AMBIGUITY, TEMPORALITY, AND AGENCY IN ONLINE HEALTH COMMUNITIES FOR DYSTHYMIA

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AMBIGUITY, TEMPORALITY, AND AGENCY IN ONLINE HEALTH COMMUNITIES FOR DYSTHYMIA

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 Within the heterogeneous amalgam that constitutes "depression" exists dysthymia—a chronic, mild subtype that is rarely the sole focus of public discussion or academic research on the subject of depression. If depression in general is an experientially and linguistically ambiguous phenomenon, as is often claimed, then dysthymia can be considered especially ambiguous given that its chronic, low-grade symptoms are difficult to distinguish from one's habitual self. Informed by Kenneth Burke's views on the rhetorical productivity of ambiguity, this dissertation provides a rhetorical account of dysthymia's ambiguity. It traces a rhetorical history of the conditions that led to dysthymia's construction as a strategically ambiguous diagnostic entity in the *DSM-III*, as well as the conditions that led to dysthymia's replacement with "Persistent Depressive Disorder" in the *DSM-5*. In addition to providing historical context, this dissertation rhetorically analyzes interactions in online health communities for dysthymia, identifying the ways in which dysthymia's ambiguity functions as a rhetorical resource. Despite conventional wisdom suggesting that recent biopsychiatric explanations of depression have fully displaced previous psychoanalytic explanations, Chapter 2 of this dissertation observes that explanatory aspects of both paradigms blend together in dysthymia online health communities, which provides a useful strategy for negotiating matters of agency. Focusing on temporality, Chapter 3 argues that the temporal perspectives present in online accounts of dysthymia are marked by temporal expansion rather than the temporal contraction often seen in accounts of chronic physical illness. In contrast to temporal contraction, which is thought to often bolster an

individual's felt sense of agency in the present, this chapter argues that temporal expansion may tend to attenuate one's felt sense of agency in the present. Chapter 4 explores online health community members' widespread dissatisfaction with the label of dysthymia, most of which centers upon the disorder's designation as "mild." This chapter describes the rhetorical conundrum occasioned by being diagnosed with a "mild" or "high-functioning" mood disorder, and identifies the strategies used to challenge the aptness of "mild" as a descriptor for the subjective experience of dysthymia.

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1.0   INTRODUCTION

Much has been said on the subject of how difficult it is to describe depression at the level of subjective experience. This difficulty, however, appears to fuel rather than foreclose attempts at description—one could take as evidence the surge of depression memoirs that began in the 1990s and shows no signs of abating. Depression memoirists, in what could be seen as a performative contradiction of sorts, routinely preface their memoirs with an acknowledgement that our language is not up to task of adequately capturing and conveying the subjective experience of depression. For example, William Styron (1990), an American author whose memoir is among the most widely cited within the genre, explains that, "Depression is a disorder of mood, so mysteriously painful and elusive in the way it becomes known to the self—to the mediating intellect—as to verge close to being *beyond description*" (p. 7, emphasis added).

The difficulty of linguistically rendering depression pervades not only at the level of subjective experience, but also at the level of formal definition. Unlike narrators of depression, however, nosologists of depression—those who formalize the categories found within the pages of the *Diagnostic and Statistic Manual of Mental Disorders*—do not, as a matter of convention, acknowledge the difficulty of their task. Part of this difficulty stems from the simple fact that, throughout the history of psychiatry and across cultures, disagreement abounds as to which diagnostic criteria should be considered constitutive of depression. Furthermore, as phenomenologist Matthew Ratcliffe (2015) suggests, our formal definitions of depression house

within their blurry boundaries an impressively diverse range of human experience, which in turn, "exacerbates the problem of communicating and understanding experiences of depression" (p. 3). Given this, Ratcliffe sees it as no surprise that, within psychiatry, "there is considerable disagreement institutionally over what depression is, where its boundaries lie, and what its subtypes are" (p 3). In a similar vein, sociologist Ilpo Helén (2007) finds that the trouble with defining depression has to do partly with the "blurred boundaries between sorrow, dejection, and depressive illness" (p. 150). The blurriness of these boundaries lead her to conclude that depression is "not an entity but an amalgam, characterized by ambiguity and contestation" (p. 150).

Within the ambiguous, heterogeneous amalgam that constitutes "depression" exists an exceedingly ambiguous subtype that is rarely the sole focus of public discussion or academic research on depression: so-called chronic mild depression, a disorder that went by the formal name of "Dysthymia" from the publication of the *DSM-III* in 1980 up until the publication of the *DSM-5* in 2013, at which point it was relabeled "Persistent Depressive Disorder."[1] If depression in general is said to be an experientially and linguistically ambiguous phenomenon, this is arguably especially true of dysthymia, a diagnostic entity perched near the hazy border that separates "normality" from major affective disorders (Akiskal, 2001). A glance at the diagnostic criteria, copied below from the *DSM-5* entry, does little to clarify matters.

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[1] I mostly use the *DSM-IV* term "dysthymia" throughout this dissertation, for reasons I describe later in the subsection of the chapter titled "the problem of nosological instability."

Persistent Depressive Disorder (Dysthymia)

Diagnostic Criteria

300.4 (F34.1)

This disorder represents a consolidation of DSM-IV-defined chronic major depressive disorder and dysthymic disorder.

A. Depressed mood for most of the day, for more days than not, as indicated by either subjective account or observation by others, for at least 2 years.

Note: In children and adolescents, mood can be irritable and duration must be at least 1 year.

B. Presence, while depressed, of two (or more) of the following:

1.   Poor appetite or overeating.
2.   Insomnia or hypersomnia.
3.   Low energy or fatigue.
4.   Low self-esteem.
5.   Poor concentration or difficulty making decisions.
6.   Feelings of hopelessness.

C.   During the 2-year period (1 year for children or adolescents) of the disturbance, the individual has never been without the symptoms in Criteria A and B for more than 2 months at a time.

 What can be gleaned from the formal diagnostic criteria? The primary criterion, A, appears

more or less tautological: chronic depression is defined by chronically depressed mood.

Furthermore, there is a temporal vagueness embedded in this criterion: the "depressed mood"

that characterizes the disorder is one that lasts for "most of the day," and occurs "more days than

not" over the course of a two-year period. In short, one could argue that there is terminological ambiguity baked into this definition, and many mental health practitioners themselves would not object. Paul Fink (2010), a psychotherapist and professor of psychiatry, states that, "Dysthymic disorder is one of those diagnoses in the *DSM-IV* that seems to be *characterized by ambiguity*" (p. 14, emphasis added).

While terminological ambiguity might seem likely to confound or hinder communication, the work of rhetorical theorist Kenneth Burke has emphasized that areas of ambiguity are particularly fruitful sites of inquiry for rhetoricians. These areas of ambiguity, Burke (1945) suggests, often function as "zones of transformation" wherein that which was once considered X (in this case, non-pathological mood states) comes to be understood as Y (symptoms of a clinical depression subtype). At a time when more and more people are flocking to the so-called "online couch" of Internet-based mental health information, one could regard *online health communities* for dysthymia as possible zones of transformation, or spaces in which the ambiguity of dysthymia gives rise to new understandings of one's moods, one's mental health status, one's sense of self.

"Ambiguity, Temporality, and Agency in Online Health Communities for Dysthymia" seeks to provide a rhetorical account of dysthymia's ambiguity. It does so in two ways. First, it traces a rhetorically-inflected history of dysthymia as a diagnostic entity, contextualizing the conditions that led to its birth in the *DSM-III*, and exploring the conditions that preceded its death in the *DSM-5*. This history is woven together with a rhetorical analysis of interactions that unfolded in three dysthymia online health communities between the years of 2004 and 2014. Before describing the theoretical contexts and methodological approaches that inform this dissertation, I frame the central problem of dysthymia's ambiguity, drawing on fictional

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representations of chronic depression from television and literature. After doing so, I situate dysthymia's ambiguity within the context of contemporary digital media, using insights from philosophy of science and rhetoric of medicine.

1.1   WALTER WHITE, THE DEPRESSION PERSON, AND TWO SENSES OF 'INTERACTIVITY'

The television series *Breaking Bad* follows a man recently diagnosed with cancer, Walter White, as he transforms from a mild-mannered if slightly morose high school chemistry teacher into a prominent, violence-prone methamphetamine manufacturer. The show's popularity surged as it reached its finale in 2013, and in the years since, cast and crew members have often been asked by interviewers to comment on the psychology of the show's main character. In several of these interviews, Bryan Cranston, the actor who plays Walter White, was asked to identify the emotional "core" of his character and his character's underlying motivations for entering a high-risk world of violence and criminality. Cranston's answer came as a surprise to some. Describing the difficulty of locating his character's emotional and motivational core, he said, "First looking for it, I had the hardest time finding where Walter lived. Then in a conversation at dinner once, someone was talking about depression once, and I went, 'Whoa, that's where it is.'…Over the years, his entire adult life, he would just gloss over it, keep pushing it down." Cranston remarked that, "Once I caught onto that, it informed everything" (Moaba, 2013). In a subsequent interview, Cranston stated that, had Walter White simply been prescribed an antidepressant, "it would have been a short series" (Tannenbaum, 2013).

In Cranston's formulation, and in many accounts of depression circulating within both professional literature and public discourse, the problem of depression—in all its subtypes but particularly as its relates to its "mild" subtype, dysthymia—is framed as one of *recognition* and *acknowledgement*. The undergirding logic often seems to be that if people will simply stop "pushing depression down" or "glossing it over," then they can pursue intervention and begin the process of reorienting their minds, their bodies, their lives. But framing the problem as one of mere acknowledgement or recognition obscures the complex communicative work that may often be involved in acquiring the label of "depression," especially when that depression looks like, for instance, Walter White's. Walter goes to work everyday. On the whole, he appears to have good relationships with family members. He does not appear to struggle with eating or sleeping. Those closest to him would likely describe his everyday mood states and behaviors as "stable." Given all this, it is likely that, had Walter White been diagnosed, it would have been with dysthymia rather than Major Depressive Disorder, since the symptoms of the latter are thought to impede functionality in more obvious and outwardly observable ways. In short, Walter White's "depression" is not recognizable to himself or those around him as depression.

Mental health professionals writing on the topic of dysthymia often formulate the problem of dysthymia similarly to Cranston; that is, they frame it as a problem of recognizing what is already there. David Hellerstein, a professor of psychiatry at Columbia University, claims that, "Part of the problem is that many people mistake the symptoms for their personality. They may assume that they're just pessimistic or self-conscious or moody. After struggling for so many years, people come to view the fog of depression as their normal functioning" (Tartakovsky, 2016). One might be tempted to ask, what differentiates a "pessimistic or self-conscious or moody" person and a "dysthymic" person? How do some people come to

experience themselves as one kind or another, given that there is no blood test or brain scan that

can distinguish pessimism, self-consciousness, or moodiness from dysthymia (and also given

that pessimism, self-consciousness or moodiness are common experiential states)? David Foster

Wallace—whose authorial legacy includes his own depression—wrote a short story titled simply,

"The Depressed Person," (1997) that can perhaps shed light.

"The Depressed Person" is both the title of and name assigned to the main character in

Wallace's darkly humorous short story. He never gives his protagonist a first or last name, and

that is perhaps because depression appears to be such a central part not only of who she

understands herself to be, but also what she *does*. And it is the doing of her depression that

Wallace meticulously details throughout the story. The Depressed Person, like Walter White,

appears chronically unhappy, but is able to hold down a job despite it, and maintains

relationships with others. That, however, is where the similarities end.

The Depressed Person goes three days a week to a psychotherapist who prescribes

several drugs to treat the depression, and specializes in an empathic, nonjudgmental form of

therapy. In addition to prescribing a regimen of antidepressants, the therapist provides the

Depressed Person with a particular vocabulary for relating to herself and others; for example, the

Depressed Person's half-dozen closest friends become known as her "Support System." Since

they are geographically scattered, the Depressed Person contacts at least one member of the

"Support System" nightly via telephone. Since she is unable to describe the experience of

depression itself, she settles for expressing its context, or as Wallace puts it, "the circumstances,

both past and ongoing, which were somehow related to the pain, to its etiology and cause" (p.

57). The recollection and description of contextual factors related to depression lend structure

and stability to the Depressed Persons depression narrative, a practice that is supported by writing in her therapist-endorsed "Feelings Journal."

In short, one could say that it takes a lot of work—in concert with others—for the Depressed Person to experience herself as a chronically depressed person. In Wallace's formulation, depression is not something that one merely "has" in the same way that one has books on a bookshelf or cups in a cupboard. Within the story, one can identify the following five ingredients for psychological self-invention that Nikolas Rose describes in his 1996 book, *Inventing Ourselves: Psychology, Power, and Personhood*: 1) a "pastoral technology" in the form of the empathic, confessional patient-therapist relationship; 2) an "authority" in the form of the American Board of Psychiatry and Neurology, which has licensed the therapist; 3) "devices of meaning production" in the form of the vocabulary used between the patient and therapist (e.g. "Support System" and "Feelings Journal"); 4) "self-steering mechanisms," which are practices done independently but under the care of therapist, including the nightly ritual of telephoning at least one member of the Support System; and 5) "intellectual techniques" in the form of writing in the "Feelings Journal," which aids in the construction of depression autobiography. Importantly, there also economic resources involved: the therapy sessions cost $90 an hour, and frequent long distance phone calls are not inexpensive.

Clearly not every depressed person spends as much time probing her pain as the Depressed Person does, and clearly Wallace has exaggerated her characteristics for the purpose of social critique. But the story gets at something not often considered when it comes to depression: experiences of it are very much produced and mediated and rhetoricized; they are not

neutral, stable or inevitable.[2] One reason that people do not simply "have" depression is because

depression is an *interactive* classification.

The question of whether mental disorders are "real" or simply "social constructs" has

been, and continues to be, a source of energetic debate.[3] The question, at root, seems to be: do

mental disorder categories represent organic, discrete, invariant disease entities, or, do they

represent the products of socially coordinated activity, and little or nothing more? Philosopher of

science Ian Hacking has provided fresh terms for thinking through this sort of question. As a

replacement for the "real vs. socially constructed" binary that has framed so much debate about

the ontology of mental illness, he proposes a new binary: "indifferent vs. interactive."[4] It is

important to note that these terms apply to types of *classifications* (not types of people or

objects). Indifferent classifications are those that attach to entities that cannot become aware of

their classification, and are thus unable to alter their attributes or behaviors in accordance with

knowing the details of their classification. Hacking gives the example of plutonium: it is a

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[2] In a classic 1953 article, Becoming a Marihuana User, Howard S. Becker explains how something as seemingly straight-forward as first-time marijuana usage is a not a neutral or inevitable experience; it is mediated through experienced users, as well as their knowledge and techniques. He argues that first-time users have to be taught how to smoke in a way that produces effects, to recognize those effects, and to interpret those effects as pleasurable.

[3] The perspective that mental disorders represent "real" disease entities is sometimes referred to as the "medical naturalism" position. This position follows Emil Kraepelin, whose theories on mental disorder are largely credited with ushering in biopsychiatry. He argued that mental disorders represent disease entities every bit as organic and invariant as physical disease entities. The social constructionist account of mental illness is sometimes associated with the poststructural movement and its prominent theorists, Foucault and Derrida, the former of which argued (briefly put) that mental disorders are not the result of organic disease entities, but rather, the social activity of mental health practitioners.

[4] Hacking explains that claims about the "social constructedness of X" are, to him, unhelpful and imprecise. Most of these claims are intended to destabilize our notions of X as natural or inevitable (gender and race often come up as examples) and to demonstrate how contingent X actually is. But, according to Hacking, these claims do not always stipulate that what is socially constructed are the ideas about X (e.g. the *ideas about* gender and race) rather than X itself (the material existence of gendered and raced bodies). There is a difference between the social constructedness of things, and the social constructedness of classification regimes, and the meanings that get attached to these classifications. The rub, though, is that ideas about X can materially affect X and it is this rub that Hacking is trying to get at when he introduces his distinction between interactive and indifferent classifications.

human-created substance (and is potentially lethal) but it is wholly unaware of its classification and so it does not change in response to knowing how it has been classified. It is, in Hacking's terms, completely indifferent to its classification.[5]

Unlike plutonium, Attention Deficit Hyperactivity Disorder (ADHD) is an *interactive* kind of classification. With ADHD, there is, in Hacking's view, the possibility of an *interaction* between the classification of ADHD and those who are classified as having ADHD. Hacking explains how this interaction may occur, stating that, "Perhaps children diagnosed with ADHD are different from the children once called "fidgety"—in part because of theories held about them, and remedies put in place around their bad habits. Conversely, it may be that the resulting changes in the children have contributed to the evolution of ideas about problem children. This is an example of interaction"[6] (p. 102). Hacking's point is that, ultimately, an awareness of being classified in a certain way—such as, for example, "depressed,"—can change the way that people living under that label experience and orient themselves. Taken collectively, these changes at the level of individual experience can, in turn, initiate changes at the level of the classification

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[5] Some have proposed (like Mary Douglas, for instance) that interactive and indifferent kinds might exist as a continuum rather than a binary, an argument that Hacking appears to reject. Douglas (1986) gives the example of microbes. They adapt their behavior in response to our actions, becoming resistant to antibiotics and so on. But Hacking contends that they do not change their behaviors as a consequence of knowing how they've been classified. They are unaware of their classification. For him, they are an indifferent kind.

[6] Hacking also tackles "harder" psychiatric classifications, such as schizophrenia, "mental retardation," and autism in which those classified have "communication problems" and are perceived as being less aware or unaware of how they are classified and thus, ostensibly do not interact with how they are classified. Hacking rejects this, saying that, in the example of autistic children, "Part of the answer is that they are in their own ways conscious, reflective…" and he goes on to further clarify that "…I do not mean only the self-conscious reaction of a single individual to how she is classified. I mean the consequences of being so classified for the whole class of individuals and other people with whom they are intimately connected" (1999, p.115).

itself—what Hacking calls a "looping effect."[7] Looping effects are one reason why psychiatric

classifications are so unstable as compared to the classifications found within other scientific

taxonomies: the objects of psychiatric classification are "moving targets."

Hacking's concept of interactivity helps bypass the well-trodden debate about the

ontological reality of mental disorder. It also weakens the implication that mental disorder

classifications are *unidirectional*—that is, constructed by experts and applied to passive

recipients—an implication that Hacking finds lurking in many social constructionist framings of

mental illness. These unidirectional social constructionist accounts often involve the claim that

mental disorders are "invented" by some group of people with powerful interests, and are then

foisted onto another group that more or less passively absorbs them.

Depression, in all its subtypes, would be an example of an interactive classification:

people who are labeled "depressed" can become aware of being labeled as such, and this

awareness can lead to changes at the level of one's subjective experience. If enough people alter

their behaviors in accordance with the knowledge that they are labeled "depressed," it may lead

to alterations at the level of the classification itself. Depression has become "interactive" in

another sense of the term as well, one that by all indications is increasingly important to attend

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[7] The looping effect refers not only to changes in behavior; it can refer to changes in biology, too. Hacking provides an example of this "biolooping" using the classification of depression: "A person undertakes a certain regimen of behavioral modification, intended to diminish the symptoms and feelings of depression. Numerous kinds of behavior are reinforced, all of which run counter to the classification *depressed*. The patient starts to live in this new way. If the behavior modification works, then even our psychiatric understanding of depression changes. Yet simultaneously, by living in this way, adopting certain types of behavior, a certain chemical condition of the brain, thought to be correlated with depression, is alleviated. We have a dynamic working at the level of classification and at the level of biolooping," (p. 1999, p. 123).

to: the digital media by which people increasingly gather, share, and subsequently shape public knowledge about depression.[8]

According to the widely cited 2012 Pew Internet Project Research Report, health-related information seeking is among the most popular online activities, nearly on par with online shopping or news readings. In this survey, 72 per cent of U.S. Internet users said that they have searched for information to identify a medical condition that they or someone else might have, and 18 per cent say the have gone online to find others who share their health concerns or conditions.[9] Interestingly, the shortcoming that Hacking finds in social constructionist talk about mental disorder classifications—namely, the presumption of *unidirectionality*—is one that likewise plagues contemporary discourses about online health practices, at least according to rhetorician of medicine Judy Segal.

There are at least two ways of theorizing online health practices in terms of how these practices shape the subjectivities of users, according to Segal (2009). She calls them the "standard view" and the "rhetorical view," respectively. According to her, the "standard view", informs the majority of scholarly research across disciplines and public discourse on the subject of online health practices. In this view, both health information and the people seeking are conceptualized as *stable* entities: both retain their shape throughout and after the health-

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[8] Len Manovich (2001) argues that all media are technically interactive. But here, I'm using the term "interactive" in the ways that it tends to be deployed in public discourse—to refer to digital technologies. For instance, the Wikipedia page for "interactive media" says that, "Interactive media normally refers to products and services on digital computer based systems which respond to the user's actions by presenting content such as text, graphics, animation, video, audio, games, etc." See: http://en.wikipedia.org/wiki/Interactive_media.

[9] Kivits (2006) suggests that there are two factors fueling the surge in online health practices. First, people are increasingly aware that their medical care providers are time-crunched in an era of commercialized health care. Second, people are interested in receiving and discussing "everyday" health information, as opposed to the technically-oriented health information one might expect to receive in a medical care context.

information seeking transaction. The only caveat to this is that, in some accounts, there is the

implication or direct assertion that the health-information seeker comes away from the

transaction better informed, and thus "empowered." Within this view, according to Segal, there

tends to be a general equation of *information* with *empowerment*. The consumer who accesses

the information needed to make medical decisions is empowered by the information, and is able

to make informed decisions for themselves and/or others. When the health-information seekers

are not empowered by the transaction, it has to do with the accuracy of the information: as long

as the information is accurate, the consumer is empowered. Thus, the web-empowered consumer

becomes so through the acquisition of information and the ability to discern accurate from

inaccurate sources. In short, this process is conceptualized as a *unidirectional* one, according to

Segal, in which "the Web informs the patient, well or badly…" (p. 359). According to Segal, this

"standard view" leaves several important considerations unattended.

Segal encourages researches to adopt a "rhetorical view" of the relationship(s) among

web users, health information, and the Internet. A good first step she suggests, would involve

paying proportionate attention to each of the three sides of the "rhetorical triangle," which

consists of source, subject matter, and audience. The "standard" view tends to focus on the

nature of the *source*—is it accurate, inaccurate, or somewhere between? It typically leaves the

other two sides of the triangle—subject matter and audience—unattended. Turning attention

toward the other elements of the rhetorical triangle reframes the process of health information

seeking from a *unidirectional* process to a *bidirectional* process, in which "the Web makes the

user and the user makes the Web too" (p. 359). The Web makes the user "by immersing her in

information" that "casts an unimaginably wide net, and, at the same time, it may interrogate the

user directly with diagnostic checklists and hail her (that very person) as a patient" (p. 359).[10]

The user also acts back on the Web, sometimes actively—for example, posting a comment to an online health community which becomes part of another person's information seeking—and sometimes passively, as search engines typically organize information on the basis of which links are most frequently clicked.

If we were to adopt the sort of rhetorical view of Internet health information that Judy Segal encourages, we would see that it is not entirely obvious how to configure the rhetorical triangle as it pertains to the topic of this dissertation. First, there is uncertainty in terms of defining the subject matter: dysthymia. This uncertainty pervades on multiple fronts. First: what to call it? Should it go by the name *dysthymia* (the *DSM-IV* term), *chronic mild depression* (the colloquial, descriptive term that pops up in professional and public discourses alike), or *Persistent Depressive Disorder* (the *DSM-5* term)? (Later in this chapter, I describe my reasons for using the first term, which mostly boil down to the fact that this is the term around which the online health communities studied here are organized.) Second: what *is* dysthymia, and where does the mild, chronic depression that characterizes it begin and "normal unhappiness" end? This is an ambiguity with which clinicians, nosologists, and people in online health communities all grapple. In terms of the "source" or "speaker," should we assume that this role is inhabited by those who post in online health communities, or is that role more aptly assigned to the online health communities themselves, and/or the platforms that house them? Given that these online

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[10] Perhaps controversially, a key part of Segal's argument is that, taking account of the *conte*xt in which people search for online health information (including, for example, the user's location, state of mind, time of day, etc.) might lead to the conclusion that the Web remakes the user in ways that do not render her a particularly good judge of information. In short, this context—which she imagines often involves a user who is isolated, perhaps in the middle of the night, searching for information about a problem that is uncertain in origin—creates opportunities for anxiety. As evidence for this position, she cites research pertaining to the phenomenon termed "cyberchondria," which is defined by White and Horvitz (2009) as the exacerbation of health worries based on online searches for common symptoms.

health communities are organized around a *DSM* category, and given Hacking's views on the interactive nature of psychiatric classifications, could the "source" also be considered the American Psychological Association itself? Lastly, who should be considered the "audience": active members of the online health communities, or anyone who reads the publically viewable posts archived within these communities?

Although in this case (and probably in most cases), there are multiple ways to plausibly configure the elements of the rhetorical triangle, it seems reasonable to suggest that the following elements of the rhetorical triangle are present in the context of online health communities for dysthymia: 1) an inherently unstable subject matter (the classification of dysthymia changes from one edition of the *DSM* to the next); 2) an inherently unstable "audience" (the label of dysthymia, as Hacking suggests, changes the way that those so-labeled experience themselves; and as Segal suggests, the Web remakes the user); and 3) primarily text-based communication media—online health communities—that are prone to flux (given that users continually remake these online spaces, both passively and actively).

1.2   THEORETICAL AND TERMINOLOGICAL CONTEXT

1.2.1   Why Health is More Than Health

What are people *doing* when they talk about their health, physical or mental? This simple but enduring question lies at the heart of a number of overlapping fields of research in both the social sciences and humanities. Health communication, narrative medicine, the sociology of health and

illness, medical anthropology, and the rhetoric of medicine all have an interest in tackling this basic question. A thread of insight connecting these divergent fields is the shared understanding that when people talk about health, they are rarely talking *only* about health.

Despite its simplicity and import, the question of what people are doing when they talk about health and illness has only fairly recently become a focus of the fields of scholarship mentioned above. In the 1970s and 1980s, psychiatrist and medical anthropologist Arthur Kleinman (1986) helped popularize this research agenda through his work on the concept of "health beliefs." In his anthropological work, he observed that different individuals and groups often have starkly differing views about health and illness. Research into "health beliefs" was considered a first step toward treating health-talk as more than mere information transfer (Franken, 2001). This research tried to identify how people define health, how they describe experiences of illness (a focus that would go on to become its own field of scholarship, narrative medicine), the sorts of differences that exist between "expert" and "lay" accounts of health and illness, how people think about avoiding disease, and how all of these different definitions, descriptions, and beliefs about health and illness differ across populations (Radley & Billig, 2001).

While early research into the questions above has advanced a number of research agendas, one noted shortcoming is that the "health beliefs" model has tended to imply that health beliefs are fairly durable, and that they are individually constituted. The shift away from "beliefs" and toward "accounts" or "narratives" marks an interest in treating individuals' ways of thinking and talking about health as fluid, as subject to continual revision as one's life circumstances changes. In addition, this shift toward "accounts" or "narratives" has a decidedly more intersubjective flavor than the health beliefs model. As Radley and Billig (2001) state,

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health accounts "articulate a person's situation in the world, and indeed articulate that world, in which the individual will be held accountable to others (p. 222). Thus, they make that case that when one talks about one's illness, they are accounting for oneself in relation to others.

Research into health accounts and narratives has generally attempted to underscore that no particular institution, domain, or discipline can claim to set the parameters of health talk—not clinicians, not medical researchers, not the Centers for Disease Control or World Health Organization. This is because, as sociologist Robert Crawford (2004; 2006) has argued, "health" has become a key metaphor in a health-conscious era, a metaphor that is embedded with layers of meaning that stand outside the realm of "health" per se (specifically, Crawford argues that health-talk is laden with moralism, and is a prime vehicle for advancing neoliberal logics). As he puts it, "[M]edical practice has never been able to contain the irrepressible proliferation of meanings associated with health…health is metaphorical, absorbing and express a range of meanings throughout culture" (p. 405). Crawford's argument frames health-talk in ways that bear similarity to the rhetorical concept of "condensation symbols." That is, health-talk could be considered a series of symbolic practices that have a high degree of "connectivity" to a range of other, seemingly far-flung symbols in the culture; condensation symbols condense and express those meanings, the interpretation of which varies based upon the context and audience (Kaufer & Carley, 1993).

Health-talk, then, might be considered a somewhat peculiar form of discourse: it is densely packed with cultural meanings, yet, at the same time, "health" itself is often represented as largely politically neutral or nonideological. This makes health, in Metzl's (2010) words, a "desirable state" as well as a "prescribed state" and an "ideological position." What makes health-talk such a power vehicle for values is how adept it is at concealing its moral and

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ideological baggage. And yet, if one looks closely, one can identify some of the moral and ideological baggage lurking below the seemingly neutral, amoral surface. We can see this baggage, according to Metzl,

> "every time we see someone smoking and reflexively say, 'smoking is bad for your health' when what we really mean is, 'you are a bad person because you smoke.' Or when we encounter someone whose body size we deem excessive and reflexively say, 'obesity is bad for your health,' when what we mean is not that this person might have some medical problem, but that they are lazy and weak of will…or when we see a woman bottle-feeding an infant and reflexively say, "breastfeeding is better for that child's health," when what we really mean is that the woman must be a bad parent." (p. 2).

Health-talk, in this view, tends to gloss over the moral and ideological assumptions embedded within it. One reason that health-talk tends to come freighted with moral and ideological baggage may be because, as Erving Goffman's work on stigma has suggested, the recognition of "health" depends upon the construction and recognition of "unhealthy" others. Following Goffman's insights, Crawford (2006) posits that health has come to operate as a central "dividing practice" in Western societies, given that it quietly produces and reinforces stratification between those considered well, and those considered unwell.[11]

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[11] Crawford (2006) describes the logic of health-based divisions as such: "Identity is a system of multiply layered differences that superimposes one ascribed quality upon another: I am who I am because I am healthy/I am healthy because of who I am; you are who you are because you are unhealthy/you are unhealthy because of who you are." (p. 414). He goes on to point out that, "The proximity of sick friends and family members confound these strategies, and sympathy for the sick softens the judgment that people deserve the diseases they get. Nonetheless, the sick remain useful for positioning (as far as possible from the self) the abstracted qualities of disease (visual representations, risk categories, etiologies) and the imagined qualities of Otherness." (p. 414).

As will become clear in the chapters that follow, the theoretical context of this dissertation is informed by several of the interdisciplinary insights articulated above. For one, this dissertation assumes that communication about dysthymia expresses a range of meanings outside of "depression" per se. These meanings include, for example, notions of temporality, which are addressed in Chapter 3, as well as conceptions of normality, as explored in Chapter 4. In addition, this dissertation also assumes that the meanings of dysthymia are not constructed exclusively by the American Psychological Association, clinicians, researchers, mental health practitioners, or other "expert" voices. Just as "health" is not defined exclusively by "medicine," mental health is not defined exclusively—perhaps not even primarily—by the assemblage of experts and practices that Nikolas Rose (1998) collectively refers to as the "psy" disciplines.[12] This is partly because these particular disciplines, he suggests, operate according to a principle of "generosity" that appears somewhat anomalous when contrasted against other professional bodies of knowledge. This principle of generosity is evidenced by the degree to which 'psy' has been, in Rose's words, "happy, indeed eager, to 'give itself away'—to lend its vocabularies, explanations, and types of judgment to other professional groups and to implant them within its

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[12] Rose (1998) describes his use of the term 'psy' throughout his work as follows: "Collectively I refer to the ways of thinking and acting brought into existence by these disciplines since the last half of the nineteenth century as 'psy' not because they form a monolithic or coherent bloc—quite the reverse—but because they have brought into existence a variety of new ways in which human beings have come to understand themselves and do things to themselves (p. 2).

clients" (p. 2-3). In doing so, 'psy' has been quite successful in establishing what Kelly (2014) calls a "common language"—a set of discourses with a high degree of cultural portability.[13]

1.2.2   The Problem of Nosological Instability

Writing this dissertation presented several linguistic dilemmas, thanks in part to the instability of psychiatric nosology. The first and most pressing dilemma was what to call the disorder that lies at the heart of this dissertation: the disorder's *DSM-IV* term, "Dysthymia", or the revised *DSM-5* term, Persistent Depressive Disorder (PDD)? There was also a third option: using the somewhat colloquial term, "chronic mild depression." Though this third term never appeared in the *DSM*, it seems to be used almost interchangeably with the *DSM* terms in consumer literature and public discourse. "Chronic mild depression" has the benefit of being a descriptive, non-jargonistic term, and because of this, also has the benefit of possible durability; that is, this informal label is likely to remain in public usage even as the formal diagnostic terms shift.

The choice, ultimately, was to use the term "dysthymia," primarily because it is the term around which the online health communities analyzed here initially organized, and, importantly, it is the term around which they *continue to organize* despite the existence of the new *DSM-5* category PDD. It seems inevitable that in the future online health communities organized around the PDD label will emerge, but at the time this dissertation was drafted, none existed. The

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[13] Kelly (2014) explains that, "While professional practices delimit speaker competence of the 'common language' to professional discourse communities, the social values interlinked with the discourse features promote circulation of the language across a range of social occasions such that many cultural members recognize, and, in some cases, are able to describe and mimic the feature of the language variety. As a result, the community of speakers expands; the 'common language' is taken up by speakers outside the psychiatric discourse community." Kelly goes on to quote from a *The New Yorker* journalist (Spiegel, 2005) who states that the paradigm-shifting *DSM-III* (the construction of which is a focus of Chapter 1 of this dissertation), "not only revolutionized the practice of psychiatry but gave people all over the United States a new language with which to interpret their daily experiences and tame the anarchy of their emotional lives (p. 56, as quoted by Kelly, [2014], p. 175).

continued activity of online health communities for "dysthymia" (rather than PDD) reveals an incongruity between the professional discourses of psychiatry as codified in the *DSM*, and public discourses pertaining to psychiatry. This incongruity lends credence to Charland's (2004) suggestion that, "Psychiatric labels may no longer solely under the control of psychiatry" in no small part because, "the Internet provides a medium where iatrogenic labels can be kept alive by consumers even though they have been psychiatrically abolished by the medical establishment" (p. 38-39). Interestingly, while researching this dissertation I found indications that mental health practitioners also seem to participate in keeping the *DSM-IV* term dysthymia alive. While reading through discussion threads in these communities, I encountered a number of posts in which the author reported receiving a fresh diagnosis of dysthymia as recently as 2015, a full two years after the *DSM-5* term, PDD, replaced dysthymia.

The discrepancy between *DSM-5* terminology and the language of preexisting online health communities at first seemed a potential obstacle to researching this dissertation. However, this discrepancy eventually grew into an area of inquiry in its own right, partially forming the subject of the Chapter 4. During my analysis, I was intrigued to discover that a recurring topic of discussion in online health communities was frustration with the label of dysthymia and the characterization of the disorder as "mild" when compared to Major Depressive Disorder (MDD). Some even claim to have been misdiagnosed on the grounds that their experience could not possibly square with the descriptors of "mild" or "less severe." (It was interesting, then, to note how the *DSM-5* diagnosis, PDD, merges chronic cases of MDD [previously considered a categorical anomaly, since MDD, along with all other affective disorders, are defined as episodic] with preexisting cases of dysthymia. Several participants in the online health communities studied here noted that PDD's aggregation of chronic MDD with dysthymia might

serve to eliminate a perceived "depression hierarchy," in which the suffering associated with

MDD is thought to exceed the suffering associated with dysthymia.

The second terminological dilemma this dissertation presented was how to refer to people

diagnosed with dysthymia (whether informally self-diagnosed or formally diagnosed by a

practitioner). Certain ways of referring to these people, it seemed to me, implied a reification or

unqualified acceptance of the psychiatric labels themselves. As Ratcliffe (2015) suggests, it may

be "naïve and dogmatic to assume the legitimacy of a diagnostic category from the outset" and to

"accept that a distinctive kind of experience is uniquely associated with it" (p. 3). The terms

"dysthymic," "dysthymia sufferer," and even the people-first term, "people with dysthymia" all

have the potential to suggest an unqualified acceptance of the epistemological legitimacy of the

diagnosis. While I did not want to lend credence to reductionist biomedical-realist accounts of

dysthymia, I also did not want to fall into the trap that Schaffner and Tabb (2015) term

"taxonomic nihilism"—a perspective on mental disorder that explicitly rejects the possibility of

any organic/physiological contribution to psychiatric symptoms, and which has been criticized as

a contemporary instantiation of mind-body dualism.

While attempting to skirt both biomedical reductionism and taxonomic nihilism, I found

that my orientation to mental disorder might be described as a soft form of social

constructionism, sometimes called "critical realism" (Pilgrim & Bentall, 1999) which would hold

that psychiatric diagnostic categories are subject to flux on the basis of social, political, and

economic realities. This does not imply that psychiatric symptoms have no possible organic

component; this is a position that simply reiterates the symbolic interactionist axiom that that all

objects, situations, and events acquire their meanings through processes of interpretation

(Blumer, 1969). These meanings do not inhere within the objects, situations, and events themselves.

After grappling with these linguistic considerations, I landed on two primary terms that I use throughout the dissertation to refer to people in these online health communities, depending on the context provided in their posts: "people diagnosed with dysthymia," and "people who identify with the label of dysthymia," or, alternately, "people considering the label of dysthymia." These terms have been chosen to foreground the communicative action involved in understanding oneself via psychiatric terminology.

1.2.3   Contextualizing Online Health Communities as Sites of Practice

This dissertation approaches online health communities as *sites of practice*. In the context of ethnographic studies, the "practice" approach aims at providing richly detailed explanations of how social groups cohere and maintain their coherence. While "community" is a word that tends to imply warmth or tight linkages, the "practice" approach defines any grouping with shared engagement in a project as a community of practice. According to Nancy Baym (2000), one of the pioneers of online community research, "a community's structures are instantiated and recreated in habitual and recurrent ways of acting or *practices* (p. 23, original italics). While an online community may include a formal description about its purpose and guidelines for engagement, it is only through an examination of the community's actual everyday practices that one gains insight into the community (Giles & Newbold, 2013).

Since engagement in online communities is often characterized by "disembodiment" (to the extent that users are not typically visible to one another), language practices have been a central focus in practice-oriented studies of online communities. As Baym puts it, "language

practices are microcosms of the communities in which they are used" (2000, p. 23). A focus on language practices within online health communities can give insight into a community's general belief structures, its shared values, and its subjects of tension or conflict. In short, the language activities of a community have much to reveal about the community as a whole.[14] Baym quotes literary theorist Bakhtin (1981) to argue for the importance of attending to the linguistic choices of online community members: "All words have a 'taste' of a profession, genre, a tendency, a party, a particular work, a particular person, a generation, an age group, a day and hour. Each word tastes of the context and contexts in which it has lived its socially charged life; all words and forms are populated by intentions. Contextual overtones (generic, tendentious, individualistic) are inevitable in the word" (p. 293).

This dissertation approaches online health communities for dysthymia as sites of practice within the sense of the term described above; that is, it approaches them as communities constituted through their patterned ways of speaking, acting, and sense making. This last component—sense making—is a particularly complex and important practice in online health communities for dysthymia. As Karp (1994) explains, "Chronic emotional illness poses especially difficult problems for sense-making because the source of the problem is unclear and the course is uncertain" (p. 26). Further complicating matters is the fact that many users of online health communities for dysthymia are not (yet) formally diagnosed. For some users in these online health communities, they must grapple with the fact that dysthymia itself is an unclear

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[14] According to ethnographic researcher Kathy Charmaz (2006), researchers are well served by approaching language activities as somewhat *dilemmatic*; the less problematic language use seems to the researcher, the more difficult it will be to uncover insights with which to build theory. For example, she suggests identifying and examining "in vivo codes" ("in vivo" is a Latin term that translates as "within-the-living")—special phrases that are used seemingly unproblematically by speakers and are sometimes wellsprings of insight. She gives the example of "making a comeback"—a phrase used widely and seemingly unproblematically by chronic illness sufferers. She argues that this phrase actually condenses and diffuses significant meanings about health and illness shared by many of the chronically ill.

diagnostic entity, and that it is likewise unclear whether they could be aptly described as (and diagnosed as) "dysthymic."

To confront these uncertainties, one practice that many not-yet formally diagnosed users engage in involves the construction of lengthy self-introductory posts in which they articulate their lived circumstances and wonder aloud whether (or, in some cases, confidently assert that) the label of dysthymia "fits" their experience. These introductory posts can be considered one of the sorts of communicative practices through which online health communities cohere—a patterned way of acting. These introductory posts could also be considered "practice" in another sense of the word: an early attempt at practicing the inhabitation of a particular illness identity. As Strauss (1959) explains, inhabiting an illness identity entails a transformation of sorts. As he puts it, "In transformation of identities a person becomes something other than he or she was" (p. 92). For the not-yet formally diagnosed, these introductory posts might present a means for "practicing" this new identity, a sort of warm-up rhetorical performance in front of disembodied community members that one engages in before "performing" this new identity in other social contexts that might include one's friends, family members, or health care practitioners.

1.3   SITUATION IN SCHOLARSHIP

1.3.1   Rhetoric of Medicine

That there is a rhetorical component present in scientific discourse is now a less bold claim than it once was. According to Segal (2009), it was the gradual acceptance of this claim that eventually paved the way for scholars of rhetoric to begin exploring the relationship between

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rhetoric and medicine. Early work within the field of rhetoric of science focused largely on rhetoric *within* science. For example, common objects of inquiry for early rhetoricians of science included texts produced by scientists or within scientific establishments; the metaphors, narratives, and genres therein were especially common foci. One early example of this sort of work came from Charles Bazerman (1988), who set out to explore and identify the rhetorical conventions that typify the genre of the scientific research report.

Later, the field broadened its focus beyond rhetoric *within* science to include the rhetorical relationship *between* scientific and public discourses. In a widely cited example of such work, Jeanne Fahnestock (1998) explored how scientific information undergoes a sort of rhetorical transformation as it travels from technical contexts (e.g. the research report) to popular contexts (e.g. the popular science article). This transformation, she argued, entails a shift from a forensic (investigative) framing to an epideictic (celebratory) framing, with important caveats and qualifications tending to slip away in the process.

In general, rhetorical scholarship on the relationship between scientific and public discourses emphasizes less that there are rhetorical components present in scientific activity, and focuses more on how those rhetorical components themselves can, at times, be generative of scientific knowledge. In her work on a genre of scientific monographs that she calls "inspirational interdisciplinary monographs," Leah Ceccarelli's (2001) argues that some scientist-authors (namely Dobzhansky and Schrödinger) have employed rhetorical strategies that are at least partly responsible for fostering novel collaborations between rival scientific fields

that were not previously on speaking terms.[15] In a similar vein, Deirdre McCloskey (1998) has

argued that when economists fail to acknowledge the rhetoricity of their field, the actual

scientific quality of their work has a tendency to suffer.

Work within the rhetoric of science subfield paved the way for rhetoric of medicine, and

rhetoric of medicine scholars have taken many of the above interests as a starting point. Their

foci have followed a similar trajectory to rhetoric of science scholarship, starting with official

biomedical texts (i.e. rhetoric *within* medicine), and later branching outward to include the texts

and practices of publics, and relationships *between* medicine and public discourses. For example,

Martha Solomon (1985) performed a Burkean rhetorical analysis based on published medical

reports of the Tuskegee syphilis experiments, aiming to identify what role the authors' rhetorical

choices may have played in obscuring the study's obvious ethical issues, and allowing the study

to continue without objection.[16] Several decades later, Lisa Keränen (2007) studied how "patient

preferences worksheets"—documents that ask patients and their caregivers to specify which

technical interventions they would like to receive or decline in the context of end-of-life care—

operate as a rhetorical boundary objects, ostensibly inducing cooperation among competing

social worlds, including the vernacular world of patients, the technical world of doctors, and the

institutional world of administrators (though Keränen finds that, ultimately, the worksheet

mostly serves the purposes of the latter party).

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[15] Ceccarelli (2001) points to Dobzhanky's 1937 *Genetics and the Origin of Species*, which played a role in catalyzing the field of evolutionary biology and Schrödinger's 1944 *What is Life*, which played a role in forming molecular biology. She also explores Edward O. Wilson's attempt to form a field of sociobiology with his 1998 text *Consilience*, and explores why this attempt largely fell flat.

[16] Solomon (1985) concluded that the medical reports alternately framed the study's black male participants as the "scene" upon which disease played out, as well as the "agency" by which the study's authors sought new knowledge. Taken together, this framing dehumanized the men in the study, and in turn "emphasized the discontinuities between them and the physicians reading the journals" (p. 233).

Rhetoric of medicine scholars are particularly interested in rhetorically-charged interactions between patients and their physicians at a time when medical authority is said to be in flux. Judy Segal (2005), considered a pioneer of the field, has explored the rhetorical predicament of hypochondria: the hypochondriac patient cannot persuade her physician that she is ill, and the physician cannot persuade the patients that she is well. More recently, "neuro-talk" has become an especially common object of attention, with Jordyn Jack even suggesting that a new subfield—"neurorhetorics'—be created in order to explore how the proliferation of neuroscientific discourses is reshaping public policy, as well as fundamental understandings of what it means to be human.

In a recent special issue of the *Journal of Medical Humanities*, Lisa Keränen (2014) opined that, "[I]n an era punctuated by persistent calls for "public participation," "patient participation," or "user involvement" in biomedical and health processes, we need to assess the multiple ways that publics already interface with biomedical and health knowledge formation, contestation, decision making, and practices" (103). In doing so, she suggests, rhetoric of medicine and medical humanities scholars can get a stronger grasp on the ways in which publics shape the contours of health and medical practices.

Rhetoric of medicine scholarship has touched on the subject of depression. Our understandings of what depression is and what it is like to be depressed are formed primarily through the language we use to describe and diagnose it. For that reason, it is said to be a diagnostic phenomenon fully saturated by language (Emmons, 2010). It is not surprising, then, that scholars of rhetoric and communication have explored how depression is discursively rendered and rhetoricized by patients, experts, and publics. Katherine Pryal (2010), for example, has performed a rhetorical analysis, supported by insights from disability studies, an

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autobiographical genre that she terms the "mood memoir." In doing so, she collected and analyzed memoirs from several prominent public figures with Major Depressive Disorder to identify the rhetorical conventions employed therein, arguing that these conventions increased opportunities for the rhetorical participation of a population (those with mental disorders) that has historically been excluded from public forms of rhetorical engagement. In doing so, she echoes rhetorician Carolyn Miller's (1984) claim that genre itself can constitute a form of social action.

Like Pryal's genre analysis mentioned above, Jenell Johnson's (2010) study of depression texts is informed by a blend of rhetorical theory and disability theory. Johnson analyzed the proliferation of texts—interview transcripts, press conference coverage, and news publications—that cropped up in the wake of a political controversy known as the "Eagleton Affair." At the center of the controversy was 1972 Vice Presidential candidate Terry Eagleton, who was asked to leave the McGovern Presidential campaign after it surfaced that he had been hospitalized more than once for Major Depressive Disorder. Through a rhetorical analysis of these texts, Jenell argues that stigma attaches to those with mental disorders in ways that produce an invisible but rhetorically disabling effect she calls "kakoethos" or bad character.

Rhetorical explorations of depression discourse are often critical of psychiatric knowledge, and seem to be operating from the sort of antipsychiatry position articulated by Thomas Szaz. Szaz—himself a psychiatrist with a psychoanalytic bent—is the author of a well-known book, *The Myth of Mental Illness* (1961). A central argument in this book is that "mental" is ultimately a metaphor for the physical brain, and metaphors are not reflective of reality. (This is not just a rhetorical claim; it is also an ontological one.) As a metaphor, he argues, the

linguistic packaging of "mental" illness relieves diagnosticians of the need to provide evidence of physical corroboration for their diagnoses.

Operating from an arguably Szazian perspective, rhetorician Richard Vatz (2006) examined the rhetorical dynamics of Doug Duncan's gubernatorial campaign in Maryland. Duncan had been performing well in the polls, and appeared a viable candidate, but dropped out of the race unexpectedly due to a diagnosis of depression. Because it was framed in the language of mental disorder, Vatz argues, there was no public pushback, and no one questioned the possible ulterior motives for the suspension of his campaign. From Vatz's perspective, this was problematic because it is evidence that the public has uncritically incorporated psychiatric logics and vocabularies, with the consequence of infantilizing and de-responsibilizing subjects. In his view, problematic choices or behaviors fall beyond scrutiny when accounted for with the logic and language of mental disorder.

While Vatz is concerned that psychiatric rhetoric de-responsibilizes subjects, additional rhetorical scholarship on depression manifests the opposite concern: that the discourses of depression responsibilize subjects in accordance with neoliberal modes of governance. As one would imagine, this work draws heavily on Foucauldian insights on the productive nature of power. This scholarship is marked by concern for the ways in which depression functions as a gendered and gendering disorder, producing docile female bodies that eagerly and responsibly engage in self-governance. For example, Nicole Hurt (2007) rhetorically analyzed news-media coverage on the subject of depression, arguing that it tends to position women's bodies as volatile and naturally inferior to men's by, for example, continually emphasizing the "protective effect" of testosterone against depression. While this may be true, she argues that the continual

emphasis on the role of the hormonal supplants consideration of the social, economic, and political factors that may contribute to women's disproportionate unhappiness.

Kimberly Emmons' (2010) critical rhetorical analysis of a broad corpus of depression texts from 1995-2005 (including news stories, depression-oriented websites, direct-to-consumer ads, etc.) reaches a conclusion similar to Hurt's: the dominant discourses of depression coheres into patterns that construct the sufferer as female. She argues that the language used to describe symptoms—for example, "excessive weepiness"—primes the public to think of depression as a femininely-coded illness. Like Pryal (2010), Emmons attends to the social functions of genres, in particular the genre of the "self-diagnostic quiz" for depression. She argues that these quizzes encourage a form of self-monitoring that she calls "self-doctoring"—a practice that entails interpreting one's experience through the terms made available by Western biopsychiatry. Self-doctoring, in her view, "orchestrates the submission of the self to medical and chemical interventions" (p. 159). In place of self-doctoring, she offers the alternative of "rhetorical self-care," which she sees as a rhetorical practice that involves a dialogic interaction between the patient and the discourses of medicine. Self-care involves the patient becoming something of a rhetorical critic of medical discourses, which Emmons believes will open patients' rhetorical choices and allow them to construct a more complex identity in relation to the categories of health and illness.

Ann Cvetkovich (2012), a professor of English and Women's and Gender Studies, has written a book on the subject of depression that resonates with the work of rhetorical critics mentioned above. Though her work is informed by affect theory rather than rhetorical theory, her argument echoes the shape of arguments produced by Emmons (2010) and Hurt (2007). Her book is part cultural critique and part memoir, and is intended to counter what she considers to

be a wave of "mainstream" depression memoirs that uncritically accept the terminology and logic of Western biomedicine, and, in her view ultimately endorse pharmaceutical intervention. She opens her book with an *apologia* (incidentally, a generic convention that Pryal [2010] identified in her analysis of "mood memoirs") in which she discloses her motivations for writing a scholarly text about depression in the first-person. She states, "This is my version of a Prozac memoir, bad connotations included. But I want to write it precisely because I don't believe in Prozac. No, I think it's a scam…discussions about the biochemical causes of depression might be plausible, but I find them trivial…A drug that masks the symptoms of a response to a fucked-up world or fucked-up life doesn't tell me anything" (p. 15). She goes on to interrogate the linkages between political realities and affective responses to those realities, concluding, similarly to Hurt (2007) and Emmons (2010), that, by framing depression as a medical disease we fail to account for the ways in which social and cultural conditions cultivate the bad "public feelings" we call depression. Her advice for depressed people is not to accept the neurochemical narrative of depression's etiology, but to "keep moving" and "help people"—advice that, to some, "smacks of moralizing" (Zambreno, 2013).

1.3.2   Sociology of Health and Illness and Medical Anthropology

Sociologists of health and illness share many guiding assumptions and interests with rhetoricians of medicine. Sociologists of health and illness assume that "health" is not an objectively definable or measurable property like, for instance, height. The same holds true for "madness" or

"mental illness," as Foucault famously argued.[17] Rather, sociologists take "health" and its corresponding category of "illness" to be a historically, culturally, and geographically shifting package of symbols, metaphors, and practices. Sociologists of health and illness are particularly interested in the ways that health and illness are socially defined and enacted across space and time, and how these definitions and enactments are carried out through concrete practices and processes. For this reason, sociologists often attend more to institutional practices than do rhetoricians, whose tendency is to focus more on discursive practices.

Because of this abiding interest in concrete practices, sociologists of health and illness often conduct their research within the actual physical settings that house the objects/discourses/practices that interest them. Anselm Strauss, who pioneered research with Juliet Corbin (1988) on the practices by which chronic physical illnesses are managed, developed an adaptable approach called "grounded theory," which has been influential within the field. This approach, in Baszanger's (1998) words, acknowledges that "people's processes for defining situations…precede the researcher's entry into the field" and thus, "the researcher must work in the actual environments in which the actions occur, in 'natural' situations, to analytically relate participants' perspectives to the environments through which they emerge" (p. 354). This approach also emphasizes the importance of facilitating emergence by not predetermining research questions or the modes of analysis in advance and by remaining interpretively flexible throughout the research process.

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[17] Foucault's work has always been difficult to place, and the question of whether his books belong on the shelves that house philosophy, sociology, or literary criticism texts has no firm answer. The case could be made, however, that his hugely influential tomes *Madness and Civilization* (1964) and the *Birth of the Clinic* (1963) belong alongside other prominent texts within the sociology of health and illness. In *Madness and Civilization*, Foucault shows how there is no single, stable thing known as "madness"—just different ways of defining/confining the "mad" across time and space. In the latter, he famously coined the phrase "the medical gaze," which he considered a new way of constructing an organizing knowledge about the body in the context of research medicine.

Peter Conrad has arguably become one of the field's most prominent sociologists of health and illness. His critique of "the medicalization of society" (2005) argues that many of the realms and activities of everyday life that used to be thought of as "normal" or "expected" or perhaps even "natural" (all loaded terms, of course), are increasingly being folded into the jurisdiction of medicine. While sociologist Eliot Freidson (1970) identified medicine as one of the most autonomous professions, Conrad says that the medicalization of society should not be solely, or even primarily, attributed to the activities of medical practitioners. Instead, advancements in biotechnology, the broader push toward the commercialization of healthcare, and the desires of "consumers" themselves must be accounted for as prime contributors to medicalization processes.

Emily Martin (2007) and Annemarie Mol (2002) work within an adjacent field, medical anthropology. Their work has provided "praxiographically" thick descriptions of two subjects of interest: the cultural meanings of bipolar disorder, and the clinical management of atherosclerosis, respectively. Martin's work shows that, as bipolar diagnoses have skyrocketed, public attention has tended to focus on the disorder's depressive episodes, but not its manic episodes. This might make sense, she thinks, considering that depression is related to unproductivity and mania to productivity; thus, she reads the cultural symbols that attach to bipolar disorder within the context of an advanced capitalist society that has a vested interest in maintaining the economic productivity of its members. Meanwhile, based on her research of the practices by which atherosclerosis is diagnosed and managed, Mol argues that there no single thing callled "atherosclerosis." Rather, there are multiple ontologies of atherosclerosis that come into being based on the ways that the disease is "enacted" across different sites of practice.

Atherosclerosis, she suggests, is one thing in the physician's office, another in the surgical ward, and another still in the laboratory.

Like atherosclerosis, depression has also been defined as multiple in both ontological and epistemological terms. Focusing on diagnosis and treatment of depression in Finnish medical practice, sociologist Ilpo Helén (2007) contends that treatment of depression is complicated by the fact that depression is a "multiple object." She states that, "Depression as a mental disorder is a composite of parallel but divergent facts and definitions due to the dispersion of professional and public settings where mental health is discussed and taken care of" (p. 150). Ilka Kangas (2001) also a sociologist, echoes Helén's (2007) formulation of depression as multiple, stating that, "Whereas the etiology and causes of depression are contested and complex within the field of disciplines, the lay explanations, perceptions, and theories likewise express this multiplicity and reflection" (p. 89). In a similar vein, anthropologist Joseph Dumit (2003) has argued that even the most "objective" components of depression—specifically, visual images of brain scans suggestive of depression—leave space for a multiplicity of interpretations. He concludes that there is far more flexibility to negotiate so-called "received-facts" (such as brain scans interpreted by clinicians) about the "objective-self" (the material brain and body) than one might think, stating that, "Even in the face of received-facts about ourselves such as brain images, there is room for negotiation and redefinition" (p. 44).

Renata Kokanovic et al. (2013) explore the multiplicity of ways in which primary care patients diagnosed with depression redefine and negotiate the meanings of their diagnosed illness. Given the shift toward patient-centeredness—an approach to medical care that emphasizes heterogeneity—Kokanovic et al. argue that understanding the divergent ways in which people think and talk through depression is a particularly salient aim. They identify three

ways in which primary care patients think and talk about depression: through explanatory models, through explanatory maps, and through illness narratives. Patients using explanatory models tend to utilize a single-cause logic that identifies "chemical imbalances" as the underlying etiology of depression.[18] Patients using explanatory maps tend to convey uncertainty about the cause(s) of depression, often discussing multiple possible causes at once, going from one to the next in a meandering fashion. Patients using illness narratives situate their illness within the context of their social and personal life circumstances. Patients in primary care settings, the authors conclude, frequently blend elements of all three together in an effort to contextualize their depression diagnoses.

1.3.3 Narrative Medicine

Narrative medicine is an interdisciplinary field in which one finds the work of sociologists of health and illness, such as Arthur Frank, medical anthropologists, such as Arthur Kleinman, and rhetoricians of medicine, such as Judy Segal. Narrative medicine is a field built on the recognition that narratives are, in Kenneth Burke's (1941) words, "equipment for living" (p. 293). We live *with* stories and *through* them, these authors suggest. They serve as both "a mode of reasoning and a mode of representation" (Richardson, 1990, p. 132). As a mode of reasoning, narratives help make sense of the complex and fluid relationship between ourselves and the world around us. As a mode of representation, we use narratives to relay our understandings to others. This field frequently acknowledges that narratives have a strong rhetorical element: we

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[18] The authors explain that "models" for conceptualizing illness have largely fallen out of favor in sociology, given that they are static, tend to emphasize singular causes, and convey health beliefs as fixed rather than flexible.

use them to persuade ourselves of the kind of people we are, and we use them to relay this understanding to others in a fashion that (we hope) they will find persuasive. Walter Fisher (1984) argues that narratives are just as persuasive as a strong logical argument, if not more so, a claim which pushes back against some social scientific views of humans as rational decision makers. This does not imply that all narratives are persuasive, of course; some will lack what Fisher calls "narrative fidelity" and, as a result, will fail to "ring true" to an audience.

The field of narrative medicine gained strong momentum in the 1990s, thanks in no small part to the efforts of bioethicists and physicians who believe that narrative competence is a crucial component of quality doctoring. The prominence of patient narratives has been considered a means for rebalancing the quantitative impulses of Western biomedicine with an impulse that is more humanistic (Keränen, 2014). Physician Rita Charon (2006), for example, argues that doctors must learn to listen to patients' narratives as intently as they listen to descriptions of their symptoms; doing so, she suggests, would increase the quality of medical care that physicians are able to deliver to their patients. Taking patient narratives seriously does not only increase the quality of medical care, as scholars within the field suggest. For many, it can also serve a therapeutic function; Arthur Kleinman (1988) and Arthur Frank (1996) have both claimed that an emphasis on these narratives place patients back into the narrative centers of their own experiences.

At a time when patient narratives are increasingly celebrated for their medical and therapeutic functions, it is important to note that patients do not fashion their narratives of illness out of thin air; they draw on dominant narrative frameworks. Frank (1995) typologizes three such frameworks in his widely cited book, *The Wounded Storyteller*. The first framework houses what he calls "restitution narratives," which tend to detail the author's journey from illness back

to health, ultimately emphasizing the *restorability* of health. The second framework comprises what Frank terms "quest narratives," which are similar to restitution narratives, but tend to emphasize the changes one undergoes in the face of suffering (insights gained, skins thickened, appreciation for life enhanced, etc.) rather than the restorability of health. The third and final framework includes what Frank labels "chaos narratives." These are the rarest narrative form, according to Frank. Chaos narratives are devoid of typical narrative structure and coherence; they signal pain and confusion, and are often uncomfortable for audiences, who sometimes subtly nudge the speaker to reformulate their story within one of the other two frameworks.

An appreciation for patient narratives might well help to humanize medical practice, but they are not a panacea, so cautions Judy Segal (2005). She notes the way that mainstream narratives of breast cancer (sometimes referred to as "pathographies") serve a particular epideictic function, as they consistently celebrate and reaffirm certain cultural values. Commonly reaffirmed values in these particular narratives include unrelenting optimism, good humor, and courage in the midst of struggle—sometimes, she notes, the embraced value seems to be that of struggle itself. Not only do illness narratives serve an epideictic function, Segal argues, so too does the wide-scale embrace of illness narratives in and of itself. The continually reaffirmed value is that of narrative coherence, she argues, and this might not always be empowering for patients or conducive to quality medial care. When patients feel enjoined to construct a coherent story of their illness, Segal notes, they may feel constrained from understanding their illness in other, non-narrative ways. In addition, she worries about the extent to which the championing of personal narratives of illness is potentially depoliticizing, given that their focus is on individual experiences of illness rather than, for example, structural causes of illness.

1.4   METHODS

Online health communities are characterized by a blend of stability and fluidity, and the methods that this dissertation uses to analyze interactions in these communities are blended as well. The stability of online communities stems from the fact that they house what is essentially an archive of messages: one can typically search specific topics, authors, or messages posted, both from the recent and distant past. In this sense, the context for interaction is shaped prior to a new user's entrance: whether creating a new thread or responding to an existing one, the user cannot simply repeat or ignore what already been said (Segal, 2009). The fluidity of these communities stem from the fact that, each time a new post appears, the context for interaction is reshaped going forward, becoming part of what the next incoming user finds.

This dissertation utilizes generative rhetorical criticism, coupled with methodological insights from grounded theory approaches to interpretive textual analysis. Because this dissertation regards online health interactions as instances of persuasive discourse—with the power to shape and reshape the perspectives of those who post and encounter them—generative rhetorical criticism was chosen with the hopes of providing an account of the persuasive element present in these texts. The volume of textual data analyzed here motivated the choice of grounded theory as a methodological complement, since grounded theory offers a systematic method for working through text, line-by-line. These two methods furnish the researcher with flexible sets of methodological principles rather than firm procedural prescriptions, and are well suited to one another because both "focus on words, phrases, and sentences as units of analysis" (Gardner, 2011, p. 292).

Generative rhetorical criticism is an adaptable approach that does not begin with a pre-formed question or unit of analysis. Rather, it begins with encountering a "curious" text or

collection of texts that intrigue the critic, though at this point the critic is likely unable to articulate precisely what it is about the text that intrigues them. The critic then engages in "broad-brush coding" that involves observing and recording the major features of the artifact(s); "major" features are those that appear with the greatest frequency or strongest intensity (Foss, 2004). After observing these so-called major features, the critic develops a coding process (for instance, grouping similar-seeming things together into categories) that will aid in the process of interpretation. Ideally, this coding process ends up being quite generative in and of itself: by organizing and naming categories in a particular way, the critic gains insight into the persuasive function(s) of the texts at hand.

In addition to generative rhetorical criticism, this dissertation derives methodological insights from grounded theory approaches to interpretive textual analysis. Like generative rhetorical criticism, grounded theory aims at facilitating emergence throughout the research process. Researchers do not impose rigid preexisting questions or theoretical structures on the data they study; instead they work through their data inductively, "coding" for recurring thematic concepts, gathering new data as needed, and refining thematic codes as appropriate. During this process, the research question or problem is continually refined, with the ultimate aim of developing an original theory that richly contextualizes the social phenomenon at hand.

Though both grounded theorists and generative rhetorical critics try not to form inflexible questions or preconceived notions about their data, they do not approach their data empty-handed. They inevitably bring their own ways of seeing with them, including their "guiding interests, sensitizing concepts, and disciplinary perspectives" (Charmaz, 2006, p. 30). Kenneth Burke (1966) might have collectively termed these interests, concepts, and perspectives a "terministic screen," which he defines as a sort of grid of intelligibility that is, "composed of

terms through which humans perceive the world, and that directs attention away from some interpretations and toward others" (p. 45). Ideally, a terministic screen functions more as a point of departure than a strict line of demarcation in the context of interpretive analysis. Furthermore, neither grounded theorists nor generative rhetorical critics imply that the analysis process somehow makes the meaning of texts "transparent"; they are enjoined to view these meanings as situated. Thus, both methods stress that theorists/critics are obliged to be reflexive about what they see, and how they see it.

1.4.1 Data Collection

The data analyzed in this dissertation consist of *extant* texts. Unlike elicited texts, the researcher plays no role in the construction of extant texts. Researchers examine extant texts "as data to address their research questions although these texts were produced for other—often very different—purposes" (Charmaz, 2006, p. 6). Researchers sometimes prefer to work with extant texts because collecting these texts is less obtrusive when compared to elicited texts. This is especially true of extant *Internet-based* texts, which are easily accessible and unobtrusively gathered. While extant Internet-based texts have the advantage of accessibility, they bring them methodological and ethical concerns that are as-of-yet unsettled in qualitative Internet research scholarship.

The methodological concerns regarding the study of extant Internet-based texts have to do primarily with questions of contexts, or, more specifically, the common lack of context. Whereas researchers working with elicited texts typically have in-depth knowledge of their participants' social identities (age, socioeconomic status, racial and ethnic background, gender, geographic location, and so on), Internet-based texts generally come with this social information, and even when it is provided or implied, the researcher has no foolproof way of ascertaining its

accuracy. For a rhetorical critic, the fact that these posts typically appear without social information (age, geography, gender, racial background, etc.) arguably contributes to the rhetoricity of the posts themselves. Put another way, the "disembodied" nature of these posts need not be considered a detriment to the study, but could be regarded instead as an aspect of the posts' rhetorical character. In fact, it is possible that the lack of socially identifying information actually *increases* the identifiability of such posts because readers may be able to "see themselves" in other users' descriptions of experience regardless of whether their social identities match up similarly to the author's.

In addition to methodological concerns, there are also ethical concerns regarding the use of extant Internet-based texts in academic research. Several concepts are key to understanding the debate about the use of these texts in academic research. The first concept is that of a "human subject"—a term that has a long history in discussions of research ethics, and which originated in *medical* research contexts, not humanities or social science research contexts. As scholars writing on behalf of the Association of Internet Researchers (AoIR) point out, the term has frequently "been criticized for being ill-suited to models of inquiry that follow non-biomedical procedures for interacting with people or don't interact directly with people at all, for example, studying published texts" (Markham & Buchanan, 2012, p. 6). When researchers analyze pre-existing, publically viewable discourse online, it could be argued that they are interacting with "data" or "discourse" but not with "human subjects" per se.

The second relevant concept in the world of Internet-based research ethics has to do with the distinction between public and private, a distinction that becomes particularly germane when researchers work with "open-access" texts, as I do in this dissertation. ("Open-access" typically refers to content that is not password protected.) While it has long been legally permissible for

researchers to observe others' "public behavior" without announcing their presence as researchers, questions continue to be raised about whether it is ethically permissible to do so in Internet-based contexts. In a 2013 document outlining recommendations for best research practices, the US Secretary Advisory Committee on Human Research Protections (SACHRP) explains that researchers' observations of "public behavior" have long been excluded from regulatory oversight of any kind, which raises the question of what counts as "public behavior" in Internet-based contexts. The SACHRP explains that "public behavior" should exclude any behavior that a person reasonably expects not to be observed or recorded; they suggest that posting in an open-access forum counts as public behavior, especially because archived posts are ipso facto recorded. Overall, the general consensus is that open, non-password protected forums are public spaces and should be contextualized as such in the context of academic research (Gronning, 2015).

Despite the fact that observation of public behavior is excluded from institutional oversight, researchers using open-access Internet-based texts are obliged to engage with the third relevant concept, which is "harm." It is generally accepted that researchers have the obligation not to engage in research that poses substantial harm to others, and that they ought to do what they can to minimize the possibility of harm. Gronning (2015) explains that competing obligations are often at play when conceptualizing harm in academic research. On the one hand, the researcher has an ethical obligation not to engage in research activity that is likely to cause harm to subjects. On the other hand, the researcher has a social and institutional obligation to produce strong research that advances knowledge. Given these competing obligations, some researchers using publically available Internet texts take the precautionary step of announcing their presence in discussion forums or other online spaces. Others go even further and seek

informed consent from discussion forum participants when it is feasible to do so. Such approaches seek to minimize harm by erring on the side of transparency. However, the "transparency" approach is not without possible harm: as Gronning (2015) explains, a researcher's announcement of presence and purpose can induce anxiety and disrupt ongoing social norms in the online contexts they seek to study. Thus, a researcher has to assess the likelihood and magnitude of harm caused by announcing one's presence, as well as the likelihood and magnitude of harm caused by not announcing one's presence.

The decision about whether or not to announce one's presence and/or seek informed consent is ultimately contextual and depends upon consideration of a number of factors including the online community's general perceptions of privacy, its stated rules for engagement, and the researcher's aims (Eysenbach & Till, 2001; Garcia et al., 2009; Giles & Newbold, 2011). It can be difficult to ascertain whether a community thinks of its activity as unfolding in a "private room" or a "public space," but a few factors suggest that the community might think of itself more as a "private room": the requirement of registration/membership to view content, a very limited number of members, and codified group norms that signal an expectation of privacy (Eysenbach & Till, 2001). Some sites' terms of use specifically state that researchers are not welcome to lurk. The online communities selected for inclusion in this dissertation exhibited none of these cues. However, one community, PsychForums.com, stated in its terms of service that all content on the site should be considered in the same regard as Letters to the Editor, for which the newspaper owns the copyright.

Furthermore, Giles and Newbold (2011) suggest that the decision of whether to announce one's presence and/or seek informed consent should be based, to some extent, on the aims of the researcher. If the researcher is invested in advocating for a particular group, and thus intends to

speak "on behalf" of this group in some way, then the researcher may feel more obliged to announce her presence. If the researcher's aim is to merely make broad observations about discursive trends, then the ethical concerns associated with not announcing one's presence may be less prominent when weighed against the methodological concerns associated with announcing one's presence, including, most pressingly, the potential disruption of the group's ongoing communicative practices.

This dissertation analyzed preexisting open-access Internet texts (in this case, non-password protected posts in publically viewable online health communities), a research activity understood to be exempt from institutional oversight. However, I could have opted to announce my presence or seek informed consent, which I debated doing. In the end, I did not announce my presence as a researcher, and I did not seek informed consent. This decision had to do mostly with the infeasibility of tracking down the authors of the analyzed posts. At the time of data collection, I set my temporal boundaries to include posts from a ten-year period spanning from 2005-2015. Given that the majority of included posts were at least several years old by the time of data collection, seeking informed consent would have been very difficult, if not impossible. This problem was especially pressing given that most community members were inactive by the time I observed their postings.

While this dissertation project is exempted from institutional oversight given that it analyzes pre-existing, open-access texts, I still considered the possibility of harm. The SACHRP (2013) guidelines for ethical research recommend that the researcher consider both the likelihood and magnitude of harm posed by their research project. For example a high-magnitude harm, such as the revelation of personally identifying information that could lead to identify theft, criminal or civil liability, should be cause for concern even if the probability of occurrence is

low. This dissertation arguably poses a low probability of harm. First, all users' information had been anonymized by online health communities in which users participated, thus posing minimal risk for personally identifying information. Second, I took additional steps to increase anonymity, including not revealing usernames or the URLs of posts, though the inclusion of both are recommended by APA citation guidelines. It bears mentioning that one of the three online health communities from which data was gathered is no longer visible; it underwent a "freeze" in 2015 and posts are no longer accessible. With regard to the two other online health communities from which data was gathered, I copied and pasted long blocks of quoted text from included posts into a Google search engine to ascertain whether doing so leads back to the original URLs. This search experiment failed to link copied text back to the original posts.

In conceptualizing the methods of this dissertation, I considered the ethical concerns discussed above from a rhetorical perspective. A rhetorical critic might argue that all open-access Internet texts fall squarely in the space of public discourse and all instances of public discourse are potentially persuasive (Segal, 2009). These texts do not emerge out of this air; they are fashioned out of available cultural knowledge and thus offer insight into the particularities of that cultural knowledge. Furthermore, a rhetorician might treat the accounts of illness that circulate in online health communities not only as *descriptive* accounts (that answer the question of what it is like to live under a particular diagnosis) but also as *prescriptive* accounts (that answer the question of how one ought to live under a particular diagnosis). Such texts, then, are not simply amenable to rhetorical criticism, their persuasive potential calls for it, especially at a time when evermore people seek and shape health information online.

The data analyzed in this dissertation consist of publically viewable, extant Internet texts found in three online health communities organized around the category of dysthymia. These

communities were identified through an open search for the terms "dysthymia" and "group." Any sites produced by this search that had password-protected content, or that required site membership to view posts, were excluded. (Sites were not excluded if they required site membership to *add* a new post, however.) Thus, all data analyzed in this dissertation falls squarely within the public domain. These three communities are housed at PsychForums.com, MDJunction.com, and ExperienceProject.com. A brief description of each follows below.

The first site, PsychForums.com describes itself as a "Psychology and Mental Health Forum." At the bottom of its home page, the following statistics are listed: 185,314 members, 171,085 total topics, and 2,020,212 total posts. This site houses multiple subforums organized around the following categories: General, Abuse, Anxiety, Developmental, Cognitive, Dissociative, Eating, Factitious, Impulse-Control, Mood, Personality, Psychotic, Sexual, Sleep, Somatoform, Addictions, Therapy, and General Health. Within the category of "Mood" one finds four forums: Bipolar Disorder, Seasonal Affective Disorder, Clinical Depression and Postpartum Depression. The "Clinical Depression" forum is where one finds the subforum for Dysthymia (which, as of 2018, still goes by its *DSM-IV* term rather than the *DSM-5* term PDD). Its linkage to any official sponsors is not evident. There are no visible sidebar advertisements at the present time (2018), though there is a link to donate, and a link to advertise on the site. On the site, one finds a page that lists the "Forum Rules." One section of the rule page states that the following are prohibited: "Posts that advise any member or people in general not to take medication prescribed by a licensed physician or not to follow any other advice given by a licensed physician or other mental health professional; Posts that attempt to diagnose any member or to dispute a diagnosis given to a member by a qualified mental health professional; presenting

yourself or your opinions in any kind of professional capacity." Despite these admonitions, I found that it is common practice for users to suggest diagnoses to another.

The second site, MDJunction.com, describes itself as "a meeting place for people who deal with health challenges." The site's "About" page states that it was created in 2006, and is now home to more than 800 online support groups that were visited by more than 16,000,000 people in the last year. A bit of information about the site's genesis is included: "We were inspired to start a Patient Empowering Network by Dalia Eliezer, a strong and unique woman who touched us with her vigorous fight against breast cancer. Her story and the supporting family beside her have brought MDJunction to life." Clicking on the "Support Topics" page will take you to a list of 27 topics ranging from skin and hair, to women's health, to infectious diseases. "Dysthymia" can be found among the 104 subtopics listed under the category "Mental Health." The page for dysthymia is described as "a community of patients, family members, and friends dedicated to dealing with Dysthymia, together." Like the first site, this site shows no evidence of sponsorship ties and there are no visible advertisements.

The last site, ExperienceProject.com stands in contrast to the former two. Unlike the two above, this particular site was not exclusively organized around issues pertaining to physical and mental health. The site, which describes its purpose as "social networking," states that it was initially created as an online community for people with multiple sclerosis, but soon expanded to include other diseases, and from there, branched out to include various social experiences (like divorce, for example). The site's Facebook page claims that over 70 million "experiences" have been shared on the site between its creation in 2007 and its "freeze" in 2016. At that point, it was announced that the site was taking a break in order to "figure out a future path forward." Logins were frozen, and no new memberships could be created. Up until March of 2018, the site and all

its related content remained visible, but at present (April 2018) the site's URL redirects users to a mostly blank page explaining that the site is currently "taking a break". Luckily, data collection and analysis for this dissertation had been completed well before the site underwent its supposedly temporary "freeze."

Data collection occurred between December of 2014 and June of 2015. In the process of collection, I elected to sample posts from the ten-year period that spans from 2005-2015. That some of these posts are now more than a decade old, and that one of the sites that housed them now appears defunct, need not be considered a limitation of the study. Rather, part of the value of this analysis is that it offers insight into the particularities of a specific period in time—a period that is on the heels of several particularly salient cultural and pharmacological developments. For one, the 1990s—proclaimed by then-President George H.W. Bush as the "Decade of the Brain—ushered in a new scientific and cultural interest in all things "neuro," that shows no signs of abating. Secondly, the first selective serotonin reuptake inhibitor—Prozac (fluoxetine)—was approved for the treatment of depression in 1987, and generic versions became available in 2001. The result, according to Horwitz & Wakefield (2007) was a pharmaceutical and cultural sea change. Public discussion of depression surged during this time period (Emmons, 2010), and so too, of course, did prescriptions for antidepressants. Lastly, online communities in general, and online health communities in particular, moved into mainstream Internet culture during this time.

This textual corpus gathered from these communities, from between 2004-2014, totals 86,246 words, consisting of 469 posts (including both thread-initiating posts and replies),

authored by 207 unique posters.[19] Each line of this textual data was subjected to line-by-line coding between the months of June 2015 to September 2015. During this time, three broad themes emerged that later formed the chapter structure of this dissertation, and which is previewed below.

1.5   CHAPTER PREVIEWS

Chapter 2, "Ambiguity, Agency, and the Fitting Room," begins by providing a brief rhetorical history of the construction of dysthymia as diagnostic classification in the context of the years leading up to the publication of the 1980 *DSM-III*. In doing so, this chapter departs from rhetorical scholarship on the relationship between depression and ambiguity, which has tended to identify the pharmaceutical industry as the primary engine driving depression's definitional ambiguity (Emmons, 2010; Segal, 2005). This chapter suggests that, in the case of dysthymia, strategic definitional ambiguity was useful for smoothing the institutional tensions between biological psychiatrists and psychoanalysts that had flared throughout the construction of the paradigm-shifting *DSM-III*.

This chapter then examines how dysthymia's definitional ambiguity is harnessed as a rhetorical resource in the context of online health interactions. In doing so, it finds that elements of psychoanalytic and biopsychiatric explanations of dysthymia blend together in these online health interactions. This blending of paradigms provides a useful strategy for navigating the

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[19] APA citation guidelines for Online Forums/Discussion Board postings recommend including the author's user name, title of message, date, and URL where the message is archived. In this dissertation, I have omitted user names and the URLs. I have included the title of the message, the date, and the site to which the message was posted (not the URL where the message is archived).

subject of agency as it pertains to questions of dysthymia's causality and treatment. Using

Kenneth Burke's conceptual pairing of symbolic action/nonsymbolic motion, this section of the

chapter observes that when people frame dysthymia's causality in psychoanalytic terms, they

tend to *renounce* individual agency, and when they frame dysthymia's treatment in

biopsychiatric terms, they tend to *reclaim* individual agency.

Lastly, this chapter offers the metaphor of "fitting rooms" for conceptualizing online

health communities in which the informal self-diagnosis of dysthymia appears to be a common

aim. Rather than metaphorizing these spaces as "waiting rooms"—in which people bide their

time until they can visit a mental health practitioner and obtain formal diagnosis—this chapter

suggests that they might function more akin to "fitting rooms." This metaphor is apt for several

reasons, the first being online health community members' frequent mentions of how well they

"fit" into the label of dysthymia, or, alternately, how well the label of dysthymia "fit" them.

Additional reasons for suggesting this metaphor include the fact that online health community

members, like patrons of clothing store fitting rooms, often tried on more than one diagnostic

label, solicited feedback from others about how well the labels "fit," and also appeared not to

want to leave the fitting room "empty-handed" (that is, without a presumed diagnosis). The

chapter concludes by suggesting that this particular metaphor may be especially apt in an era of

commercialized health care, wherein mental health diagnoses are likened to commodities

(Esposito & Perez, 2014).

Chapter 3, "Coming to Terms with Temporality," contributes to the body of scholarship

that addresses the temporal dimensions of chronic illness accounts. While this body of literature

has thus far focused primarily on the temporal dimensions of accounts of chronic *physical*

illness, this chapter suggests that it is likewise important to attend to the temporalizing of chronic

mental illness accounts. After pulling from several bodies of literature to establish the claim that ways of thinking about time guide the construction of illness narratives and conceptualizations of agency therein, this chapter examines the temporalizing of accounts of dysthymia in online health communities.

This chapter finds that people in online health communities do not describe the subjective experience of dysthymia as particularly problematic in the *immediate present*; rather, they often explain that dysthymia's intolerability stems from recollecting the ways in which the disorder has tainted one's past, and from anticipating the ways in which it will continue to taint one's future. In short, this chapter suggests that the temporal perspectives that structure online accounts of dysthymia are marked by *temporal expansion*, rather than the temporal contraction (e.g. "living one day at a time") that has been observed in accounts of chronic physical illness (Charmaz, 1992). This chapter dubs these temporally expansive accounts "panoramic temporal perspectives."

This chapter goes on to suggest that panoramic temporal perspectives have a certain utility in dysthymia online health communities, given that these stretched-out temporal perspectives enable a process relevant to the communities' aims, which this chapter terms "retrospective identification." This chapter defines retrospective identification as a process through which the onset of dysthymia and contextual features related to its onset are identified. Through this process, things that one previously considered "just part of my personality"—say, gloominess or pessimism—are recontextualized and appropriated as evidence of chronic mood disorder. After describing how the past is configured in panoramic temporal accounts, the chapter turns to the question of how panoramic temporal perspectives seem to shape understandings of the future. While the sort of temporal contraction found in chronic physical

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illness accounts tend to confer a sense of agency in the face of uncertain future (Charmaz, 1992; 2006), this chapter considers that panoramic temporal perspectives may function in the inverse: that is, they might have the effect of attenuating the an author's felt sense of agency as it pertains to the future.

Chapter 4, "The Trouble with "Mild" Depression and the Contraction of Normality," contextualizes the *DSM-5* revision process that resulted in dysthymia's label death and replacement with a freshly crafted diagnosis, Persistent Depressive Disorder (PDD). This revision process was unique in that the American Psychological Association, for the first time in its history, invited the "general public" to view and comment on its diagnostic criteria drafts. This chapter situated this unprecedented move by putting into conversation two contrasting perspectives—one from a rhetorician of medicine and one from a philosopher of science. The former suggests that the public played no meaningful role in the revision process, since the APA crafted the "subject positions" for the general public to inhabit (thus, the APA was producing its own feedback rather than discovering the public's); the latter suggests that the general public had already been playing a non-trivial role in all *DSM* revision processes due to the interactive, looping nature of psychiatric classifications.

After contextualizing the *DSM-5* revision process, this chapter explores community responses to the "label death" of dysthymia, and finds that its death was regarded favorably. This was not surprising given how frequently and intensely community members voiced dissatisfaction with the label of dysthymia in their posts. Much of this dissatisfaction, the chapter finds, stems from the disorder's designation as "mild," especially when compared against its nosological counterpart, Major Depressive Disorder. This section of the chapter contemplates how being diagnosed with a "mild" mood disorder occasions a rhetorical dilemma of sorts: if

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individuals do not emphasize the severity of their symptoms, they risk being interpreted by others as "normal" people, yet if they overemphasize their symptoms, they risk being perceived as malingerers, prone to hyperbolic descriptions of suffering.

This chapter goes on to identify several strategies that people in online health communities employ that seem to contend with the rhetorical dilemma described above. The first involves reframing individual success as something that occurs *because of*, rather than *despite*, dysthymia (the logic being that work/school/etc. give people a means to distract themselves from their symptoms). The second strategy involves highlighting the features of dysthymia that make it uniquely intolerable, including, in particular, its *liminality* (given that it is conceptually situated in between "normality" and major affective disorder). This liminality, users agued, limits opportunities for support and understanding, both from people with more "severe" mood disorders, and from those without mood disorders. The third strategy involves deploying particularly narrow conceptions of "normal," such that "normal" becomes more sharply distinct from the experience of dysthymia. The chapter ends by meditating upon the possible implications entailed by contractions of normality, and points to indications that contractions in the meanings of normality are not confined to dysthymia online health communities.

2.0   AMBIGUITY, AGENCY, AND THE FITTING ROOM

> [I]nstead of considering it our task to "dispose of" any ambiguity by merely
> disclosing the fact that it is an ambiguity, we rather consider it our task to study
> and clarify the resources of ambiguity. For in the course of this work, we shall
> deal with many kinds of transformation—and it is in the areas of ambiguity that
> transformation takes place; in fact, without such areas, transformation would be
> impossible.
>
> –Kenneth Burke, *A Grammar of Motives*

Throughout the 19th century, lucidity and precision were regarded as hallmarks of superior

spoken and written expression. Ambiguity, that quality of language that resists clarity and grants

"multiple plausible interpretations or explanations" was therefore seen as a stylistic flaw to be

avoided or remedied (Olson, 2001, p. 26). Attitudes toward ambiguity warmed in the 20th

century, especially for those whose rhetorical sensibilities skewed sophistic, including, notably,

Kenneth Burke. Burke viewed ambiguity—in both its symbolic and experiential forms—not as

undesirable but as an inevitable, unresolvable aspect of human life that takes center stage when

paradoxes in lived experience give rise to, and are mirrored by, paradoxes in language (or vice

versa). One such paradox that held Burke's fascination was what he called the "ambiguity of

substance." This paradox concerns the most basic function of language—naming—and its nature

is reflected in our paradoxical usage of term "substance" itself. Burke noted that when the

"substance" of a thing is the subject (another member of the "sub" word family) of discussion,

the discussion typically centers on the qualities considered most *essential or intrinsic* to the

thing; these qualities are what make the thing itself and not something else. And yet in an

etymologically traceable and literal sense "substance" denotes the *contextual, extrinsic* elements

that underlie and are supportive of the thing: the thing's sub-stance. For Burke, every human

attempt to define a substance, to enclose it, to trace its borders, involves a simultaneous and

subtle shifting of focus onto that which the thing is not.[20] This "unresolvable ambiguity" stems

from the fact that "no two things or acts or situations are exactly alike," and that each object, act,

or situation stands as both "a part of" and "apart from" its broader context (Burke, 1945, p. xix).

While the human preoccupation with *categorizing* is thought to reveal a desire to clarify

the ambiguities that permeate human experience, Burke believed that the resolution of

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[20] Burke is not the only or first to observe that no substance can be considered "in itself." He notes that, for Spinoza, "each single object in the universe is "defined" (determined, limited, bounded) by the others things that surround it," (1945, p. 25). Given the contextual character of language, it has been argued that every act of definition entails negation, because to designate what something is, is to simultaneously designate what it is not. Parallels have been drawn between Burke's approach to the ambiguity of substance and Derrida's work on what he called the "undecideability" of language. McClure and Cabral (2009) explain that, for Derrida, undecideability does not stem from the ambiguity or instability of any single term in a language, but rather stems from the totality of our language systems, and the way that each signifier within this system finds its meaning through its connection to/difference from other terms. If any given term only acquires meaning through its difference from other terms, then there is no stable groundwork signifier from which to pin down the precise meanings of other terms, just a mass of "irreducible otherness" that "prevents any totalizing or idealizing within the system" (p. 27). Where Burke's work departs from Spinoza's or Derrida's is that its focus is on the *pragmatic* and *rhetorical* implications of ambiguity; he was fascinated by how ambiguity motivates and shapes the rhetorical processes by which humans come to form (and reform) their understandings of reality.

ambiguity, even if possible, would be undesirable. [21] This is because it is partly the impossibility of escaping ambiguity, in all its forms, that fuels rhetorical invention: if subjects under deliberation manifested crisply in shades of black and white rather than muddy greys, what need would there be for persuasion in the first place? Furthermore, since no two individuals interpret or respond to symbols in precisely the same way, the argument has been made that "all symbolic strategies, however subtly, trade on ambiguity to perform persuasive work" (Olson, 2001, p. 29). Thus, having taken as given the necessity of ambiguity for rhetoric, Burke (1945) avowed that what rhetoricians want "is not terms that avoid ambiguity, but terms that clearly reveal the strategic spots at which ambiguities necessarily arise...Instead of considering it our task to dispose of any ambiguity by merely disclosing the fact that it is an ambiguity, we consider it our task to study and clarity the resources of ambiguity. For in the course of this work we shall deal with many kinds of transformation—and it is in the areas of ambiguity that transformation takes place" (p. xvii-xix). Rhetoricians, then, seek not necessarily to merely identify and/or reduce ambiguity where it exists, but to contemplate how ambiguity is harnessed as a generative rhetorical resource.

It is the rhetorical productivity of ambiguity that makes depression, or, more specifically, the discourses that seek to define it, a compelling topic of inquiry for rhetoricians of medicine. So prevalent and pliable are these discourses that some have come to regard depression "not as

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[21] Categorization—the cognitive and/or formal act of grouping things together on the basis of perceived similarities—has generally been a topic that falls to psychology (not rhetoric), where it has been theorized as a fundamental cognitive process that springs from a biological imperative. Social psychologist Michael Billig (1996), however, treats categorization and its less frequently discussed counterpart, particularization, not only as matters of cognition but as matters of rhetoric. He suggests that these two forms of thought—categorization and particularization—"provide the basic outlines of argumentative forms" (p.6) and that our choices about when to categorize (and which category to select) and when to particularize (and on the basis of which characteristic/s) are not infrequently matters of "deeply felt controversy" (p. 138).

an entity but an amalgam, characterized by ambiguity and contestation" (Helén, 2007). In experiential terms, it has been said that depression troubles the subject's capacity for language and eludes description (this may seem counterintuitive, given the profusion of depression memoirs from the 1990s onward [22]), while on a practical level, clinicians, as well as critics of psychiatry, frequently acknowledge that no remotely clear line exists that can be called upon to definitively separate what might be called "normal sadness" from what ought to be approached as a treatable disorder (Horwitz and Wakefield, 2007). The line designed to separate normality from pathology is especially blurred when applied to the "mild" depression subtype, dysthymia, which has been said to "occupy a position between normality and major affective disorders" (Akiskal, 2001, 28). Furthermore, noted American psychiatrist Hagop Akiskal (1997), has noted that, because of dysthymia's chronic and minor symptoms (relative to Major Depressive Disorder), there is "difficulty in separating low-grade depressives from their habitual selves" and so, for these low-grade depressives, "life disruptions and difficulties due to depression were not easily separable from events in their lives" (p. 2).

One might think that the field of psychiatry, which has for some time been striving to model itself after the epistemic protocols of Western biomedicine, would seek to clarify the definitional ambiguity of depression, especially its "mild" subtype, in order to forge a clearer and firmer distinction between nonpathological states of sadness and clinically treatable depression. Rhetoric of medicine scholars, operating mostly from critical positions, have pointed to the thriving psycho-pharmaceutical industry as the primary engine driving depression's definitional ambiguity. As Emmons (2010) sees it, ambiguous descriptions of depression in both clinical and

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[22] A few high profile examples of the 1990s depression autobiography trend include psychologist Kay Redfield Jamison's (1995) *An Unquiet Mind: A Memoir of Mood and Madness*; novelist William Styron's (1990) *Darkness Visible: A Memoir of Madness*; and journalist Elizabeth Wurtzel's (1994) *Prozac Nation*.

public discourses would at first glance "seem to counter the needs of biomedicine, where a precise definition would more accurately align with targeted pharmaceutical interventions" (p. 63-64). But, she goes on, it quickly becomes clear that "a strategic imprecision does more work that definitive definitions ever could in the service of encouraging pharmaceutical intervention" (p. 64). In this view, the strategically imprecise language that suffuses depression discourses—fuzzy categorical definitions, the merging of symptoms with disorder, the public portrayal of depression as simultaneously exceptional and mundane—can be traced, at least in large part, to the pharmaceutical industry and the broader biopsychiatry paradigm that has normalized psychopharmacologic treatments for the problem(s) called depression.

If even trained clinicians have difficulty distinguishing between normal sadness and clinical depression, one wonders how so-called laypersons go about making this distinction. In an age of online health, wherein diagnostic criteria for mental disorders is widely and rapidly accessible, the question becomes especially salient. As a growing body of scholarship suggests, online health communities increasingly function as spaces in which these sorts of distinctions are made (Charland, 2004; Giles, 2014; Giles and Newbold, 2011). These communities, then, can plausibly regarded as spaces abuzz with rhetorical activity, what Burke might have called "zones of transformation" in which something that was previously regarded as A comes to be understood as B. The informal self-diagnosis of a mental disorder is certainly an instance of one such transformation, in the sense that something which was previously regarded as one thing—a generally pessimistic outlook, say—is rhetorically reconfigured into something else, such as, in this case, a mood disorder symptom.

In contrast to the rhetorics of patient education and empowerment that pervade general discussions of online health phenomena, the topic of internet-aided self-diagnosis tends to be

discussed in skeptical or cautionary tones, especially as it pertains to mental disorders.[23] For

instance, a few top entries produced by a Google search for the term "self-diagnosis" include

"The Dangers of Self-Diagnosis" on the *Psychology Today* website (Pillay, 2010); "The Dangers

of Using Google to Self-Diagnose" from *Women's Health Magazine* online (Abassi, 2015); and

"Self-diagnosis on Internet not always good practice" from the *Harvard Gazette* site (Miller,

2015). The general thesis of these articles seems to be that online health information, for which

the public has an ever-expanding appetite, feeds into so-called "cyberchondria"—the digital

version of hypochondria.[24]

       Skepticism likewise runs through the (for now, sparse) rhetorical scholarship on the

subject of self-diagnosing depression. Focusing on the linguistic and experiential ambiguity of

hypochondria, Segal (2008) paints a picture of self-diagnostic transformation that involves

rhetoricizing one kind of ambiguous disorder—in this case, hypochondria—as another,

depression. She lays out the transformational scene as follows:

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[23] The move toward "patient empowerment" seen in scholarly literature and various public health campaigns is very much linked with the move toward defining patients as consumers—of health services, of course, but especially of information. In a widely cited article, "The importance of patient empowerment in health system reform," Leonie Segal (1998) articulates what it might mean to consider patients as consumers: "Consumers require more than information to contribute effectively to decisions about their own health. Consumers also require confidence and competence to act on information and a capacity to influence the services they access. This requires an understanding of their own health…and acceptance of responsibility for decisions about their own health care. Consumers need to become empowered" (p. 31). The flipside of patient empowerment, it seems, is *responsibility* and, as Crawford (2004) points out, this push toward patient responsibility has likely been mobilized to service a variety of political and economic agendas, including, for instance employers' desire to shift a greater proportion of health care costs to their employees.

[24] White and Horwitz (2008) are typically credited with coining the term in their research article entitled, "Cybercondria: Studies in the escalation of medical concerns in web search." In their research, the authors found that web search engines return content about rare, severe conditions based on searches for "likely innocuous symptoms" and that this phenomenon escalates the intensity of searchers' medical concerns. Though this widely cited research article helped popularize the term, "cyberchondriac" (a portmanteau of "cyber" and "hypochondriac") appeared as early as 2001, in the United Kingdom publication, *The Independent*, in an article whose title asked, "Are you a cybercondriac?"

What follows is a rhetorical account using the example of depression as part of the

process of "making" the hypochondriac—one who becomes attached, in this case,

to a diagnosis of mental illness. The story presented is by now familiar. Diagnostic

information, arguably too available, is presented in such a way as to make self-

diagnosis irresistible. You (any you) feel unusually miserable, maybe inexplicably

bleak and sad. You read the Zoloft advertisement in *People Magazine* and do the

checklist for depression; maybe you record the mnemonic that comes with the

checklist so you don't forget how you quality for the diagnosis. Your sadness has

been translated by the ad into the language of a disorder with a disease

classification. You go to your doctor, as the ad suggests you do, and with the

diagnosis in hand—in search of confirmation and also a prescription for this

disease that is both created and treated by the drug available for it (p. 83-84).

In this account, pharmaceutical agents are the engines propelling the self-diagnostic

transformation: they "created" the disease, their advertisement translated the reader's sadness

into the vocabulary of depression, and their prescription is the culminating event that cements the

self-diagnoser's new subjectivity as "depressed person." The role of the reader in this account is

nominal, as conveyed through usage of the passive voice (e.g. "Your sadness has been translated

by the ad.")

Emmons (2010) considers the self-diagnosis of depression through a lens similar to

Segal's—as an act grounded firmly within the biopsychiatric paradigm, with pharmaceutical

agents constituting the truly active agents of the process. She opens her 2010 book, *Black Dogs

and Blue Words: Depression and Gender in the Age of Self-Care*," by meditating upon a then-

recent *New Yorker* cartoon. This cartoon depicts a woman hunched over a computer keyboard in

what is presumably a home office (a kitchen is just out of frame) with her back to a male companion who poses a question that captions the image: "How's the self-diagnosis coming?" For Emmons, "The vignette is funny because it so succinctly captures the migration of medical authority from doctor's office to individual, computer-mediated reflection" (p. 2). As a result of this migration, "[T]exts—presumably the self-diagnostic quizzes readily available on consumer Web sites—mediate her "expert" and "patient" identities. The cartoon displays a growing reliance on interactions between isolated individuals and the texts that construct health and illness. The woman's companion does not look at her as he passes; there is no indication that she is in dialogue with anyone else; her self-diagnosis is a monological practice" (p. 2-3).

This chapter departs from these rhetorical perspectives on the ambiguity of depression, and does so by making three key moves. First, it traces a brief, rhetorically-inflected history of dysthymia as a diagnostic classification. It argues that the disorder's blurry definitional borders can indeed be understood as a form of strategic imprecision, but suggests that the imprecision originally served a purpose in addition to that which is often imagined (i.e. the pharmaceutical industry's interest in expanding the populations to whom a depression diagnosis could plausibly be applied). Specifically, this chapter advances the claim that dysthymia was constructed in a strategically ambiguous way partly to smooth tensions between adherents to a fading paradigm, the psychoanalytic tradition, and those paving the way for the soon-to-be hegemonic paradigm, biopsychiatry. Because dysthymia was originally conceived as a "minor" complement to Major Depressive Disorder—an affective disorder rooted firmly within the parameters of biopsychiatry—it had a similar enough nosological character that biological psychiatrists felt comfortable diagnosing it. At the same time, because dysthymia was defined as "chronic," it was in alignment with the views of psychoanalysts who considered their persistently malcontent

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patients to not merely "have" depression but to essentially "be" depressives. Thus, dysthymia was a comprehensible diagnostic entity from within the context of either paradigm, and it was considered amenable to treatment from either paradigm in the form of antidepressant medications, and/or long-term psychotherapy, respectively.

After contextualizing the ambiguous construction of dysthymia, this chapter shifts focus to the subject of how this ambiguous diagnostic entity is defined and informally self-diagnosed in online health interactions. Despite the conventional wisdom that psychoanalytic vocabularies have largely been abandoned in favor of biopsychiatric explanations for mental disorders, this chapter observes that aspects of both of the above paradigms—psychoanalytic and biopsychiatric—blend together, providing a useful strategy for negotiating agency as it pertains to matters causality and treatment. Here, Kenneth Burke's conceptual pairing of symbolic action/nonsymbolic motion is used as a theoretical lens through which to view these discussions about causality and treatment, and their entailed implications for understandings of agency. In doing so, this chapter notes that when psychoanalytic explanations of dysthymia's causality are offered, causality is often framed as a matter of motion—of that which lies beyond the symbolic control or influence of the individual. Matters of treatment, however, are rhetoricized as symbolically meaningful, agentive action. This rhetorical strategy, it is suggested, navigates the symbolic agency/nonsymbolic motion dialectic by resisting totalizing vocabularies that would position dysthymia as a matter of pure motion (that which is not amenable to symbolic intervention) or pure symbolic action (that which is amenable to symbolic intervention).

Finally, this chapter offers a metaphor—the "fitting room"—for conceptualizing online health interactions in which informal self-diagnosis appears to be the aim. While I had previously assumed that these spaces function akin to "waiting rooms"—where patients bide

their time until they can be formally diagnosed by a practitioner—this chapter posits that they function more akin to *fitting rooms*, wherein people "try on" different diagnostic labels, assess how well they fit, and solicit feedback from others before taking further action. This metaphor was initially born from the recognition that language related to diagnostic "fit" was consistently deployed in these online health interactions: people regularly deliberated how well the label of dysthymia "fit" them or, alternately, how well they "fit into" the label of dysthymia. Like consumers in clothing store fitting rooms, the patrons of online health communities were apt to try on more than one diagnostic label, solicit feedback from others about how well the label fit, sometimes having other labels suggested to them. Perhaps the most important similarity, however, is that people appear not to want to leave the metaphorical fitting room empty-handed. This metaphor is perhaps becoming especially appropriate considering the era of commercialized, "consumer-driven" health care in which we are said to now exist.

2.1 DYSTHYMIA IN THE *DSM-III*: THE BIRTH OF A STRATEGICALLY IMPRECISE CLASSIFICATION

It may be tempting to regard the definitional ambiguity of dysthymia—the so-called "midpoint" between normality and major affective disorder—as a phenomenon produced and maintained primarily or solely because blurred definitional boundaries align smoothly with pharmaceutical agendas that seek to expand the population to which the classification can be applied. While certainly a plausible view, this chapter suggests that it is incomplete. To fully appreciate the rhetorical flexibility of dysthymia as a diagnostic entity, it is useful to take account of the

institutional conditions and constraints under which the classification was initially crafted prior to its debut in the pages of the *DSM-III* in 1980. Taking account of these conditions and constraints suggests that dysthymia can indeed be understood as a form of strategic imprecision, however, the aim of the strategy was not (only) the marketing of antidepressants, but (also) the soothing of intraprofessional tensions simmering within the American Psychological Association (APA) prior to the publication of the path breaking *DSM-III*.

While historical accounts of psychiatry and development of its so-called bible—the *Diagnostic and Statistical Manual of Mental Disorders*—vary based on who is doing the accounting, virtually all flag the publication of the *DSM-III* as an unmistakable shifting of paradigms.[25] And as is customary of paradigm shifts, there was no shortage of conflict within the APA during this time, with tensions flaring between flag-bearers of the emerging paradigm and loyalists to the fading paradigm. In this case, the emerging paradigm was that of biopsychiatry, an approach to mental disorder that was a return to, or an extension upon, the views of German psychiatrist Emil Kraepelin, which had come to prominence in the beginning of the 20th century. In Kraepelin's view, mental illnesses were not unlike physical illnesses: both, according to him, have discrete, invariant, and discoverable biological bases, as well as observably consistent trajectories. Furthermore, he operated from the perspective that the classification of these origins and trajectories constitutes a legitimate area of scientific research in its own right (McCarthy & Gerring, 1994).

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[25] As many authors, including McCarthy and Gerring (1994), note, the field of psychiatry was suffering a rhetorical crisis prior to the publication of the *DSM-III*: a lack of diagnostic reliability. Putting it simply, "diagnostic reliability" refers the likelihood of different practitioners coming to the same diagnosis based on a given patient's symptoms. The changes made to the *DSM-III* revision, intended to address this issue, ended up being far more extensive than anyone had expected. But in attempting to address the rhetorical crisis of low diagnostic reliability, the field faced a new potential rhetorical crisis: if the DSM shifted so radically from the second to the third edition (with the third edition undermining much of the content of the second) then how could either edition (or later editions) be seen as credible knowledge?

Kraepelin and other biological psychiatrists believed that it was crucial to classify the trajectories of different mental disorders in order to base treatment protocols upon them. And so, a return to so-called "Kraepelinian" theory meant that the classification of disorders (based on clinical observation) took on a newly exigent weight during this time. This push toward classification aligned psychiatry's priorities more closely with those of biomedicine. (Not to mention, a freshly revised version of the International Statistical Classification of Diseases and Related Health Problems (ICD) appeared in 1968, adding some additional pressure for psychiatry to produce its own diagnostically reliable text.) In addition to a keen emphasis on classification, biomedicine and biopsychiatry share key philosophical underpinnings in terms of their views on patients, disease, and the relationship between the two. Like the biomedical model of medicine that views physical illness as a *departure* from the body's "standard" mode of function, biopsychiatry regards the symptoms of mental disorders an interruption in the "normal" course of life (Greco, 1993). The goal of treatment is thus *restorative* in nature and calls for little or no attention to the individual's life course prior to the onset of illness. These philosophical underpinnings are very much at odds with those of the previous psychiatric paradigm, which had been built upon the foundation of psychoanalytic theory.

The ascendancy of the biopsychiatric paradigm came, of course, at the expense of the former paradigm, which had grown out of the psychoanalytic (sometimes referred to as

"psychodynamic" or "psychotherapeutic") tradition.[26] This psychoanalytic paradigm had

enjoyed a hegemonic hold on psychiatry for the several decades leading up the *DSM-III*,

spreading its palpable Freudian influence throughout the pages of the *DSM-II* and, to a lesser

extent, *DSM-I* (Shorter, 2008).[27] The symptoms that characterize mental disorders, according to

psychoanalytic theory, arise on the basis of psychic conflicts bubbling about within the

unconscious.[28] The resolution of such conflicts, many of which are presumed to be deeply-rooted

in early childhood experience, are the overarching goal of psychoanalytic treatment models that

have collectively been dubbed the "talking cure." The talking cure is premised upon the

assumption that patients "know more about what has caused their symptoms than they

consciously think" and that, through various discursive practices, including, for example, free

association, patients can recollect the onset and probable "cause" of their symptoms which in

turn ameliorates their symptoms and suffering (Sharpe & Faulkner, 2014, p. 4). Unlike

biopsychiatry, which regards the onset of mental disorder as a discontinuity, the psychoanalytic

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[26] The terms "psychoanalysis" and "psychodynamic therapy" tend to be used interchangeably and while they are related, they are distinct. The former term is most closely associated with the ideas of Sigmund Freud, who was not the only theorist of psychoanalysis but was probably the most prolific. Psychodynamic therapies grew out of the Freudian psychoanalytic tradition. They are similar in their theoretical underpinnings but diverge in practice, one of the most obvious divergences being therapy frequency and duration: psychoanalytic therapy tends to be based on more frequent appointments (typically, several per week) spread out over a longer of duration of time as compared to psychodynamic therapy.

[27] While Freudian theory does not exert as much influence on psychiatry today as it once did, it continues to animate the public imagination, especially as they pertain to notions of the human "mind". Gibbons (2014) explains that it is often overlooked "how key Freudian ideas became widely shared beliefs about the mind, entering the realm of doxa…these ideas continue to exert an often-surreptitious influence even today" (p. 432).

[28] Freud's "unconscious" refers to a tripartite structure that forms the psyche. The structure consists of three forces necessitating balance: the id (an impulsive, animalistic drive that is biologically inscribed), the superego (which adheres to rules and norms and is regulated by society's force on the individual mind) and the ego (which attempts to bridge the adversarial relationship between the former two). Freud deemed his notion of the unconscious—which suggests that human behavior is guided by forces and motives that lie below the level of consciousness—as one of the three great blows to human narcissism, the other two of which resulted from the Copernican revolution and Darwin's theory of evolution respectively.

approach regards the onset of mental disorder as "logically continuous with the normal life of the individual and consistent with personal attributes" (Greco, 1993, p. 359). In short, the psychoanalytic approach to mental disorder calls for attention to the individual's life *prior to* the onset of symptoms. The excavation of the past thus takes on symbolic significance that puts it at odds with the biopsychiatry paradigm, which, like the biomedical model of Western medicine, views illness as a discontinuity or divergence from one's "standard" mode of function.

As is clear from a basic sketch of these two psychiatric traditions, their respective approaches to mental disorder—theoretically and practically—are not easily reconcilable. Despite these two paradigms' philosophical incompatibilities, and despite the fact the majority of the *DSM-III* task force "despised" psychoanalysis, Robert Spitzer, as head of the *DSM-III* task force, reportedly felt a sense of responsibility for fostering some sort of rapprochement between adherents to these rival schools of thought (Shorter, 2015). Initially, Spitzer thought that peppering the Freudian term "neurotic" throughout the pages of the *DSM-III* would be adequate appeasement for the psychoanalysts. [29] But, apparently, this proved an inadequate compromise, as, "the psychoanalysts held out for something more than a bunch of vague references to neurosis strewn throughout the text" (Shorter, 2013, 138). Some other rhetorical salve would thus have to be formulated.

After having drafted what was to become "Major Depressive Disorder," task force members felt that the classification logically called for a "Minor Depressive Disorder" complement. These two forms of depression would not only be distinguished in terms of

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[29] Freud theorized that mental health results when the three components of the unconscious are balanced and in harmony with external reality. When this delicate balance is disturbed, mental disorder befalls the individual, the form of which depends upon the mechanism used to contend with the imbalance. Neurosis results when the ego stays in external reality and silences the id, via repression. If one were to instead reject external reality and succumb to the id via disavowal, psychosis would result (Sharpe & Faulkner, 2008).

severity, but in terms of temporality: major depression, like other affective disorders, would be episodic while its minor counterpart would be chronic.[30] Each of several variations of the drafted category "Minor Depression" were poorly received by psychoanalysts who recognized that this category would completely subsume one of their most commonly deployed diagnostic entities: neurotic depression. Following this poor reception, the proposed category of "Minor Depression," was eliminated, though in discussing the elimination, Spitzer did not publicly foreground psychoanalysts' concerns. He instead focused the issue of third party payment, claiming that a so-called "minor" depressive disorder was a rhetorically doomed classification that failed to capture how "devastating" the disorder's effects could be, and its implementation would thus be "inviting disaster in so far as third party payment would be concerned" (as quoted by Shorter, 2008, p. 161).

And so, the *DSM-III* task force began the process of crafting a new diagnostic entity that would take its place, and they landed on the term "dysthymia." Spitzer apparently found the term in a psychiatric dictionary, and was struck by its simplicity and descriptiveness (*thymia* translates as "mood" and dys as generally "bad"), qualities that he claimed were not so much necessary for the clinician or researcher, but were owed to the public. In a rhetorically significant move, he parenthetically placed the phrase "neurotic depression" after dysthymia in a nod of deference to the psychoanalyst contingent. This "capitulation" to "political pressure" (in the words of colleagues) has since been deemed the "neurotic peace treaty" (Shorter, 2008). By most

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[30] One particularly impactful side effect of this drafting was that all non-chronic instances of depression hereafter fell within the confines of a major affective disorder.

accounts, this gesture went a long way toward soothing the psychoanalysts' concerns of complete displacement by the *DSM-III*.[31]

With Freudian roots peering out from inside those parentheses, the psychoanalysts could see that the diagnostic classification of dysthymia was compatible in other ways with their previously beloved neurotic depression. Because it was defined as chronic in nature (there had been discussions of using the less psychoanalyst-friendly term "intermittent" instead) dysthymia conformed to the sensibilities of psychoanalysts who considered these persistently gloomy patients not to merely "have" depression but to essentially "be" depressives. Furthermore, since the disorder was considered low-grade in terms of its symptom severity, pharmacologic interventions did not necessarily need to be the first-resort option for treatment; psychotherapeutic treatments could be tried first, whether as a standalone or as a complement to antidepressants. Of course, given that it would be a sort of nosological cousin to Major Depressive Disorder—the *DSM-III* classification that, more than any other, signaled the sharp turn toward biopsychiatry—dysthymia would be amenable to treatment from practitioners with backgrounds in biopsychiatry as well (Wakefield & Horwitz, 2007). In short, Spitzer and the *DSM-III* task force, guided by the operating principle of inclusivity, shaped a depressive diagnostic entity that was comprehensible and treatable within the confines of these two distinct psychiatric schools of thought.

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[31] Shorter explains how laden with politics the *DSM-III* revision process was: "As their work got underway, the task force was fully aware of the massive resistance that awaited them from various quarters, and so the fruit of their efforts, *DSM-III*, was not really a scientific document but a *political* one." 157. The principle criterion that guided Spitzer more than any other was *inclusivity*. Spitzer stated that, "If any group of clinicians had a diagnosis that they thought was very important, with few exceptions, we would include it. That's the only way to make it acceptable to everyone. If we had just said, okay the Washington U group only recognizes 16 categories so we'll have 16 categories in the *DSM-III'* that would be ridiculous. We had to decide at every point: what do we do with the analysts who want 'narcissistic'? What do we do with the veterans who want 'PTSD'? And the solution was 'we'll include it'" (as quoted by Shorter, 2008, p. 157).

2.2   DEFINING DYSTHYMIA ONLINE: CAUSATION, TREATMENT, AND THE QUESTION OF AGENCY

Robert Spitzer and the *DSM-III* task force likely could not have foreseen that, in the future, information about their arduously crafted diagnostic criteria would come to be acquired as frequently (and far more rapidly) in the home office (or laptop, or smartphone) as the doctor's office. The ambiguity of dysthymia, maintained at least in part to quell intraprofessional tension, can now be harnessed as a rhetorical resource in the context of online health communities populated by rhetors seeking to understand what dysthymia is, whether the label "fits" them, and how it is impacting their moods, their experiences, their identities. Keeping in view dysthymia's history as an ambiguous diagnostic entity brings into sharper focus how aspects of both paradigms—the psychoanalytic and biopsychiatric—mingle and blend in online health communities for dysthymia, and can be drawn up flexibly, in particular when discussion implicates the fraught question of agency. In this section, an observed rhetorical trend of particular interest (perhaps because it at first seems counterintuitive) is that, when matters pertaining to causality were framed in psychoanalytic terms, the notion of individual agency was

renounced and when matters pertaining to treatment were framed in biopsychiatric terms, individual agency was *reclaimed.*[32]

"Etiology" derives from the Greek term *aitiologia*; "aitia" denotes *"cause"* or *"responsibility"* and it is not only the preoccupation of nosologists. Solomon (2001) notes that, "After enduring diagnosis [of depression], most people seek causation, despite the fact that knowing why you are sick has no immediate bearing on treating the sickness" (p. 20). While identifying the "cause" of depression might not have an immediate bearing on treatment, the felt entanglement between causality and responsibility sheds light on why the pondering of underlying causes is such a common step after diagnosis. That a formal diagnosis of depression prompts reflection about possible causes has been fairly well established (Kangas, 2001; Karp, 1996; Renata et al., 2013). However, this chapter finds that causation-seeking also tends to be a preoccupation for the not-yet diagnosed. For those who appear uncertain about whether dysthymia constitutes an appropriate diagnosis, identifying a possible "cause" can ostensibly reduce this uncertainty and strengthen the conviction that the diagnosis would be appropriate. It is not unusual for people to blend together aspects of both paradigms when searching for causation.

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[32] The subject of "agency" generates debates across the social science and humanities; thus, a complete recounting of each field's treatment of the topic is beyond the scope of this dissertation. In the field of rhetoric, "traditionalist" theories of agency foreground the concepts of individual voice, intentionality, and choice; rhetorical agency is exercised when an individual's persuasive efforts are aligned with her intentions, when she is "in charge" of her own rhetoric (which may or may not achieve the desired effect). More recent work on the subject of rhetorical agency tends to focus on the relationship between the agent, the agent's broader context, and the constraints therein. For a summary of rhetorical scholarship on the subject of agency as it pertains to science and technical communication, see a recent article by Walsh (2016), entitled "The Great Chain of Being: Manifesto on the Problem of Agency in Science Communication."

(2014, June 9). Do I have Chronic Dysthymia? Message posted to
http://psychforums.com/dysthymia.

I recently stumbled across this website while doing some research and think
its a great place to talk about things alot of people without mood disorders
wouldn't understand.

The past few years I have felt real depression. And I have done almost
everything in my power to heal it. I have eaten mostly fruits and veggies,
exercised regularly, slept 9 hours per night, cut gluten, tried supplements and
even hormone replacement therapy. Even meditation didn't help me get
happy, it just helped me stop thinking.

Sometimes I think, this has to be my life circumstance! "Its because I'm not
socializing enough", or "because I'm not with the man of my dreams." The
excuses go on and on...

But other days I think, there is no reason for me to be sad. I have a beautiful
dog, a great boyfriend, a vegetable garden, and pursuing the career of my
dreams. There is no reason for me to be sad right now.

My mom has Bipolar 2, and she is pretty much an expert on the subject. She
has sworn I have chronic dysthymia, saying that I have been sad/moody since
I was 13. This was also the year I stopped cheerleading and got bullied in
highschool. So its hard to tell whats really going on with me.

(2014, June 10). Re: Do I have Chronic Dysthymia? Message posted to
http://psychoforums.com/dysthymia
Two things jump out at me from your discourse.
1. Mum is Bi-polar so genes are at work here.
2. A bullying event at thirteen that was powerful enough for you to remember
it.
Whats wrong with you I cannot say, but if you read my stuff posted here you
will find we have similar symptoms, and I don't really know whats wrong
with me either, which I think is also part of the self-doubt and continual
questioning that is part of it.
I manage by managing. I have avoided situations and relationships that cause
stress and can trigger an episode of full blown depression. Experience has
shown I cannot adequately handle things that most ordinary folk deal with, I
just go to pieces.
If it is Dysthymia then you are stuck with it. Sounds like you have managed to
build a good life for yourself despite it and I congratulate you, the challenge
now is not to let the way you feel destroy it all because that's what tends to
happen, no one likes being around a sad and/or grumpy person.
Meds made me a zombie too and effectively snuffed out my brain power
when I most needed it, so now I don't touch them ever.

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In this causation-seeking post, we see explanatory aspects from both paradigms blending together—a traumatic childhood event and "genes"— to (seemingly) strengthen the case that dysthymia is an appropriate diagnosis for the poster. In fact, the respondent reconfigures the poster's expressed uncertainty into further evidence of dysthymia since "continual questioning" is "part of [dysthymia]".

Both paradigms have cemented in public consciousness the notion that an "imbalance" lies at the heart of depressive disorders. Where the paradigms diverge is in theorizing of what, precisely, the imbalance consists and how to resolve it. The psychoanalytic paradigm posits that the symptoms of mental disorder result from an imbalance of unconscious motives and forces. For those with mental disorders, it is theorized, there is failure to reconcile the basic unconscious conflicts that pop up throughout the process of human maturation; it is further theorized that this failure is explicable in light of the person's formative experiences, particularly with caregivers. In 1911, Freud's pupil Karl Abraham offered an enduring psychoanalytic theory of depression's etiology in which he posited, in short, that the unconscious imbalance occurs when a depressed person suffers loss or rejection and then assumes that the world is hostile to him/her, and so s/he develops hostility toward the world, focusing sharply on all its flaw and faults. However, the depressed person is unable to express this hostility outwardly, so the hostility is rerouted inward, taking aim at the self (Sharpe & Faulkner, 2008).

From within the biopsychiatric paradigm, the answer to the question of depression's etiology is to be found in neurochemistry.[33] Neurotransmitters—chemicals that help neurons "communicate"—have become particularly salient in public discourses about the cause of

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[33] In the 1950s, a major source of controversy concerned whether mental disorders were the result of electrical or chemical imbalances in the brain. The success of electroconvulsive therapy during this time had convinced many that the root of the imbalance was electrical; once psychopharmacologic treatments became the treatment standard, the conventional wisdom shifted accordingly.

depression. After it was discovered that antidepressants affect levels of the neurotransmitter serotonin in the brain, the term "neurotransmitter" became a central part of the public vocabulary about what depression is and what causes it. Anti-stigma campaigns in particular seized on this piece of (now-outmoded) neuroscientific knowledge, ostensibly because they thought that it would help to decouple depression from questions about the agency of the individual.[34] As Solomon (2001), puts it, "The word chemical seems to assuage the feelings of responsibility people have for the stressed-out discontent of not liking their jobs, worrying about getting old, failing at love, hating their families. There is a pleasant freedom from guilt that has been attached to chemical. If your brain is predisposed to depression, you need not blame yourself for it" (p. 21). An example of the "chemical" explanation is invoked follows below. (I noted that these chemical explanations of dysthymia tended to be drawn upon more often by people who were counseling others—usually people new to the community—on the nature of dysthymia, rather than people describing their own experiences with dysthymia.)

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[34] For years, serotonin imbalance has been considered a major contributing factor to the development of depression in humans. This theory has been bolstered by the fact that the most commonly prescribed antidepressants, SSRIs, affect levels of serotonin in the brain and thus appear to ameliorate depression symptoms by increasing serotonin. Several studies, some of which have made public news, have challenged the serotonin-imbalance theory of depression. In one such study, called a "breakthrough" by popular media, mice were genetically altered, rendering them incapable of producing serotonin. In this study, the mice with no serotonin were not more inclined toward depressive behaviors than their serotonin-producing counterparts. Mice with and without serotonin also responded similarly to antidepressant therapy, suggesting that serotonin may play a lesser role in the development of depression than previously thought. While this study has been fairly well publicized, picked up by *New York Daily News*, for instance, this "news" is hardly new. For many years, mental health professionals and researchers have criticized the serotonin imbalance theory as oversimplified.

(2010, April 5). Re: know I should just wait for the dr… Message posted to http://psychforums.com/dysthymia.

You're right; meds are a serious thing. I also think that you're correct in the sense that the right diagnosis can help you get better meds.

The problem, though is that every person is different, so sometimes finding the right cocktail takes time...and withdrawal...and lots and lots of patience. But once that's found, you're usually good to go. Maybe some minor adjustments. Your neurochemistry is not your fault and nothing to feel bad about. It might be frustrating, but there is a high chance that you will get the correct meds. Especially since you mentioned being more specific with your therapist. Communication is a must..

From a rhetorical perspective, discussions centering on dysthymia's causality and treatment are rich because of how intertwined they are with notions of agency. Kenneth Burke's conceptual pairing of symbolic action/nonsymbolic motion is a useful theoretical lens through which to view these discussions about causality and treatment, and their implications for understandings of agency. Burke's dialectic captures a fundamental distinction that we make about the sorts of occurrences that shape our lives. Briefly put, the difference is between those occurrences that we consider symbolically meaningful, which are positioned within the realm of "symbolic action," and those that we do not, which are positioned within the realm of "nonsymbolic motion." The latter is the realm of that we regard as *determined*, as that which stands stubbornly outside the realm of human agency.[35] This realm would include, for example, sheer physical motions that occur without voluntary human action: waves crashing, wind

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[35] For Burke (1978) the human condition is characterized by a desire for *freedom from motion*. To this end, humans are endlessly preoccupied with transforming the world of motion into phenomena that are amenable to symbolic action.

blowing, hearts beating, lungs filling with air.[36] These are not seen as symbolically agentive acts in and of themselves, but various symbolic meanings can nonetheless attach to them. For example, one has no hand in choosing the physical characteristics of one's cranium, but that did not stop the growth of an entire field (phrenology) dedicated to uncovering the characterological attributes that these physical qualities symbolized.

The realm of symbolic action, in contrast to nonsymbolic motion, consists of that which is considered agentive and symbolically meaningful, and can be symbolically readjusted in accordance with our communicative and rhetorical capacities: all of our communicative actions, our choice of words, our interpretations of others' actions. The tension between symbolic action and nonsymbolic motion fascinated Burke, because he considered this tension so enigmatic, so fundamental to rhetorical constructions of reality and, importantly, so *rhetorically manipulable*. That is to say, whether an occurrence is positioned within the realm of the symbolically meaningful or the nonsymbolically determined is not always as obvious as might be assumed; these matters are continually up for debate and such debates are often impassioned. For example, French and Brown (2011) show how the issue of obesity is rife with debate over whether body shape and size should be interpreted via vocabularies that foreground symbolic action or nonsymbolic motion. Those that favor the former, they argue, take body shape and size to be physical qualities that symbolize the embodied, intentional choices of the individual (e.g. willpower or lack thereof, health consciousness or lack thereof, the acceptance or refusal of social mores). In this view, individuals' symbolic actions can, and should, be called upon overtake the nonsymbolic motion of the individual's body. There is another camp of rhetors,

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[36] It is important to note that Burke does not simply offer the symbolic action/nonsymbolic motion distinction as a way for distinguishing between the mind and the body, or the natural and the social, but, as Crable (2003) has put it, "His terminology describes the process by which these distinctions emerge" (p. 125).

however, who favor treating obesity as a matter of nonsymbolic motion, often putting forth the "set-point theory" to make their case: the set-point theory posits that the body, thanks to a predetermined metabolic rate, has a general weight "setpoint" from which it may fluctuate on the basis of an individual's efforts to manipulate it but to which it will generally return despite these efforts. This theory suggests that intentional actions taken on the part of the individual (symbolic action) are, in general, not enough to overtake involuntary (non-agentive) nonsymbolic motion.

Explanations that frame dysthymia in purely chemical terms, which vaulted to prominence in the context of an advancing biopsychiatry paradigm, take the question of causality and drop it neatly into the confined realm of nonsymbolic motion, where questions pertaining to symbolic action and more importantly, agency do not apply. Health communication scholarship suggests that tendency to stress the chemical components of mental disorder above any possible others (i.e., to utilize motion-heavy vocabularies) has become stronger in recent decades, and is especially noticeable in efforts to loosen the entrenched distinction between physical disease and mental disorder (Barr & Rose, 2008; Kokanovic et al., 2007). The preservation of this distinction is thought to be stigmatizing, as it implies that physical diseases are a matter of motion while mental disorders are a matter of action. And so, attempts are made to use terms that foreground the motion of depression, relegating action to the background. Interestingly, in some ways, the opposite process occurs with respect to physical illnesses, notably cancer. That is, there are efforts made to reframe the experience of cancer in ways that elevate action above motion. The "battle" metaphor of illness—which is associated most strongly with cancer—is one example of such efforts.[37] The "battle" metaphor is ostensibly intended to empower the sufferer in the face

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[37] Metaphors for illness have in recent decades fallen under increased scrutiny, especially since Sontag (1978, 1989) drew attention to their prevalence and unintended consequences, chief among them the implication that individuals bear a sense of moral responsibility for their illnesses.

of what appears to be pure, unrelenting motion—the uncontrolled proliferation of abnormal cells. The battle metaphor reframes this uncontrollable motion, nudging it closer to the realm of human agency.

In discussion of depressive disorders, metaphors are often called upon to perform the inverse of the battle metaphor: to reframe a phenomenon historically linked to the realm of symbolic action—mental illness—and to reposition it within the realm of nonsymbolic motion. One especially well-trodden metaphor that has been drawn upon to drive this transformation is the "depression is to diabetes as antidepressants are to insulin" analogy.[38] This analogy has historically been deployed to induce medication compliance in patients that might otherwise be resistant to the idea of antidepressant medication (McMullen & Sigurdson, 2014). One reason that people cite for not wanting to take antidepressants is that doing so somehow constitutes "cheating." There is a sense that a problem amenable to symbolic action (depression) should not be treated via nonsymbolic motion (antidepressant). Or, as Solomon (2001) has framed this dilemma, "The conflict between psychodynamic therapy and medication is ultimately a conflict on moral grounds; we tend categorically to assume that if the problem is responsive to psychotherapeutic dialogue, it is a problem you should be able to overcome with simple rigor, while a problem responsive to the ingestion of chemicals is not your fault and requires no rigor of you" (p. 102). An example of this dilemma in action follows below, as a poster describes a

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[38] Despite continued widespread usage, this analogy has come under scrutiny both in terms of its accuracy and its usefulness. McMullen and Sigurdson (2014) unravel this analogy by pointing out that: 1) there is no test for depression, whereas diabetes is easily diagnosed via glucose testing; 2) how antidepressants work (and indeed, whether they work) is not well understood whereas the function of synthetic insulin is; 3) depression can improve without treatment whereas diabetes cannot and 4) it is unclear whether the target of this analogy is type 1 or type 2 diabetes and the implications would differ accordingly. Furthermore, patients themselves seem to often be disheartened by this analogy which seems to suggest that (especially if this analogy is understood to refer to type 1 diabetes) depression will be a lifelong affliction requiring ongoing usage of medication.

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thought process that pits the sense that antidepressants as "cheating" against a desire for the

expedient effects that medication might offer.

> (2008, October 1). I need advice. Message posted to
> http://psychforums.com/dysthymia.
>
> My question is this:
> -- How safe are antidepressants? I used to be completely opposed, thinking that I
> can just alter my thought processes, and through the power of plasticity, change
> my outlook. But I keep finding myself thinking of the same things over and over.
> I can live with this -- everyone needs to have a bad day now and then, but I think
> it is affecting my social life. While I don't enjoy sitting in isolation, it almost
> always feels better to me than being around other people -- I'm simply losing
> interest in other people.
>
> My largest fear is that I take anti-depressants, feel better, and then suffer
> withdrawal when I try to stop them. Can anyone recommend an antidepressant
> with the lowest rate of withdrawal symptoms?
>
> My delema is that I feel I would be cheating, or taking the easy way out of this,
> instead of just accepting myself.

The sort of ambivalence about antidepressants permeating the post above is not uncommon.

Scholarship on the subject has been fairly consistent in pointing to the ambivalence and flux that

characterizes people's attitudes toward their antidepressants (Barr & Rose, 2008; Grime &

Pollock, 2002; Karp, 2004). As Barr and Rose (2008) summarize this ambivalence, "On the one

hand, people wanted to continue taking antidepressants if it kept their symptoms away and yet

simultaneously felt that they were 'weaker' for needing to say on drugs and desired to 'sort

themselves out' without recourse to medicine," (p. 953). "Sorting oneself out," it seems, is

perceived as something that is accomplished through the application of concerted symbolic

action, not impassive motion.

It is possible that the need to negotiate the symbolic agency/nonsymbolic motion dialectic is felt especially keenly when discussing dysthymia (as opposed to, say, MDD) because its symptoms are chronic and mild, and as Akiskal (1997, 2001) has noted, difficult to disentangle from the broader concept of "personality." One rhetorical strategy for negotiating the dialectic is to frame causality as a matter of motion—as that which lies outside the agency of the individual—and to frame treatment as a matter of symbolic action, as a matter of agency. This strategy sidesteps reductive vocabularies that would locate dysthymia entirely within the realm of motion or exclusively within the realm of action. It also enables individuals to deal flexibly with the question of agency: agency is renounced as it pertains to causality, and reclaimed as it pertains to treatment. Interestingly, when explanations of causality are framed in psychoanalytic terms (terms that one might assume are suggestive of action more so than motion) the need to renounce agency seemed especially pronounced. For example, see below.

(2012, December 25). Re: Maybe someone can help me out. Message posted to http://psychforums.com/dysthymia.

Things kind of feel like they are getting better. My biggest issue in the past was that I was very guilty about feeling this way. I'd get even more depressed when I couldn't pull myself out of it or just flip a switch in my head and be happy. I compared myself to others way too much. I really hated myself, but I wouldn't admit it because expressing how I felt really deep down inside hurt. But lately I've been seeing that I've just been afflicted with these problems and they aren't my fault. I shouldn't beat myself up so much about problems that I really don't have much control over. I've been a lot more comfortable just expressing my emotions instead of bottling them up because I saw them as a flaw in my character.

My insurance is changing again, but once it does I'm going to be visiting a psychiatrist. One of my biggest issues I believe is my perfectionist mentality. I wanted to be perfect, which is an impossible thing to do. And the only reason I wanted to be perfect was to distance myself far away from my inner self that was damaged and I didn't want others to see that, I didn't even want to see it. I've spent a long time being in denial and thinking if I just ignored my problem enough it would go away.

Classic tenets of the psychoanalytic explanation of mental symptoms are invoked above. This poster claims to have "wanted to be perfect" in order to create distance from an "inner self that was damaged" that s/he did not want "others to see" and did not even want to see him/herself. This builds from the psychoanalytic tenet that unconscious conflicts and the failure to resolve them (for example, "being in denial and thinking if I just ignored my problem enough it would go away") cause the symptoms that characterize mental disorder. The psychoanalytic explanation for mental symptoms might appear to lie closer to the realm of symbolic action than motion, given that unconscious conflicts are thought to carry heavy symbolic weight and that the resolution of symptoms is predicated upon the resolution of conflicts through intensive symbolic intervention guided by an analyst. (Burke [1969] once asked, "What could be more profoundly rhetorical" than psychoanalytic theory [p. 37]). Perhaps it is the whiff of symbolic action emanating from psychoanalytic explanations of causality that prompts the strong renunciations

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of agency phrased above: being "afflicted with problems" that "aren't my fault" and that "I don't have much control over." Given that these problems are not controllable by the individual, it would be unreasonable to expect a person to "pull myself out of it" or "flip a switch." These two metaphors—"pull myself out of it" and "flip a switch"—are conceptually similar to another metaphor that recurs commonly throughout online interactions: the metaphor of "snapping out of it" which is invoked to underscore how unrealistic it is to expect that an individual could pull off such a feat. These metaphors are, at root, concerned with agency, and more specifically with *its renunciation*.

Symbolic action is reclaimed, perhaps paradoxically, when discussions turn to the matter of psychopharmacologic treatment. While antidepressant medication would seem a likely candidate for placement within the realm of simple biological motion—the molecules in the medication alter the behavior of molecules in the brain without intentional, agentive action on the part of the medication-taker—in online interactions it was rarely positioned in this way. Posters frequently caution others against viewing antidepressants as a "magic bullet" or "magic pills" that resolve the problem of dysthymia through simple physiological motion (as posited by the widespread "depression is to diabetes as antidepressants is to insulin" analogy). One poster, responding to another user who wonders whether s/he might have dysthymia, succinctly captures what appears to be a prevalent sentiment:

(2012, September 18). Re: Maybe someone can help me out. Message posted to http://psychforums.com/dysthymia.

Hey,
It's more likely you want a psychiatrist/psychologist(therapist) pairing. Usually psychiatrists make diagnoses. - But avoid one who just prescribes drugs. In my experience, at least, struggles arising out of the brain require more than raw chemical support if they're truly going to be healed.

In this post, the problem of dysthymia has its origins in the brain, but the treatment of this problem "require[s] more than raw chemical support" in order to be effective. Treatment, then, is not treated as a simple matter of motion: there is agency at work here. In many posts, this point is underlined through repeated references to *magic* and *miracles*, with posters counseling one another to expect neither when embarking on an antidepressant regimen. Below, a poster responds to a question about whether dysthymia appears to be accurate diagnosis for the original poster. The poster responds in the affirmative (suggesting that, yes, dysthymia appears to be an accurate descriptor) and then offers the following perspective on antidepressant medication.

(2011, December 10). Re: Maybe I have dysthymia… Message posted to http://psychforums.com/dysthymia.

A point to note: Whatever medication you receive, it will not be a magic pill that will make you start to jump for joy each morning. So, while I do believe that going to a doctor is positive, please don't expect miracles to happen - they never do. Getting through this will involve a long process of changing the habits in your life that are making you feel depressed.

If I were in your situation, I would list the problems - as you see them - and then prioritise them. You mention work, for example. If you feel that it is a major source of your sadness, then make a concerted effort to find a new job. Start by updating your CV/Résumé and then email it to employers. Finding a new job can actually be exciting.

This post pushes back against the supposition that antidepressants solve the problem of depression in the same way motion-based way that insulin solves the problem of diabetes. According to this poster, one should not expect the medication to work either quickly or dramatically. Instead, "getting through" dysthymia entails a "long process" of habit-reformation and expenditure of effort to chip away at the contextual factors that exacerbate dysthymia. Symbolic action—purposeful, agentive effort—is considered a meaningful and necessary part of the process of improving dysthymia symptoms. Antidepressants and the biological motion they represent are thought of as having a role to play in treatment, but this role is *supporting* in scope. The starring role is thought to belong to the individual agent and is performed via symbolically meaningful interventions.

> (2011, December 11). Re: Maybe I have dysthymia… Message posted to
> http://psychforums.com/dysthymia.
>
> I don't expect or even want a "magic pill." I'm just hoping that if I get some
> sort of medication it will put me in a somewhat better frame of mind so I can
> deal with the issues that are making me depressed. I'm just caught in a vicious
> cycle right now. Unfortunately, due to social anxiety, finding a job is not
> exciting. Starting a new job might be, but the road to get there I expect to be
> torturous.

In the post above and in similar posts where the prudence of incorporating an antidepressant regimen into one's life is deliberated, the poster makes a point to temper their hopes for the efficacy of antidepressant medication. "Magic pills" are neither expected nor desired. The expressed hope is a modest one: that the medication will establish a "slightly better frame of

mind" that enables "dealing with the issues that are making me depressed." In these sorts of discussions, people seem to be implicitly recirculating the contemporary psychotherapeutic adage that "antidepressants help those that help themselves"—an adage that foregrounds the role of individual striving, which is *complemented* by, but *not caused* by, antidepressants. While it is clear that *talking about* antidepressant medication is a rhetorical matter, it could be argued that *taking* medication can in some sense be understood as a rhetorical act in itself. In establishing a medication regimen, one is at the same time establishing an explanation for the discontent whose "root cause" might otherwise be inexplicable (dysthymia); doing so also declares that the nature of that discontent lies somewhat beyond the realm of one's own agency. To take medication could be seen as an act that declares one's discontent (at least partly) the product of nonsymbolic motion. And yet, in discussions of treatment, posters frequently underscore the role of individual agency and action in the treatment of dysthymia.

Overall, it appears that one strategy drawn upon to navigate the action/motion dialectic is to *renounce agency* as it pertains to the causality—to position it beyond the scope of individual control—and to *reclaim agency* as it pertains to dysthymia's treatment.[39] Coming down too forcefully on one side or the other of Burke's symbolic action/nonsymbolic motion dialectic could guide rhetors toward vocabularies with largely undesirable implications: if dysthymia is to be considered exclusively within the realm of symbolic action, then there is a clear risk of wading into the stigmatizing territory known as "victim-blaming"; conversely, if dysthymia is

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[39] While researching this dissertation, I observed a University of Pittsburgh Medical Center (UPMC) advertising campaign that seems to be premised on this precise rhetorical strategy: renouncing individual agency as it pertains to causality and then reclaiming agency where treatment is concerned. The campaign is built on patients' relaying their illness narratives, always ending with the slogan: "I didn't choose _____ (for instance, a brain hemorrhage, cancer, or some other ailment) but I did choose UPMC." Agency, in this formulation, is renounced with regard to the illness, and then reclaimed via choosing healthcare providers.

construed as a matter of sheer motion, a picture is painted of a hopeless situation with a helpless protagonist. By renouncing agency vis-à-vis causality and seizing agency vis-à-vis treatment, one avoids the rhetorical excesses and unwelcome implications that could result from coming down exclusively on either side of the symbolic agency/nonsymbolic motion divide. At a time when "patient agency" and "patient empowerment" have become buzzwords in discourses of health and illness, attention has been focused primarily on how agency is seized by patients, which both reflects and contributes to a growing tendency to regard health and illness as matters of symbolic action.[40] Given this tendency, rhetoricians of medicine might begin to inquire into the inverse: how is agency resisted or renounced in matters of health and illness?

2.3   THE FITTING ROOM: "GETTING INTO" DIAGNOSIS

The section above has examined online discussions that work to define dysthymia, and has considered how these definitions are intertwined with the complicated matter of agency. As has been suggested, these acts of definition center often on the question of causality—where does dysthymia *come from*?—and treatment—how is this disorder to be managed? Aspects of both the psychoanalytic paradigm and the biopsychiatric paradigm animate such discussions. When considering dysthymia's rhetorical role within the *DSM-III*—the fact that it was, in effect, a "compromise" disorder—it is perhaps unsurprising that aspects of both paradigms underpin

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[40] Sociologist Robert Crawford refers to a similar phenomenon that he calls "healthism" and defines as the "striking moralization" of contemporary health-talk. Monica Greco (1993) suggests that the moralizing qualities of contemporary health discourses work to instill in subjects a "duty to be well."

discussions about what dysthymia is and how to treat it. Having established dysthymia's strategic ambiguity within the context of *DSM-III* and how this ambiguity is harnessed in contemporary online discourses about dysthymia, attention will briefly now turn to another piece of history from the *DSM-III*. This component of the *DSM-III* has been called its most significant contribution to Western psychiatry: the "Feighner" criteria, or the concept of utilizing diagnostic criteria in the form of itemized symptom lists to guide both psychiatric classification and diagnosis.

Within the psychoanalytic tradition, diagnosis did not play an especially significant role in treatment. Some analysts even thought that presenting patients with a formal diagnosis could damage their therapeutic work together. However, as the biopsychiatric revolution gathered momentum, diagnosis took on unprecedented significance. For a field that was trying more and more to contour itself into the shape of an empirically grounded science, weak diagnostic reliability was psychiatry's Achilles' heel. Prior to the *DSM-III*, the likelihood of two practitioners agreeing on a given patient's diagnosis was said to be barely better than chance (Kendler, 2010). This was, as McCarthy and Gerring (1994) point out, a major rhetorical problem for a field that was struggling to be seen as a legitimate scientific endeavor, modeled after and equally valid to Western biomedicine.

Within this context—a field struggling to strengthen its diagnostic reliability—an important paper entered into the fray in 1972, written by John Feighner and other researchers at Washington University titled "Diagnostic criteria for use in psychiatric research." The aim of the paper was to codify diagnostic criteria for 15 mental disorders, including what would eventually become Major Depressive Disorder. The paper affirmed the Kraepelinian tenets that mental disorders should have firm definitions, and that these definitions should be built upon itemized

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symptom lists and exclusionary criteria (Kendler et al., 2010). These itemized lists came to be known as the "Feighner criteria."

The Feighner criteria were not formulated necessarily for practitioners but for researchers, as they were "an attempt to relive researchers of the multiplicity of different imprecise definitions then in use and thus to make possible more cumulative, comparable, and reproducible research" (Horwitz & Wakefield, 2007 p. 91). But the Feighner criteria had its biggest impact on clinical diagnosis, as diagnosis thereafter hinged upon patients manifesting a minimum number of symptoms from the list. As Shorter (2015) puts it, "The main innovation of the *DSM-III* was not the architectonics of the diagnosis, but in the Feighner "diagnostic criteria," the list of symptoms a patient would require in order to "get into" the diagnosis, as the expression went" (p. 62). Once the Feighner criteria were adopted as the organizational blueprint for *DSM-III*, definitions of mental disorders became, in essence, equivalent to their symptoms.

A *Psychiatric Times* article, published in 2010, metaphorizes the Feighner criteria as "fishing nets" and nosologists as fishermen, since, "Fishermen, like nosologists, want to capture not just *any* fish" (Sadler, 2010). Because fishermen want to catch "not just any fish," fishing nets are constructed to be simultaneously inclusionary and exclusionary—to lock certain fish in, and allow others out. In the same way, the ideal diagnostic category is built in such a way that

the appropriate patients easily "fit into" a diagnosis while at the same time ushering others out by way of, primarily, exclusionary criteria.[41]

In theory, it stands to reason that, like fishing nets, diagnostic criteria operate as intended when their subjects are *not acutely aware of them*. If fish became aware of the details and placement of fishing nets, they would be better equipped to avoid them; the same could be true of patients and diagnostic criteria. Since the diagnostic criteria are, for the most part, based on patient-reported symptoms rather than externally observable signs, a patient wishing to evade a particular diagnosis could merely neglect to report certain symptoms in order to avoid a particular diagnosis. [42] However, thanks to developments in communication media, as well as the successes of the consumer health movement—which demanded perhaps above all greater accessibility of health information—diagnostic criteria for various mental disorders are a mere Google search away.[43] The metaphorical patient-fish now knows where the net is cast, what it looks like, and most interestingly, appears to *want to be caught*.

When embarking on this research project, I initially thought that, for the undiagnosed, online mental health communities likely functioned as digital waiting rooms, frequented by

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[41] Exclusionary criteria are intended to steer certain kinds of patients out of a given diagnosis. For example, the *DSM-IV* listed bereavement (stipulated as the loss of a loved one within the past two months) an exclusionary criterion for Major Depressive Disorder diagnoses. This criterion was supposed to prevent the misdiagnosis of "normal grief" as clinical depression. Controversially, *DSM-V* (2013) has removed this bereavement exclusion, claiming that the exclusion gave the false impression that grief somehow had a protective effect against depression and caused clinicians to overlook some number of depressed patients. See:
http://www.dsm5.org/Documents/Bereavement%20Exclusion%20Fact%20Sheet.pdf.

[42] This does not hold true for all mental disorders. For instance, some of the symptoms of schizophrenia are often externally observed rather than patient-reported.

[43] The "consumer health movement" refers to the number of advocacy groups that coalesced during the 1970s, most of which were organized around the themes of accessibility (of information) and empowerment. The women's heath movement played a significant role in shaping the organizing rhetorics of these groups. As Kline (2005) explains, "Education and self-help were central strategies…In the process, ordinary women transformed themselves from passive patients to active consumers, building feminist coalitions centered on patients' rights, disability rights, and reproductive rights" (p. 82).

people biding their time until they could get the appropriate authority to perform diagnosis. But I have come to think that these communities function more like digital fitting rooms, in which one can try "getting into" a diagnosis and solicit feedback from others about how well the label "fits." This metaphor first occurred to me because of the persistence of discussions referencing the degree of "fit" between the individual and the symptom profile of dysthymia. Some posts convey a high degree of certainty about the appropriateness of the fit, with users claiming that the psychodiagnostic label "fits me like a glove." Other posters express their uncertainty by describing which aspects of the label seem to fit them and which do not. Another slight variation of the "fit" phrasing occurs when posters describe how "I fit it" (where the "it" refers to the diagnostic category of dysthymia). The difference between these two phrasings is subtle, but also meaningful as they imply different views on the relationship between the patient and the disorder. In one instance, the disorder "fits" the patient and in the other, the patient "fits" the disorder.

The "I fit it" phrasing maps more smoothly onto the original logic of the Feighner criteria, constructed as a screen that allowed certain patients in and filtered others out. The patients who "got into" diagnosis, as the expression went in psychiatry, were the ones who met the minimum number of "required" symptoms. When one states that they "fit" into the diagnosis, it could be argued that the individual is operating from a biomedical perspective on the relationship between patient and disease, in which the patient is regarded *as an instance of* a given disease category. This perspective emphasizes the universality of disease characteristics— one of four central assumptions underlying Western biomedicine (Mishler, 2002)—over the

individual characteristics of the patient presenting with the disease. [44] According to some, this

perspective regarding the presumed universality of disease characteristics is weakening, as

medical practice is undergoing an "epistemological shift…from doctor-centered to patient-

centered care" (Kokanovic et al., 2013, p. 116). One consequence of this shift is an emphasis on

patient *heterogeneity*, which has meant that, "Patients are no longer considered as specific

instances of a disease to be locally negotiated" (May et al., 2006, p. 1024-1025). Nonetheless, an

example of the "I fit it" phrasing—which conforms more closely to the view of patient as

instance of disease—follows below.

> (2005, December 28). I know I don't have this…advice?? Message posted to
> http://psychforums.com/dysthymia.
>
> More specifically, I'd like to know if your moods can switch rapidly. Can you
> have a longterm undercurrent of mild/severe depression, yet daily fluctuate
> between being unable to get out of bed and complete routine tasks, then feel a
> rush of energy and euphoria that leads to rapid, excited talking; routinely
> sprinting up to six miles; and being the "life of the party," while sober? Or
> feeling the psychomotor retardation symptoms while feeling utterly euphoric
> and optimistic about your life?
>
> I know that I DO fit many (or all) of the basic criteria (chronic fatigue,
> overeating, hypersomnia, etc) but I don't meet the following: "Individuals
> experiencing Dysthymic Disorder generally experience little or no pleasure in
> their lives. They see life instead, as gloomy and sad. If you are experiencing
> Dysthymic Disorder it may seem like you have been depressed your whole
> life; never knowing a time when you were happy, content, or excited."

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[44] Misher (2002) claims that four underlying assumptions about health, bodies, and illness govern the
model that has come to be called "biomedicine." First, disease represents a divergence from the body's
standard, measurable mode of function. Second, diseases result from specific causes, the origins of which
are scientifically discoverable. Third, diseases have universal features in terms of their symptoms. Lastly,
physicians ideally operate as agents of science.

As this post shows, the specific diagnostic criteria for dysthymia, and whether or not the user "meets them" is the focus; little information is provided about the details of the poster's personal experience with dysthymia. In short, the details of the category are emphasized over the experiences of the individual.

The opposite phrasing occurred with greater frequency throughout the posts that I observed. That is, phrasing that involved some variation of "it fits me" rather than "I fit it" (again, "it" being the diagnostic category of dysthymia). In this case, it could be argued that the unique experiences of the individual are emphasized above the universal characteristics of the diagnostic category. In such instances, the diagnostic label is being deployed in a way that *particularizes the self*; the label becomes a layer of personal identity. Admittedly, the difference between these two phrasings is subtle. However, it is the difference between positioning oneself within the confines of a category, and using a category to particularize the self. Examples of the "It fits me" phrasing follow below:

> (2007, May 30). So…I have dysthymia. Message posted to
> http://psychforums.com/dysthymia.
>
> I've long suspected that I've had dysthymia, ever since I read about it on wikipedia. The description on the site fit me like a glove. I haven't experienced pure joy or happiness for a long time now. I've had a few episodes of major depression in my life, coupled with the dysthymia. I don't remember much about middle school, except taunts, bullying, and "friends" making my life a living hell.

In instances of "it fits me" phrasing, details of the poster's personal experience are often included, such as in the above post wherein details about the individual's middle school experiences and challenges with friendships are referenced. A second example follows.

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(2012, July 8). Re: I am new to all of this. Message posted to
http://MDJunction.com/dysthymia.

I have never been on medication, just received my first dose of Prozac today
and will start tomorrow taking those. I am awaiting further diagnosis with a
psych in the coming months. I honestly never thought of bipolar being a
option, but now that I have looked into it, Bipolar II/Cyclothymia might be a
good fit and at the pre-screening I had today I remember the doctor mentioning
cyclothymia as a possibility. Personally I still go wit the assumption of
Dysthymia because I feel it fits better, but I will take anything at this point, and
am very thankful to you for pointing this out for me.

In these posts, the category of dysthymia fits the self, rather than the self fitting into the category

of dysthymia. Other possible "fits" are considered, which is part of the reason I began to view

online health communities as "fitting rooms" for the not-yet diagnosed. While posters often

discuss the reasons that dysthymia is a good fit as a diagnostic label, many are inclined to focus

on the reasons why the label might not fit. When I initially began researching dysthymia and the

process of self-diagnosing it, I assumed that, because dysthymia is a "subthreshold" mood

disorder (a state that is not "normal" but is less pathological than a major affective disorder) that

people self-diagnosing it would be very confident in their diagnosis: because of its vague

symptoms, it would not be difficult for people to "see themselves" in the list of symptoms. But it

seems to me now that the same broad, elastic diagnostic criteria that makes it easy to "see

oneself" in the label, are perhaps equally likely to invite uncertainty on the part of the self-

diagnoser. Perhaps the broader the diagnostic criteria, the more likely people will be to focus on

the ways in which their experiences diverge from the criteria. For a brief example, see below.

(2012, April 2). Re: Definition, Symptoms, Causes & Treatment. Message posted to http://psychforums.com/dysthymia.

I've got a question about dysthymia.. can someone have this and feel emotionless? and be easily irritable? because most other things fit. I feel like I'm between everything, diagnosis-wise

For people considering dysthymia as a potential diagnosis, and perhaps for people considering the appropriateness of other "subthreshold" mood disorders, the sense of being "in-between" diagnoses appears common. In some posts, the poster focuses more on the reasons why dysthymia might *not* be an appropriate diagnosis as opposed to the reasons that it might be appropriate. In these sorts of posts, though, it is important to note that the poster appears not to deliberate whether they have dysthymia or *no* mental disorder at all; rather, they contemplate whether they have dysthymia *and/or* some other mental disorder. When posters disclose the ways in which their experiences might be at odds with the diagnostic criteria for dysthymia, these divergences are often accounted for by referencing the possibility of other disorders— whether as sole diagnoses, or as "comorbid" (i.e., co-occurring) disorders.

Interestingly, Giles and Newbold (2013) have pointed out how the issue of comorbidity, when disclosed in online health communities, threatens the coherence of the illness identity around which the community is formed. They state, "Comorbidity—the existence of two or more diagnoses in the same individual—is a frequent phenomenon in mental health practice, it threatens the acquisition of a coherent online identity such as "bipolar" or "aspie" (p.482). In the communities studied here, this did not appear to be a concern. It is possibe that because of its ambiguity diagnostic profile (when compared especially to its counterpart, MDD), dysthymia does not invite concerns about coherence in online health communities; the concern is more

about proving the existence of a disorder (*any* disorder—as one user states, "I will take anything at this point") in a person who might otherwise appear non-disordered.

> (2010, April 1). I know I should just wait for the dr… Message posted to http://psychforums.com/dysthymia.
>
> That said, I don't meet the requirements for major depression right now (I have in the past) and I have been dealing with this thinking back, probably since 10-12. Its only gotten worse, it seems, especially over this past year, when my symptoms have skyrocketed. Even my hubby says they have. I have self injury issues, and I have had social issues as far back as 5-6, when I used to let friends walk all over me and wouldnt stand up to them, and it has only gotten worse to the point that soemtimes I get afraid to even talk to people. Other times its nto so much of a problem. Still, whatever this is, its been around a long time and it only sometimes seems to be as deep as moderate-major depression. Like I can still function readily, just not without feelign like I want to rip someones throat out frequently, or not without snappign at people for even so much as looking at me wrong. Unless I am havign soem of my joyful periods, then you cant get me down.
>
> I guess dysthymia fits me better because of the length of time I have been dealign with it, but I am not always down...
> seriously, i dont think I fit into any category, yet fit into them all.
>
> (2010, April 3). Re: I know I should just wait for the dr… Message posted to http://psychforums.com/dysthymia.
>
> Like I said in the other posts, check into cyclothymia.
>
> These angry outbursts can be difficult to separate from bipolar...I think that if you think really hard and find a root cause for something (like the anger, which appears to stem from social issues rather than a mental illness), then you'll be able to find a more accurate diagnosis together with your therapist.

The ubiquity of language pertaining to "fit" is what initially led me to consider that online health communities for mental disorders might function more akin to "fitting rooms" than "waiting rooms." Though, the more I read through postings, the more the metaphor seemed apt. People in

these spaces try on diagnostic labels, and like clothing, assess the fit—too loose? too long?—before deciding whether to proceed with the "purchase." People deliberating a diagnosis, like those deliberating a clothing purchase, not only focus on how well the label fits, but the ways in which the label fits poorly. Soliciting feedback from others helps to allay concerns, or to intensify them. This process seems to bear little similarity to the processes of self-diagnosis that Segal (2005) and Emmons (2010) imagine, as outlined earlier in the chapter. Segal, for example, suggests that diagnostic information, "arguably too available" (p. 83), when discovered by a person feeling "unusually miserable," translates sadness into the vocabulary of disorder, which in turn spurs a self diagnosis that propels them to their doctors' offices to request diagnosis and, more importantly, a prescription for antidepressants. Emmons, likewise, views the process of self-diagnosis as a *monological* one, wherein people construct health and illness identities in isolated interactions with texts. Both accounts seem to suggest that people are quickly and wholly persuaded about the appropriateness of the fit between diagnostic criteria and their "symptoms." And yet, as this section shows, uncertainty about the appropriateness of fit was a common theme of posts, often followed up with solicitation for feedback from others.

Another similarity between the clothing store fitting room and the online health community fitting room is that, in general, *people seem not to want to leave empty-handed*. That is, no one appears to leave the community persuaded that they are not suffering from any form of mental disorder. This became especially apparent to me when, for reasons unrelated to this dissertation, I began visiting an online health community for a particular type of precancer/cancer. In this community, the posts from people diagnosed with precancer vastly outnumbered the posts from those diagnosed with cancer (much to the chagrin of those in the community with cancer diagnoses who described feeling pushed out of the community by those

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with lesser diagnoses). One reason for this asymmetry is undoubtedly because people are diagnosed with precancer in far greater numbers than cancer. But it seemed to me possible that the *uncertainty* attached to precancer motivates these posts: precancer occupies a liminal space between cancer and non-cancer, in much the same way that dysthymia is thought to mark a "midpoint" between normal happiness and major depression. In any case, I noticed that anxious precancer posters who wondered whether they had undiagnosed cancer (rather than simply precancer) seemed to be following a procedure similar to dysthymia posters: describing symptoms, offering a possible diagnosis to account for one's symptoms—undiagnosed cancer (as opposed to mere precancer)—and requesting feedback from others about the likelihood that the self-diagnosis was correct. However, in the precancer/cancer community, the posters appeared to be seeking assurance that the label did not fit, that the explanation of cancer was *not a good fit* for their symptoms. The precancer posters wanted to leave the community empty-handed, unburdened of the suspected diagnosis. In dysthymia communities, the opposite seems to be the case. People seek assurance that they have a suspected diagnosis, they seek assurance that the label seems to be a good fit. And when the label is deemed ill fitting, other possibilities are broached by the poster or offered up by the other posters who chime in. Again, they seem not to want to leave empty-handed; in the words of a poster above "I still go wit[h] the assumption of Dysthymia because I feel it fits better, *but I will take anything at this point*" (italics added).

2.4   SUMMARY AND CONCLUSIONS

This chapter has woven together a brief history of dysthymia's construction as an ambiguous diagnostic classification with observations about how this definitional ambiguity is harness as a rhetorical resource in dysthymia online health communities. The historical context recounted within this chapter suggests that dysthymia's definitional ambiguity was not (only) a strategy for expanding the population to which a depressive disorder could be applied; this definitional vagueness was (also) intended to smooth tensions simmering between psychoanalysts and biological psychiatrists during production of the paradigm-shifting *DSM-III*. Robert Spitzer, head of the *DSM-III* task force and epistemological diplomat, oversaw the construction of dysthymia as a "borderline" depressive diagnostic entity that honored aspects of both paradigms. Specifically, dysthymia was fashioned as a "minor" or "mild" complement to Major Depressive Disorder— considered a hallmark disorder of the biopsychiatric paradigm that would go on to be diagnosed twice as often—but that notably diverged from its better-known nosological cousin in terms of temporality. Because dysthymia was defined as chronic (whereas all other affective disorders were considered episodic) it aligned with the sensibilities of psychoanalysts who considered such patients not to merely "have" depression but to essentially "be" depressives, and thus potential candidates for long-term talk therapy.

Next, this chapter turned attention to interactions in online health communities, exploring how explanatory aspects from both psychiatry paradigms—the psychoanalytic and the biopsychiatric—blend together in online discussions centered on dysthymia's causality and treatment. This section of the chapter employed Kenneth Burke's conceptual pairing of symbolic action/nonsymbolic motion as a theoretical lens through which to observe discussions of causality, treatment, and agency in online health communities. In doing so, it suggested that the

contemporary biomedical/biopsychiatric explanation of dysthymia (which emphasizes its neurochemistry) positions the disorder within the realm of "nonsymbolic motion"—Kenneth Burke's term for the realm of the determined, that which resists linguistic influence or other forms of symbolic intervention. The psychoanalytic explanation of depression, however, conceptualizes depression as a manifestation of inner conflicts bubbling away within the unconscious, which need to be symbolically rendered in order to attain resolution; this account positions dysthymia somewhere within the realm of symbolic action—that which can be intentionally altered by symbolic engagement. In short, it would seem that the psychoanalytic account of dysthymia *implicates individual agency* as it pertains to dysthymia, and that the biopsychiatric account *dispels individual agency* as it pertains to dysthymia.

Contrary to what might be expected, this chapter found that when psychoanalytic explanations of dysthymia's causality were invoked, individual agency tended to be *renounced,* and when antidepressants (championed by the biomedical paradigm) were discussed as a method of treatment, individual agency tended to be *reclaimed*. This rhetorical strategy navigates the symbolic agency/nonsymbolic motion dialectic by resisting totalizing vocabularies that would locate dysthymia exclusively within the realm of motion or exclusively within the realm of symbolic action. To locate dysthymia squarely within the realm of motion would have the benefit of perhaps obviating questions about responsibility for one's illness, but might have the undesirable side effect of leaving one with the uneasy sense that they are simply at the mercy of the body. On the other hand, to locate dysthymia squarely within the realm of symbolic action would grant that individual striving is potentially efficacious in the management of one's illness, but might have the potential side effect of framing the existence of the illness itself as a matter of voluntary action, as an expression of one's will (or lack thereof). As "patient agency" and

"patient empowerment" increasingly permeate health discourses, it will likely be important for rhetoricians to not only inquire into the rhetorical strategies that patients employ to *claim* agency, but also the strategies they use to *renounce* it. Perhaps such inquiries will turn up strategies similar to the one observed in this chapter: the renunciation of agency as it pertains to causality and the reclamation of agency as it pertains to treatment.

Lastly, this chapter offered a metaphor for thinking about online health community interactions in which informal self-diagnosis seems a frequent aim: the fitting room. This section of the chapter recounted an important historical morsel from the *DSM-III* revision context: the 1972 "Feighner criteria"—a paper credited with mainstreaming the usage of operationalized diagnostic criteria in psychiatric classification and diagnosis. The Feighner criteria helped establish contemporary diagnostic processes in which patients must manifest a minimum number of symptoms from itemized lists in order to "get into diagnosis," as the expression went. At the time the Feighner criteria were adopted into widespread psychiatric usage, researchers probably did not imagine that in a few short decades, these itemized symptom lists would be as widely and easily accessible as the Internet and direct-to-consumer advertising has made them. This has led to concerns that individuals wishing to be diagnosed with a given mental disorder will simply memorize the diagnostic criteria and parrot it back to practitioners who will have no choice but to allow the patient to "get into" that diagnosis. An assumption underlying these concerns is that people wishing to "get into" diagnosis act with certainty that their self-selected diagnosis is the correct one. This is an assumption that I began researching with, and for this reason, I supposed that dysthymia online health communities probably functioned akin to waiting rooms: spaces where people simply bide their time as they await formal diagnosis.

Instead, this chapter posited that online health communities for dysthymia function more like metaphorical "fitting rooms," as spaces wherein people "get into" or "try on" diagnostic labels, assess the appropriateness of the fit, and solicit feedback from others before taking further action (such as, for example, stating their intention to pursue formal diagnosis). This metaphor was initially born out of noticing the frequency of references to diagnostic "fitness" throughout the communities: people often deliberated about how well the label of dysthymia "fit them" or, alternately phrased, how well they "fit into" the label of dysthymia. Beyond this ubiquitous language of fitness, people in the metaphorical fitting room act in other ways that are similar to patrons in clothing store fitting rooms: they solicit feedback from others about how well the label fits, often try on more than one label, and perhaps most strikingly, appear not to want to leave room empty-handed. (In the words of one poster, "I will take anything at this point.") The fitting room metaphor may be especially appropriate considering the era of so-called "consumer-driven" healthcare in which we are said to have entered. While in the past, scholars have focused on the injustices visited upon populations who are disproportionately ushered into depression diagnoses (Charland, 2004; Hurt, 2007), it is possible that in our contemporary context of consumer-driven health care, diagnostic injustice will be thought to occur primarily when people are excluded from diagnosis, turned away empty-handed.

3.0   COMING TO TERMS WITH TEMPORALITY

> Like physical pain that becomes chronic, [mild depression] is miserable not so much because it is intolerable *in the moment* as because it is intolerable to have *known it in the moments gone* and to look forward only to *knowing it in the moments to come*. The present tense of mild depression envisages no alleviation because it feels like knowledge.
>
> —Andrew Solomon, 2001

While drafting this chapter in 2016, the findings of a new study, published in the *Journal of Psychopharmacology,* made their way into popular science media coverage. With its somewhat cumbersome title, "Decreased mental time travel to the past correlates with default-mode network disintegration under lysergic acid diethylamide," the study offered evidence that the ingestion of lysergic acid diethylamide (better known in its acronym form, LSD) appeared to improve depression symptoms in the study's participants. The authors did not attribute this therapeutic effect to LSD's widely known and much fabled propensity to alter sensory perceptions; rather, they hypothesized that this benefit stems largely from the drug's potential to alter how people *think about time*. The implication of the study, then, is that certain ways of thinking about time are intertwined somehow with the subjective experience of depression, including specifically one particular way of temporalizing that the study dubs "mental time travel." The authors define this phenomenon as the "ability of humans to mentally project

themselves backwards and forwards in time, to recollect aspects of past autobiographical

episodes or imagined future experiences" (Speth et al., 2016, p. 344). According to the study, a

predilection for so-called mental time travel, as measured by fMRI technology, was

disproportionately identified in the brains of people diagnosed with depression and subsequently

diminished post LSD-consumption, alongside the severity of depression symptoms. This study

immediately caught my attention because its findings—though arrived at via radically different

methods and with radically different objects of inquiry—resonated with what, at the time, were

shaping up to be the central claims offered by this chapter.

In the broadest terms, this chapter argues for the importance of attending to the *temporal*

dimensions of subjective accounts of dysthymia.[45] This claim stems from an observation made

during the initial analysis of the online health communities studied here: subjective accounts of

dysthymia frequently formulate the problematic experience of dysthymia in ways that seem

deeply rooted in particular perspectives on time. This chapter first examines how, in a practical

way, the temporalizing of dysthymia accounts in online health communities enables practices of

informal self-diagnosis—a common communicative aim of online mental health communities in

general (Giles, 2011). This chapter terms one such practice "retrospective identification." On a

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[45] With the exception of the literature review, I mostly use the term "account" rather than "narrative" because it has, to my ear, a slightly more befitting rhetorical undertone, although narrative would be an accurate description of the content of the posts in online health communities studied here. While "narrative" is generally defined as the relaying of causally related events, an "account" could be considered a particular sort of narrative, one that renders the author "accountable" to a given audience in a given context. As Radley and Billig (1996) suggest, "accounts are always produced in situations and they gain their meaning from the rhetorical activities of those situations" (p. 224). Such accounts are neither stable nor undilemmatic, especially as they pertain to matters of health and illness. As Radley and Billig further point out, "Any shortfall in health has important implications for other areas of one's life (e.g. work, personal relationships), in terms of which people feel that they are evaluated. Accounts of health and illness are, therefore, more than descriptions of one's physical conditions…They also articulate a person's situation in the world, and indeed, articulate that world, in which the individual will be held accountable to others" (p. 221).

more abstract level, the ways that these accounts are temporalized shape understandings of agency and possibility as they pertain to the disorder's recollected onset in the past and anticipated trajectory in the future.

The relationship between temporality and illness has been a topic of interest across the social sciences and humanities, with a particular emphasis on the experiences of individuals with chronic illnesses, as well as their caretakers, who often construct new time structures and perspectives in the event of diagnosis and the subsequent trajectory of illness.[46] Though they may seem somewhat abstract, temporal perspectives often have practical aims and concrete effects in practice: they are constructed to respond to the daily challenges—physical, social, rhetorical, etc.—that often crop up in the wake of chronic illness. Charmaz (1992), for example, describes how people with chronic illnesses often immerse themselves deeply within the immediate present, constricting their views of time in an effort to exist within a temporal framework that she terms "living one day at a time."

"Living one day at a time" has some practical advantages. For some, putting on temporal blinders seems to ameliorate the general sense of overwhelmedness that often accompanies long views of a future replete with appointments stacked upon appointments, continual recalibration of medications, batteries of tests and so forth. Living one day at a time also divides the various forms of ongoing labor that many chronic illnesses necessitate into more manageable, discrete chunks. This immersion in the present, according to Charmaz (1992), often has the ultimate effect of *conferring control* in the face of the profound destabilization and uncertainty that chronic illness so often presents. This chapter will return to this particular temporal

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[46] Though related, time "structures" and "perspectives" have slightly different meanings within sociology literature; the former has to do with the practical management of time as it pertains to daily activities, the latter has more to do with the ways in which people reflect upon and broadly conceptualize the past, present, and future.

perspective—"living one day at a time"—because it provides a stark counterexample to the sorts of temporal perspectives constructed in the online accounts of dysthymia studied here.

In addition to having practical effects on, for example, the management of medication regimens or juggling of appointments, ways of thinking about time *guide the construction of illness accounts*. And how these illness accounts are temporalized configure and convey a narrator's ideas about agency and responsibility as they pertain to health and illness. As Bulow and Hyden (2003) argue, the temporalizing of illness accounts, and the punctuation of events therein, shape understandings of constraint and possibility:

> Every suffering and illness has a history—a past, a present, and a future. Thus suffering and illnesses raise questions associated with temporality: were the past events necessary and unavoidable, could anything else have happened, and what will happen next?...The construction of the order and the relationship between events involves asking questions about factors including the result of one's own action or lack of action, about necessity and externally-originating constraints, about what might have been possible but never occurred (p. 71-74).

As the authors suggest above, the temporal aspects of illness accounts engage the thorny and rhetorically malleable matter of should be regarded as the most salient contributing factor to one's current state of health/illness: externally-originating constraints or internally-motivated action (or lack thereof). Such determinations—or more precisely, the *processes by which such determinations are made*—were at the heart of Burke's interest when he crafted the dialectical

pairing of symbolic action and nonsymbolic motion, an important concept from the previous chapter.

After synthesizing several bodies of literature to establish the relationship between temporality and subjective accounts of illness, this chapter probes the temporalizing of dysthymia accounts in online health communities. First, it explores the general characteristics of the temporal perspectives commonly established within the context of the online health communities studied here, perspectives that are dubbed "panoramic." Briefly summarized, panoramic temporal perspectives are characterized by *temporal expansion* (rather than the contraction that has been observed within accounts of chronic physical illness) and are marked by a declared sense of detachment from the present rather than an immersion within it. Next, the chapter focuses on a communicative aim that these expansive temporal perspectives ostensibly help accomplish, and which might be particularly salient in an age of online health: a practice that this chapter terms "retrospective identification." Retrospective identification is a practice through which aspects of the self previously understood as part of one's "personality" come to be understood as symptoms of dysthymia, the clinical diagnosis of which requires (minimally) two years' worth of mood recollection on the part of the patient. Lastly, this chapter points to the ways in which panoramic temporal perspectives shape seem to perceptions of the future, including the anticipated trajectory of the disorder.

3.1 THE OBJECTIVITY AND SUBJECTIVITY OF TEMPORALITY

The central focus of this chapter is the subject of time in online health accounts of dysthymia, or more specifically, the subject of temporality. First, it bears mentioning that "time" and "temporality" are related concepts but not equivalent: temporality generally refers to the experience of lived time. The role that time plays in terms of shaping both the broad rhythms of collective life and the finer details of individual experience has made it a topic of interest across many fields, an interest that is perhaps especially keen for phenomenologists, psychologists, and sociologists. Often quoted in literature reviews of time is sociologist Emile Durkheim, who regarded time as the ultimate engine of social order, without which "society" as we know it would be unthinkable.

The so-called "macrosocial" view of time—that is, viewing time as a sort of social glue or engine of collective order—is useful for explaining societal rhythms and flows, but sheds dim light on the *subjective* experience of time, and does not account for the ways in which individuals can have widely variable experiences of time even when said experiences are unfolding in the same given context (Flahtery, 1999). A two-hour lecture, for example, might pass rapidly for the lecturer, while the same two hours might pass agonizingly slowly for a particular audience member.[47] Phenomenologists have taken up the question of what accounts for this variability, operating from the premise that temporality is, on its most basic level, a fundamental layer of subjectivity. Part of what makes the subjective experience of time

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[47] Flahtery (2000) has suggested that one's perception of time is especially likely to expand based on very high or very low levels of activity. An experience that seems packed with activity, such as a car accident for example, can seem to stretch on forever, as can a period of time characterized by low levels of activity, such as waiting on the phone for customer service.

compelling is the fact that we can go about our lives often completely unaware of the role

temporality plays in shaping the emotional character of our experiences, while at other times we

are acutely aware of time's passage and the various emotional impacts it has on us, including, for

example, frustration, (it has been said that boredom is simply an awareness of time passing),

sadness, nostalgia, etc.[48]

Temporality can be difficult to theorize because it arguably rests somewhere between the

objective and subjective, or perhaps, as has been suggested, it arises from the interplay between

the two (Flahtery, 2000). There is clearly an objective dimension to time, captured in the various

metrics that have been constructed to coordinate our social rhythms: clocks, timers, calendars,

etc. These technologies may objectively *mark* time, but as media studies scholar Nowotny (2015)

has remarked, they can never subjectively *make* time.[49] The only thing that "makes time" is a

human subject, and this occurs by fusing together the heterogeneous, discrete moments of lived

experience into a "coherent sense of persistence" (Flahtery, 2000, p. 1).

The transformation by which discrete moment-to-moment experiences gel into a coherent

thread of perception is generally referred to in time-oriented literature as the phenomenon of

"duration." The essence of duration, according to Edmund Husserl, who wrote prolifically on the

nature of time consciousness, is the continual interplay between memory and experience.

Without memory of the discrete moments in time that elapsed prior to the unfolding present,

there would be no building blocks from which to fuse together a sense of duration; likewise, the

recollection of past experience produces future-focused expectations that shape one's experience

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[48] While nostalgia is often theorized spatially—as a desire to return to a particular *place*—Boym (2001) argues that it is perhaps more often a longing for immersion in a different kind of time, "the time of our childhood, the slower rhythms of our dreams" or perhaps "time out of time, not encumbered by appointment books" (p. 8).

[49] Nowotny (2015) writes, "technologies alone can never manufacture time, any more than clocks" (p. 39).

in the present.[50] Minkowski (1933) famously called the experience of duration "lived time" and for this reason suggests that time is, "a synonym for life in the broadest sense of the word" (p.13). This is a claim that bears resemblance to Aristotle's formulation of time in *Physics,* in which he proposes that time could be considered the sum total of change or movement within the world.

3.2   BEYOND LINEAR VIEWS OF TIME

George Herbert Mead, perhaps the main authorizing figure in symbolic interactionist theories of time, proclaimed that the self is, fundamentally, a "temporal process" (1932, p. 13). As participants in the temporal process by which selves are constituted, Mead argued that individuals do not merely *respond* to their physical and social realities, they *actively construct* the meanings of these realities through their interactions with the various people and things within them, and also in interaction with themselves as they continually reconstruct the past, envision the future, and act in the present according to these reconstructions and envisionings. Viewing time as a dynamic, constructive process rather than a static, objective metric pushes back against "liner" views of time in which time is conceived as a fixed straight line that reaches back into the past, traces its way into the present, and trudges forward into the future. Interactionist theories, by contrast, do not follow this traditional linear past-present-future progression. They instead tend to use the present as a point of departure, and consider how

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[50] The experience of duration is considered so central to the production of meaning in human life that diseases that preclude or impinge upon the ability to experience duration—notably, for example Alzheimer's disease—are regarded as agents that rob life of the possibility of meaning. See for example, http://www.nytimes.com/2015/05/17/magazine/the-last-day-of-her-life.html.

people are constantly using the present to reinterpret the past and project into the future on the basis of emergent events (Barken, 2014). These reinterpretations and projections in turn shape how one perceives and acts within the present.

Mead, focused on the extent to which reconstructions of the past and projections into the future color one's experience of the present, formulated the concept of the "specious present." For him, the present is "specious" because the borders that separate the past, present, and future from one another are not stationary or inflexible, but dynamic and porous.[51] In *Philosophy of the Act* (1933), he remarks that he specious present is assembled of "the imagery of past and future experiences taken out of their place…It is a real duration, but this duration has no relation to the completion of these act. These experiences belong to the reconstruction to which a later response will take place. They belong to the beginning of a later act. As such they are in a present" (p. 221). As summarized by Natanson (1973), this means that the present is not specious in the sense that it is somehow false, but because it "has at its active borders the content of the past and expectations of the future" (p. 75). These active borders mark a time span "extending back to memories of the past and forward to anticipations of the future" (Barken, 2014, p. 697). The

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[51] Interestingly, the past decade has seen the emergence of a movement whose central aim is to make the "specious present" decidedly less specious: the "mindfulness movement," which has so far been couched in a vocabulary of mental health and wellbeing. The movement, whose general principles have been derived from Buddhist contemplative traditions, touts the health benefits of habituating oneself to become more fully immersed in the so-called "present moment." One of the commonest strategies taught within the movement is paying very close attention to the details and character of one's present experience, to in essence dissolve the "active borders" between the past, present, and future and to locate oneself firmly within the discrete present moment. Within the discourses that have sprung up around the movement, it is often hinted at and sometimes explicitly claimed that reconstructions of the past and projections into the future are in some ways intrinsically opposed to wellbeing and psychological health. While criticisms of the mindfulness movement exist and are likely to multiply, the movement is of interest because it is perhaps poised to popularize the notion of a causal linkage between mental health and ways of thinking about and experiencing time.

"present" then, is a more multifaceted and expansive phenomenon than everyday usage of the term typically suggests.

3.3   THE TEMPORALIZING OF ILLNESS NARRATIVES

To the extent that the temporal dimensions of health and illness have been theorized, the focus has been largely on the relationship between temporality and narrative. This attention to narrative likely stems at least in part from the so-called "narrative turn" in the humanities and social sciences, a shift that has called for a renewed focus on storytelling as a fundamental aspect of human experience, one that operates both as a mode of reasoning about our experiences and a means for representing those experiences to others (Bruner, 2001). In addition to academia's narrative turn, structural changes in medicine have converged to center patient narratives, the study of which has since burgeoned into its own subfield called "narrative medicine." For some, this shift is evidence that that the Western paradigm of biomedical authority has been punctured, paving the way for the question of subjective patient experience to (re)assert itself (Morris, 2002).[52]

Another development that has likely played a role in the re-centering of patient experience originated not necessarily within the confines of medicine proper, but more so from public sphere outside it: specifically, the digital age and the proliferation of health-related

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[52] In Morris' (2000) estimation, the "grand narrative" of Western biomedicine has withered in much the same way that other planes of authority from which so-called "grand narratives" derive, have weakened, allowing for the proliferation of the fragmented micro-narratives that Lyotard famously (1979) claimed are characteristic of the postmodern condition.

information and communication forums that it has brought with it. This digital communication climate has meant that patients have a more diverse range of knowledge to draw upon when fashioning narratives, and importantly, a greater number of forums in which to share such narratives with the possibility of an audience.[53] As Bury (2001) describes the professional and social dynamics of this shift:

> Where once the bio-medical paradigm held sway (and where doctors jealously guarded its secrets), now lay people have access to an increasing range of information and ideas about the origins, courses, and outcomes of illness and its treatment. This too fuels the reduction medical authority as the fountain of all official knowledge about illness, and expands the range of culturally available narratives that can be articulated. Though these, admittedly are often drawn from alternative professionally-crafted knowledge, for example, via self-help groups focusing on specific chronic disease or "mediated ideas' taken from multifarious public discourses, their scope provides people with much greater opportunity to fashion personal narratives that connect the private sphere with public forms of knowledge (p. 268).

Another structural change implicated in the re-centering of patient experience has to do with what is perhaps one of biomedicine's greatest crowning achievements, an achievement that is decidedly *temporal* in its essence: the transformation of many acute (i.e., catastrophic and

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[53] As Jurecic (2012) has suggested, how people narrativize their experiences of health and illness is only ever one half of the question; the other side of the question concerns who will listen to such narratives, and, what will they hear when they are told?

generally short-lived) illnesses into chronic illnesses. Management of chronic illnesses tends to

enjoin patients (and their caretakers) to assume a more active role in the management of their

own medical care, making the question of the subjective patient view both more visible and more

pressing as the "contingencies of everyday life reassert themselves" (Bury, 2001, p. 267). [54]

Type 1 Diabetes is often pointed to as a paradigmatic example of the acute-chronic

transformation that has called for greater patient participation. Before the development of insulin

therapy in 1922, a diagnosis of diabetes was nothing short of a terminal diagnosis. Since then, it

has come to mean a lifetime of carefully dispensed insulin, meticulously monitored blood

glucose, and closely regulated eating habits, at least for the so-deemed "compliant" diabetic.[55]

These efforts are generally spearheaded by the patient, and importantly, *their effects are*

temporal in nature. Maines (1983), for example, stresses the centrality of temporality in the

subjective diabetic experience, arguing that "it is the temporal dimension that unites the diabetic

experience, in terms of its other dimensions: physiological, emotional, social, interpersonal,

technological, organizational, institutional and personal arenas" (p. 103-104). Maines points out

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[54] Just as the mindfulness movement, as discussed in an earlier footnote, is co-optable by the forces of
neoliberalism, so too is the patient empowerment movement, which Crawford (2004) points out has, for
example, created a favorable rhetorical climate in which employers feel "empowered" to shift a greater
portion of insurance costs to their employees.
[55] The notion of patient "compliance," though still in wide usage in medical literature, is now regarded as
fraught by the field of bioethics and humanities disciplines. Like Maines (1983), Martins (2005) also sets
his sights on type 1 diabetes, showing how concepts of "compliance" and its cousin term "adherence"
gained their relevance thanks to biotechnological advancements. These achievements have ostensibly
bolstered patient agency but the model of agency often implied by compliance research presupposes "that
agency can be transferred from one individual to another through an exchange of certified knowledge,
skills, or technologies" (p. 61). This way of thinking about compliance and agency, Martins argues, fails
to attend to the ways in which biotechnologies have altered the meanings of the agency and compliance,
not to mention of the meanings of the body itself. Segal (2007), meanwhile, attends to the moves
underway to replace the patient "compliance" terminological framework —the tone of which now
registers to some as overly paternalistic—with models that stress shared decision making between expert
and patient, most notably "concordance." Unpacking the "concordance" paradigm from a rhetorical
perspective, Segal finds that it is simply "compliance" dressed in more egalitarian clothing, and argues for
critical attention the ways in which this seemingly neutral model serves the interests of the
pharmaceutical industry generally and commercialized healthcare more broadly.

that for some diabetics, in particular so-deemed "compliant" diabetics, there is often a sense that time is compressing, that the borders between tenses are shifting and blurring to the point that they are "almost too close to one another to present meaningful distinctions" (p. 112). For the less compliant diabetics, those who resist the biopsychiatric fact of their diabetes by adopting an attitude that "whatever happens, happens," time might not compress but expand, becoming amorphous and unfocused, "lacking the sharp edges of time consciousness" (p. 112).

In addition to foregrounding the ins and outs of daily patient life, chronic illnesses are thought to significantly destabilize ongoing life narratives, calling for substantive revision to help integrate the illness into one's biographical identity. Through the interdisciplinary body of literature on illness narratives runs a distinct thread that thematizes the onset of chronic illness as *disruption* or *interruption,* in the sense that illness can wrench loose previously entrenched aspects of one's biographical identity (Bury, 1982; Frank, 1995; Radley & Billig, 1996; Hyde, 2016). The notion of illness as biographical disruption has been of particular interest for sociologists, given the sociological premise that it is possible to "learn a good deal about day-to-day in routine settings from analyzing circumstances in which those settings are radically disturbed" (Giddens, 1979, p. 123). Thus, we stand to learn something about the everyday by looking at exactly the opposite: events that are seen as somehow extraordinary, those that upend the patterns and rhythms of the everyday. Put another way, the exceptional has potential to illuminate its opposite, the mundane. In the same way, sociologists have contended that learning about the experience of dramatic illness sheds light on supposedly undilemmatic experiences of

health or non-illness, and thus, looking at instances of what might be considered "disrupted"

biographies can reveal something about the nature of not-yet-disrupted biographies.[56]

An intersubjective dimension emerges when theorizing chronic illness as disruption: chronic illnesses "disrupt" not only the life of the afflicted individual, these disruptions are prone to ripple outward into the lives of others. Thus, for the person with a chronic illness, there may be complicated rhetorical work involved in negotiating these disruptions, especially vis-à-vis requesting the care, assistance, and "entitlements" (certainly a loaded term) that many chronic illnesses require, including government assistance programs, the labor of caregivers, the flexibility of employers and so on. Given the intersubjective dimensions of these "disruptions," it has been claimed that people with chronic illness often put a great deal of communicative work into providing an "account" of their illness, and the various forms of disruption that their illnesses may come to entail (Radley and Billig, 1996).

Distancing oneself from illness—assiduously maintaining a space between one's self-concept and one's illness—is one way of accounting for one's illness and the potential disruptions entailed by it. It is worth noticing that "disruption" is a term that carries an implicitly negative valence. This implicit negative valence has perhaps fueled the notion that people with chronic illnesses are enjoined to do some kind of rhetorical work to separate themselves from their illnesses, in order to preserve certain aspects of their previously stable biography. In other words, there is an assumption that people often feel compelled to *disidentify* from their illness. People disidentifying from their illness "try to keep illness at the margins of their lives and

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[56] Conceptualizing the onset of chronic illness as 'biographical disruption' has significant temporal implications, because "disruption" suggests a clean line of separation that divides life into "normal befores" and "disrupted afters." This makes most sense within a linear temporal framework, where time is thought of as a straight arrow from the past into the present and from the present into the future, however uncertain that future may be.

outside the boundaries of their self-concepts. Though sometimes people can do that, at other time

they must struggle to do so, and at times they cannot" (Charmaz, 1992, p. 4). Implicated in this

rhetorical move is the enduring question of agency (and responsibility) that emerges time and

again in discussions of illness specifically and embodiment generally. As Bury (2001)

summarizes it, "To be able to hold the disease 'at a distance' as it were, assists the claim that one

is victim of external forces. To do anything less is to accept fully the burden of responsibility"

(p. 173). Also, because of this negative valence, conceptualizing illness as disruption often

comes packaged with an assumption that people with chronic illnesses are [or should be] seeking

some sort of *restoration* to a former state of affairs.[57]

Despite the negative valence of "disruption", a rhetorical perspective might invite

consideration of the ways in which *identifying with* an illness can likewise serve important

functions in a given context; the choice to do so likely depends as much on the type of illness as

the individual's sense of identity and present life circumstances. For example, sufferers of

historically contested illnesses sometimes strongly identify with their illness, finding ways to

fuse the diagnostically fuzzy entity with their sense of identity, which seems to be part of a larger

strategy to legitimate the ontology of the contested illness itself (Segal, 2005; Graham, 2009).

The question of whether and how to identify with or disidentify from one's illness is

perhaps especially complicated as it applies to *mental* illnesses, given that they root in the

mind/brain—the mysterious entity that often operates as a metonym for selfhood. Journalist

Tracy Thompson, who has been treated for Major Depressive Disorder, has written about the

dilemma in ways that Dumit (2003) seizes upon to illuminate the tricky rhetorical dynamics

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[57] In his path breaking typology of the narratives people develop after health-jeopardizing events, Frank
(1996) pointed to the "restitution" narrative as one of the commonest in the West: this narrative is
characterized by dogged belief in the restorability of a former state of health. The restitution narrative, as
Frank points out, typically entails a conceptual dissociation of self from body.

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involved in identifying with or separating oneself from illnesses thought to originate in the brain, the so-called seat consciousness. Thompson (1990) articulates the dilemma as follows (as quoted by Dumit [2003], p. 42).

> I could say, *There is something wrong with my brain*. That was a different thing from saying, *There is something wrong with me*. The second was self-pitying; the first was a simple, factual statement. It was a subtle nuance, easy to miss. But as I grasped the difference—and it was slippery, I kept losing it at first—other doors began to open in my mind: *Depression is an illness. I am sick. I need to be here [in this mental institution] because I'm defective, not because I'm a moral leper, not because I've fallen from grace or turned my back on God, but for one simple reason: because I am sick.* But there my thinking stalled. So I was sick. But this was my brain I was talking about, not my gallbladder or kidneys. It had some mysterious property called "consciousness." It produced behavior, the sum total of which was somehow me. If I wanted to say that my brain was sick, I could stop there and disavow responsibility for that sickness—but if I did that, I would be giving up my idea of autonomy in the world. I would be simply a product of some chemical abnormality in a lumpy gray organ between my ears (p. 189-190, original italics).

Thompson's dilemma, as Dumit (2003) formulates it, concerns whether, and how, she can disidentify with her depression without *disavowing her self* in the process. As Dumit unpacks the dilemma, "She *is* a depressed person because she *has* a depressed brain. The too-simple cultural

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alternatives of either being responsible for her sickness, or not being her brain are complicated. She is her brain against her brain: she is now a person with depression fighting that depression…She comes to see herself, and she becomes, a particular kind of person, a kind she shares with others who also have depression and who are people with depression" (p. 42).

Dumit's reading of Thompson's memoir echoes one of the main arguments from the previous chapter: when issues of etiology are foregrounded in discourses about depression, they are often framed in the vocabulary of Burke's nonsymbolic motion (i.e,. biopsychiatric processes that are deemed outside the scope of symbolic remediation), and when issues of treatment emerge, the tend to be framed as matters of symbolic action (i.e., matters amenable to agentive forms of symbolic intervention). In the forthcoming exploration of discussions in online health communities, notions responsibility and agency surface once more, but this time with a focus on the issue of temporality and with an interest in how different ways of temporalizing illness shape perceptions of agency and responsibility.

An observation that runs through the sociology of health and illness, articulated by Charmaz (1992), is that "being ill gives rise to ways—often new ways—of experiencing time" (p. 4). In an age of so-called healthism, a term coined by sociologist Robert Crawford to describe the "striking moralization" of contemporary health discourses and practices, the need to attend to the temporalizing of illness and concomitant conceptualizations of agency/responsibility is a pressing one. As Bulow and Hyden (2003) note, people who are in the position of narrativizing their illness experiences (which one would imagine to be a position that many, if not most, would be put in when acute or chronic illness presents) "use time to create a narrative based on a balancing act between personal responsibility and liability, between hope and despair, between the possible and the actual" (p. 72).

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It is important, then, to attend to the various forms of temporality that emerge in accounts of illness and how these temporalities link up with notions of responsibility and agency. Morson (1994), a literary theorist, explains the importance of attending to temporality in narratives, stating, "Over the centuries, concepts essential to our sense of being human, such as blame, hope, guilt, and regret, have been closely linked with beliefs about the nature of time. Whether events are fated, on the one hand, or something indeterministic and fundamentally contingent, on the other, affects how we think about ourselves and our lives" (p. 2). Such questions become particularly salient when applied to the slippery terrain of mental disorders given the degree to which notions of the mind/brain are imbricated with notions of selfhood.

3.4   PANORAMIC TEMPORAL PERSPECTIVES

In *The Noonday Demon: An Atlas of Depression* (2001), Andrew Solomon considers the differences between mild and major depression at the level of individual experience. About mild depression, Solomon has this to say: "[I]t is miserable not so much because it is intolerable in the moment as because it is intolerable to have known it in the moments gone and to look forward only to knowing it in the moments to come. The present tense of mild depression envisages no alleviation because it feels like knowledge" (p. 16). While one might think that the primary distinction between "mild" and "major" depression would be the severity of symptoms (with mild depression being a sort of watered down version of major depression), Solomon here has homed in on the issue of temporality. Perhaps this should not be surprising, given that dysthymia (or as he colloquially refers to it, mild depression) is an illness defined explicitly in terms of the relationship between mood and temporality. That is to say, the difference between "normal"

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periods of sadness and the sadness that characterizes dysthymia is not to be found in the specific

qualities or overall character of the sadness but in its persistence (that is, its temporality).

While analyzing interactions in online health communities, the claim that Solomon

advances—that the intolerability of mild depression stems not so much from its moment-to-

moment subjective character as from "having known it in the moments gone by and to look

forward only to knowing it in the moments to come" —repeatedly struck me anew. Or perhaps

more precisely, the *implication* of this claim continually occurred to me: the subjective

experience of dysthymia might not be regarded as particularly unpleasant in the present tense,

but it *becomes* unpleasant when viewed through the lens of the distant past (which is often

described in online health accounts of dysthymia as having been "wasted" or "tainted" by the

blanketing effects of the disorder) and with an eye toward the future (in which, it is typically

predicted, the problems of the past will continue to reassert themselves).

The subjective experience of depression—ostensibly in all its various subtypes—has been

said to elude literal description, and so it is no surprise that metaphors are often crafted to capture

something of its experiential character (Ratcliffe, 2015). In one of the online health communities

examined here, a repeatedly deployed metaphor is particularly striking in terms of how smoothly

it maps onto Solomon's claim above. This metaphor is weather-based in nature, and so one

might assume that it would be predominantly spatial in terms of its orientation, but I view it

instead as *deeply rooted in time*.[58] That is, the temporal dimension of this particular metaphor

seems to have a stronger resonance than the spatial dimension. Weather-based metaphors are

repeatedly deployed by one of the "group leaders" in the MDJunction.com community, often for

the purpose of advising newer members as they work to formulate expectations regarding the

likely trajectory of illness. [59] Below are two iterations of the metaphor:

> (2014, November 11). Re: Ahh Dysthymia. Message posted to
> http://MDJunction.com/dysthymia.
>
> I like to think of it as every day being the 10th day in a row where it rains. You
> get so tired of it being lousy, but there isn't a thing that will actually fix it. You
> can take meds like you use an umbrella-- it's fine in a mist, but not so great in a
> heavy downpour. Really all you can do is learn to accept the rain. That's my
> Dysthymia metaphor for the day!

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[58] Weather-based metaphors intended to capture something about the experience of depression are certainly not confined to online health communities. William Styron, in his autobiography of depression, *Darkness Visible* (1990), which is considered a path breaking memoir, has the following to say about his depression in one of the book's most widely quoted lines: "Beginning at about three o'clock…I'd feel the horror, like some poisonous fogbank, roll in upon my mind, forcing me to bed (p. 58). Here, the weather (a "fogbank" rolling in) has specific temporal orientation, it begins at about three o'clock in the afternoon. For another example of metaphors linking together time and weather, consider the following from Andrew Solomon, in which he delineates the experience of major from mild depression: "It is not pleasant to experience decay, to find yourself exposed to the ravages of an *almost daily rain*, and to know that you are turning into something feeble, that more and more of you will blow off the first *strong wind*, making you less and less. Some people can accumulate more emotional rust than others. Depression starts out insipid, *fogs the days* into a dull color, weakens ordinary actions until their clear shapes are obscured by the effort they require, leaves you tired and bored and self-obsessed—but you can get through all that. Not happily, perhaps, but you can get through. No one has ever been able to define the collapse point that marks major depression, but when you get there, there's not much mistaking it…*Depression exists in time*. A patient may say that he has spent certain months suffering depression, but this is a way of *imposing a measurement on the immeasurable*. All that one can really say for certain is that one has known major depression, and that one does or does not have it at any given present moment." (p. 17, italics added). Interestingly, Solomon appears to delineate mild from major depression to the extent that the former does not render the experience of time practically incoherent, while the latter does.

[59] According to MDJunction.com, role of online health community "group leader" consists primarily of welcoming new members, maintaining conversations when activity slows, ensuring that new threads do not go unanswered, monitoring posts for inappropriate content, and banning members if deemed necessary.

In the first usage of the weather metaphor, an isolated instance of poor weather is not described as problematic in and of itself. Rainy weather on a particular day—"the 10th day"—is transformed into something unpleasant, even intolerable, when it is placed within the broader context of the previous nine days, each of which was characterized by similarly dreary weather. Put another way, the tenth day of rain is not the problem. The tenth rainy day only *becomes* problematic in the context of nine preceding days of similar weather. As a result, the group leader counsels, the only pragmatic course of action is to anticipate future rainy weather and acclimate to that prospect. Thus, it is claimed that the *present* manifestation of dysthymia is not intolerable. However, it becomes difficult to tolerate when placed within the context of an undesirable past, which then leads to anticipations of a similarly unfulfilling future.

That experiences of chronic illness often involve shifts in ways of thinking about time has been noted across fields, including, especially, medical sociology. As mentioned earlier, Charmaz (1992) has detailed how individuals with chronic illnesses often describe a sense of being yanked into the immediate present, especially when symptoms are severe or escalating in nature. The intensity of symptoms, and their disruptive effects, she posits, often pulls people toward adopting a temporal framework summed up by the *in vivo* code, "living one day at a time." [60] As she defines it, living one day at a time means "dealing with illness on a day-to-day basis, holding future plans and even ordinary activities in abeyance while the person, and, often, others deal with the illness" (Charmaz, 2014, p. 180). This temporal framework is not simply an

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[60] The Latin phrase "in vivo," translates as "within the living." Grounded theory methodology encourages researchers to identify and unpack "in vivo codes," which are phrases or buzz words with meanings so taken-for-granted that they are rarely stated explicitly. For example, an in vivo code that recurs throughout the online health communities studied here is "snap out of it"—it is most frequently used when participants discuss the (im)possibility of "snapping out of" their dysthymia.

effect of illness, it is an active *strategy* for contending with it on a practical level, in terms of managing daily activities, and on a perspectival level, in terms of constructing the meanings of illness. Perhaps most importantly, Charmaz notes that immersion in the immediate present often seems to have the effect of conferring a sense of *control* in the face of uncertain illness trajectories.

While people with chronic illnesses frequently describe a sense of immersion in the present moment—whether that immersion is perceived as voluntary or involuntary—accounts of dysthymia in online health communities are organized within a temporal framework that could plausibly be regarded as the inverse of living one day at a time. That is, people often provide accounts of dysthymia describe a sense of *detachment* from the present tense of their lives and immersion in a sprawling temporal landscape that stretches from the remote past into the distant future. They do not prune their views of time in order to lodge themselves more deeply within the present. Instead, in their accounts, they describe a sense of being whisked out of the present tense of their lives and immersed (or, perhaps more apropos, "stuck") in an expansive temporal terrain that this chapter terms "panoramic" temporality.

Panorama is a term that refers to space, not time. Perhaps most commonly the term is used in reference to photography. In photography, a panorama can be a type of perspective, specifically a broad, uninterrupted view of the area that surrounds the observer. It can also refer to a type of image that provides a wide, horizontally elongated view of its subject matter. Both senses of the term are appropriate to describe the temporal perspectives frequently drawn upon narrate the accounts of dysthymia examined here. People authoring the online health accounts examined here often describe their experience with dysthymia in broad temporal terms, briefly locating their sense of the present somewhere within the sprawl. They seem to describe their

experiences using in the voice of a passive, distant observer—a spectator of the photograph

rather than the photographer. An example follows:

(2013, July 7). How am I Supposed to Make a Marriage Work? Message posted to http://experienceproject.com/dysthymia.

Well I guess it all started for me- with what is actually one of my earliest memories. My Parents fighting over who should have custody of me after they had decided to divorce.

I guess as [a] five year old it seemed much more dramatic ot me than it actually was. Looking back at that memory, I literally feel like one was tugging on one arm whilst the other was tugging on the opposite one like some sort of rag doll.

All though my childhood, people were very caring and thoughtful, always making sure to take me to one side and ask me in that very nice but somehow condescending way "are you alright?" and "How do you feel?" Honest answer – I don't know! I didn't feel like I had a right to be upset, I felt like if I voiced my opinion my parents would divorce me & I would be on my own.

From then on, I think I felt something akin to joy at times, but it wasn't really happiness. It was the echo of what I should be feeling & me displaying an outward sign of that to get people off my back.

It wasn't until three years ago, that my fiancée finally got me to go see a psychiatrist and I was diagnosed with this thing that I had never heard of – dysthymia- and put me on medication. Then it all came flooding back. Actual happiness existed within me- that's great, right?

Well for about a week it was there. Then I realized that I had spent 25 years of my life never feeling good about myself, my surroundings, my loved ones – it was all a lie! Instead of getting better, I got much, much worse. I spiraled into a depression, slowly cutting off from everyone.
I developed an increased sense of social anxiety that had always been there, but which started to take over my life. I stopped talking to my fiancée, I find it more difficult than ever to open up to her about my feeling, thought and opinions.

We are getting married in 4 days and we seem to be arguing more than ever because I don't tell her the smallest bits of information regarding what I am doing, thinking or feeling.

About the only emotion I am sure about is that I lover more than life itself, but I don't think that she can see that. I don't think that she can see that I care about her any more or that I value her

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This account of dysthymia exemplifies what this chapter calls a "panoramic" temporal perspective. The temporal bounds of this account are stretched and expansive, starting with a recounting of a memory identified as one of the author's earliest: parental tension over custody. The account later ends with a focus on a future event, the author's upcoming nuptials and concomitant concerns about how to "make a marriage work" in a relational context that will presumably be colored by the symptoms of a chronic mood disorder. Unlike Charmaz' "living one day at a time," which involves narrowing one's temporal perspective in order to making the present moment more livable, panoramic temporal perspectives broaden temporality rather than contracting it. This perspective produces a broadly stretched view of one's life in light of disorder, often starting with distant past experiences considered "milestones" in the development of dysthymia (usually a specific childhood event or relationship) and progressing to a meditation on the future, which, it is assumed, will continue to be impeded upon by the wide-ranging effects of the disorder.

Accounts of dysthymia assembled via panoramic temporal perspectives often evoke a sense of *time gone by*, of large segments of elapsed time tainted, stolen, or wasted by the effects of the disorder. Some, like the author above, describe feeling much worse in the face of diagnosis when they come to believe that a significant portion of time has been "wasted" because of a disorder, as though the problem of "wasted time" would be more tolerable were it attributable to something other than a mood disorder. The act of naming a clearly experienced but ill-defined problem is often regarded as one with rhetorical and pragmatic significance— whether that problem is social, political, biological, etc. in nature. This is because naming defines, delimits, and demystifies that which was previously amorphous or opaque, which in turn helps to render the newly defined problem actionable. Some posts include a description of

feeling empowered in the wake of formal diagnosis, since the problem "finally has a name" and

"the enemy" has been identified. At the same time, other posts, such as the one above, describe

the opposite; that is, a description of feeling disempowered upon formal diagnosis, of feeling

worse after the longstanding, previously unnamed problem has been linguistically defined.

> (2015, May 1). I Have Dysthymia**.** Message posted to
> http://experienceproject.com/dysthymia.
>
> [Context: Most likely caused by the death of my mother when I was three and
> an authoritarian and emotionally unavailable father] It went undetected
> because it isn't THAT bad, as most dysthymics will tell you, things are just
> very rarely great. I've dealt with a lot of meaningless sadness, if you realy
> want to get a feel for what it's like to have dysthymia, watch Annie Hally by
> Woody Allen, there's a great line in there that succinctly sums up being
> dysthymic, [I'm paraphrasing] "I think there's two camps in life, there's the
> miserable and the horrible, the horrible I could never imagine being part of the
> horrible, you know, starving children, terminal cases so I'm grateful to be part
> of the miserable." In short, at least in my case with early-onset dysthymia there
> was never much happiness to go around. I remember from my earliest
> experiences of metacognition and before, I was never really excited about a lot,
> and when I was it was one of those things that caused a feeling of electricity to
> run through me that quickly petered out. In fact I remember having a very toxic
> pessimistic outlook and thought process fro very early on, even as an 8-year
> old at Chuck E. Cheese I'd wander muttering how ****** things were to
> myself. It was around the same time my grades took an absolute nosedive
> although I'd been designated as gifted, 9 years later and a few days before I'
> set to begin psychotherapy and taking medication they still haven't recovered,
> which has been a really big source of problems and the only reason I even
> sought help that's how under-the-radar a chronic low-level depression can be.
> For a long time I lived with a sense of optimistic sadness that I enjoyed
> tremendously, "yeah things always turn out alright, but so what?" I can
> probably attribute a premature maturity to depression, nothing else crushes
> your idealism and goals so efficiently. I take refuge in books, politics, finance
> and social situations paradoxically invigorate me. But apart from that, it's just
> a rainless cloud that lingers, blocking you from even imagining the other side
> and achieving this mystical "potential" everybody talks about. Overall, I'm
> grateful to be part of the miserable.

A panoramic temporal perspective provides the narrative framework established in post above, which incorporates aspects of the psychoanalytic explanation of dysthymia (i.e., an explanation that emphasizes the indelible impact of early childhood events and formative relationships with caregivers). This post begins with an explication of the contextual factors that the author places in a causal relationship to the onset of dysthymia, then subcategorizes the author's dysthymia as "early onset," a label applied to dysthymia when diagnosed before age 21. From the author's present perspective, the symptoms of dysthymia manifested at an early age, as young as 8 years old. While the past features quite prominently in this post, the author concludes with a contemplation of the future: dysthymia is metaphorized as a "rainless cloud that lingers," blocking one "from even imagining the other side and achieving this mystical "potential" that everyone talks about." This particular usage brings to light another element of weather-based metaphors. Such metaphors not only describe the perceived all-encompassing effects of dysthymia, in that these effects thoroughly color one's affective atmosphere, they also emphasize temporality: weather not only shapes experiences in the present, it also guides ideas about future possibilities: the weather is *forecast*, which may influence decisions and actions within the present.

In the post above, the author only briefly mentions details from the present, including the fact that s/he is set to begin psychotherapy and medication in a few day's time. This post is one of several in which the author mentions plans to begin formal interventions (counseling, therapy, medication, etc.) in the coming days. It seems possible, then, that these sorts of posts can sometimes function as a sort of "practice run" prior to the first therapy session: an opportunity to "set one's story straight" so that the past can be harnessed as an explanatory resource in the therapeutic settings that one expects to enter into in the near future. Thus, one way to think about

the function of online mental health communities is as *practice* sites, not only in the sense that Baym (2000) and other media studies scholars have defined—that is, that online "communities" constituted by their communicative practices—but also because they offer a sort of rhetorical rehearsal space for those who will be transporting their stories to other audiences, such as, in this case, therapists or other practitioners.

(2014, March 5). How do I start? Message posted to
http://psychforums.com/dysthymia.

I reckon I have suffered from depression all my life- or at least for the majority
of it – if that's possible? In the past I have taken Prozac, had therapy
(psychotherapist and psychologist) and read widely on the subject.

I have now self diagnosed myself with dysthymia and a large dose of
associated anxiety induced apathy. The weird thing is no one else really knows
– or at least they pretend not to. Outwardly I function relatively normally. I
work part time and earn reasonable money but I do absolutely NOTHING
other than that which I absolutely have to do (ie look after my children, go to
work, shop and cook).

I can remember feeling happy but it seems so long ago, in another world that I
once lived in a long time ago. I look at other people's lives and I wonder what
on earth it is that they are doing, caring about this and that and the other
because nothing has any point to it so what is the point in doing anything?
Nothing really matters does it? Nothing I do or say or am or try to be really
matters. The thing is though, I HATE LOATHE and DESPISE feeling like
this. I have read every self-help website and book that there is and I still can't
find my starting point. Nowadays I have even stopped trying to try if that
makes sense, because I know the outcome will be negative, that it won't make
any difference. I feel as if I have run out of options and that I don't want to live
anymore because there is no point in living. I am not suicidal (I have children)
but if I didn't have them I would have checked out by now because life is
simply too bloody difficult to do and to be honest I cant be bothered to fight it
anymore.
I constantly image myself in a life at some point in the future where I am
completely sorted and living a life that brings me reward. But it seems
impossible to reach that point. I can't find my first step. I search and search
and search for a point of change. I keep planning and thinking that tomorrow
or next week I will change and be able to do SOMETHING to change how I
live but every single day I wake up knowing that the day will be the same as
the last one and the one before that and so on and so on.

Does anyone have a similar experience that they can tell me about? What
worked for you? What made you 'snap out of it' or is that wishful thinking?

In the above post, the author considers that dysthymia has colored the totality of their lived

experience up to this point. In this expansive temporal terrain, positive emotions such as

happiness are described as existing very far from the present, so far away as to "constitute another world." The author imagines that most people are generally unaware of scope of dysthymia's wide-reaching effects, because "outwardly" the author "functions relatively normally." (The rhetorical conundrum posed by being perceived as a "high-functioning" person is commonly discussed throughout these online health communities, and is a theme that will be explored in the following chapter.) Adopting this broad view of time has ostensibly aided in the author's self-diagnosis of dysthymia, a diagnosed further refined by reference to "anxiety induced apathy." As opposed to a sole or predominant focus on the past and a thorough description of how it has been affected by dysthymia, this author focuses more on contemplating the future, anticipating the extent to which it will affected by dysthymia.

As is typical of panoramically structured posts, here too the present is not described as particularly problematic in and of itself. The problem with the present is identified (or perhaps even *produced*) through *recollections* of the past and *anticipations* of the future. The author states that they "wake up knowing that the day will be the same as the last one and the one before and so on and so on." This sentiment bears similarity to the weather-based metaphor mentioned earlier in the chapter, a metaphor that likens the present tense of dysthymia to the tenth day in a row of rain; the tenth day of rain becomes problematic only within the context of recollecting the nine preceding days of rain. This sentiment is also similar to Solomon's (2001) claim that "the present tense of dysthymia envisages no alleviation because *it feels like knowledge*" (p. 16, italics added). The author here does not simply *anticipate* that the present day will be the "same as the last one and so on and so on" but rather "wakes up *knowing*" that this will be the case. Across the online health communities studied here, a commonly posed question concerns whether dysthymia is something that one can "snap out of," with the typical response being that this is not

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possible. The frequency of such questions about the possibility of "snapping out of" dysthymia,

and uniformity of responses emphasizing the impossibility of doing so, makes sense if one

considers the experience of dysthymia tantamount to knowledge: while people might describe

"snapping out of" attitudes or moods, it would seem that *knowledge* is not something one can

"snap out of" easily.

3.4.1   Retrospective Identification

Dysthymia is a mental disorder with a definition that hinges on temporality, which is to say that

it is very much a temporally-defined condition. One reason for this is that the moods that

characterize its symptoms are not defined as abnormal in terms of their *qualities*; rather they

become abnormal through their *persistence*. Furthermore, it is a temporally-defined condition in

that can only be *diagnosed looking backwards:* the presence of symptoms over the course of at

least two years' time is a prerequisite for a diagnosis of dysthymia.[61] The panoramic temporal

perspectives described in the previous section enable an important process in dysthymia online

health communities: *retrospective identification*. (I use the term identification, rather than

diagnosis, because it can be used in two different senses, summed up by different prepositions:

identification *of* (the illness itself) and identification *with* (a community of individuals who share

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[61] This strong emphasis on the past is unsurprising given dysthymia's psychoanalytic roots—roots that have historically stressed the importance of searching for etiology via predominantly discursive interrogation of the patient's past. Such interrogation is considered necessary because, in the psychoanalytic view, mental disorder does not represent a departure from a previous state of mental health but is seen as "logically continuous" with the person's past experiences and relationships (Greco, 1993). Bipsychiatry, historically, has not aggressively pursued the etiology of mental disorders, it has instead focused on the classification of outward symptoms. Psychoanalytic theory and practice, however, have been very much entangled with questions of etiology, by providing historically coherent explanations for a given patient's feelings, thoughts, behaviors, etc.

the diagnosis and entailed experiences). Retrospective identification involves identifying the initial onset of dysthymia and its related contextual factors; it also has to do with identifying oneself as belonging in a particular category with others, it means coming to understand oneself as a certain *kind* of person.

Taking the sort of social interactionist perspective articulated by Mead earlier in the chapter, one could argue that retrospective identification of dysthymia is rhetorical practice through which new understandings of the self are actively *produced*; it is not a passive or undilemmatic discovery made when, for example, an advertisement "translates" one's experience into a psychiatric vocabulary, as it sometimes portrayed to be in public discourses on the dangers of self-diagnosis in a digital age (Segal, 2005). Such self-understandings are actively produced rather than discovered that occurs, as Kuhn (2002) has concisely remarked, one "cannot access the past in any unmediated form" (p. 155). Memory is not a stable repository of past experiences that can be neutrally accessed, and neither are the technologies to which we outsource the task of recording and recalling these memories, whether a diary, a self-diagnostic checklist, a camera, a museum, or a post in an online health community.[62] While the non-neutrality of memory in general makes the recollection of any kind of past experience a potentially error-prone exercise, the recollections of *past moods* can be considered a particularly slippery endeavor since moods

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[62] Online health communities are not only spaces in which people pose questions, solicit feedback, and share information. They are, in some sense, dynamic repositories of memory, places thriving with pieces and parts of autobiographies. They are repositories of memory because authors can revisit previous post in the days, months or years after they post them, but at a more fundamental level, they are memory repositories because in the act of formulating accounts of illness, memory is being exercised, carving a path for future understandings and accounts of illness. And unlike a diary, there is the possibility of audience. (Although it could be argued that a diary is in a sense written for an imagined audience, whether that imagined audience consists of a future self or potential interlopers.)

in the present are thought to color recollections of one's moods in the past, a phenomenon

referred to in psychology literature as "mood congruent" recall bias.[63]

Retrospective identification can occur before or after formal diagnosis, and is typically

performed by the author of a given post, though sometimes the ostensible point of a post is to

retrospectively identify the illness of another person—typically, the author's partner or spouse—

along with a request for advice on how to handle the delicate act of relaying this so-called

"other-led diagnosis" to the presumed-to-be affected person (Giles & Newbold, 2011). As

mentioned earlier, people describe different emotional responses in the wake of retrospective

identification, many having to do with changing conceptions of self. Some people describe a

sense of epiphany and relief in the wake of retrospective identification, of relishing the

demystification that occurs after 'having a name for it.' Others describe a deepening of their

feelings of depression in the aftermath of retrospective identification, for reasons often related to

the past (such as the lament that the past has been "wasted" for no good reason, given that the

problem was clinically actionable) or the future ("does 'chronic' mean 'forever?'" some ask)

Below are some instances of retrospective identification as it unfolds in these communities.

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[63] Psychology literature terms this problem "mood congruent bias" or "mood congruent memory" and suggests that it casts a problematic light on the mood inventories that are often used in the process of formally diagnosing mood disorders. These 'recall' biases refer to a phenomenon in which people more rapidly or more efficiently retrieve memories that are congruent with their present mood state. If a person takes an online questionnaire while in a depressed mood and the questionnaire asks the person to report their mood states over the past two weeks, the theory of mood congruent bias would suggest that the person will be more likely to recall negative experiences that occurred over the two week period as opposed to positive experiences, given that such experiences are more "congruent" with the person's present mood.

(Posted August 27, 2013). Ahh Dysthymia… Message posted to
http://MDJunction.com/dysthymia.

Well, it turns out (recently diagnosed) that I have had dysthymia for probably
20 years. Not just "oh he's just that way" or "He's just introverted" or (insert
dysthymia misunderstanding here).

Anyway, I do recognize that I have had a mild depression for years, and I once
chalked it up to that "Quirkalone" idea that seemed popular a few years ago
and still lingers today.

This is not to say that I haven't led what most would call a "full life" – I have
two Masters and a PhD, I've lived abroad and been skydiving, worked at the
Pentagon, and a lot of other fulfilling things I wont bore you with here. I think
that, for me, this condition hasn't been paralyzingly bad, in that I haven't been
able to do anything with my life. I've had many relationships, and I think been
otherwise fairly "normal."

There was a long time, about 6 years, though, where I turned to wine (in
excess) to alleviate my mood at night and that turned into a major problem. I
wish I'd known about dysth earlier, and that might have been avoided. Sober 5
years now, and that's not an issue anymore.

The last six months, though, I find I have no interests. No ambition. No drive.
No reason to do anything but just waste my days away and wait for night when
I can sleep and not be awake for this I've never been suicidal, though I have
thought about it. But that option's not for me.

I've tried SSRI's, etc., and they have all either not worked or inflicted terrible
side effects, so those aren't for me. The only "fixes" I have ever found have
been exercise (usually it takes quite a bit to make a difference – im guessing
due to the need to release endorphins), proper diet (especially juicing)
and…no, that's really it…(con't)
I also had issues with anxiety for a time, but that seems to have dissipated,
other than my social anxiety, which has been with me since I was a child. That,
like dysth, I think will just be with me forever.

Going to psychotherapy again, though I've also never found that to truly help.

Anyway, just wanted to introduce myself and share my experiences. Maybe
they will help someone feel not so alone. Because in truth, most of us truly
aren't "alone" - we just (because of our depression) avoid social situations and
just (speaking for myself again) the last thing I want is someone to hang out
with and just discuss things that aren't, ultimately, important to me. Actually,
few things are. Nothing excites me, nothing interests me. I am just…here.

As the post above illustrates, the retrospective identification of dysthymia can recontextualize an individual's understanding of the past in sweeping, potent ways. In the post above, the author, having been recently (ostensibly formally) diagnosed now considers the past twenty years to have been shaped by dysthymia. This upends the author's former self-definitions that fall outside the vocabulary of mood disorder, such as "introverted," "solitary," and an adherent to the "Quirkyalone" movement.[64] After retrospective identification, the author considers introversion and solitary tendencies to be previously mislabeled manifestations of something that is a more accurate self-label, dysthymia.

In a study of online mental health communities, Giles and Newbold (2011) contextualize self-diagnosis as a form of *identity work* that grows out of the categories in the *DSM* and often operates as a rhetorical resource deployed to mitigate the culturally ingrained tendency to attribute negative outcomes or behaviors to the individual.[65] They state that, "part of the *DSM*-category appeal lies in its apparent explanatory power for behaviors that otherwise leave individuals open to blame and accountability" (p. 421). Thus, they posit that the categories of the *DSM* serve to transform what could be regarded as negative or socially undesirable behaviors into the unfortunate byproducts of mental disorder and might thus be regarded as largely outside the locus of an individual's control. However, as this post suggests, it seems an inverse process of attribution can also occur after retrospective identification. That is, positive behaviors or

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[64] The "quirkyalone movement" was popularized largely on the Internet in the early 2000s. It generally refers to people who eschew dating and intimate relationships in favor of solitude.

[65] Beech (2008) defines "identity work" as a "a set of active processes (such as forming, strengthening and revising) which serve to construct a sense of identity." Following the insights of Goffman (1961), these active processes are thought to be deeply performative, interactive, and contextual. Identity work is also multiple and thus something of a balancing act, given that individuals are engaged in "a mélange of different identity projects, co-present within the self but distinct and potentially conflicting" (p. 52). There is also an important temporal component to identity work, because each discrete enactment of identity contains "the shadow of encounters past and the foreshadow of encounters yet to come" (p. 52).

accomplishments come to be represented and possibly regarded as doubly impressive. While "negative or socially undesirable behaviors" might be thought to occur *because of* mental disorder, positive outcomes or socially desirable behaviors might be thought to occur *in spite of* mental disorder, thus making them especially commendable, agent-driven achievements. While attaining advanced degrees (in the author's case, two Master's degrees and a Doctorate) might already be generally regarded as accomplishments in many contexts, it could be argued that such achievements take on an additionally impressive quality in light of the fact that they are now thought to have been accomplished in spite of the challenges that mental disorders often pose. However, stressing one's accomplishments in this context is potentially fraught. As mentioned earlier in discussion of the rhetorical conundrum of borderline mental disorders, the appearance of normalcy and what would seem a high level of function are potentially discrediting for people laying claim to mental illness identities. This conundrum of so-called "borderline" or "high-functioning" mental disorders will be discussed in the subsequent chapter.

(2015, March 18). My Wife has Dysthymia…how can I help? Message posted to http://MDJunction.com/dysthymia.

I've been married for almost 20 years to a woman who has suffered (undiagnosed) for most of her life (42 years old). Things have not been easy to say that least.

Right now things are rough, I've done everything I can over the years to help and hang on. This diagnosis may change everything, but it will not be easy!

Someone here must have some advice for me, I've taken the approach that her well being comes before our relationship while still supporting the relationship. Without her getting help there is no us. But what do I do? It's like a mine field, you never know when the next explosion is going to take place.

We have 3 kids, they have asked point blank why I continue to stay in the relationship. It's a hard thing to hear when you think you've put on a brave face for all the years trying to shield them from the fallout of a bad day or a bad week or in this case a bad year/s.

I understand that this disease is at least partially genetic, my father in law suffers from some form of depression, his brother committed suicide, my wife's Grand Mother had depression issues, and now I'm suspecting our 15 year old daughter may be experiencing some of the same symptoms.

We have access to counseling, and any other resource that may be required. I've spent 20 years supporting this relationship and have committed to continue until there is nothing else I can possibly do. I can see my wife for who she really is and not for what this disease has turned her into, however she has suffered for so long that she feels this is who she actually is.

Again, I need your advice. Thanks in advance

Retrospectively identifying *someone else's* dysthymia would seem to be a complex and

rhetorically delicate process for all parties involved. It is unclear exactly how the author above

arrived at the conclusion that his wife has suffered "most of her life" from undiagnosed

dysthymia; it is likewise unclear whether she herself concurs with the author about the

appropriateness of the diagnosis. What is clear is that retrospective identification of dysthymia is

a powerful tool for recontextualizing the past, and that, in this case, these recontextualizations have built hopeful projections into the future: as the author of this post states, the diagnosis of dysthymia "may change everything."

The retrospective identification of dysthymia appears to have heightened the author's sense of ethical obligation to his wife so that the two can, as the title of his post says, "make [the] marriage work." Without the diagnosis, the author might simply consider himself a person stuck in an unsatisfying or unworkable marriage. By retrospectively identifying his wife's dysthymia, the author becomes not just a person enduring a bad marriage, but a person enduring challenges for the purpose of preserving a marriage in spite of the havoc wrought by a mood disorder, and also for the purpose of supporting a spouse who has long suffered from an undiagnosed mood disorder. Rather than expressing ambivalence or a desire to terminate his marriage, the author expresses a sense of duty to maintain his marriage and support his spouse until "there is nothing left" that can possibly be done.

This sense of obligation becomes especially powerful given that the author can "see my wife for who she really is" rather than "what this disease has turned her into." His wife, meanwhile, "has suffered for so long that she feels this is who she actually is." This ambiguity—the slippage between mood disorder and some more essential, core aspect of self—is a common topic in public discourses about mental health and illness in general, but is said to be particularly murky as it pertains to dysthymia due to the subtlety and chronicity of its symptoms. Recall Hellerstein's (2016) remarks, quoted earlier, about the underdiagnosis of dysthymia: "Part of the problem is that many people mistake the symptoms for their personality. They may assume that they're just pessimistic or self-conscious or moody. After struggling for so many years, people come to view the fog of depression as their normal functioning" (Tartakovsky, 2016).

Retrospective identification, then, is one process by which this distinction—between a merely pessimistic or self-conscious or moody" and a person suffering from dysthymia—emerges and reshapes previous understandings of self and/or others. Stressing the "at least partly genetic" roots of dysthymia seems to help the author of this post distinguish between who his wife "really is" and "what this disease has turned her into." Interestingly, in scholarly and public discourses, it was anticipated that research into the *genetic* basis of mental disorders would obviate the need for people grapple with such distinctions by finally clarifying the hazy line between mental disorder and personhood. That is, if a disorder is thought of as *genetic*, then the symptoms arising out of that disorder are not considered part of one's *personality* (Barr & Rose, 2008). But as Dumit (2003) suggests, in an age of enthusiasm for genetic discourse, genes "can become a synecdoche for one's identity" and so, rather than reconciling this ambiguity, the public uptake of genomic rhetorics might well have the effect of further entrenching it (p. 44).

(2006, August 19). I diagnosed myself. Please read. Message posted to
http://psychforums.com/dysthymia.

I have been reading a lot on my own depression symptoms and other
depression disorders. When I came across dysthymia I knew it hit what I had
all my life right on.

Reading the symptoms of dysthymia and reading some of the posts on this
forum, I knew it was exactly what I have. I haven't been evaluated by any
psych therapists or anyone. I made the diagnosis myself just for matching the
symptoms 100 percent.

Now, I am not sure where to go for here. I initially came to this site for support
for working on self-esteem issues and how its affecting my marital and
domestic problem but I can now see the root of what's really "going on with
me." I have been feeling depressed continually for all I can remember. I can
never enjoy life, I can never recall a time when I was happy, hopelessness,
pessimism, poor appetite, poor sleep…etc.

I had a really traumatic childhood, so I knew it started early with me. My life
was black and gloomy everyday. I cant love, or work like other people. I have
a very hard time making social interactions, or making decisions. I always
thought this was just my personality. I always though I am just a person who is
"unable" to carry out normal functions of life. But now it's making total sense.

I diagnosed myself, but obviously I can't treat myself. So what do I do now? I
want to get better for my children. I want to be able to enjoy life and stop being
so inactive and isolated and negative. I am tired of being depressed every darn
day. I want to stop worrying. I want to stop thinking that the future is hopeless
and that there is nothing that can make things better (I thought that's how life
was)

Please help. Where do I go from here? What should I do? Are there other ways
besides meds? Anyone who has this, please help. I would appreciate your
insights. Thank you.

In this post, the author explicitly states that a diagnosis of dysthymia has been arrived at via self-

diagnosis. While self-diagnosing dysthymia was not the author's initial motivation for visiting

the online health community, the author describes feeling hailed by the description of dysthymia,

and is now able to see "the root of what's really going on." As a result of "matching the

symptoms 100 percent" the author "knew [dysthymia] hit what I had all my life right on."

Childhood, which the author describes as traumatic, is identified as the context of dysthymia's

onset, after which point the author was not "like other people."

Here, as in other instances of retrospective identification, the author recontexutalizes the

past in ways that destabilize previous notions of self, paving the way for a distinction to emerge

between dysthymia and what the author "always thought was…just my personality." The author

previously regarded gloominess, trouble making decisions, and an inability to carry out "normal

functions of life" as mere "personality" traits rather than evidence of an underlying mental

disorder. As in the previous post, the author requests advice from others regarding how to

address the present and future now that the past has been recontextualized as a by-product of

dysthymia. Specifically, this author requests advice on whether it is possible to treat dysthymia

without medication. This is not uncommon; many online health community members state a

preference to abstain from medication regimens. The stated reasons vary; some fear the

possibility of side effects, others state that medication feels like a form of "cheating," a sentiment

that hints at the sort of ambivalence sociologists have claimed is widespread with regard to

psychopharmacological interventions in general, and antidepressants in particular.[66]

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[66] Barr & Rose (2008) summarize the character of patient ambivalence toward antidepressants: "On the one hand, people wanted to continue taking antidepressants if it kept their symptoms away and yet simultaneously felt that they were 'weaker' for needing to stay on drugs and desired to 'sort themselves out' without recourse to medicine…Feelings of ambivalence were also heightened by the fact that patients could not fathom staying on antidepressants indefinitely, even when they were effective" (p. 953).

3.4.2   Forecasting the Future

The problem with dysthymia, as it is formulated and conveyed in many of these accounts, cannot be reduced to its (retrospectively-identified) role in shaping the past. That is, the problem is not simply that one had a traumatic childhood, or that one can recall a turning point after which everyday tasks seemed pointless, or that it is difficult to recollect a period of time during which one felt "genuinely" happy. A significant part of the problem is described as the knowledge that so much time has elapsed in one's short lifespan, time not well spent, and, importantly, this knowledge dims the sense that a more fulfilling future might be possible. This squares with Solomon's (2001) formulation of mild depression as a subjective experience that is constituted in large part by an "acute awareness of transience and limitation" (p. 17). Such temporal preoccupation—the keen awareness of time's ceaseless forward movement and its connection to diminished possibility —seems to permeate many accounts of dysthymia, including this brief one below that succinctly summarizes this sentiment:

> (2015, February 19). How to let go of things that can't be. Message posted to
> http://MDJunction.com/dysthymia.
>
> At my age and stage of life, there are some things that might have happened
> and didn't and now probably won't.
>
> This brings me down hugely.

Another community member chimes in, who also represents the stark fact of time's passing— and what this passing means for future possibilities—as crucial to the development and perpetuation of their dysthymic experience.

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(2015, February 20). Re: How to let go of things that can't be. Message posted to http://MDJunction.com/dysthymia.

I can definitely relate to the feeling of loss, though I try hard not to dwell on it. I'm 60 and didn't learn I had Dysthymia until 3 years ago, so I spent probably 40 years of my life thinking I was the problem that I was just a miserable person with a attitude that sucked and I couldn't conquer it no matter what I tried. What's past is past of course and no one should live there; that is obvious. I try to stay focused on the fact that now I know the truth and there are things (meds/therapy) that can help me accept myself and feel more fulfilled in my life.

When I was first diagnosed, I made the mistake of thinking: Oh now that I know what the problem is I can see about fixing it, as if it was as easy as taking ibuprofen for a headache. As anyone reading this will know, it was a rude awakening finding out that was not the case cause a whole new realm of struggle was opened up. I do continually remind myself that I'm blessed to even know, as many people never find out and remain in their current state for their while life. Had it not been for a very intuitive family doctor, I would still be there.

In the post above, the quantitative and qualitative aspects of time blur together. [67] That is to say, a sharp focus on the quantitative dimension of time—the sheer, stubborn fact that one's lifespan is finite and elapsing, measurable in days, weeks, years—impinges upon perceptions of time's qualitative aspects, of what is deemed possible or likely to unfold in the time that remains in one's lifespan. The following post expresses similar sentiments.

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[67] While it may be commonplace to think of time as an exclusively quantitative measure, the ancient Greeks had two terms for time, one to denote its quantitative dimensions and another for its qualitative components. Chronos, with its familiar "chron" prefix, refers to time as an objective measurement with a direct connection to other forms of measurement: ages, lengths, rates, etc. Kairos, on the other hand, refers to the curious, qualitative aspects of time, or perhaps more accurately, timing. In rhetorical scholarship, the concept of kairos refers to the "right" moment in time for a particular discourse to take shape.

(2014, March 5). How do I start? Message posted to
http://psychforums.com/dysthymia.

I constantly imagine myself in a life at some point in the future where I am
completely sorted and living a life that brings me reward. But it seems
impossible to reach that point. I can't find my first step. I search and search and
search for a point of change. I keep planning and thinking that tomorrow or next
week I will change and be able to do SOMETHING to change how I live but
every single day I wake up knowing that the day will be the same as the last one
and the one before that and so on and so on.

In this post, the author places "searching," "planning," and "thinking" about the future at odds

with knowledge of the present: *knowing* that every "today" will be the same as so many

preceding yesterdays. (Recall Solomon's (2001) claim that the "present tense of dysthymia

envisages no alleviation because it *feels like knowledge* (p. 16).) Thus the awareness of time's

passage is difficult to shake, specifically time that is (retrospectively) thought to have consisted

mainly of empty days sliding one another, each one feeling more or less the same as the day

before. This awareness dulls the sense that it may be possible to locate an opportune kairotic

moment, or a "point of change" from which to disrupt the forgoing gloomy monotony of the

present and construct a vision of the future in which satisfying experiences are possible. As been

pointed out, the view of illness as disruption generally implies that *restoration* to a previous state

of health is being sought (Bury, 2001; Frank, 1995). Dysthymia, however, does not appear to be

considered as a *disruption* in one's life course, but an enduring aspect of one's biographical

identity. And so, authors such as the one above might not be thinking of their aspiration as

restoration to a former state of affairs but rather *reinvention—*a perhaps markedly taller order.

(2011, May 11). I have Dysthymia. Message posted to
http://experienceproject.com/dysthymia.

First I was told that I have depression, then a personality disorder now
Dysthymia. I really done like that name. I feel really unmotivated and feel that
there is no future for me. I am 29 and want to be married and have children but
I don't think that I can do these things. Dysthymia makes me feel like I cant do
anything, makes me really not talk to anyone. I used to teach but now feel like
I don't have the skills. I talk less and feel like my co-ordination, memory,
enjoyment from anything is gone. I think it has been a slow progression. I have
forced myself to be happy at times and can no longer put up a front. I feel aged
and cant see the point of trying new things as I feel low afterward. I have two
degrees and have had a happy life- but slowly my happiness has gone.
Sometimes I resent my family who are happy going about their normal day of
work, socializing, etc. I used to like those things too but now constantly have
to watch my behavior so no one suspects there might be something wrong with
me . I have been seeing a counselor for about a year and am on Citalopram to
help give me good feelings. I have been through a lot in my mind thinking
random thoughts about people, life for the past three years. Sometimes when
Im trying to tell people how I feel I have got angry. Like my mother, because
she cant understand it. Shes like well just get a job and youll be right, or join a
group. I used to want to do these things but don't really now. I feel robbed of a
future and wish I wasn't like this. It seems to get worse with age or something,
as I remember throughout high school I woud withdraw myself from peers for
a short period of time, then it got worse. Like others my age I would love to be
married and living with normal thoughts of how we are going to pay the bills,
etc, when should we have children, to have a companion. I feel I would have
nothing to offer as I don't have anything to offer myself let alone someone
else. I feel robbed.

About to turn thirty years old, the author of the post meditates upon experiences that are

desirable, but, in her/his estimation, not likely to occur, such as the traditional adulthood markers

of marriage, children, etc. The author describes a feeling of having been "robbed" of the sort of

future that had previously been envisioned. The previous section on retrospective identification

suggested that the subjective experience of the immediate present was not often represented as

problematic; much more effort was devoted to reconstructing the problematic features of one's

past. Here, dysthymia is not described as dilemmatic so much in its present manifestation as

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much as for what it foretells about the future. Projections of a bleak future, one devoid of possibility, one unlike that which was hoped for in earlier, more optimistic times, is described as an integral part of producing the subjective experience of dysthymia in the present.

3.5   SUMMARY AND CONCLUSIONS

Having explored the temporal dimensions of online health accounts of dysthymia, this chapter contributes to the body of literature that examines the relationship between temporality and illness. To date, this literature has focused mainly on how the onset of chronic *physical* illness often leads to temporal readjustments, both for those diagnosed with illness and those involved in their care. It has shown that these temporal adaptations can have practical utility for managing the activities of daily living by helping people, for example, stay on top off their medication regimens, juggle appointments, coordinate in-home care, and so on. On a more abstract level, though, reshaped temporal perspectives—new ways of thinking about time—link up with reshaped ideas about control, about possibility, about agency. Charmaz (1992), for example, has sketched the details of a temporal perspective often adopted by individuals with chronic physical illnesses that she calls "living one day at a time." Living one day at a time entails a deep immersion within the present, accompanied by sharply circumscribed views of time, and halted projections into the future. This absorption into the present is regarded as an active coping mechanism, given that it seems to *confer a sense of control* in the face of chronic illness diagnosis and management.

The temporal perspectives defined and elaborated upon in this chapter—that is, those that frequently structure accounts of dysthymia in online health communities—have been termed "panoramic," and they provide a stark counter-perspective to "living one day at a time." The chapter contended that panoramic temporal perspectives are drawn upon when people describe a sense of being whisked out of the immediate present and positioned within an expansive temporal terrain that often begins with a reconstruction of events from the (bleak) distant past and concludes with a contemplation of dimmed future expectations. Within this temporal landscape, the problem of dysthymia is not described as existing solely or even primarily within the immediate present: the present *becomes* problematic when perceived through the lens of the remote past and envisioned future, with empty days seeming to slide into one another to form bridge between the two. I was surprised to find, upon editing a draft of this chapter, the following description of dysthymia from David J. Hellerstein, an American psychiatrist: "Experts refer to dysthymia as a paradoxical condition because it appears mild day to day but becomes brutal long-term," (Tartakovsky, 2016). While living one day at a time often seems to have the effect of imbuing individuals with a sense of control, the accounts examined in this chapter wondered whether panoramic temporal perspectives might do something akin to the opposite; that is, they might have the side effect of attenuating one's felt sense of control over the emotional character of one's life.

Panoramic temporal perspectives have practical utility in an age of online mental health, wherein self-diagnosis is taking on new forms and new impetus. In the case of *chronic* mood disorders such as dysthymia, stretched-out panoramic temporal perspectives furnish the user with a workable framework for *retrospectively identifying* the onset of illness. The chapter defined "retrospective identification" as a process through which the onset of disorder and contextual

features related to its onset are identified.[68] Through retrospective identification, the distinction between mere "gloominess" and chronic depression emerges: what one previously considered "just part of my personality" comes to be regarded as evidence of chronic mood disorder. This transformation of gloominess into mood disorder transforms understandings of various other aspects of one's life related to relationships, related to employment, related to broader notions of agency. Interestingly, some described feelings of deepened depression upon formal diagnosis of dysthymia; they articulated the sense that, since the previously unnamed "problem" is in fact a clinically defined and therapeutically manageable entity, the "problem" could have potentially been intervened upon earlier, and perhaps there were other directions life could have taken, had earlier intervention occurred. Implicit in such an articulation is the sense that if the problem had been "just their personality" (and thus, not necessarily clinically actionable) the past was not "wasted" since there was no other direction life could have taken: their unhappiness was more or less determined.

Where time is concerned, notions of agency and possibility seem often to lurk in the conceptual background. The sorts of transformations that spring up in the wake of retrospective diagnosis point to a paradox as it pertains to temporality and agency: that the past both can and cannot be changed. In the words of Barken (2014), the past is both "revocable and irrevocable"

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[68] It is worth noting the ways in which the visual structure and technological affordances of the online health communities observed here support the temporal perspectives deployed therein. In these online health communities, there are no "tags" for authors to select from to specify the topic or purpose of their post (e.g. "medication question," "symptom discussion," "therapy resources," etc.) if there were, temporal circumscription might be the result. When authors begin a new post, visually speaking they are met with a large open box into which to type, and there is no word limit. And so, this might aid or encourage the tendency to assemble lengthy narrative accounts of illness, those that have a beginning (most typically in the contextual features of one's childhood), a middle, and an end (often a look into the future). These technological affordances, coupled with the fact that a chronic mood disorder share a murky boundary with a broader concept of "personality," likely contribute to the communicative norm of lengthy self-introductory posts that narrativize dysthymia in temporally expansive terms.

(p. 4). That is, events of the past cannot be returned to and modified; but since every act of recollection is a remediation arising in the present, it is perhaps possible to exercise these recollections differently, to frame them differently, and therefore to experience them differently. Perhaps this is what American novelist Tom Robbins had in mind when he had the protagonist of a novel suggest that, "it's never too late to have a happy childhood"—a quotation that has since become the subject of many an inspirational meme floating around digital culture.

The chapter went on to contend that retrospective identification not only reformulates ideas about agency pertaining to the past (i.e., wondering how things might have gone differently) but also ideas about possibility in the future. Here, the weather-based metaphor circulating in online health communities and analyzed in the chapter, becomes relevant. This metaphor likens the subjective experience of dysthymia to waking up on the "tenth day of rainy weather," knowing that each day in the future will be similarly rainy. When this metaphor was invoked, the author suggested that the only act of agency that one can call upon to contend with this knowledge is to "accept the rain." This description portrays the subjective experience of dysthymia as miserable not so much because of how it manifests in the present (which contrasts with how many people describe the moment-to-moment unpleasantness of MDD) but, in Solomon's (2001) words, this unpleasantness stems from "from knowing it in the moments gone by and to look forward only to knowing it in the moments to come" (p. 16). Because the present tense of dysthymia—a present tense that is shaped by reconstructions of the remote past and projections into the distant future—"feels like knowledge," it becomes difficult to imagine, as one author calls it, "a point of change" from which to initiate some kind of process of reinvention. Thus, ways of thinking about time might play an important, though underacknowledged, role in describing the subjective experience of dysthymia. While

scholarship, especially from the fields of health communication and medical sociology, has begun to explore the ways in which temporality is configured in accounts of chronic *physical* illnesses, this chapter suggests that the ways in which temporality is configured in accounts of chronic *mental* illnesses also merit sustained attention.

4.0 THE TROUBLE WITH "MILD" DEPRESSION AND THE CONTRACTION OF "NORMAL"

> We are especially concerned with classifications that, when known by people or those around them, and put to work in institutions, change the ways in which individuals experience themselves—and may even lead people to evolve their feelings and behavior in part because they are so classified.
> —Ian Hacking, *The Social Construction of What*?

In a seminal 1971 study, "Being sane in insane places," psychologist David Rosenhan marveled at what he considered the *stickiness* of psychodiagnostic labels. He noted that, once applied by an authority figure to patients in the study (who happened to be students of his, feigning schizophrenia symptoms for the purposes of the study), psychodiagnostic labels adhered to their recipients, even after the total dissipation of symptoms. (The patients were discharged with a diagnosis of "schizophrenia in remission.") And yet, in addition to their stickiness, psychodiagnostic labels are also remarkable for their *ephemerality*, as each new edition of the *Diagnostic and Statistical Manual of Mental Disorders* marks the birth of newly crafted diagnostic categories, the carving and polishing of preexisting categories, and the death of abolished categories. And, of course, some of these label deaths apply to categories with which people have come to closely identify. While more attention has been paid to the ethics of applying labels rather than removing them, label removal is a fraught phenomenon with the potential to throw established illness identities into disarray, in turn prompting questions that are arguably ontological in nature. New categories create, as Hacking puts it, "new ways for people

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to be."[69] If new categories create new ways for people to be, then the abolishment of categories raises the inverse question of whether label removal eliminates "ways for people to be."

As we have transitioned from a medical age of "professional dominance" (Freidson, 1970) and "doctor's orders," into an era of commercialized healthcare, the stickiness of psychodiagnostic labels has once again come under scrutiny, but with a focus on a different set of actors. As Charland (2004) describes the new milieu of labeling: "psychiatric paternalism and the definition and deployment of psychiatric labels was once the exclusive prerogative of the psychiatric profession. Neither patients nor their patient groups were consulted when psychiatric labels were applied and removed. Today, psychiatric labeling is a much more complex process, subject to numerous social, political, and economic interests" (p. 342). In contrast to Rosenhan's brand of label stickiness—a stickiness generated primarily "from above," (i.e. the experts in his study who discharged asymptomatic patients with the label "schizophrenia in remission")—contemporary label stickiness can be maintained "from below," by the labeled themselves, who have come to identify, sometimes very strongly, with a particular psychodiagnostic label.

Of course, the reaction of the labeled to news of impending label death varies, and can range from acceptance, to indifference, to what Charland (2004) calls "label death refusal." The defining feature of the latter is "a refusal by some psychiatric patients to relinquish their iatrogenic identity provided by their medical diagnostic labels" (p. 335). As tempting as it may be to view label death refusal as a completely novel phenomenon that has emerged in a contemporary medical zeitgeist that privileges patient autonomy, Charland cautions against this

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[69] In *Historical Ontology*, Hacking (2004) deconstructs Davidson's (2001) claim that there existed no "perverts" prior to the second half of the nineteenth century, as "pervert" was not yet a way for a person to be. In doing so, Hacking coins a concept he calls "dynamic nominalism, which refers to the process by which new classifications construct new "kinds" of people and these new "kinds" in turn change their behavior, which leads to changes in the classification.

view, explaining that, "In one way there is nothing new about the existence of refusals of this type; they probably go back to the dawn of psychiatry. But there is another way in which the refusals we are concerned with are novel. This is the medium in which they take place, namely, the Internet" (p. 335-336). At this time, few studies of internet-mediated reactions to "label death" exist. Those that do tend to focus on instances in which patients strongly oppose, or simply refuse, label death. In these instances, people have come to closely identify with a given psychiatric label, and ardently oppose the American Psychological Association's attempts to revise or abolish the label, sometimes keeping the label alive by refusing to disband or rename the online health communities that have sprung up around the label.

And yet, internet-mediated responses to label death that are characterized largely by either indifference or acceptance—as opposed to resistance or rejection—are at least equally as interesting from a rhetorical point of view, and perhaps, in certain cases, even more so. In the case of dysthymia, which was removed from the *DSM-5* (2013) and replaced with "Persistent Depressive Disorder" (PDD), the online health community response was decidedly sparse, and decidedly warm. There are few posts pertaining to the topic, and the few posts that do exist regard the label death of dysthymia as a generally positive development for those labeled by it. Though posts on the topic were quite limited, there is reason to suggest that these few positive posts are likely to be at least somewhat representative of broader community sentiments, given the widespread and fairly intense dissatisfaction that users often expressed when discussing the label of dysthymia itself.

This chapter explores community reactions to dysthymia's replacement wit Persistent Depressive Disorder, which requires unpacking users' expressed dissatisfaction with the label of dysthymia. First, it provides some detail regarding the *DSM-5* revision process that resulted in

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dysthymia's replacement by PDD. Next, it unpacks community members' dissatisfaction with dysthymia, much of which centers upon notions that the disorder is a "mild" complement to its nosological cousin, Major Depressive Disorder (MDD). In doing so, it suggests that psychiatric labels defined as "mild" can present a rhetorical conundrum of sorts for those so labeled. This chapter identifies and describes online health community members' strategies for contending with this conundrum. Of particular interest here is how the meaning of "normality" is constructed (or more accurately, contracted) such that it becomes more cleanly distinguishable from the subjective experience of dysthymia.

4.1   *DSM-5*: AN "INTERACTIVE" REVISION PROCESS

When philosopher of medicine Louis Charland wrote in 2004 that, "At no time in the history of psychiatry have members of the public exercised so much power over the psychiatric establishment that serves them," he likely would not have been surprised to learn that, in 2010, the American Psychological Association (APA) would directly solicit the "general public" to participate in the *DSM-5* revision process (p. 342). Three years prior to the debut of *DSM-5*, the APA launched a website—www.dsm5.org—that included information about the revision process, and perhaps more importantly, drafts of proposed diagnostic criteria for various disorders. The "general public," for the first time in the history of the APA, was thus invited to peruse and provide commentary on the drafted criteria. This being the case, one could plausibly advance the claim that the public was invited to participate in shaping the professional

knowledge found within the pages of the *DSM-5*. However, not all would agree with such a claim.

The APA's positing of a given, preexistent "general public" does not escape the scrutiny of rhetoricians. Operating from the perspective that rhetorical address works to constitute the subject positions of its audience, Kelly (2014) argues that "the *DSM-5* draft diagnostic criteria establish possible identity positions for audience members to inhabit, and, in doing so, provide "narratized" subject positions for the locus of experience and action" (p. 172).[70] Of particular interest from a rhetorical view is the inclusion of draft criteria that takes the form of "patient-reported speech." "Reported speech" is a blended genre (and rhetorical resource) in which an individual (or group of individuals) recontextualizes and reports the speech of another individual (or group of individuals).[71]

In the context of the *DSM-5* public website, patient-reported speech was found in the form of first-person utterances that were employed to clarify and contextualize diagnostic criteria in the form of "everyday" language, the kinds of statements a layperson with a diagnosis might use to describe their experience of living under that diagnosis. For example, one *DSM-5* draft criterion for Post-Traumatic Stress Disorder included "persistent or exaggerated expectations about self, others, or the world." Placed in parentheses next to the criterion were instances of patient-reported speech meant to exemplify the symptom in everyday lingo: "I am bad," "No one

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[70] Here, Kelly is operating from a "constitutive" rhetorical perspective. Such a perspective encourages rhetoricians to note how, in the very act of rhetorical address, rhetors establish possible identity positions for its audience. In this way, the act of rhetorical address "constitutes" its own audience members; audience members did not exist as such prior to being addressed as such. According to Charland (1987), such a move has ideological implications "not merely because they provide individuals with narratives to inhabit as subjects and motives to experience, but because they insert "narratized" subjects-as-agents into the world" (p. 143).

[71] Psychiatric discourses have long been known to blend genres, including, of course, Freud, who famously blended nosology and narrative (McCarthy & Gerring, 1994).

can be trusted," "The world is completely dangerous." Alternately, this might be expressed as, e.g. "I've lost my soul forever," or "My whole nervous system is permanently ruined." (As quoted by Kelly, 2014, p. 178). From a constitutive rhetorical perspective, these instances of "reported speech" provided "narratized subject positions" for members of general public to inhabit, with the possible side effect of increasing the cultural portability of the "common language" of psychiatry. As Kelly explains,

> The presence of stereotypical patient "voice" on the draft diagnostic criteria, detached from local context, provides an opportunity for readers to identify with and inhabit the unidentified, ambiguous, anonymous "voice" or persona represented in the discourse   fragments, and thus reported speech facilitates the cultural portability of the "common   language"…The speech reports become a kind of disembodied, transmissible sound bite—decontextualized and detached from an individual speaking subject yet paradoxically representative of psychiatric knowledge. (p. 180).

By hailing the public as co-participants in the process of producing psychiatric knowledge, the APA invited members of the general public to regard themselves as "exemplary speakers" of a professional discourse. Here, two things are worth nothing. First, each revision of the *DSM* threatens to undermine its own aims; dramatic revisions of the text could be regarded as attenuating the perceived reliability of knowledge in the previous text, which in turn threatens undermine the field's claim to scientifically principled and reliable knowledge. Second, it is worth noting how increasing the cultural portability of a professional discourse is a fairly unusual

aim among other professions (medicine, law, etc.), as many often appear to be invested in maintaining both the precision and exclusionary qualities of their disciplinary-specific (jargonistic, some might say) forms of language.[72]

A constitutive rhetorical perspective on the matter might suggest that the APA was not so much *discovering* the public's feedback, but, in a sense, *actively creating* it by crafting the possible subject positions from which the public could voice "their" perspectives. This raises the question: was the APA's solicitation of public feedback an essentially empty gesture, or did the public meaningfully contribute to the revision process? While a constitutive rhetorical perspective would likely favor the former, viewing the situation through the lens of Hacking's (1999) concept of interactivity might render the question more or less moot. Specifically, Hacking's work on the interactivity of mental disorder classifications could be drawn upon to argue that the "public"—or at least, members of the public to whom the *DSM* diagnoses are applied—had *already been playing a non-trivial role* in the rearchitecture of the *DSM*'s diagnoses, prior to the APA's solicitation of public feedback. This is because of the intrinsically interactive, looping nature of the classifications that populate the pages of the *DSM*.

Hacking, aiming to bypass debate over which social science classifications are "socially constructed" and which are "real," reframes the question by offering a distinction between "interactive" and "indifferent" kinds of classifications. While both kinds of classifications are subject to change over time, interactive classifications involve a recursive relationship between a classification and those so classified by it. As Hacking sees it, those classified by a label alter

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[72] It is not only professions such as law and medicine that appear invested in maintaining the exclusionary, jargonistic features of their professional languages. In the 1990s, the humanities came under scrutiny for what was deemed jargonistic, unnecessarily complicated prose. Butler (1999) defended the use of such language on ideological grounds. Her basic argument is that counterhegemonic ideas require the use of a specialized language that stands outside "common language," even if such language is less comprehensible to a general audience.

their behavior—in ways sometimes subtle, sometimes substantial—in accordance with the knowledge of how they are classified. Collectively, over time, these changes render the label ill-fitting and in need of recalibration. Thus, there is a process of co-evolution, in which the classification and the classified each have a role to play in the molding and remolding of the other. Hacking (1999) describes this process of joint evolution as such:

> We are especially concerned with classifications that, when known by people or those around them, and put to work in institutions, change the ways in which individuals experience themselves—and may even lead people to evolve their feelings and behavior in part because they are so classified. Such kinds (of people and their behavior) are interactive kinds. This ugly phrase has the merit of recalling actors, agency, and action. The inter may suggest the way in which the classification and the individual classified may interact, the way in which the actors may become self-aware as being of a kind, if only because of being treated or institutionalized as of that kind, and so experience themselves that way (p. 104).

Knowledge of how one is classified—the requisite feature of Hacking's interactivity—comes in different forms, as there are different types of knowledge and different ways of coming to know things. For example, *definitional* knowledge of the details of a given classification has a character that is distinct from the *experiential k*nowledge that comes with living under that classification. For Hacking, knowledge of one's classification is possible even in cases where the classified would seem, by virtue of their particular classification, to be necessarily unaware of how they are classified. He gives the example of severely autistic children, explaining that,

"Autism may seem problematic for my idea of interactive kinds. So how can the classification interact with the children? Part of the answer is that they are in their own ways aware, conscious, reflective, and in the experience of those who work with autistic children, very good at manipulating other people, despite their problems of lack of affect and rapport" (p. 115).

It could be argued that psychiatric classifications present the possibility for particularly potent forms of interaction between classification and classified. Unlike other interactive classifications that are nebulous and do not fall squarely within the province of any one particular institution, profession, or body of knowledge—for example, classifications such as "child" or "victim" or "American" that have different, sometimes contradictory, meanings in different contexts—psychiatric classifications are codified in the form of an institutional text (the *DSM*) whose categories circulate far and wide, with rhetorical salience that has steadily spread across multiple domains of public life.

Hacking's interactivity is one that grants some degree of agency to the classified, even to those whose classifications would seem to preclude the exercise of meaningful agency, such as the example of children living with severe forms of autism spectrum disorders. In this formulation, agency becomes a property exercised in concert with other agentive beings or bodies. While Hacking's notion of interactivity takes as given the agency of the classified, Charland (2004) believes that it does not go far enough, because it does not fully account for the role of consumer *autonomy* in an era of commercialized healthcare. As he puts it, Hacking's concept of interactivity,

> fails to mention one central aspect of the manufacture of iatrogenic identity,
> namely the role of autonomy. Compared to previous ages where paternalism was
> the dominant ethical and political ideology, we now live in an age where the right

to self-determination of the individual is paramount. Autonomy is enshrined in

both law and ethics in the doctrine of informed consent. It is also manifest in the

openness to pluralism and diversity so prevalent today. Autonomy [has] economic

dimensions and is reflected in the important place of consumer culture. These

combined social manifestations of autonomy have had dramatic consequences for

the practice of psychiatry and the "manufacture" of psychiatric labels (p. 342).

Thus, according to Charland (2004), a philosophical study of psychiatric classification, including

the death of psychiatric classification, needs to attend to the increasingly central role that

consumers are (sometimes) now able to play in the labeling process, a role that is made possible,

in no small part, by our contemporary digital communication climate.

4.2   LABEL DEATH IN ONLINE HEALTH COMMUNITIES

If the increased legal, ethical, and cultural salience of autonomy has given the patients a louder

voice in the recursive process of label interactivity, one could speculate that our contemporary

digital communication climate plays a role here too, by clearing a shorter, more direct path for

interaction between classifiers and classified. The post-2000 years have seen an explosion of

online health resources with the potential to facilitate interaction: communities, fora, symptom

checkers, blogs, quizzes, clickbait, and so forth. These resources run the gamut from those that

are fully "user-led" (i.e., no corporate or organizational sponsorship of any kind) to those that are

entirely under the management of a professional organization, patient advocacy group, or corporation.

As it pertains the to the revision and/or death of psychiatric classifications, online health communities offer spaces in which information about impending changes can circulate and reactions can be formulated; these reactions are archived and can then accessed by community "outsiders" including, theoretically at least, members of the APA themselves, should they be motivated to go searching for such information. Online community reaction to label revision and death is, at present, relatively unexplored terrain despite being a phenomenon with relevance to numerous academic disciplines (for example, bioethics, health communication, and digital media studies just to name a few).

When attention is paid to the shifts engendered by the new nosological arrangements in the *DSM,* it tends to come from within what might be called the "medicalization critique" framework, and so that (critical) attention tends to center upon the creation of new disorders, not the death of existing disorders. [73] But, as Giles (2014) points out, "Just as psychiatry has the power to bestow "illness" upon individual citizens, it also has the ability to deny or remove it, against the will of those individuals who—for whatever reason—desire to own their diagnosis, a genuine ethical concern" (p. 180). Of particular ethical concern for Giles (2014) is the way that revision of the *DSM*, and the deletion of certain disorders, can create identity dilemmas for those whose labels have been abolished. As Charland puts it, people sometimes "react to a change in labeling as though it invalidates their experiences living under that label" (p. 337).

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[73] One possible reason for this lack of attention may be that label death is a phenomenon whose frequency is starkly overshadowed by its opposite phenomenon: label birth. A quick glance at the relevant numbers reveals the following: the first (1952) edition of the DSM listed 128 categories, the second edition (1968) included 193, the third edition (1980) contained 228, the fourth (1994) offered 383, and the fifth (2013) had swelled to 541.

Interestingly, the most controversial update of the *DSM-5* did not involve the addition of

new categories, and as such, did not engender the standard medicalization critique about how the

latest edition of the *DSM* pathologizes everyday experience and stigmatizes "mere eccentricities"

(Giles, 2014, p. 180). Instead, the most controversial aspect of the *DSM-5* involved not label

creation but label death: specifically, the death of the short-lived but culturally significant (and

rhetorically generative) Asperger's disorder. Only nineteen years old at the time of its label

death, Asperger's disorder had already found its way into mainstream public culture during its

short lifespan, thanks in part to numerous film and television representations, as well as a

handful of prominent public figures with the diagnosis.

At the time of its label death, individuals diagnosed with Asperger's disorder had

cultivated a vibrant online presence in the form of several prominent, highly active online

communities organized around the disorder.[74] It is from within these online communities that the

constructed identity of the "Aspie" emerged in the early 2000s, and it was within these

communities that news of the impending *DSM* abolishment of Asperger's disorder circulated in

the years leading up to the 2013 publication of the *DSM-5*. Many were displeased with the

APA's plan to abolish the disorder and subsume it into the broader autism disorder spectrum.

This displeasure took several forms, one form, according to Giles (2014), one of which was sheer

defiance: people suggested that "there was little the *DSM* could do to damage the AD community

itself" because AD "has 'achieved' too much over the last two decades, spawning an entire

culture (including the major websites) for it to be washed away simply by changing diagnostic

criteria" (p. 189). Individuals espousing such sentiments seemed, according to Giles (2014),

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[74] In fact, it has been suggested that the correlation between the rise in Internet use in the United States and the rise in autism diagnoses is not a coincidence, given that those with communication hindrances are often attracted to asynchronous forms of communication (John, 2010).

quite confident that the diagnosis of AD would remain a viable disorder outside the walls of

recognition built by the APA, the *DSM*, and the professional discourses of mental disorder.[75]

A major source on controversy in the "aspie" communities studied by Giles (2014) was

the APA's proposal not just to do away with AD, but to incorporate it into the broader autism

spectrum of disorders. This incorporation is consistent with the *DSM-5*'s general shift away from

a strictly *categorical* model of classification and toward the logic of *dimensional* (i.e. spectral)

classification. Categorical diagnosis focuses on matching a patient to an appropriate category on

the basis of the presence of symptoms, whereas dimensional diagnosis places a patient on a

spectrum and assesses the degree of symptom severity.

As the APA put out in a statement leading up the publication of the *DSM-5*: "The

upcoming fifth edition of the [*DSM-5*] introduces an integration of a dimensional approach to

diagnosis and classification with the current categorical approach. Previous editions of the *DSM*

used a strictly categorical model requiring a clinician to determine that a disorder was present or

absent. The dimensional approach, which allows a clinician more latitude to assess the severity

of a condition and *does not imply a concrete threshold between "normality" and disorder*, is

now incorporated via select diagnoses" (American Psychiatric Association, 2013, italics added).

For some in the "aspie" communities studied by Giles, the shift from categorical to a

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[75] Defiance was one six reactions typologized by Giles (2014) in his study of "aspie" communities' reaction to the proposed abolishment of AD. These reactions include: acceptance (many suggested that the death of AD would pave the way for deeper identification among people on the spectrum rather than maintaining an "elitist" categorical classification system), fear (involving concerns about diagnostic criteria being tightened and thus, the possibility that many with AD would be pushed off the spectrum altogether and would be unable to access services), rejection (these individuals tended to operate from a critical psychiatry position, and thus, rejected the DSM's claims to validity), defiance (those who expressed intent to keep their label alive after publication of the DSM-5), suspicion (including those who suggest the APA was simply buckling to public pressure to reign in the so-called "autism epidemic" by tightening the diagnostic criteria) and reassurance (those who aimed to smooth tensions among community members and alleviate concerns about underdiagnosis).

dimensional system not only induced concerns about diagnostic precision, but also led to concerns about the possibility of being diagnostically lumped in with the broader autism disorder spectrum, which for some evoked, "bygone childhood experiences where a diagnosis of autism condemned them to the company of very low-functioning playmates" (Giles, 2014, p. 192).

Dysthymia, like Asperger's disorder underwent a label death in the *DSM-5*, but a much quieter death and one that was, in the communities studied here, positively regarded when it was discussed, which was not often. While label death can be resisted defiantly as in the case of AD, label death can also be resisted nonchalantly, simply as a matter of convenience. Rather than establishing new communities, members maintain the old label and in a way, keep the old label alive in order to avoid any serious overhauling of the online health communities. Data collection for this dissertation began in late 2014, a little over a year after the label death of dysthymia, and the label birth of PDD. At that time, no online communities existed that were organized around Persistent Depressive Disorder. Thus, there can be a lag of sorts between professional and public terminologies. This lag is not confined to members of the "public" but also clinicians themselves, some of whom admit to deploying terminology consistent with the *DSM-IV*, because it is what they themselves, as well as their patients, are more familiar with and are thus more comfortable using.[76]

The question of how people react to the *DSM* death of a label with which they currently identify is not an uncomplicated rhetorical matter: these labels are connected with material repercussions (such as, for example, access to services), they often buttress a sense of identity for the labeled, and they form the basis of communities, such as the ones studied here. What does it

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[76] See, for example, this informational YouTube video on the subject, created by a licensed therapist, who states that she prefers to use the term "dysthymia" rather than PDD, because that is the terminology that she was taught while in school: https://www.youtube.com/watch?v=mOwOwQB4kvg.

mean to presently identify with a given label, but simultaneously advocate the abolishment of that same label? Below is one of the few threads identified in this chapter that pertain to the *DSM-5* abolishment of dysthymia and to the establishment of a new label, PDD. In the short thread that appears below, posters seem quite receptive to the *DSM-5* changes to their classification, and respond to them positively.

(2015, April 9). Persistent depressive disorder. Posted to
http://MDJunction.com/dysthymia.

is dsthymia's newest name. I guess they somehow decided there is a purprose
to renaming it.

(2015, April 9). Re: Persistent depressive disorder. Posted to
http://MDJunction.com/dysthymia.

oh great......

Dysthymia is an old latin name.

Why the Fuck can't they fix it ????

(2015, April 10). Re: Persistent depressive disorder. Posted to
http://MDJunction.com/dysthymia.

Believe it or not-- I'm actually OK with that. It acknowledges that this is
persistent depression and gets rid of the notion that it's "mild", like we have a
papercut or something. Dysthymia is anything but "mild" chronic depression

(2015, April 11). Re: Persistent depressive disorder. Posted to
http://MDJunction.com/dysthymia.

Yeah, I have to agree. Despair is a common emotion I feel with this illness,
and I would never use the word "mild" to describe that feeling.

(2015, April 15). Re: Persistent depressive disorder. Posted to
http://MDJunction.com/dysthymia.

So very much agreed, but there' something that happens when a name
changes...like Idk I feel connected to the word dysthymia...I'll continue to use
it despite PDD which also has a ring to it. In with the old and in with the new.

While the above thread was among the few explicitly addressed the replacement of dysthymia

with PDD, dissatisfaction with certain aspects of dysthymia as a diagnostic label was

widespread, so much so in fact, that the rest of the chapter is dedicated to unpacking this label

dissatisfaction and identifying the strategies community members use to contend with this dissatisfaction. This dissatisfaction hinges, as can be seen above, on the notion that dysthymia is a "mild" mood disorder. Indeed, "dysthymia" and "mild depression" seemed to be used almost interchangeably in public discourse when this dissertation project began. Given that dysthymia and mild depression as treated as synonyms, community members deploy certain strategies to disentangle the two terms. In the forthcoming section, I will explain three such strategies. First, community members articulate their perceived "functionality" as a quality of their lives that is maintained *not despite* dysthymia, but *because* of it. In this way, that which could be perceived as potentially discrediting one's claim to illness is repurposed as evidence of illness. Second, community members point to dysthymia's peculiar liminality to argue against the notion that the disorder is mild or relatively bearable. Lastly, community members define "normality" in a way that arguably contracts its meaning (compared to its more typical usage), which in turn serves to increase the conceptual distance between the experience of dysthymia disorder and "normal" experience.

4.3   THE TROUBLE WITH "MILD" DEPRESSION

"Mild depression," if picked apart, is a curious pair of words. This pairing could even be viewed as a contradiction in terms: to call something "mild" is generally meant to convey a sense of triviality, possibly gentleness; depression, meanwhile, tends to be described as a nontrivial experience. Take, for example, famous literary descriptions of what it means to be depressed at the level of subjective experience. In *Infinite Jest* (1996), for example, David Foster Wallace

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describes depression as "a sense of poisoning that pervades the self at the self's most elementary levels" rendering the depressed unable "to perceive any other person or thing as independent of the universal pain that is digesting her cell by cell" (p. 693-694). Or take the first sentence of the Centers for Disease Control's online depression "fact sheet" in which it is stated that, depression is "a serious medical illness and important public health issue." The World Health Organization's online "fact sheet" emphasizes that depression is "the leading cause of disability worldwide." None of these descriptions seem particularly compatible with a qualifier such as "mild."

To identify with a psychodiagnostic label, and simultaneously support the label's abolishment would seem to entail some degree of *ambivalence*. Though it may be used synonymously with *ambiguity*—a central concept in Chapter 1 of this dissertation—ambivalence is a distinct linguistic and experiential phenomenon. Psychological conceptions of ambivalence refer to a state of being in which one is of "mixed minds" about someone or something. The term is often attributed to German psychiatrist Eugen Blueler, but was later seized upon and popularized by Freud to explain the contradictory forces that structure mental life. For example, Freud noted the commonplace phenomenon in which a person harbors seemingly equal doses of love and hate, simultaneously, toward the same object. Freud suggested that in order to "reconcile" this ambivalence, there is a repression of one of the two conflicting emotions (with hatred often getting the short end of the stick) (Bleger, 2013).

While the psychological conception of ambivalence stems from the notion that people have conflicting inner forces brewing within the psyche, sociological conceptions of ambivalence focus less on interior dimensions of human life, and more on its exterior, intersubjective dimensions. Robert K. Merton, for example, traced the contours of a phenomenon

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he calls "sociological ambivalence." According to Merton (1967), this concept was developed as a complement to psychological ambivalence, and directs attention to the ways in which "ambivalence comes to be built into the structure of social statuses and roles. It directs us to examine the processes in the social structure that affect the probability of ambivalence turning into particular kinds of role-relations" (p. 5). To illustrate, Merton highlights the meanings attached to the role of "good doctor." Being a good doctor, he suggests, does not only mean exhibiting competence, but simultaneously exhibiting care and friendliness. To appear to be a "good doctor" means to simultaneously appear to be a "good friend." Thus, Merton concluded, being efficient at doctoring is not sufficient criteria for being a 'good doctor'; there are extraoccupational duties involved, and this includes being a 'friend.'

The sociological ambivalence entailed by the role of "good doctor" can be extended to the role of "good patient," as Radley and Billig (1996) have demonstrated. Though there are instances in which the sociological ambivalence of patienthood may be less applicable (for example, the unconscious patient or the newborn infant), being a "good patient" means more than being a sick person in need of care. As Radley and Billig argue, "The patient must appear to be more than a patient; a display of healthiness, or normality, is also required, for the ill person to be appear worthy of receiving the entitlements. If the ill person is only an ill person they will fail to warrant their special claims, as they will do so if they appear to be healthy. In this respect, the ill person is both more and less than a physically functioning body" (p. 222). This ambivalence highlights the rhetorical demands placed on patients to be both sufficiently healthy and ill simultaneously, and to perform both health and illness in a balanced way. To overemphasize or overperform one's healthiness it to risk being perceived as a "malingerer" or

"whiner," while to overemphasize or overperform one's sickness puts one at risk of otherizing oneself, and/or discrediting oneself as a reliable narrator of one's own experience.

If the social structure of certain statuses and roles can affect, in Merton's words, "the probability of ambivalence," is it possible that the discursive structure of certain psychodiagnostic labels can likewise affect the probability of ambivalence turning up? And if so, what kinds of labels should be considered the most likely candidates for this ambivalence? It seems reasonable to suggest that "borderline" or "subthreshold" psychodiagnostic labels, such as dysthymia, provide ample reasons for ambivalence on the part of the labeled. The sort of ambivalence might be a useful framework for understanding how one could identify with a label and simultaneously advocate for its abolishment.

Dissatisfaction with the label of dysthymia is a consistent theme of discussions in the online health communities studied here. The trend of voicing dissatisfaction with the label of dysthymia was evident in the communities for years leading up the publication of *DSM-5*, which has abolished the label and offered a new one in its place—PDD. (Interestingly, PDD is a label that appears, whether through coincidence or due in part to the sorts of interactive processes that Hacking describes, calibrated to ameliorate some of the reasons for this dissatisfaction, given that the classification focuses on chronicity rather than symptom severity.) Most of this dissatisfaction hinges upon the description of dysthymia as a "mild" version of depression. Community members employ various strategies to discredit the notion that dysthymia is "mild" mental disorder; I describe three of these strategies in the following section. The first strategy involves redefining "functionality" as that which is achieved because of, not despite, the disorder. The second focuses on elucidating the peculiar liminality experienced by those occupying a dysthymia diagnosis, which makes the experience of the disorder worse than it is

often perceived, because it limits opportunities for understanding and support from others. The third strategy involves defining "normality" narrowly, in ways that make it incompatible with the experience of dysthymia.

4.3.1 Problematizing "Mild"

Hagop Akiskal, a prominent American psychiatrist, has said that dysthymics "occupy a position between normality and major affective disorder" (2001, p. 28). During the era of inpatient psychiatric care, there were no diagnostic classifications to account for those occupying what was seen as this murky middle-ground position. Before outpatient psychiatric care became routine, Kraepelin—credited with initiating Western psychiatry's pivot toward the biomedical model of mental illness—noticed "milder mood disturbances" among the family members of those receiving inpatient care, usually those hospitalized for major affective disorders such as major depression and bipolar disorder (Akiskal, 2001). Eventually, diagnostic classifications were created to house those individuals residing in the poorly lit territory that exists between normality and major affective pathology.[77]

Despite the fact that diagnostic space was eventually cleared for those occupying "middle positions" between normality and major affective disorder, individuals in online health communities voiced frustration with the sense that their disorder is still perceived—whether by themselves or by others—as occupying a conceptually murky space in between normality and major affective disorder. These users often articulated the sense that they diagnostic space they occupy is characterized not just by ambiguity, but also by *liminality*. "Liminal" derives from the

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[77] A notable example of one such diagnostic classification is cyclothymia, which (like dysthymia) is regarded as a less severe, but more chronic form of Bipolar Disorder.

Latin "limin," a term often translated as "threshold,"—a space through which one crosses on their way to someplace else. Liminality notably appeared in the work of anthropologist Van Gennep (1960), in his ethnographic studies of ritual societies. In his work, liminality refers to a stage in the process of social transformation; during this process, one disidentifies with a previous classification, entering into a temporary state during which there is a dissolution of the social order, followed by the individual's reclassification and reincorporation back into the social order. Thus, an essential quality of liminal states, objects, or beings is their *mutability*: they are prone to transformation. The next widely cited scholarly usage of liminality comes from sociologist Victor Turner (1969) who studied non-ritual societies, and who used the term less with regard to an in-between stage in a transformative process, and more with regard to a general sense or state of in-betweenness, particularly where opposites are at play. For Turner, a liminal entity is "neither this nor that and yet it is both" (p. 99). Paying attention to liminal entities and their treatment within a social group, Turner thought, could yield broader insight into social ordering practices.

In literary studies, liminality is often deployed as a concept to describe a murkily defined space—symbolic or physical—that is sandwiched in between other, more clearly defined spaces. (This can apply to the conceptual space in between categories.) By virtue of existing close to, but ultimately outside of, better-established categories, it is often suggested that liminal entities threaten the structural integrity of these adjacent categories, and are thus stigmatized. The stigma surrounding the phenomenon of intersexedness is sometimes referenced to illustrate how categories that are 'both yet neither' threaten the structural integrity of adjacent categories (Sytsma, 2006).

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On the topic of stigma and liminality, Jackson (2005) asks why it is that physical pain—an invisible and universal experience—becomes stigmatized only in its *chronic* forms. Jackson concludes that it has to do with the fact that chronic pain is a liminal phenomenon, and like other liminal entities, it threatens established boundaries of other entities. As Jackson puts it, "ambiguous beings and objects, being neither one thing nor the other, are disturbing and threatening" and that such ambiguity "turns sufferers into quintessentially liminal figures, vulnerable to the stigmatization such figures so often provoke because the sufferer transgresses several crucial boundaries that people find essential for understanding, ordering, and evaluating experience" (p. 346). In particular, chronic physical pain clouds the lines of demarcation that exist between mind and body, between the wholly agentive and the fully involuntary, and, more generally, between the categories of health and illness themselves.

Dysthymia, characterized not by chronic physical pain but chronic low mood, could be thought of as a liminal diagnostic entity, perhaps in the sense of being a temporally defined stage in a process (as dysthymia sufferers are thought to commonly lapse into the more clearly pathological MDD), but more so in the sense of being positioned in-between more clearly defined categorical spaces. Dysthymia used to be considered a "subthreshold" disorder (recall that "limin" is often translated as "threshold") and it was thought that oftentimes, people diagnosed with dysthymia eventually develop major depression (Akiskal, 2001). In this way, dysthymia was considered as in-between stage in the process during which one goes from "normal" moods to a 'subthreshold' disorder (not quite normal yet not quite fully sick) to full-blown major affective disorder. Thus, the sort of *mutability* that Van Gennep (1960) refers to is relevant to early understandings of dysthymia. More broadly, however, dysthymia is a category that is described as being sandwiched between "normality" and more observably disabling

mental disorders, such as MDD. As such, one could say that dysthymia—despite having a *DSM* category all its own—occupies a liminal diagnostic space in between more clearly defined spaces, somewhere between "normal" and "major affective disorder."

In online health communities, members sometimes described this sense of liminality as a significant source of frustration, and something that actually adds to the disabling effects of the disorder itself. For this members, being diagnosed with what is considered a "mild" mood disorder is accompanied by an unsettling sense that one occupies a space that is not well understood by others: it not well understood by people who have "normal" moods, and it is not well understood by people diagnosed with major affective disorders. An example of this sense of liminality follows below.

(2014, March 11). I feel like I have a lot of disabilities but all mild. Message posted to http://MDJunction.com/dysthymia.

It feels like mine are all so mild that no one understands. People with a severe problem would love to have it mild and people without it have no idea what it feels like.

Dysthymia-not as severe as it could be. Yes there are times of severe depression-mostly from hormonal changes.

Suspected BP-type 2. Depression is mild but it is like my moods and thoughts don't match. Mixed state? And

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higher moods are too rare and mild for me to understand those who have it worse but at the same time those without any BP symptoms have no idea what it is like. And people with it worse have no idea what it is like to have anything mild and would love to have it as mild as I do. I would too in their state.

Epilepsy-almost controlled.

Asperger's Syndrome, again milder than others have it.

Fibromyalgia-same. Not in as much pain as most in the fibro groups and I have more energy than them.

learning disability-NOS. No one understands what it is like. I think mine is more severe than others think. Most don't even know because it isn't a 'visible disability'.

Personality disorder-again not severe as others have it. So they can't understand that it is still frustrating and I can't understand them. And those without it can't understand either of us. I tell very few people about it. I usually just blame it all on Asperger's since I am ok with talking about that.

Ugh. Still frustrating and I feel very misunderstood. No with any of the disabilities that have it severe can understand me because they would love to have it as mild as I do. And no one without it can understand because they don't know what it is like to have it at all.

Every one of those listed above is very frustrating and having them all is hard. I can't go to the groups for each because they all have it worse. Many assume that what I say is as frequent as theirs because that is their experience. I probably would too.

I'm glad I don't have these things worse. But I'm still wondering what to do.

Can't get help because I can work some. I work about 3 hours a day and 5 days a week. (13.5 hours a week, with the fewest hours on Wednesdays). I can socialize in activities that are around people but not interacting. Like at the library's computer lab. People are there but you don't have to interact. I get food stamps and live in subsidized housing but apparently things have to be severe to be counted as a disability by the government and by people in general.

Ok, enough venting.

Have a good day everyone. And knowing me, I will be ok by later this afternoon.

This post articulates the frustration that can accompany being diagnosed with a liminal diagnostic entity; that is, a diagnostic entity considered "mild" when compared to other, more disabling mood disorders, and yet this diagnostic entity disqualifies people from being considered, by themselves or others, as "normal." This liminality, it is argued, actually adds to the difficulty of dysthymia itself because it restricts possibilities for understanding from people who reside within the better-established categories that sandwich dysthymia—namely, normality and major affective disorders. The author of this post argues that people with dysthymia are straddling a boundary between normality and more severe pathology, and that people with firm footing in either one of these more clearly established categories are incapable or unwilling to extend understanding and/or support to people with "mild" disorders.

As the author puts it, "People with a severe problem would love to have it mild and people without it have no idea what it feels like…No [one] with any of the disabilities that have it severe can understand me because they would love to have it as mild as I do. And no one without it can understand because they don't know what it is like to have it at all." This not only limits the opportunities to be understood by others, but also limits the person's access to social support. The author mentions not feeling comfortable enough to frequent support groups, because most participants in those groups "have it worse" and, because the effects of these "mild" disorders are not disabling enough to prevent one from working, thus disqualifying one from entitlements because "apparently things have to be severe to be counted as a disability by the government and people in general." In this way, this post cites the "mildness" of dysthymia as a quality that actually adds to the problematic nature of the disorder. Put another way, its "not-so-badness" actually makes it worse.

It is possible that being wedged into the awkward diagnostic space between normality and major affective disorder could intensify the sort of ambivalence that Radley and Billig (1996) describe in their elaboration of what it means to be a "good patient." They suggest that one cannot appear *too* sick, lest they undermine their own credibility as a rhetor. This is particularly true in the case of mental illnesses, since as Pryal (2010) points out, people with MDD have long been excluded from rhetorical participation since often they come to be seen as unreliable narrators, even on the topic of their own experiences. At the same time that one cannot appear overly incapacitated, one can also not appear overly healthy, for to do so could jeopardize one's claims to an illness identity which in turn puts one at risk of being perceived as a "malingerer"—a label that Akiskal (1997) suggests clinicians have historically misapplied to dysthymics, chiefly because of their observed tendency to offer "hyperbolic descriptions of suffering" that "contrast so strongly with the relative absence of objectively ascertainable depression" (p. 12). There were posts in the communities studied here wherein authors seemed to be grappling with precisely this sort of rhetorical dilemma. In particular, some authors appeared to feel the need to account for their outward appearance of healthiness and/or functionality. For example, this post:

(2010, July 30). Dysthymia - less severe? Message posted to
http://psychforums.com/dysthymia.

I think I got lumped into a dysthymic diagnosis because I am high functioning
and have been depressed for FOREVER (since at least the time I was about 7).
But I read the wikipedia article and it makes it sound as if dysthymia is less
severe than major depressive disorder. It just hasn't been my experience.
I was always good at school because studying gave me something to do that
would take my mind off of the fact that I hated myself. That in turn translates
into "successful."
Avoidant personality disorder seems to describe me pretty well, plus long term
depression and long term being suicidal. Oh, and I fit the criteria for body
dysmorphic disorder, EXCEPT for the fact that I'm not delusional about it (I'm
just being realistic!) and I don't obsess over trying to fix the defects. I just wear
baggy clothes and try not to go out much.

How do you guys feel about being classified as "less severe" just because you've
managed to slog through life thus far? I feel like it invalidates the enormous
struggle I go through just to get up in the morning.
dailyalice

This post addresses the rhetorical dilemma that comes with having a mood disorder that is

considered a "less severe" variant of another disorder (namely, MDD, in this case). This author

in particular has zeroed in on the notion of "functionality" and laments that their outward

appearance of functionality "invalidates the enormous struggle I go through just to get up in the

morning." Interestingly, this author has harnessed the very thing that threatens to undermine the

claims to a disabling disorder—functionality—and has repurposed it as evidence of the disorder

itself: the author has managed to maintain a high level of function not *despite* dysthymia, but

because of dysthymia. The author posits that the severity of symptoms associated with dysthymia

motivated them to invest effort into education "to take my mind off the fact that I hated myself."

This seems to be one way to manage the rhetorical dilemma of being a "high functioning" person

diagnosed with an outwardly invisible mood disorder: employing a logic that recontextualizes

"functionality" as a capacity that one maintains not despite the presence of a mental disorder, but

because of the mental disorder itself. Within this framework, success or achievements, which

might otherwise weaken one's claims to "legitimate", suffering, are harnessed as evidence of the presence of disorder. Interestingly, the suggestion that dysthymics might be productive not despite but because of the disorder has precedent in the psychiatry literature. Akiskal (2001) notes that, "Dysthymic individuals at best invest whatever energy they have in work" (p. 19). The degree of dsythymics' investment in work has been considered an overcompensation for the disorganization that depression often brings with it (Tellenbach, 1980).

Authors also seize upon dysthymia's *chronicity* to argue against the notion that the disorder is mild. Specifically, it is argued that, over time, dysthymia's sheer persistence gradually transforms one's symptoms from mild or bearable into a much more serious problem that encompasses all aspects of a person's life. Again, this evokes the notion of dysthymia as a liminal state: it is a "threshold" entity that is in the process of becoming something else, something more serious, more encompassing. See the posts below:

(2012, October 18). It Isn't Mild. Message posted to
http://experienceproject.com/dysthymia.

I've been diagnosed with Dysthymia. Recently I've gotten curious as to whether all the therapy, medication, and "positive thinking" that I've been trying to do is worth it so I did a little research. Whenever I find a site that describes dysthymia it is called a "mild" form of depression but I'm sick of that phrase. For me, at least, the "mildness" has culminated into something that's becoming unbearable. I'm not suicidal. Not in the classic sense, at least. I don't look at a bottle of pills and serious think about taking them all. I've safeguarded myself from the real chance of it happening. But every night when I go to sleep I silently pray to whatever is out there that I don't wake up. I hate being around. I hate that everything is so grey and that I can't make emotional connections. Nothing is unaffected. My concentration is abysmal which means that I do more poorly in classes than I would like. I can't make emotional connections so my relationships are shallow which means that I feel isolated and misunderstood. Food doesn't taste good enough to lift my mood, emotions are fleeting, and all of my hobbies create only the briefest reprieve. What's worse is that in all my research I have never come across anybody with a story of how after a few years of fighting they finally managed to say goodbye to this constant life of grey. I don't see the point in me sticking around and every time somebody tries to convince me it only makes things worse. I live in a religious group. My family is religious, my school is intensely religious, and the state I'm in is probably one of the most religious in the country. Religion makes no impact with me but sometimes I find myself hoping there's a god so that when I pray for everything to just end somebody will listen and take pity on me. Even if religion isn't real then if I wasn't here anymore I wouldn't exist which would be far more preferable. I hate this life. Dysthymia isn't mild for me, it's something that has permeated every facet of my life. I hate it and I just want it to go away.

(2013, July 2015). Re: It Isn't Mild. Message posted to
http://experienceproject.com/dysthymia.
m sick of people calling dysthymia "mild" too. I once had someone say that dysthymia was just a case of the blues. In a book by someone who had "major depression" the author called dysthymia just "mildly annoying." It's not "mildly" annoying and it's not a case of the blues.

I think dysthymia is even more difficult to cope with than so called major depression because at least the person with major depression can remember a time when they were happy. Dysthymics often can't remember the last time they didn't feel the way they did.

In this post, the author seeks to explicitly decouple dysthymia from its oft-accompanied qualifier "mild." The argument in favor of this decoupling is rooted in dysthymia's chronicity. The author suggests that the chronic symptoms of dysthymia have "culminated into something that's becoming unbearable" and which has "permeated every facet of life." This description echoes Solomon's (2001) delineation of the experiential differences between dysthymia and MDD. While MDD is described as the total collapse of the structure of one's life, dysthymia's symptoms undermine a person in a cumulative and more insidious way; he describes dysthymia as "a gradual and sometimes permanent thing that undermines people the way rust weakens iron" (p. 16). These claims suggest that "mild" is not an appropriate term to describe the subjective experience of depression because the chronicity of dysthymia gradually transforms "mild" symptoms into "unbearable" symptoms. Put another way, it is *over time* that mild symptoms come to be regarded as intolerable.

In the reply post above, the respondent also points to dysthymia's chronicity to challenge the notion that dysthymia is a "mild" disorder. To do so, the symptoms of dysthymia are contrasted against its nosological neighbor, MDD. Reasons are offered as to why dysthymia might even be considered more problematic than MDD. Specifically, it is suggested that because dysthymia is chronic rather than episodic (as MDD is episodic), dysthymics, in contrast to people with MDD, are not even able to recall periods during which they were asymptomatic. As the author puts it, "I think dysthymia is even more difficult to cope with than so called major depression because at least the person with major depression can remember a time they were happy." The author suggests that a short time period characterized by "severe" symptoms would be preferable to "years of joylessness and hopelessness."

All of these posts contend with the rhetorical dilemma of being wedged into the awkward diagnostic space that Akiskal (2001) describes as "between normality and major affective disorder" (p. 28). The strategy drawn upon to contend with this dilemma is to increase the conceptual contrast between dysthymia and normality by emphasizing the particularly problematic nature of chronic symptoms that, over time, transform into intolerable symptoms. These posts emphasize the ways in which "mild" is not an apt qualifier for dysthymia. Another strategy to contend with the sense of "in-betweenness" is to construct the meaning of "normal" such that it contrasts more starkly with the subjective experience of dysthymia. In other words, the strategy is not to focus on defining the meaning of dysthymia (in ways that render it incompatible with normality), but to focus on defining the meaning of normality (in ways that render it incompatible with the dysthymia). This strategy forms the focus of the following section.

4.4   CONSTRUCTING (AND CONTRACTING) NORMALITY

When the unfixed nature of the line that separates psychological normality from psychological disorder comes under critique, generally the discussion centers on how definitions of pathology have expanded in recent decades (Conrad, 2005; White & Horvitz, 2007. This is particularly true of medicalization critiques more generally; such critiques tend to trace the ways in which things that used to be considered nonmedical (i.e., nonpathological or "normal") problems, conditions,

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or experiences come to be defined as medical problems with medical solutions.[78] Working from

a medicalization framework thus encourages scrutiny of the means by which what "pathology"

expands, which, in turn, arguably takes the focus away from scrutiny of the means by which the

corollary concept—"normality"—contracts. Scrutinizing how "normal" is discursively

contracted might not seem as intriguing as scrutinizing how "pathology" is discursively

expanded, but doing so may lend insight into how people (or, at least, people in online health

communities for dysthymia) contend with the rhetorical dilemmas occasioned by being

diagnosed with a "mild" or "high-functioning" mental disorder. Such insight perhaps becomes

especially valuable given the common concern, articulated in both public and professional

discourses, that dysthymics are especially vulnerable to being misclassed as "normal."

To express concern over the pathologizing of "normal" problems of living risks implying

that "normal" is a sturdy given, rather than a temporally and contextually shifting construct.

Take, for example, psychologist Nick Haslam's (2016) much-discussed article on the notion of

"concept creep," which he defines as a relatively contemporary phenomenon in which

psychological concepts with negative valence undergo definitional expansion. Specifically, he

explores the expanding concepts of abuse, bullying, trauma, mental disorder, addiction and

prejudice.[79] Haslam cautions that, "Expanding the concept of mental disorder can pathologize

normal experiences…and engender a sense of diminished agency" (p. 14). [80] Take, as another

example, *DSM-IV* architect Allen Frances' (2013) book, *Saving Normal*, in which it is suggested

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[78] As Conrad (2005) points out in the *Medicalization of Society*, the verb "medicalize" is typically used prescriptively, to mean "overmedicalize."

[79] In this paper, Haslam distinguishes between two forms of so-called concept creep: "vertical" and "horizontal." The former refers to a form of conceptual expansion wherein the concept grows in order to accommodate "milder" but qualitatively similar versions of the phenomena at hand. The latter occurs when a concept begins to encompass qualitatively dissimilar phenomena.

[80] Haslam notes that the conceptual expansion of mental disorder receives much more scrutiny than the conceptual expansion of abuse, bullying, trauma, addiction, or prejudice.

that "way too much treatment is given to the normal "worried well" who are harmed by it; far too little help is available for those who are really ill... "Normal" badly needs saving; sick people desperately require treatment" (p. xv). However, what constitutes Haslam's "normal experience," increasingly subject to pathologization, and Frances' "normal" that calls for preservation, is neither obvious nor static.[81]

Inclusivity—an increasingly evoked aspirational value across domains of contemporary public life— has found its way into discussions of the *DSM-5,* and has implications for understanding the possible shrinkage in conceptions of normality. The push toward an "inclusive" edition of the *DSM* has taken the form of lowering the diagnostic threshold for certain disorders, and by emphasizing a dimensional (i.e., spectrum-based) rather than categorical approach to the classification and diagnosis of mental disorders (Pickersgill, 2012). This push toward inclusivity arguably acknowledges the power of diagnosis: diagnoses are a gateway to treatment, social services, and, perhaps above all, meaning-making. Among others, one side effect of this more "inclusive system of diagnosis" is that the "pool of 'normality' shrinks to a mere puddle" (Wykes & Callard, 2010, p. 302).

The line between the normality and pathology in general is already said to be difficult enough to distinguish (clinically, socially, philosophically) likely due in no small part to its shifting nature. When it comes to identifying a "mild" mood disorder such as dysthymia, the difficulty only increases, supposedly. Thus, there are oft-cited concerns about dysthymic people (or now, people with PDD) going undiagnosed, having been mistakenly categorized as

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[81] Frances (2013) himself acknowledges that "normal" is a particularly problematic concept to define, in part because it exists in a tautological semantic relationship to "abnormal." He notes, "The dictionary definitions of normal are all entirely and beguilingly tautological. To know what is normal you have to know what is abnormal" (p. 4). And abnormal is defined as "those things that are not normal or regular or natural or typical or usual or conforming to a norm…[T]here is no real definition of either, and no meaningful definitional line between them." (p. 4).

"normal."[82] The users of dysthymia online health communities voice such concerns, knowing

that they do not readily come across as "disordered" and so, they are at risk of being perceived

(by clinicians, employers, friends, family, etc.) as "normal" people with a mere tendency toward

gloominess and pessimism, or an inability to handle life's difficulties. While it is possible that

people with more discernably disabling or stigmatizing disorders might desire to be mistaken for

"normal" in everyday life, dysthymia's definitional proximity to normality induces, for some,

heightened concerns that they will be mistaken for "normal."[83] Thus, in some accounts, there

appears to be an investment in discursively increasing the conceptual space between dysthymia

and normality, and there are two basic ways in which one could do this. The first is to bring into

sharper focus the uniquely problematic features of dysthymia, such as its liminality and

chronicity. The second is to construct a restricted notion of normality, one that stands in starker

contrast to the subjective experience of dysthymia. Below, I describe some of the ways that

normality is constructed in the online health communities studied here.

When the concept of normality is invoked in online health communication discussions, it

is often with regard to a moment of *disidentification*. That is, individuals who previously

identified with the concept of "normal" describe a moment or period of time during which they

came to disidentify with it, no longer considering it an appropriate label to describe their moods,

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[82] My sense from perusing psychiatry literature is that concerns about *underdiagnosis* and *misdiagnosis* far outweigh concerns about *overdiagnosis*.

[83] Segal's (2007) rhetorical reading of dominant breast cancer narratives provides a compelling counterexample to this section of the chapter. Segal claims that breast cancer narratives expand, rather than contract, conceptions of normality. She states "The most publicly circulating breast cancer narratives invite women to see themselves as, if not completely well, then at least completely *normal*…in many of those stories, women with breast cancer seek not to find common ground with other people who are ill or weak; rather they seek to claim the space of a new normal." She further claims that in these standard breast cancer narratives, authors seek to distance themselves from strong imputations of illness or disability, instead seeking the ideal of normal, glossing over the fact that, "the category of normal has been expanded, to include women who may be bald and breastless, but are still walking and running and shopping" (p. 9).

behaviors, or interior mental life. The practice of recounting a self-conceptual shift of this sort is certainly not unique to dysthymia, or to the narratives circulating in online health communities. So-called "mood memoirs"—a growing genre of autobiographies produced by people with MDD—are typified by a generic convention that Pryal (2010) terms the "moment of awakening." In this moment of awakening, the author recounts a pivotal event or moment in time after which they came to accept a diagnosis of MDD. This moment of awakening typically constitutes "both the turning point in the author's life and the impetus for the narrative" (p. 490). In the mood memoirs that Pryal analyzes, the moment of awakening is typically rendered fairly dramatically: it is a moment in which one's symptoms have become sufficiently disruptive that the individual comes to accept a diagnosis.[84]

Dysthymia does not have "severe" symptoms that stand in stark contrast to "normality." Its symptoms are, by definition, mild, and so do not contrast sharply with one's "usual mood." This makes it difficult to draw a distinction between "symptoms of disorder" and one's "habitual self" (Akiskal, 2001). Lacking a dramatic, pivotal moment of awakening, some users of dysthymia online health communities recount subtler moments of recognition. In contrast to the MDD memoirs that Pryal analyzes, the authors of these online accounts do not recount a moment of *identifying with a disorder*, as much as they come to *disidentify with the label of "normal."* In these accounts of recognition, the authors describe prior modes of self-classification, such as, for

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[84] Pryal (2010) notes that the moment of awakening in mood memoirs is somewhat of a rhetorical paradox. As she describes the paradox, "The mood memoirist's awakening is unique among similar genres in that the narrator is recounting the awareness of a mental illness, an illness which, in a paradoxical fashion, does not impede the author's self awareness. This apparent paradox renders the awakening moment as particularly rhetorically powerful: the precision of descriptions of awakening establishes the author's reliability as narrator, despite the author's mood memoir. By describing the awakening with ostensible clarity, precision, honesty, and self awareness, the memoirist tacitly invites the audience to trust her narration of events. In short, although the mood memoir is a study of mental illness, the awakening implies that the illness does not impede the narrator's ability to tell the story" (p. 490).

example, "I always assumed the way I felt was normal" or "I was surprised to learn that people felt differently from me." In short, these authors recount a moment in time or process by which they cease to believe that "normal" is an accurate descriptor for their experience. In doing so, these authors often construct the meaning of "normal" in ways that place the concept at odds with their experience. Generally, this involves defining "normal" in a restricted sense. Below follows an example.

> (2013, September 6). Re: Ahh Dysthymia. Message posted to
> http://MDJunction.com/dysthymia.
>
> I can relate. I too have had a pretty good life. Been off and on medication for
> years. I get feeling better and then I quit taking meds. It takes about six months to
> go down the dysthymia hill and then I am back to square one. The problem is that
> the medication doesn't work when I restart it. I just found out that this is what I
> have. So now I am waiting to get another prescription, but this time I know that I
> will have to take medication, even if I feel that I don't need it. I get so frustrated. I
> know what I am capable of and yet I just can't get going. No enjoyment in
> anything, just doing what I have to do to get through the day. There is a the weird
> thing that I found out through this diagnosis. All my life, I thought that everybody
> was the same as me. I thought the way I felt and looked at life was normal. Low
> self esteem, insomnia, no follow through, constant down feeling, overly critical,
> negative, judgemental. Always start things, exercise, diet and never follow
> through. If I didn't have to do it to survive or for my family or someone else, I
> didn't do it. I became a saviour. That way I could just go by logic without
> emotion. Everyone thought I was great, but they didn't know what I was dealing
> with on a daily basis.
> Okay, enough about me. Hope everyone is okay and the sun will rise every day,
> even if you can't see it.

In the post above, the author states, "All my life, I thought that everybody was the same as me. I thought the way I felt and looked at life was normal." In this author's formulation, "normal" refers not to externally observable behaviors, nor does it pertain explicitly to impeded function—a typical demarcation criteria for the diagnosis of mental disorders. Instead, in this account, "normality," or a lack thereof, is something that is ascertained *subjectively*; it is a quality

attached primarily to feelings and perspectives, described by the author as "the way I felt and looked at the world." The author goes on to specify the types of feelings and perspectives that, following diagnosis, are now (presumably) interpreted correctly as disordered rather than normal. These feelings and perspectives include low self-esteem, persistent "down" feeling, being "overly critical, negative and judgmental."

"Normal" people, by contrast of this formulation, would have robust self esteem, upbeat moods, a sense of optimism, and would avoid being overly critical, negative, or judgmental—an arguably quite narrow definition of normality. Because these qualities of "normality" are attached to the interiority of one's mental life, and not externally manifested signs of disorder, an incongruity between one's interior experience and external presentation is possible. This sort of dissonance is described by the author as such: 'Everyone thought I was great, but they didn't know what I was dealing with on a daily basis." It is possible, then, for one to exhibit external markers of normality (whatever such markers might be thought to consist of) but to subjectively assess their inner life as abnormal or disordered.

(2012, March 26). Spiral. Message posted to
http://experienceproject.com/dysthymia.

I have been depressed since my teenage years and was finally diagnosed with
Dysthymia a few years ago. I am the single mother of 2 boys with a full-time job.
If it weren't for therapy and meds I would still be spending my life asleep with an
occasional burst of energy. I hit rock bottom when my husband and I separated 6
years ago and I finally got some help. Even with the meds, my energy level is
low most of the time, but I suppose it's worth it to not hate everyone at the very
least. I have held down a full-time job for 5 and a half years now, something I
used to think was simply not possible. I always thought it was just me being lazy
and worthless, but a good therapist informed me otherwise.
It amazes me that dysthymia is described as "mild" depression. It can destroy all
quality of life and wear you down with its never-ending tunnel of hopelessness.
Even after I was diagnosed, it took years for the novelty to sink in- I just couldn't
convince myself that I wasn't just useless and spoiled, that I should be able to get
up in the morning and care about things. I was told to find God and told to eat
right and told to suck it up and do what needed to be done to make myself a
better mother and successful person. But I couldn't seem to ever see the light at
the end of the tunnel. Everything was pointless, so why bother when dreams are
so much more pleasant? I never wanted pity for my depression, I just wanted it to
GO AWAY. I wanted to feel normal and content but I didn't know how for years.
I may never be an upbeat, perky chick, but I am so glad I got help when I did.
Now I can function and even do things for others simply because I *want to*.

The post above echoes an earlier theme, specifically, that notion that dysthymia is a disorder

whose gradual culmination "wears you down" over time. This description comports with

Solomon's (2001) claim that the symptoms of dysthymia are not debilitating in their initial

onset; over time, however, their effects accumulate until they are capable of undermining an

individual in the way that, as he says, "rust weakens iron." (p. 16). Thus, dysthymia is again

conceived as a shape-shifting entity, prone to transformation over time. Like the author of the

previous post, this author also defines normality as a quality that manifests chiefly in one's

interior mental life: "normal" describes the way that the author "wanted to feel" rather than, for

instance, how the author wishes to be perceived by others. The author grants that they may never

be "an upbeat, perky chick" but credits therapy and medication with enabling them to "function

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and do things for others simply because I *want* to." While dysthymia is generally considered to be less function-impeding than MDD, this author has implied that "normal" functioning is not simply a matter of one's behaviors, but a matter of *what motivates* those behaviors—for instance, genuine desire rather than a vague sense of obligation.

(2010. April 22). Didn't Know What I Felt Wasn't Normal. Message posted to
http://experienceproject.com/dysthymia.

Hi everyone,

I am a 54 year old mom of 3 grown kids. Divorced after 22 years of marriage (not by my choice).

I never realized until recently that how I felt emotionally on a daily basis was not the norm!! I thought everyone had the same kinds of thought patterns that I have. I have always been a "negative thinker", socially quiet and shy, always seeing the glass as half empty. I think the grass looks greener on the other side of the fence, but then when I do get there its no better than where I came from. I have people in my life who I have always thought are just so fake because they are always acting happy!! Maybe they really are?!?! I just never realized that was a possible way to feel since I have NEVER been that way.

Occassionally I would feel content (although not so much since my divorce 6 years ago), but never truly what I think "happy" would feel like. The demise of my marriage I think was in great part due to my dysthymia.

I see a Psychiatrist regularly and have been on many different psych meds--none of which have quite done the trick. I have had some momentary lifts in my mood I guess from the meds, but nothing lasting. There is no reason in my life circumstances that I should feel so "down" for as long as I can remember. My childhood was normal--no abuse, 2 loving parents, 5 great siblings. I'm educated, relatively physically healthy, upper middle class, raised 3 normal seemingly well adjusted intelligent children.Why can't I be happy. I have struggled with this question for a long time.When I was a teen and in college I remember i was always be looking for something, someone to make my life better, happy. That happy state of being remains elusive still today.

I do thank God every day that my kids seem to have come through childhood unscathed by my mood disorder. Not so lucky with my adult relationships. I'm sure that adds to my dysthymic state of mind these days.

Hope that I meet some other folks that can relate to this. Some days are so hard without anyone to talk with who understands.

This author above narrates a moment of recognition during which time they realized that "how I felt emotionally on a daily basis was not the norm." As with the posts above, in this post, "normal" is conceptualized as a quality of thought, feeling, or worldview, not a quality of behavior of other outwardly noticeable characteristics. The feelings and thoughts that are regarded as "not the norm" include: "negative thinking," being "socially quiet and shy" and "always seeing the glass as half empty." Patterns of thoughts and feelings that, by contrast, would be "within the norm" might include positive thinking, social extraversion, and an optimistic temperament that includes a tendency toward "seeing the glass as half full."

4.4.1   Shifting Conceptions of Normality Elsewhere

As noted earlier in this chapter, the typical lack of noticeably impeded functionality that characterizes dysthymia (and the apparent "normalcy" that such lack of impeded functionality might suggest) likely places rhetorical demands of those diagnosed with dysthymia. Specifically, the outward appearance of normalcy potentially jeopardizes their claims to a chronic illness identity, thus they risk being perceived as "malingerers" (Akiskal, 2001). At the same time, if one appears overly ill, they risk being regarded as an unreliable narrator of their own experience (Radley & Billig, 1996; Pryal, 2010). One way to negotiate this rhetorical conflict, as I suggest in the above section, is to reconstruct the meaning of dysthymia in ways that emphasize and expand upon dysthymia's uniquely problematic features. For example, authors in online health communities have seized on the peculiar liminality of dysthymia to suggest that, in some ways, this condition actually induces more suffering than MDD, despite being characterized by symptoms that are "less severe."

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A second strategy to contend with this rhetorical conflict is to reconstruct the meaning of "normal" in ways that render it narrow, and that provide a starker contrast to the experience of dysthymia. Specifically, "normal," in these accounts refers to worldviews, motivations, and feelings. Users often suggest something along the lines of "I didn't know that what I felt wasn't normal" or "I thought everyone felt the same as me." Thus, users describe a moment in time, or a temporal process, during which they came to disidentify with the concept of "normal." Following this moment, users go on to offer evidence that they do not fit within the concept of normal, which in turn helps to construct the very idea of what "normal" is or is not. When elaborated upon, users tend to suggest that so-deemed "normal" people experience high levels of energy, optimistic thought patterns, and that they undertake action out of "genuine desire" as opposed to a sense of obligation.

Thus, in these formulations, "normal" does not seem to refer to the *absence* of socially aberrant or undesirable feelings/behaviors/experiences (which would constitute a fairly broad definition of "normal" in the same way that defining "health" as the absence of illness constitutes a fairly broad definition of "health). Instead, the concept of normal refers to the *presence* of behaviors/feelings/experiences that are considered socially desirable or productive. This arguably constitutes a much more restricted notion of normality. And so, it could be argued that users contend with the rhetorical dilemma of having a "mild" or "high-functioning" disorder not only by expanding or amplifying the characteristics of dysthymia that make it uniquely miserable, but also by contracting the construct of "normal" in order to demonstrate that their experience does not fit within it.

Given the possible incongruity between outward signs of normality and one's inward mental state, this narrow definition of "normal" might not even apply to those who appear to

meet all the outward benchmarks of normalcy, users suggest. Some users claim that this incongruity characterizes their lives, such as the user who states that, "Everyone thought I was great, but they didn't know what I was dealing with on a daily basis." Thus, the bounds of an already contracted concept—normality—contract yet again, in accordance with the acknowledgement that the outward appearance of normality can actually be an indication of concealed disorder.

The possibility of an incongruity between one's outwardly "normal" state of function and inwardly depressed mental state seems an increasingly common acknowledgment in public discourse. Take, for example, TheMighty.com, a website that describes itself as a community for people facing "disease, disability, and mental illness. (Within this community, there are 376,000 followers on the topic of "Depression.") This site has published multiple articles in recent years seemingly meant to educate the public about the effects that this incongruity has on people who suffer from "high functioning" mental illnesses, including what it terms "high-functioning anxiety" and "high-functioning depression." Writing for the site, an author listed as Dr. Margaret Rutherford elaborates the difference between so-called "classic depression" and so-called "Perfectly Hidden Depression." She states, "People with classic depression are overwhelmed by loss or difficulty in their lives. They can't function, and are lost. People with Perfectly Hidden Depression are overwhelmed by the idea that anyone might find out that they aren't all they seem—that the backstory of their lives might be discovered. They function far too well" (Rutherford, 2016). With Perfectly Hidden Depression, the author explains, the goal of treatment is to "help someone engage with their inner self—to acknowledge and work through their denial of pain." This poses an interesting question: if one functions "normally" and does not

acknowledge the presence of symptoms (or, in the author's formulation, denies the existence of serious of pain), how is "depressed" an apt descriptor of that person's experience?

Another contributor to TheMighty.com has written an article titled "19 Problems Only Happy People With Depression Understand." Written from the first-person perspective, this author provides an numerically itemized list of misunderstandings one can expect to encounter living under the diagnosis of a "mild" or "high-functioning" disorder. The second item on the list states that "Just because it looks like I am doing well doesn't mean I am…Usually, the better it seems, the harder I am working to hide something" (Alexandra, 2017). [85] Thus, the outward appearance of "doing well" is not evidence of a lack of disorder, in fact, it can be interpreted as evidence that the opposite is true. In other words, the appearance of normality can actually be interpreted as evidence of disorder. This echoes the suggestions of online health community users, as described earlier, that they function well not *despite* but *because of* disorder.

While nothing in this chapter can be claimed as representative of broader public (or even representative of the perspectives of people with dysthymia outside these communities), one can certainly find indications in public discourse that a narrowing in discursive constructions of "normality" is underway, should one go looking for such indications. For example, *Scientific American*—the oldest U.S. popular science magazine and website since 1996—recently published an article titled "Mental Illness Is Far More Common Than We Knew". In the article's first paragraph, the authors state that a survey of epidemiological research suggests that,

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[85] Here, the first-person perspective is worth noting. While the title suggests that the article contains a list of problems that will be recognizable to "Happy People With Depression," each problem is articulated from the first-person perspective (i.e. "I" statements.) Though these problems are articulated from the author's point of view, the title suggests that they are problems that are common to a specific group of people. This recalls Kelly's (2014) suggestion that the first-person statements that are included in the *DSM-5* draft diagnostic criteria are recontextualized instances of patient speech that, in essence, provide people with a portable "script" of sorts for understanding and relaying their experiences and symptoms.

"[M]ental illnesses are so common that almost everyone will develop at least one diagnosable mental disorder at some point in their life. Most of these people will never receive treatment, and their relationships, job performance, and life satisfaction will likely suffer" (Reuben & Shaefer, 2017). If "almost everyone" will meet the criteria for a diagnosable mental disorder at some point in their lifetime, then those who will never experience a mental disorder constitute a divergence from the norm. Such divergence from the norm, the authors suggest, constitutes a meaningful subject of inquiry. They state, "[T]he few individuals who never seem to develop a disorder may offer psychology a new avenue of study, allowing researchers to ask what it takes to be abnormally, enduringly mentally *well*." (Reuben & Shaefer, 2017). Thus, the prospect of an enduring lack of mental disorder, the authors suggest, constitutes its own form of psychological abnormality. They further suggest that, given the epidemiological evidence, "[S]ociety should begin to view mental illnesses like bone breaks, kidney stones, and common colds—as part of the normal wear and tear of life."

If mental illnesses are metaphorized as broken bones or common colds, then the experience of mental illness can no longer be considered abnormal, and the experience of mental health can no longer be considered normal. Here, it is not just that the definition of "normal" is being contracted, it is that now attaches to a phenomenon with which it used to be considered at odds: mental illness. Rose (2009) has suggested that, with the expansion of the concept of mental disorder, "[I]t now appears that a lifetime without disorder, at least in this expanded definition, and now mapped onto the brain, would be somewhat abnormal—or to put it another way, mental abnormality has become normalized—simultaneously a condition to be treated a mode of existence to be expected" (p. 17).

There are other indications that "normal" might be losing its coherence as a concept not just within 'psy' disciplines, but in the health sciences as well. Rose (2009) explores how the increasing power of genomics might come to signal the end of "normality," given that there is no "normal" genome, there is no "normal" genetic risk, and there is no "normal" genetic predisposition. In an era of genomic medicine (not to mention a broader push toward personalized medicine) normal might not be considered a useful, or actionable, concept.[86] As Rose puts it, "[I]n the area of disorders of the body and mind at least, we are moving from dividing practices based on the binary of normality and abnormality to practices based on the idea that all individuals vary, and that most, if not all, carry molecular variations that can in particular circumstances lead to disorders of body and mind, but which, once known, are potentially correctible. In the human genome, "normal is rare." Or rather, there is no normal genome—variation *is* the norm" (p. 11). Here, Rose's emphasis on *correctibility* is worth noting. It could be suggested that what is "normal," historically speaking, has changed in accordance with many factors, and one such factor is correctibility. For example, Carl Elliot (2003) has pointed out that shyness used to be considered a "normal" (i.e. common and non-problematic) character disposition, until drugs aimed at treating "social anxiety" became available. It could be that the more problems of "everyday" life that become correctible, the more we should expect a

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[86] The push toward "personalized" medicine, ushered in largely thanks to genomic science, dovetails with another trend in medicine: preventive medicine. Preventive medicine has found its way into psychiatry, having led to the development a relatively recent "preventive psychiatry" subfield. Preventive psychiatry seeks to, among other things, identify individuals "at risk" for developing a mental disorder and to initiate treatment prior to the disorder's onset. This could be a good example of what Rose (2009) terms "governing through susceptibilities." He states that, "What susceptibility promises, in an age of genomics, is more than risk assessment and risk management—more, that is to say, than intervention based on a correlation between factors…Susceptibility is something that can be defined at the level of the individual body itself—a variation within the sequence of DNA that bases in an individual's genome that predispose that person the development of a particular disease or disorder" (p. 83). The calculation of susceptibility made possible by genomics, Rose suggests, has broken the taken-for-granted linkage between health and normality, since susceptibility "escapes the logic of health as normativity" (p. 84).

contraction of "normal." (And of course, it goes without saying that the pharmaceutical industry is one party that is likely especially enthusiastic about the prospect of narrowed conceptions of normality.)

The *DSM-5*'s shift from categorical to dimensional classifications—a move that the APA claims was motivated in part by the desire to become more "inclusive"—could also be claimed as possible evidence that conceptions of normality are contracting. Kupfer & Kuhl (2013) state that concerns have been raised "about *DSM-5* being too inclusive, thus stigmatizing what might be considered normal conditions as mental illness" (p. 88). It is possible to view the *DSM-5*'s "inclusivity" as simply another step forward in the decades of mission creep visually symbolized by the successively thicker spines of the *DSM* editions (and of course, one could speculate, fueled in no small part by the APA's tight ties to both the insurance and pharmaceutical industries), as its organizing text eats away at the corners of "normal" and converts them into pathologies. While such a critique of the *DSM*'s "inclusivity" certainly resonates with critical psychiatry and antipsychiatry perspectives, one could argue that the APA is not only engaging in mission creep but is also being responsive to the fact that the language of mental illness, in Solomon's (2001) words, "can be enormously empowering to marginal people who have no way to describe or understand their experiences" (p. 361). Access to the "endlessly manipulable" vocabulary of mental illness is not evenly spread throughout society; it is likely that "Those more advantaged members of a society experience their illness through that vocabulary" (p. 361). Thus, it is possible to see the DSM-5's inclusivity as motivated by a concern for social justice, or by an interest in *appearing* motivated by a concern for social justice.

When pondering contracting conceptions of normality, broadening one's cultural lens beyond psychiatry proper can draw one's attention toward seemingly tangential factors, such as

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the surging genre termed "pathography," or, sometimes, "illness narratives." Such narratives are championed for counterbalancing the quantitative impulses of biomedical discourse with rich descriptions of patient experience. For this reason, many regard the genre of pathography as empowering to patients: it places them back in the center of their own lived experiences. Thus, pathography has a decidedly epideictic flavor, according to Segal (2005), both in the sense that individual pathographies elevate certain virtues, and in the sense that the wholesale embrace of pathography genre has a prescriptive character: it establishes narrativizing as an appropriate and desirable response to illness. And, one might ask, does the genre itself elevate the experience of illness itself (i.e. suffering) to the level of a rarely questioned virtue?

It has been suggested that certain cultural conditions—specifically, neoliberal modes of thought and policy—exert pressure on individuals to formulate and share narratives of suffering. For example, Nair (2014), writing on the subject of sexual abuse and exploitation, has suggested that our contemporary public discourses produce and prioritize what she terms "the confessional subject" which she defines as a type of subjectivity that is produced and authenticated through the sharing of personal suffering narratives. She suggests that, [I]n some ways, the perfect neoliberal subject is becoming the traumatized subject, the subject of trauma" (Nair, 2014). This squares with Haslam's (2012) designation of "trauma" as one of the six psychological concepts that have undergone significant conceptual expansion in recent decades. Seen through this lens, there may be a sense in which "normal" has perhaps begun to carry with it a dismissive character, to the extent that it downplays, challenges, or invalidates one's claim to psychic suffering or hardships. Indeed, when frustration with the designation of dysthymia as "mild" was a topic of discussion in online health communities, a common argument was that this designation

constituted a diminishment of their emotional pain and furthermore, a devaluation of accomplishments achieved despite/because of the presence of disorder.

Normativity has long had a prescriptive character; that is, "normal" is not a mere neutral description of what *is* the case, but often functions as moralized prescription for what *should be* the case, or, *should not* be the case. For example, a quote from actor Misha Collins that has circulated throughout Internet meme culture and found its way onto t-shirts, mugs, and notebooks proclaims: "I want to live in a world where normal is an insult." One might be tempted to ponder whether, in the context of contemporary mental health discourses, the nature of normal's prescriptive character has shifted: that is, one should strive not to be "normal" but to be a highly individuated person. At the very least, it might offer an answer to Haslam's posed question about why it only tends to be psychology's negative concepts that undergo expansion, while positive concepts either stay the same, or contract.

4.5 SUMMARY AND CONCLUSIONS

In the 1970s, research coming out of psychology marveled at the peculiar "stickiness" of psychiatric labels as they were applied to (symptom-feigning) inpatients, maintaining their adherence even after the total dissipation of symptoms (Rosenhan et al., 1971). Despite their durability, psychiatric classifications are also remarkably ephemeral; new disorders appear in each edition of the *DSM*, and previous disorders vanish—a phenomenon that philosopher of medicine Louis Charland (2004) has termed "label death." For some, the phenomenon of label

death prompts ontological questions: for example, does the 2013 abolishment of Asperger's disorder necessarily mean that people with Asperger's disorder no longer exist? For others, label death generates ethical and material concerns, given that psychiatric labels are often a gateway for social services, and also given how tightly these labels can link to a person's sense of identity. How should psychiatry go about revising its diagnostic manual, knowing that changes from one edition to the text are bound to destabilize at least some percentage of the currently labeled public? Given these sorts of concerns, it is no wonder that, when it comes to label death, most attention has been focused on the removal of labels that *generate opposition*, sometimes ardent, on the part of the labeled. That is, attention has been centered on the cases in which many people want to maintain their current label. In the relatively few studies of label death that exist, online health communities have been a focal point, given that they offer spaces in which news of impending label death can be circulated and collective responses can be formulated. Perhaps more importantly, online health communities are places wherein the label can be "kept alive" after death, through a refusal to disband or rename the community.

Dysthymia underwent label death in the 2013, when the *DSM-5* was published. This chapter contributes to the scholarship on label death, in part, by exploring online health community responses to label death that are characterized largely by *indifference or acceptance,* as opposed to the label death opposition evident in other studies of label death. First, it contextualized the *DSM-5* revision process, a process that was unique in that the APA, for the first time, created a website for the public that included drafts of diagnostic criteria, along with solicitations for feedback. To situate this unprecedented move within a theoretical context, the chapter put into conversation contrasting scholarship from the fields of rhetoric of medicine and philosophy of science, respectively. The former suggested that the public likely did not

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meaningfully contribute to the revision process because the APA created the subject positions for the "general public" to inhabit; the latter suggests that members of the public had already been playing a non-trivial role in the *DSM* revision process, because of the looping, essentially interactive nature of psychiatric classifications.

The *DSM-5* revision process ultimately resulted in dysthymia's abolishment and replacement with Persistent Depressive Disorder, which is a disorder that collapses all previous diagnoses of dysthymia with chronic (and therefore atypical) diagnoses of MDD. Thus, the *chronicity* of symptoms, rather than *severity* of symptoms, is foregrounded in the diagnostic entity of PDD. This development was favorably regarded by members of online health communities because, in the words of one member, it "acknowledges that this is persistent depression and gets rid of the notion that it's "mild," like we have a papercut or something. Dysthymia is anything but mild depression."

From here, the chapter unpacked community members' widespread dissatisfaction with the classification of dysthymia, much of which centers upon the notion that it is "mild." This section of the chapter contemplated how having a "mild" or "borderline" or "high-functioning" psychiatric disorder occasions a rhetorical conundrum of sorts: on the one hand, if individuals do not emphasize the severity of their symptoms, they risk being interpreted as "normal" people (i.e. people without a diagnosed/diagnosable mood disorder) albeit with a tendency toward gloominess, or an attenuated ability to handle the problems of everyday living. On the other hand, if they overemphasize their symptoms, they risk being interpreted by practitioners as "malingerers" prone to "hyperbolic descriptions" of suffering for which there is no outwardly discernable evidence (Akiskal, 2001); they also risk, as health-oriented scholarship has pointed

out, discrediting themselves on the grounds that they are too ill to be regarded as reliable narrators of their own experience (Radley & Billig, 1996; Pryal, 2010),

The chapter identified strategies that people in online health communities drew upon that appear to contend with the sort of rhetorical dilemma described above. The first includes reframing specific successes or general "functionality" as that which has been achieved *because of*, not *despite*, dysthymia (because success in school, work, etc., gives people a means to distract themselves from the symptoms of their mood disorder, as the argument goes). The second strategy involves pointing to the features that make dysthymia a uniquely miserable diagnosis to live under, in particular, its *liminality*: that is, its conceptual positioning between "normality" and "major affective disorder." This being the case, posts in online health communities suggest that being grouped into this liminal diagnostic category limits possibilities for support and understanding, both from people who do not have a mood disorder, and from those who have a more "severe" mental disorder. Interestingly, there may be empirical support for this argument: recent social network research has suggested that, "relative to those with less severe affective disorders, individuals with severe diagnoses and more visible symptoms of mental illness have larger, more broadly functional networks, as well as more supporters who are aware of and sympathetic toward the illness situation" (Perry, 2011, p. 460).

Because being miscategorized by others as "normal" appears to be a significant concern for some, this chapter then turned its attention to how "normality" is constructed in these communities. It suggested that "normality" is defined in relatively narrow ways that increase the conceptual space between the subjective experience of "normal" and the subjective experience of "dysthymia." For example, when "normal" was evoked in online discussion, it was often with regard to a moment of disidentification, a point in time during which an individual realizes that

"how they felt" or "looked at the world" was "not normal." By defining normality primarily in terms of inwardly assessed criteria such as worldviews and motivations or lack thereof (rather than in terms of any outwardly observable criteria such as behavior or functionality) normality becomes something that can only truly be assessed subjectively. In closing, the chapter reflects on broader trends—in genomic science, in narrative medicine, and in public culture—that may signal similarly contracting conceptions of normality.

5.0 CONCLUSION

For rhetoricians, subjects that are marked by ambiguity and paradox have been of special interest. Depression is a subject marked by both. While state policy, awareness-raising campaigns, and consumer-oriented health literature typically convey confidence that depression is a scientifically known entity, historical and contemporary literature on the topic—from both the sciences and humanities—suggests otherwise. Instead, there is longstanding and continued uncertainty about what depression is, what causes it, and how to best treat it. Thus, it has been argued that depression is a subject not simply touched by ambiguity, but *characterized* by it (Helén, 2007; Fink, 2010).

There is also something paradoxical about the relationship between depression and language. On the one hand, depression has long been said to trouble the subject's capacity for language, and many claims have been made about its fundamental indescribability. Yet, at the same time, the topic of depression generates and enormous amount of discourse, both public and professional. Certainly, part of this salience can be attributed to the staggering ubiquity of depressive diagnoses (in 2015, the World Health Organization claimed that 322 million people worldwide are affected by depression). In addition to diagnostic ubiquity, this dissertation has contemplated the possibility that the *ambiguity* of depression might be a part of its discursive generativity, as it presents openings for rhetorical engagement whereas clarity might instead signal closure. Thus, the ambiguity of depression could be considered a rhetorical fuel of sorts.

While the prerogative of the perfectionist, philosopher, or scientist might be to reduce instances of ambiguity, Kenneth Burke (1945) famously articulated that rhetoricians have a different relationship to ambiguity: they aim not to reduce it, but to explore its usage as a rhetorical resource. Thus, it is not a surprise that depression has attracted attention from rhetoricians. One such example comes from Emmons (2010), who concluded that dominant discourses circulating around the topic of depression reflect our deep cultural immersion within the biopsychiatric paradigm. Meanwhile, Segal (2005) has suggested that the ambiguity of depression sets the stage for cases of mistaken identity, in which one ambiguously defined disorder (in her case of interest, hypochondria) can plausibly masquerade as another, depression. In a different vein, Johnson (2010) has argued that, despite its invisibility, depression results in a rhetorical disabling effect she calls "kakoethos", and Pryal (2010) has pointed to the depression memoir as a socially meaningful genre that depressed rhetors have deployed to overcome the stigmatizing effects—or "kakoethos"—of the disorder.

What the above-mentioned scholarship has in common is a shared focus, whether explicit or implicit, on Major Depressive Disorder (MDD). This is not surprising: MDD has been called the "breakout star" of the *DSM-III*, and the "diagnostic core" of mood disorders (Shorter, 2008; Helén, 2011). And yet, within the category of depressive disorders, there is one subcategory that is especially ambiguous, due both to its low-grade severity and its chronicity—dysthymia—that has yet to be the sole focus of rhetorical inquiry. This dissertation sought to address this gap, and it did so by homing in on two so-called "areas of transformation" or spaces in which old meanings are turned over, giving rise to new ones (Burke, 1945). The first zone of transformation that this dissertation traced was arguably macro-level, and consisted of the revisions that ultimately culminated in dysthymia's label birth in the *DSM-III* and label death in

the *DSM-5*. The second and more substantive zone of transformation this dissertation explored

consisted of the micro-level interactions occurring in online health communities for dysthymia,

which allow people to interact with the label of dysthymia, themselves, and one another. In the

section that follows below, I review the contours and main claims made by each chapter.

5.1   REVIEW OF TERRAIN

Chapter 2 of this dissertation, titled "Ambiguity, Agency, and the Fitting Room," was made up

of three distinct but interrelated sections. The first section provided a brief rhetorical history that

contextualized dysthymia as a strategically ambiguous diagnostic entity. I am not the first to

approach depression as strategically ambiguous: Emmons (2010) explores how the definitional

vagueness and malleability of depression's diagnostic profile was maintained rather than

clarified "in order to expand the potential patient population" (p. 93). Of course, this account of

depression's strategic ambiguity—which posits a causal alignment between definitional

imprecision and pharmaceutical industry incentives—is plausible, but as it pertains to dysthymia

specifically (as opposed to depressive disorders in aggregate) this chapter suggested that such a

view is incomplete. This section of the chapter recounted the institutionally tumultuous years

leading up to 1980 publication of the paradigm-shifting *DSM-III,* a period of the American

Psychological Association's history that was characterized by consistent tension between those

adhering to the fading psychoanalytic paradigm, and those championing the emergent

biopsychiatric paradigm.

After crafting Major Depressive Disorder—a disorder that, according to Shorter (2008) is considered by some to be most representative of the biopsychiatry paradigm, and which many psychoanalysts feared would come to supplant their often-diagnosed "neurotic depression"—the APA task force overseeing the *DSM-III* revisions constructed a loosely defined "mild" depressive disorder in the form of dysthymia. Importantly, dysthymia appeared to honor aspects of both paradigms: it functioned as a "mild" complement to MDD—the breakthrough star of the biopsychiatric paradigm—and was potentially treatable with antidepressants, just as MDD was. At the same time, it was defined as chronic (whereas all other affective disorders were defined as episodic), which conformed to psychoanalytic view that these patients did not merely experience depressive episodes; they essentially *were depressives*. Thus, dysthymia was nosologically familiar to, and diagnosable by, adherents to either paradigm. While, as a diagnostic category, dysthymia may not quite reach the formal definition of a "boundary object" the disorder is constructed in such a way that it functioned similarly to one, in that it is characterized by interpretive flexibility, and it may have helped to induce cooperation in the absence of consensus (Starr, 2010).

After tracing the rhetorical resources afforded by ambiguity in a historical professional context, this chapter fixed its attention on the contemporary context of dysthymia online health communities, to inquire into the rhetorical resources of dysthymia's ambiguity in online health interactions. While the rhetorical accounts of depression mentioned above often claim or imply that public discourses of depression reflect our complete saturation within the biopsychiatric paradigm, this chapter found that people in online health communities for dysthymia flexibly made use of explanatory aspects from both paradigms, the biopsychiatric and the psychoanalytic. In doing so, participants in online health communities resisted totalizing vocabularies that would

locate dysthymia as a matter of pure symbolic action (Burke's (1977) term for phenomena that are considered amenable to symbolic intervention, and which thus imply the possibility of individual agency) or a matter of pure nonsymbolic motion (Burke's term for the realm of phenomena we consider determined, which exists outside the scope of symbolic intervention and thus forecloses the possibility of individual agency). Perhaps counterintuitively, this chapter found that when participants discussed the question of dysthymia's *causality*, they often relied on explanatory aspects from the psychoanalytic paradigm, and when doing so, they explicitly *renounced* the possibility of individual agency. When discussion centered on the treatment of dysthymia, it was often couched in biopsychiatric terms, and in these discussions, the possibility of individual agency was *reclaimed*.

The third section of the chapter focused on informal practices of self-diagnosis in online health communities. This section discussed what has been called the most important innovation of the *DSM-III,* the so-called "Feigner criteria," or the clinical practice of requiring a combination of symptoms from itemized lists in order for a patient to "get into" diagnosis, as the expression apparently went. The professional language of "getting into" diagnosis was paralleled by a similar expression in online health communities: participants often deliberated how well they "fit into" the label of dysthymia, or, alternately, how well the label of dysthymia "fit" them. Exploring this language of "fitness," this section of the chapter offered a metaphor for contextualizing self-diagnosis in these particular online health communities: the "fitting room." While I had previously encountered the metaphor of the "waiting room" for online mental health communities (i.e., a space people inhabit while they presumably wait to be seen by a mental health practitioner and obtain a formal diagnosis), my sense was that these online spaces functioned more similarly to clothing store fitting rooms. Specifically, participants in these

online health communities appeared to try on the label of dysthymia, assess how well "it fit," sometimes soliciting feedback from others and "trying on" other labels to see if they "fit" better. Importantly, participants in these online health communities also appeared to act similarly to patrons of clothing store fitting rooms in the sense that no one seems enthused to leave empty-handed, without a presumed diagnosis. In an era of commercialized, consumer-oriented health-care, the "fitting room" metaphor may be especially apt.

In Chapter 3, titled "Coming to Terms with Temporality," I explored the role of temporality in online health accounts of dysthymia. Scholarship from across fields has demonstrated that the onset of chronic *physical* illness often leads to reshaped temporal perspectives, or ways of thinking about and narrativizing time. One such perspective, termed "living one day at a time," entails a contraction of one's temporal boundaries such that the immediate present comes into sharp focus, with the distant past and remote future receding from view (Charmaz, 1992). Temporal contraction, it has been suggested, serves as a strategy for conferring control in the face of uncertainty, and for punctuating the various forms of labor that chronic illness care often entails.

This chapter identified a common temporal perspective that seemed to structure many online health accounts of dysthymia, which it dubbed "panoramic." Panoramic temporal perspectives contrast sharply with the temporal contraction entailed by the perspective Charmaz (1992) calls "living one day at a time." Panoramic temporal perspectives entail broadly stretched views of time that start by painting a picture of a bleak remote past (typically involving the context of one's childhood), and end with an envisioning of one's dim future prospects. Rather than immersing one in the present, those employing panoramic temporal perspectives to structure accounts of illness often described a feeling of detachment from the immediate present.

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Within the accounts structured by panoramic temporal perspectives, dysthymia is not described as especially problematic in the context of the immediate present; rather, dysthymia *becomes* especially problematic through recollections of its effects on the past (which many described as "tainted" or "wasted" due the disorder) and through anticipations of its effects on the future (which many said they expected to be similarly tainted by the disorder). Interestingly, this aligns with the somewhat paradoxical claim, made by a prominent American psychiatrist, that dysthymia "appears mild day to day but *becomes* brutal long-term" (Tartakovsky, 2016, emphasis added). This sentiment is captured by a metaphor that one user consistently deployed to explain the subjective experience of dysthymia, especially to community newcomers. In this metaphor, the individual suggests that the subjective experience of dysthymia is akin to waking up on the tenth day of rainy weather and knowing that the rain will continue well into the future.

This chapter suggested that panoramic temporal perspectives provide a workable framework for a practice it termed "retrospective identification." As observed in the online health communities studied here, retrospective identification involves demarcating a moment in time and recontextualizing it as the onset of one's illness. This recontextualization of the past leads to reshaped understandings of other aspects of one's life, including one's sense of self, one's relationships with others, and one's expectations for the future.

A practice like retrospective identification highlights something paradoxical with regard to agency and temporality: that the past both can and cannot be changed. It is simultaneously "irrevocable and revocable" (Barken, 2014, p. 698). The past is irrevocable because it has already transpired, and its contents cannot be revisited and/or altered in accordance with our present wishes. And yet, every act of recollection is a remediation arising in the immediate present, and which affects how we experience the present. And so, there is perhaps an argument

to be made that we can experience the past differently by exercising our recollections differently, and narrativizing them different.

When the past is recontextualized via retrospective identification, it not only colors how one experiences the present, but also shapes how one expects to experience the future. Commonly, these future expectations involve the intransigence of one's symptoms and, accordingly, limited satisfaction and success across the domains of one's life. Implicit in such an envisioning of the future is a felt sense of attenuated agency (because, if one felt it possible to exercise meaningful agency over one's future, then envisionings of one's future would be unlikely to include limited satisfaction and success in life). And so, this chapter speculated that panoramic temporal perspectives contrast not only with the overall structure of the temporal contraction entailed by "living one day at a time," but also in terms of the possible effects: while temporal contraction often increases one's felt sense of agency, the sort of temporal expansion seen here may tend to do precisely the opposite.

Chapter 4, "The Trouble with "Mild" Depression and the Contraction of Normality," began by providing theoretical context for the *DSM-5* (2013) revision process that led to dysthymia's "label death" and replacement with another label, Persistent Depressive Disorder (PDD). The *DSM-5* revision process was unique, as the American Psychological Association, for the first time in its history, created a website for the so-called "general public" to review and comment on drafts of its diagnostic criteria. In this section, I outlined two contrasting perspectives on the role that the general public was thought to play during this process. The first was a constitutive rhetorical perspective that suggested that the public did not meaningfully contribute to the APA's revision process, because the APA had created the subject positions for the "general public" to inhabit. Thus, this perspective suggests that the APA was not

"discovering" the public's feedback; it was creating it. The second perspective came from philosophy of science, and it suggested that, because of the "interactive" nature of psychiatric classification, the public had already been participating in all of the *DSM* revision processes to date, however indirectly.

After situating the *DSM-5* revisions in this theoretical context, the chapter turned to the question of how online health communities reacted to the label death of dysthymia. Reactions were decidedly few and far between. The few discussions of dysthymia's label death that existed were framed in largely positive terms: people were happy to let go of the label of dysthymia and ready to embrace PDD. This is perhaps not surprising: PDD collapses all cases of dysthymia together with chronic cases of Major Depressive Disorder, thereby foregrounding its *chronicity*, and deemphasizing its lesser symptom severity when compared to MDD.

This chapter unpacked community members' dissatisfaction with the label of dysthymia, which centered primarily upon its designation as "mild." While one might think that a "mild" mood disorder would be preferable to a more severe mood disorder, this chapter contemplated the rhetorical difficulties occasioned by having a so-called "mild" or "borderline" mood disorder. This difficulty can be described as such: on the one hand, if individuals do not emphasize their symptoms, they risk being interpreted by others as "normal" people with an attenuated ability to cope with the everyday problems of living. On the other hand, if they overemphasize their symptoms, they risk being interpreted by others as hyperbolic in their descriptions of suffering, for which there is little outwardly discernable evidence.

The chapter identified several rhetorical strategies that individuals in online health communities drew upon, possibly to contend with the sort of rhetorical dilemma described above. The first strategy involves framing success or functionality as something that individuals

attain *due to* dysthymia, rather than *despite* dysthymia, the logic being that success in school or work gives people with dysthymia something to focus on besides their symptoms. A second strategy was to highlight the aspects of dysthymia that make it particularly unpleasant at the level of subjective experience when compared to other disorders, including MDD. This strategy foregrounded dysthymia's *liminality*, or its conceptual positioning in between "normality" and major affective disorders. This in-betweenness, community members argue, make dysthymia uniquely miserable, because people without a mood disorder cannot understand their suffering, and neither can people with a more severe mood disorder. Thus, their options for social support and understanding were described as especially limited. A third strategy was to construct the meaning of "normality" in particularly constrained ways that place it starkly at odds with the experience of dysthymia.

5.2   CONTRIBUTIONS TO SCHOLARSHIP

This dissertation makes contributions primarily to three overlapping fields of scholarship: the rhetoric of medicine, the sociology of health and illness, and narrative medicine. To date, when depression has been the subject of inquiry across these three fields, it has overwhelmingly been with an explicit or implicit focus on Major Depressive Disorder, the so-called "diagnostic core" of mood disorders (Helén, 2011). This is not particularly surprising, given that MDD has been diagnosed roughly twice as much as dysthymia/PDD to date, and also considering that most publicly circulated accounts of depression (memoirs, for example) come from the perspective of an individual living under the diagnosis of MDD. And yet, recently, scholars in the social

sciences and humanities have suggested that we ought to regard depression not as a unified, coherent condition or entity, but, in Helén's (2007) words, as "an amalgam" made up of "divergent facts and definitions" (p. 150). By focusing on a lesser-known subtype of depression that sits near the border separating "normal sadness" from major affective disorder, this dissertation contributes to the calls being made to contextualize "depression" as a heterogeneous category that houses an impressively divergent range of human experiences.

This dissertation makes a contribution to the rhetoric of medicine—a field that has been invested in questions pertaining to the *agency* of patients in various contexts of health and illness. Work within the field has paid special attention to the contexts in which patients' agency is constrained and the rhetorical strategies that patients use to overcome these constraints. For example, Stone (1997) examined how the rhetorics of patient "compliance" and "adherence" are deployed to constrain diabetic patients' agency, thereby minimizing costs associated with complications. In a similar vein, Keränen (2007) analyzed "patient preferences" worksheets (forms that ask hospital patients and/or their caregivers to specify which treatments they would like to receive or decline in the context of end-of-life care) and found that, while these forms are ostensibly deployed in the name of patient autonomy, they ultimately constrain patient agency, and instead serve the needs of hospital administrators whose primary concerns relate to legal liability. Lastly, Graham (2009) examines medical discourse on the subject of a contested syndrome, fibromyalgia, and constructs an "object-centered agency narrative" in which he argues that PET brain scans played a genuinely agentive role in the medical legitimation of fibromyalgia—something patient advocacy groups had been trying to accomplish for decades. In each of these three cases, the focus is on instances in which patient agency is constrained and how it might be regained.

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At a time when health information is more accessible than ever, and "patient empowerment" is a buzzword, it is no wonder that rhetoricians of medicine have focused primarily on the constraints placed on patient agency, and how patients negotiate those constraints to claim agency for themselves. This dissertation makes a small contribution to this field by focusing on an opposite practice—the *renunciation* of patient agency on the part of patients themselves. In chapter 1, this dissertation noted that, when matters of dysthymia's etiology were foregrounded, agency was renounced, and when matters of dysthymia's treatment were foregrounded, agency was reclaimed. This may be one strategy that people employ to negotiate excessive imputations of agency in an era of commercialized healthcare and "patient empowerment": renouncing agency for the *existence* of one's illness, and reclaiming agency when discussion shifts to the *treatment* of one's illness.

This dissertation also contributes to scholarship that examines the role of temporality in personal accounts of chronic illness, much of which comes from the sociology of health and illness and narrative medicine. This scholarship has examined how the temporal perspectives deployed by patients can significantly shape their experiences of chronic illness. For example, focusing on type 1 diabetes, Maines (1983) argues that, ultimately, temporality is the central node that unites all other dimensions of the diabetic experience, including its physiological, emotional, social, and organizational dimensions. Relatedly, Charmaz (1992) established that patients with chronic physical illnesses often "live one day at a time," which entails restricting their temporal blinders, rooting themselves firmly in the present, and holding both the past and future in abeyance. This temporal perspective, Charmaz notes, appears to confer a sense of control to those with chronic physical illnesses.

Thus far, studies that link temporality and illness have focused on chronic *physical* illnesses. This dissertation makes a contribution to this existing scholarship by focusing on the temporalizing of a chronic *mental* illness. In doing so, it defined a particular temporal perspective, dubbed "panoramic," that provides a stark counterexample to the sort of temporal contraction that sufferers of chronic physical illness often employ. Panoramic temporal perspectives involve temporal expansion and a concomitant sense of detachment from the immediate present. While it has been noted that temporal contraction appears to *confer* a felt sense of control, this dissertation observed that temporal expansion appeared to *attenuate* one's felt sense of control.

Lastly, this dissertation makes a contribution to the sparse but developing body of literature that addresses the phenomenon of "label death"—the removal or replacement of a recognized disorder from one edition of the *DSM* to the next—and explores how people living under a given label react to its death, whether impending or actual. So far, this body of scholarship has looked at online health communities as a site of particular importance, since these communities can function as spaces where impending label death can be reacted to, and where labels can be kept alive even after their death (Charland, 2004). (In fact, the online health communities studied here technically function in that capacity: they have not yet incorporated the 2013 *DSM-5* label PDD; instead, they continue organize around the *DSM-IV* label of dysthymia.) For example, Giles (2014) visited online health communities for Asperger's disorder, which was removed from the *DSM-5*, subsumed by the broader Autism disorder spectrum. One reaction that he identified among users was strong resistance to the label's removal, as many stated their intentions to carry on without renaming the vibrant online communities that had helped to foster a coherent "aspie" identity.

Thus far, the limited scholarship on label death focuses primarily on theorizing the death of labels that the labeled are still very much attached to, and reluctant to give up. From a bioethical perspective, this makes sense: these labels provide a strong sense of identity for many, and they are also gateway to social services and other forms of support. Thus, label death is a phenomenon that has the potentially to significantly destabilize the lives of the previously labeled. This dissertation, however, focused on a label death that was not met with resistance, but with nonchalance and general acceptance. Its fourth chapter was guided by the question: what does it mean to identify with a given label, and yet simultaneously advocate for its abolishment? In doing so, it brought to light the reasons why people might react ambivalently toward labels that are deemed "mild" when compared to the more obvious or disabling symptoms of other disorders.

5.3   DIRECTIONS FOR FUTURE RESEARCH

This idea for this dissertation was sparked by Kenneth Burke's claim that ambiguity serves as a major resource for rhetoric. Since my interest in part was the emergence of a discursive distinction between "normal sadness" and "clinical depression," it made sense to theorize a disorder that arguably sits closest to the hazy, mutable boundary that separates the two. In doing so, this dissertation tried to shed light on the rhetorical and communicative conditions that individuals may encounter when their experience is labeled as only "mildly" disordered. While this dissertation focused only on dysthymia, there is another so-called "subthreshold" or "subaffective" mood disorder, with similar etymology and nosology: cyclothymia—a "milder" form of bipolar disorder. Cyclothymia is defined by the experience of "low intensity" moods that

fluctuate between depressive states (that do not meet the criteria for a full-blown depressive episode) and manic states (that do not meet the criteria for a full-blown manic episode). One intriguing possibility for future research would be to integrate both disorders into the same study, for the purposes of illuminating the rhetorical dilemmas and strategies shared by those living under both labels, as well as any relevant divergences.

Something that I noted during data analysis, but did not address in this dissertation, is the regularity with which people invoke the concept of "im/balance" when describing their experiences with dysthymia. Of course, the frequent usage of this term has something to do with what American psychiatrist David McDowell (2001) has called the "modern neuromythology" of depression. This modern neuromythology, now outmoded but still in wide circulation in public culture, posits depression as a single-effect illness rooted in a neurochemical "imbalance," usually described as a deficit of serotonin. This etiological narrative has been favored by the pharmaceutical industry and popular press, and has also been taken up by practitioners who seek to quell patients' concerns about starting antidepressants (Barr & Rose, 2008). The latter have analogized depression and antidepressants to diabetes and insulin: in both depression and diabetes, there is a lack of a certain chemical (serotonin and insulin, respectively) in the body, which throws the body into a state of disequilibrium that is correctible through ingestion of the lacking chemical. (While this analogy was ostensibly intended to construct depression as a nonstigmatizing disease entity, McMullen & Sigurdson (2014) have challenged both the aptness of the metaphor itself and as well as its ability to deliver on the intended effect of destigmatization.) And yet, while reading the exchanges in online health communities, I could not help but wonder whether it was possible that references to "im/balance" functioned not only as a description of depression's etiology, but also as an implicit metaphor for the *negotiation of*

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competing demands. In time-compressed Western cultures, we endlessly hear references to "work-life balance" or "work-family balance." It could be illuminating to conduct a study that interrogates the various meanings at play in people's usages of the concept of balance in contexts pertaining to mental health generally, and depressive disorders specifically.

A final suggestion for further research involves a study that interrogates multiple contexts in which people *renounce* individual agency as it pertains to health and illness. As mentioned earlier, most communication and rhetorical scholarship on the concept of patient agency has focused on contexts wherein patient agency is constrained, and/or how patients claim agency for themselves. It is no wonder that scholars are preoccupied with these questions: Western biomedicine has historically been criticized for its perceived paternalism, and for, in Segal's (2009) words, seeking to "deprive patients of the sense that they could look after themselves" (p. 364). In recent decades, a number of developments have converged—for example, patient advocacy efforts, technological innovations that enable patients to manage their care from home, the proliferation of Internet-based health information—to ostensibly empower patients as never before. While few would champion a return to the outmoded ethos of "doctor knows best," there are ways in which the foregrounding of patient agency may work against patients' interests. For example, Crawford (2004) has suggested that employers have been seized on the rhetorics of patient agency in order to shift a greater burden of healthcare costs onto their employees. Hospital administrators and insurance companies likewise have interests that may be advanced by the enthusiastic embrace of patient agency/empowerment/autonomy, etc. Given this, it seems reasonable to suggest that studies that foreground the *renunciation* of patient agency ought to be pursued in addition to studies that foreground the *reclamation* of patient agency, as both are equally rhetorically significant communicative acts.

5.4   CLOSING THOUGHTS

In contrast to disciplines that guard the boundaries of their expert knowledge and vocabularies, the psychological professions have proven themselves remarkably generous. Over the decades, they have been, in Rose's (1998) words, "happy, indeed eager, to 'give [themselves] away,' by lending their language, explanations, and judgments to other professional groups and, especially, the broader public" (p. 33). In contemplating the enthusiastic cultural uptake of psychological vocabularies, and the modes of explanation therein, I could not help but be reminded of the words of Kenneth Burke. In *Attitudes Toward History*, he cautions that, "if we get involved enough in using words, the words in turn begin using us" (1937, p. 399). A way of restating this might be to say that contemporary psychological vocabularies do something *for* us, and something *to* us. One way to contextualize the potency of these vocabularies is to consider how effective they are at bringing into alignment a number of seemingly disconnected interests.

For individuals experiencing ill-defined forms suffering, the vocabulary of the psychological disciplines, including but not limited to the categories in the *DSM,* can have immense sense-making capacity, in that it offers an explanatory framework for interpreting (and intervening upon) general dissatisfaction, relational problems, and so forth. The wide diffusion of this vocabulary likewise suits the professional interests of mental health practitioners, most of whom would ostensibly like to our therapeutic culture continue thriving. Of course, the corporate interests of pharmaceutical companies are very well served by the ubiquity of psychological vocabularies, given their potential to bolster an already-dominant psychopharmacologic industry. In addition, this vocabulary aligns nicely with governmental interests in ensuring a hardworking, employed population filled with self-improvement-seeking consumers. Lastly, one could see psychological vocabularies as fueling certain aspects of the so-called digital economy, in which

people are encouraged to volunteer what might previously have been regarded as private (and now, potentially quite valuable) information about themselves.

While this dissertation has tried to operate in a descriptive rather than prescriptive mode, if pressed for a closing recommendation of sorts, I would perhaps advocate for the cultivation of a rhetorical relationship to psychiatric categories, one that recognizes and makes flexible use of what psychiatric categories do *for* us—e.g. offer sense-making tools, access to social services— while at the same time maintaining a certain curiosity and perhaps skepticism about what these categories might do *to* us. In practice, this might look something like the adoption of a critical realist account of mental disorder that sits between the dual poles of medical naturalism—the view that psychiatric categories represent disease entities that are real, invariant, and unshaped by human observation—and hard social constructionism, which considers psychiatric categories to represent little more than the social and discursive activities of mental health professionals (Pilgrim & Bentall, 1999).

In a critical realist account of psychiatric categories, it is not the reality of mental disorders that is socially constructed; rather, it is our theories about them that are socially constructed, and so too the methodologies by which they are constructed. As such, these theories and methods are shaped by social forces, including but not limited to social identity categories like race, gender, and class, as well as the conditions and constraints researchers experience in the course of their theorizing. A critical realist account of psychiatric categories might be most closely aligned with the needs and interests of the broader public, because it sidesteps the potential problems involved in reifying and rigidifying the inherently unstable categories that appear in the *DSM*, and it also avoids the forfeitures (of sense-making frameworks, social services gateways, etc.) that might be entailed by the broad-scale cultural uptake of a fully social

constructionist account of mental disorder. It also might encourage a productive curiosity about the conditions under which psychiatric categories emerge.

Relatedly, after writing this dissertation, I might advise caution against two pieces of conventional wisdom regarding the discourses of depression, to which our therapeutic culture currently appears well subscribed. The first is the assumption that *physicalizing* depression—that is, to consistently emphasize its status as a physical illness—will lead to its destigmatization. For people diagnosed with dysthymia/PDD specifically, this emphasis is not particularly helpful because, in contrast to MDD sufferers, their symptoms are much more subjectively reported than externally observable. (MDD symptoms include physically observable signs such as significant weight loss or gain, psychomotor retardation or agitationThus, an emphasis on the physicality of mental disorder might not destigmatize a chronic, mild mood disorder like dysthymia, and might instead draw attention to dysthymia's *lack* of physical signs, fueling perceptions that people diagnosed with it are mere malingerers or hyperbolic complainers. Furthermore, people like Greco (1993) and Crawford (2004; 2006) have convincingly argued that, in an age of "healthism"—wherein health practices have strong symbolic value—even the most physically observable illnesses come freighted with moral baggage. As Greco sees it, the previous hegemony of psychoanalytic thought inaugurated a psychosomatic understanding of (physical) illness, in which the categories of health and illness became and continue to function as "vehicles for the self-production and exercise of subjectivities endowed with the faculties of choice and free will" (1993, p. 357). Within this paradigm, she argues, disease—physical or otherwise—has come to potentially signal a failure of both rationality and moral agency. Following this line of logic, if physical illnesses have already been "psychosomatized," then there might not be much

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of an obvious benefit in pursuing the reverse—the physicalization of mental disorders—for the purposes of destigmatization.

The second assumption about which I might advise caution has to do with the narrativizing of illness, in this case a chronic, mild mental disorder. Following the so-called "narrative turn," there has been a renewed emphasis on, and enthusiastic embrace of, narrative frameworks for understanding illness (both at the individual and cultural level) and for treating illness. Pioneers of narrative medicine like Rita Charon (2006) have argued that the cultivation of "narrative competence" in physicians will not only improve the quality of physician-patient relationships, but also the quality of overall care. However, while illness narratives offer a descriptively thick complement to the comparatively thin biomedical account of illness, they are not transparently "true"—they are, by their very nature as narratives, *selective*. Something that I continually contemplated while writing chapter 3 was whether there is a risk of becoming overly attached—stuck, perhaps—to a particular way of narrativizing one's illness. In the case of the online health communities studied here, I contemplated whether the accounts I observed, structured by what I called 'panoramic temporal perspectives,' might play a role in attenuating the narrator's felt sense of control. If rumination—the tendency to fixate on the causes and consequences of one's suffering with comparatively less focus on possibilities for amelioration (Nolen-Hoeksema et al., 2008)—is linked with depression, as much research claims, then is it possible that narrativizing dysthymia could, in some ways, actually *exacerbate* its symptoms? While an answer to this question stands far outside the scope of this dissertation, I could not help but ponder it.

Another reason to avoid regarding narrative as panacea is that, given enough time and enough circulation, illness narratives risk cohering into a "standard story" that precludes or

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deflects from other narrative possibilities. Ehrenreich (2001) and Segal (2008) both claim that

this has occurred with mainstream breast cancer narratives, typified as they are by the generic

features of relentless cheerfulness, gratitude, and good humor in the face of adversity. To

construct a narrative outside of these parameters is to risk minimizing opportunities for an

audience, and for solidarity with other people who share the illness. In the context of online

health communities specifically, it may be possible for a "standard story" of illness to cohere and

rigidify at a faster rate, given that the gelling of communicative practices (for example, sharing

stories with similar structure and thematic content) is how a sense of community is formed

(Baym, 2000).

Furthermore, it bears mentioning that such narratives are not mere descriptions of *what*

illness is like, they are also prescriptions for *how* one ought to be ill: in general, narratively, and

individualistically. When narratives are individually-focused, which illness narratives

overwhelmingly tend to be, they might make collectively-focused narratives harder to tell. They

might also push other frameworks for understanding illness —those that are visual rather than

verbal, for example—further outside public consciousness. And so, while subjective experiences

of depression are remarkably diverse, so too should be the available cultural modes of

understanding and communicating those experiences.

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