTIONS ARE MADE ABOUT THIS AUDIENCE?

Key Questions – What language are the sites written in? Do they specify an American or North American audience? How accessible is the text e.g. is it medical jargon or written in easier language which most lay people can understand? What is said about costs of treatment, insurance coverage, etc? Is one or other gender singled out? What is said about social relationships e.g. family, friends, community, medical people, etc?

WHAT IS MISSING FROM OR SILENT IN THE WEBSITES?

APPENDIX B

SSRIs AND THE SEROTONIN THEORY OF DEPRESSION

THE SEROTONIN THEORY

Page #Z13: "Studies show that serotonin plays a vital role in how our body works. It controls sleep, appetite, temperature, and blood vessel tone. It's also in charge of the release of certain hormones and how much pain we feel.
Because it is linked with so many functions in our body, serotonin has an effect on a wide range of conditions such as depression.
This tie between depression and serotonin led scientists to an interesting find. Scientists believe people with depression could have an imbalance of serotonin in their brain. That means that the level of serotonin is "off". So the nerve cells can't communicate, or send messages to each other the right way. This lack of contact between cells might cause depression".

Page #Z115: "No one knows for sure what causes PMDD. But there is a natural substance in the body called serotonin (*sair-uh-toe-nin).* The symptoms of PMDD may occur when serotonin is out of balance. In PMDD, this imbalance may be related to monthly changes in hormones".

Page #P81: "While PMDD is not fully understood, many doctors believe it may be caused by an imbalance of a chemical in the body called serotonin. They normal cyclical changes in female hormones may interact with serotonin and other chemicals, and the changes may result in the mood and physical symptoms of PMDD".

Page #CL84: "Although the brain chemistry of depression is not fully understood, there does exist a growing body of evidence to support the view that people with depression have an imbalance of the brain's neurotransmitters. These are chemicals in the brain that allow nerve cells to communicate. One of these neurotransmitters is serotonin. An imbalance in serotonin may be an important factor in the development of depression".

SSRIs AND SEROTONIN

Page #CL54: "SSRIs affect how much serotonin is available by blocking its reabsorption during transmission from one nerve cell in the brain to another. Serotonin is released from one nerve cell and passed to the next. In this process, some of the serotonin released is reabsorbed by the first nerve cell. SSRIs block the reabsorption of serotonin into the first nerve cell. It is this blocking action that causes an increased amount of serotonin to become available at the next nerve cell. This is how SSRIs affect the balance of serotonin in the brain.

Page # P81: “Sarafem is an FDA-approved prescription treatment that relieves both the mood and physical symptoms of PMDD (Premenstrual Dysphoric Disorder). Many physicians believe that Sarafem helps to correct the imbalance of serotonin that could contribute to PMDD.

Page #Z13: “Zoloft helps fix this. Zoloft helps the nerve cells send message to each other the way they normally should. Watch the animation of how Zoloft works to correct this imbalance of serotonin levels in the brain”.

Page #Z115: “Zoloft of a medicine known as a Selective Serotonin Reuptake Inhibitor (SSIR). How Zoloft works for PMDD is not clear, but it may help to balance serotonin in the body. And that may help you find relief from PMDD”.

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