

Beyond Astroturfing; Web depression campaigns, personal security risk, and the promotion of mental illness

In progress, to Revise and Resubmit to Television and New Media

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Beyond Astroturfing; Deregulated web information, personal security risk, and the sale of depression

Paula M. Gardner

Abstract

This paper analyzes contemporary dominant broad-spectrum mental illness discourses created for consumers, in order to understand the role ascribed to a new American recovery subject—one articulated in the context of risk culture and neoliberalism. Specifically, the paper addresses depression discourses at the on-line media sites of insurance and pharmaceutical industries, NGO advocacy groups, and state health policy, where these organizations work to reach and impress the producing citizen/subject. The author argues that on-line depression discourses work to promote depression as an everyday risk and thereby encourage consumer/citizens to self-regulate and manage their moods. These new depression promotion practices—existing across nongovernmental, media, State and industry depression discourses—are indicative of a new era where extremist neoliberalist ideologies have become normalized in broad everyday life practices. This discourse prizes productive business class workers, rubberstamps untoward health marketing discourse, and relegates social welfare to a seat further back in the bus, and on the national American agenda.

Introduction

Published findings and WebCrawler data suggest that the majority of webservers are seeking health information. Optimistic social scientists such as Gunther Eysenbach working in “medical informatics”—an area formerly concerned with communication practices of health professionals—are increasingly concerned with meeting consumer “information needs.” And they are hopeful that consumer health informatics, in the digital age, will result in better informed consumers, capable of making self-determined health care choices. Says R. Smith (1997):

“Information technology and consumerism are synergistic forces that promote an “information age health-care system” in which consumers can, ideally, use information technology to gain access to information and control their own health care, thereby utilizing healthcare resources more efficiently.”

The title of one article, ““Relationships among Internet health information use, patient behavior and self-efficacy...” reveals its research plan-- to inquire into the credibility, accuracy,

and readability of consumer health information. (Fleischer, et. al. 2002) Social scientists such as Eysenback, however, obtain health information data via a paradigm that refrains from examining the ideological assumptions of the health information provided and the possible problematics of on-line delivery and finally, consumer success in negotiating on-line information. As a result, in analyzing medical information for consumers, Fleisher et al. (2002) boldly contend:

“Consumers now have *the same* (my italics) medical information that is currently available to providers and this availability has the potential to significantly change the relationship between patients and providers, alter the ways patients and providers communicate and help create a consumer base of power in health policy and decision making.” (Introduction)

This conjecture glosses the context of on-line health information delivery and reception, falsely assuming that on-line access ensures that *comprehensive* health research is regularly uploaded for consumers to access. The model also disregards a host of new media research regarding user’s complex negotiation of on-line data, simply assuming that information is archived and organized in an accessible manner, which is then easily acquired and effectively consumed by consumers. The statement skirts the fact that consumers obtain (potentially contrasting) information from a variety of sources—professional medical associations, consumer health sites, government policy sites and of course pharmaceutical websites—and ignores the possibility that ideologically biased assumptions articulate information with a particular slant to consumers. More, the paradigm of health informatics ignores the fact that the internet model of deregulated information has fostered misinformation regarding mental health standards. Health informatics research demonstrates either a remarkable, naïve confidence in both webmasters’ and users’ abilities to upload and access information, or more problematically, a commitment to perpetuating the practice of circulating biased medical research on line, that reifies industrial health care epistemologies and infrastructures.

This paper addresses the disinformation regarding depression and a turn toward depression promotion on-line that includes and goes beyond “astroturfing”—the term to describe pharmaceutical company’s use of consumer health groups to represent their claims. The analysis investigates how a range of organizations (pharmaceutical, consumer health, professional medical, and media), as indicated by the visual and textual culture of their sites, have become invested in biopsychiatric and neoliberal assumptions, and thus promote depression to curtail personal security risks.

Perhaps nowhere are these statements more refutable than in the on-line world of consumer depression information. Since the launch of Prozac in 1987 and the 1997 legalization of direct to consumer TV advertising in the US, mainstream media has broadly hawked mood-altering drugs to consumers. At the same time, industry, government and consumer advocacy groups have supplied consumers with broad depression information on-line. Since then, antidepressants have become common drugs, biopsychiatry accepted as the rational psychiatry, and depression an increasingly popular and destigmatized disorder --indeed, one that has arguably played a leading role in altering the way we understand mood illness and health in North America.

The constrained paradigms of social science health information studies fail to query whether users gain access to comprehensive information that allows *real* choice in interpreting and managing distress. The author is wary of assertions that new media breeds democracy—rejecting studies such as Fleisher's, where easy on-line access is confused with accurate information or efficiency of use, and informed consumer choice. Instead, the study works from the paradigm of critical and cultural studies, to evaluate these phenomena as symptoms of biopsychiatric culture. Specifically, the paper investigates the relationship between Internet architecture, personal security discourses and the promotion of depression. It employs an interdisciplinary model combining Foucaultian discourse analysis, with a visual studies interpretive model, as well as feminist cultural studies addressing the body and mental illness.

The paper targets depression discourses created for consumers by the National Alliance for the Mentally Ill, the national institute of mental health, the American psychiatric association and pharmaceutical companies Eli Lilly and Pfizer, to understand the assumptions and tenets of these mood discourses. The paper seeks to test the claim that pharmaceutical companies have simply purchased cultural influence by funding groups such as NAMI. Instead, the paper has two main points: that biopsychiatric truths are assumed across government, expert and consumer discourses and have become normalized in north American culture. Second, and related, depression discourses (the script) re-articulates risk discourses, such as Homeland Security and FEMA directives, so that consumers are made to fear depression and seek a magic bullet cure, pharmaceutical drugs.

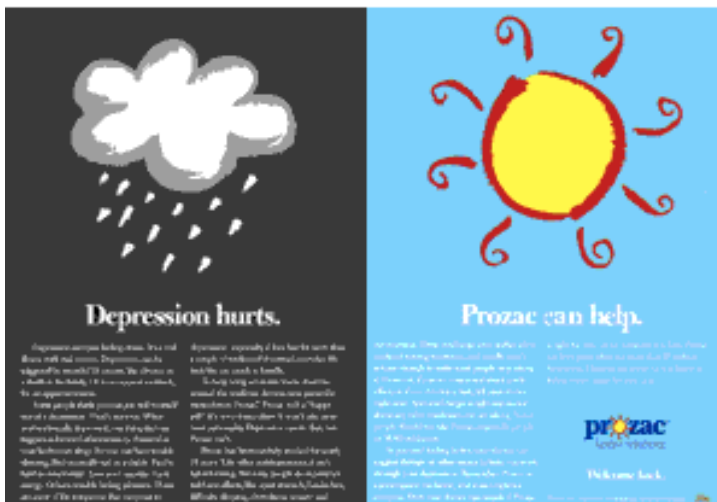
in seeking to answer this question, the paper's reveals recent new strategies that seek common to these three types of depression discourse, that all seek to ensnare consumers in the script logic, to create fear of risk and the same outcome: self-surveillance and management. These strategies include consumerized science, moralistic campaigns to combat suicide, the re-risen cyborg, and attacks on sloth. These discourses tend as well to favor consumer-capitalism,

recommend passive forms of democratic practice, and assume neoliberalism as common sense ideals.

Depression is generally presented as an insidious, widespread brain disease that presents a dire, looming danger to self, industry and society, but that, simultaneously can be easily managed via self-surveillance and pharmaceutical drugs. While savvy, highly motivated consumers with ample free time can locate comprehensive depression information directly from research studies, many Internet health consumers find promotional depression discourses difficult to resist due to particular discursive tropes. These tropes or strategies are employed to capture the web-surfing consumer, to interpolate her in risk discourse and ensnarl her in the diagnostic-recovery logic of the script, as outlined in the following.

Liberation, Rationalization and the “Modern” Recovery Subject

Antidepressant promotions published on-line call up the neoliberalist ideal of personal liberation, as part of the purchase of antidepressants. Eli Lilly’s latest campaign for Prozac offers freedom with the phrase “Welcome Back”, signifying depression as a singular condition typified as being “absent”. In contrast to the assumed ideal, rational, coherent subject, who is present, the depressed subject, unable to participate in productive society, is missing. Depression according to the pharmaceutical mythos is a biological-induced condition of absence, or, in Lilly’s terms, “an illness, not a weakness” which Prozac can fix. Eli Lilly’s “Depression Hurts, Prozac can Help” campaign (of the early 2000’s) represents Prozac as a *tool* of liberation, reserving the active liberator position for the pill-consuming subject. Eli Lilly presents itself as gracious host, greeting the consumer who employs will in the activity of brain liberation and emotional return. In an essential rhetorical act, Lilly signifies taking meds as an active, rather than a passive form of recovery—an act of self-determination—, and recasts an allegedly biological illness as a problem of individual will. Visually, the biopsychiatric paradigm of depression science is reinforced by juxtaposed weather icons, suggesting a simple, biotechnically proven choice for mood challenged (and informed) consumers.



Similarly, GlaxoSmithKline’s recent campaign for antidepressant Wellbutrin greeted interpolated consumers with the tag line, “I’m ready to experience life,” framing the mental health consumer as pro-active, engaged, rather than subjected by experts as argued by Metzl (2003)¹, and slothy-- indeed, depressed. In contrast to the antithetical passive or stationary subject, the Wellbutrin consumer —primarily Caucasian females according to focus point of the ad, and yet constrained to this demographic (as suggested by the couple in the marginal photo)—travels, experiences, consumes antidepressants.



In the same vein, the on-line advertisements for “Prozac Weekly” (2003) confront the consumer, querying: “Are you ready?” The accompanying text presents depression as a long-term proposition and continued drug consumption as the appropriate treatment. The challenge to the consumer, should she be sufficiently daring, is to interpolate herself as recovery subject made active through the choice to consume Prozac once weekly, for an undetermined time period.

¹ For an informative study of historical trends in psychotropic pharmaceutical advertising, which argues that psychoanalytic biases remain present in biopsychiatry, see Jonathan Metzl’s *Prozac on the Couch*.



Like the dominant depression script, Prozac weekly’s campaign is rife with the contradiction of promoting drug consumption as self-determination and the path to self-actualization. Ironically, depression is presented as repairable by the responsible, reasonable, and *active* (i.e. non-depressed) subject. The campaign paradoxically recognizes drug consumption as an annoying daily practice and a passive practice of self-help, juxtaposed with the idea that drugs will allow the depressed consumer to engage in a more active “focus” on her illness. The campaign is equally littered with neoliberal significations. Prozac Weekly is *itself* presented as a rationalized practice- - a way “to simplify this regime and focus on feeling better—” a sound-bite that transparently promotes Lilly’s goal of preserving consumers’ time and energy, in the service of improved productivity.

HOW PROZAC CAN HELP

Is PROZAC Weekly Right for You?

Are You Ready for PROZAC Weekly?

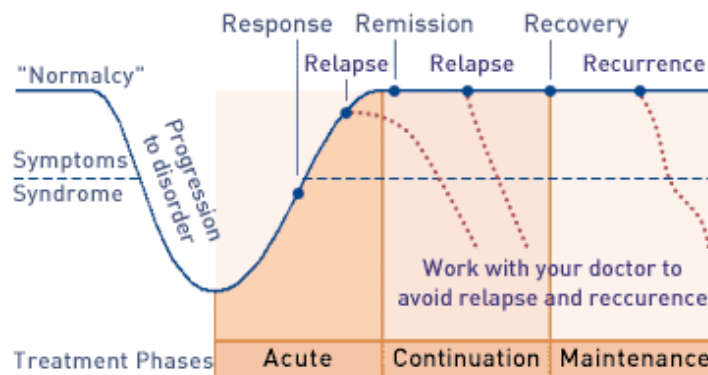
Even if you are feeling better, it's important that you continue to work with your doctor and decide together how long you should keep taking your medication. The continued treatment of depression can help prevent it from coming back. Work with your doctor to find the treatment regimen that is best for you. PROZAC® Weekly™ (fluoxetine HCl) may help you simplify this regimen and focus on feeling better.

Finally, the Prozac webpages link consumers to advice on how to “maximize recovery,” with “activities” relegated to the paradigm of biopsychiatry—talking to one’s doctor and understanding biopsychiatric science, also provided by Lilly. ² As depression is not curable, risk

² This information was taken from the Prozac webpage on October 1, 2004; the URL was and remains http://www.prozac.com/disease_information/depression.jsp?reqNavId=1.1

is unavailable. Hence, Lilly presents risk as manageable, offering a commodity that can restore the recovery subject to “normalcy” via the proactive and yet simple act of pill-consumption,

Consumerized science models frequent Big Pharma, policy groups and health advocacy websites, reinforcing the idea that managing depression risk requires ongoing activities of maintenance. On-line health consumers are routinely presented with a layperson’s version of the “Kupner Curve”, which juxtaposes “normalcy” to “depression”, signified by an ongoing series of depression recurrences and remissions. According to the graph, this one appearing on Prozac’s website (January 2007), “ups and downs” occur throughout the recovery subject’s life and are caused by biochemical brain problems alone. Depression sufferers are represented as victims of long-term, unpredictable mood fluctuations.



The curve both constructs and illustrates the insecure status of individuals with depression. This illustrated risk not unlike the risk signified in Homeland Security’s Terror Alert Chart, which routinely fluctuates America’s “risk” of terror for no reason and with little explanatory context, provides links suggesting citizens respond by surveying fellow citizens.³ The interpolated subject of the Chart who acquiesces to this uncontextualized risk discourse and counter-surveillance demands, sacrifices her right to vet the meaning of risk and thus control over her personal security, to an epistemological paradigm grounded in the authority of experts. Similarly, Lilly’s positions the Curve as epistemological source to the rational subject of depression; this interpolated subject, having assessed her status as inherently risky, is offered the option to “take control” —that is, to mitigate risk—by embracing common biopsychiatric depression epistemology and consuming Prozac. To “maximize recovery” then is to submit to depression as a long-term, unpredictable risk/ brain sickness manageable by drugs. This latest Lilly program uses the guise of self-help to push the consumer to interpolate herself in a manner that seems like identity construction. By positioning *one’s self* as a long-term recovery subject

³ The Terror Alert Chart is located at <http://www.terror-alert.com>. See -- 2007 for a further discussion on the visual and discursive correlates between terror and depression discourses.

requiring long-term drug use, the subject embraces an unstable broad-spectrum illness discourse, grounded in risk, that is, illogically, lethal and highly manageable.

The Pharmaceutical industry's deployment of self-help discourse to, paradoxically, present depression *recovery* as the *management* of chronic risk is not unlike the depression script routinely circulated by government policymakers such as the American Psychiatric Association (APA) and the NIMH. The NIMH depression webpage presents the usual ten vague depression symptoms, and while it does distinguish among major depression, manic depression and dysthymia (long term, low level depression), the webpage fails to even mention minor depression. The broad-spectrum consumer is thus compelled to interpret vague "symptoms" as major depression, and to follow the discursive path linking distress to antidepressant consumption. As in pharmaceutical discourse, antidepressants are listed as the first line of attack, their effectiveness overestimated. Finally, the NIMH proclaims that pharmaceutical treatment for major depression "may have to be maintained indefinitely." (NIMH 2007a) Demonstrating the reliance of other depression discourses upon expert statements, this exact quote is deployed by major American health insurer BlueCross Blue Shield on their "health education" page on depression. (Blue Cross Blue Shield, 2007) Distress is thus translated as illness and designated serious but treatable by drugs and careful monitoring of symptoms and drug use. Similarly, as referred to earlier, the APA's on-line depression information states ... "serotonin and norepinephrine, *might* (my italics) contribute to symptoms of depression, including anxiety, irritability and fatigue." And in keeping with the script, the APA links depression to SSRI drugs to "correct" chemical imbalances. (APA 2007) Like the NIMH, NAMI and pharmaceutical discourses, the unstable logic of biopsychiatry is reframed as rational discourse at this-- the most expert of depression information websites. Finally, the non-profit, consumer-advocacy organization NAMI provides an on-line *Understanding Depression* pamphlet that erases the indeterminacy of depression science entirely, asserting "...scientific research has ...firmly established that mental illnesses like major depression are biologically based brain diseases." (NAMI 2007) By collapsing and misrepresenting depression information, these industry, policy and non-profit advocacy groups demonstrate the use of the peculiar and yet popular discursive strategy of presenting contradictory and unstable logic as scientific discourse. Based on the high depression diagnosis rates, these tactics work effectively to create recovery consumers willing to engage in extreme mood risk-abatement. This new cultural practice constitutes a new form of self-governance at the site of everyday mood distress.

Cultivating Fear: Slippery Slope and Self-Diagnosis

The new logic of depression script is slippery, working not only to reify the expert, as argued by Lyotard (1979) and Latour (1987) but, in fact, to elide and reinstall the expert in a *new* role in psychiatric diagnosis and treatment. Even as the expert is authorized to determine depression discourse and prescribe medication as the “correct” treatment, consumer depression discourses transform the patient to actor, or more accurately, self-manager. In some cases, the consumer is addressed as expert and provided seemingly proven depression science. This ascription of authority to the consumer relies on aforementioned depression myths such as the slippery slope, suggesting a few *undiagnosed* symptoms might reasonably snowball into full-blown major depression, creating a risk of chronic lifetime major depression, possibly resulting in unemployment, poverty, and even suicide. Web information from the NIMH depression homepage declares, for example, “Without treatment, symptoms can last for weeks, months, or years.” Similarly NAMI’s (2007) Depression booklet warns

“ More than half of those who experience a single episode of depression will go on to have episodes that occur as frequently as once or even twice a year. If untreated, they may last quite long—anywhere from six months to over a year. And without treatment, the frequency of illness as well as the severity of symptoms tend to increase over time.”

These overdetermined claims, based on biased research, intentionally marginalize alternative depression theories and research, and thus “pass” as positivistic facts. Such discourse—reasonably, one may say—incites anxiety in consumers, causing them to surf on, and to take on risk-averting activities such as self-monitoring.

As argued earlier, consumer depression’s snowball logic collapses crucial distinctions among mood distress, minor depression, dysthymia and major depression so that any “symptom” can be reasonably viewed as risk of major depression.⁴ Many health policymakers and mental health advocates are eager to reduce suicide rates. Yet, policymakers and consumer advocates have erred in creating fear-inducing depression discourses *that intend* to normativize mass surveillance and self-surveillance practices, and to overdiagnose in order to sweep in the (small population of) undiagnosed severely depressed individuals. The oversweeping policy appears reasonable, again, because broad risk-abatement campaigns regarding health, safety and security

⁴ This snowball logic, drawn from a minority of depressed individuals who experience chronic depression symptoms, is not relevant to individuals on the far spectrum of distress. Researchers do tend to concur that individuals who commit suicide often suffered *chronic*, major depression. (Angst 1999.) While researchers and health policy scholars are legitimately concerned that suicide is often precipitated by chronic major depression, it is problematic that policy makers address this problem by lowering the bar for non-chronic depressions.

(i.e. tobacco, driving, teen pregnancy, financial management) have become ubiquitous in North America and are seeded with neoliberal discourses urging self-management.⁵ This generalized risk discourse, suggesting risk management as an act of good citizenship, despite that these discourses create greater surveillance of individuals by experts, greater self-surveillance and more restrictive depression discourses.

Recent activities by APA demonstrate precisely this attempt to insist on a biopsychiatric bias in public depression discourses, the expert sanctioning of antidepressant overtreatment, and the appropriation of “risk” to promote depression. After an exhaustive reexamination of clinical trials, the FDA determined in September of 2004 that SSRI antidepressant drugs are *ineffective* and even *dangerous* for pediatric and adolescent children, and announced it would issue strong advisories on labels via vivid “black box” warnings. In response, APA doctors undertook a widespread campaign in opposition to black box warnings, publishing letters to the FDA, and lobbying Congress on the matter. The APA letter, signed by Director Scully, admits that the drugs have been found to be harmful to children, even creating suicidal thoughts.⁶ Notwithstanding, the letter cited concerns that black box label details might “further frighten parents and caregivers” whose children take the meds, resulting in individuals abruptly halting consumption, or in fewer prescriptions, which he takes care to note is already the case as reported by Medco, a large pharmacy benefit manager. The APA is apparently less concerned about affirmed, existing dangers --that the use of Prozac by pediatric children is *not* proven to be effective and has been shown to be dangerous. Rather, the APA’s letter demonstrates concern regarding the risks of *possible* decreased drug use that *could* be caused by scaring parents into believing what the FDA *knows*--that SSRI’s are, in fact, harmful to children.

The APA’s letter cites some valid concerns, for example, regarding the dangers of abruptly halting antidepressant use. There is, however, a strong element of moral panic in the argument, echoing the depression script’s panicked rush to overdiagnose. The APA fails to accept that “black boxes” might be informative and perhaps reduce the number of inappropriate prescriptions of Prozac to kids with symptoms alone. Instead, speaking from a position guided by neoliberalist normativity, the APA, foremost professional psychiatric organization in the US, presents risk as *decreased* antidepressant use. The APA, then, is more concerned with the

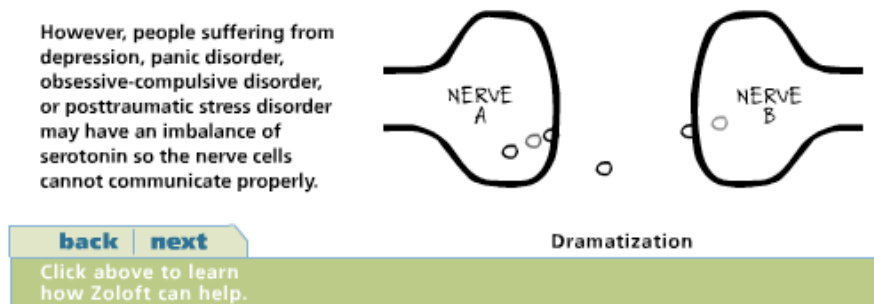
⁵ As example, consider anti-tobacco, teen pregnancy and dangerous driving campaigns in North America. The US National Day to Prevent Teen Pregnancy Campaign couples lurid sexual provocations (“Come on dirty boy, let mama...”) with the punch line (“Change your diaper”) to preach a form of self-responsibility wrapped in morality. (teenpregnancy.org/national/banners.asp.) Similarly, thrifty behavior is encouraged by a US Ad Council Public Service Announcement sating “Save your money and one day it’ll return the favor.” (adcouncil.org) (Both websites accessed from the World Wide Web March 7 2007.)

⁶ The letter, dated September 24, 2004 was posted on the APA’s website at http://www.psych.org/news_room.

potential impact of unmedicated depression, rather than the documented dangers of Prozac for children. APA discourse here is indiscernible from big pharma in seeking to highlight potential “risks” of undrugged depression, devaluing the documented harm of SSRI drugs, and arguing against labeling information that could decrease antidepressant use. Here, market logic melds with neoliberal statutes and biopsychiatric tenets; by directing consumers to trust expert recommendations to consume first and consider later, experts take part in encouraging a “healthy” consumptive market.

Mood Education through Consumerized Science

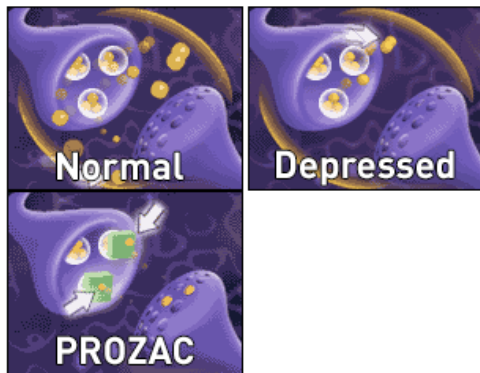
The expert role, then, is both elided and reinscribed in depression discourse. Where the APA appropriates risk for depression promotion, in a related activity, many mood discourses encourage the consumer to take on the expert role. Pharmaceutical organizations accomplish this through ads that incorporate consumer grade science, flattering the consumer as the expert of his/her mood care. Pfizer provides dumbed-down descriptions in print ads and on its webpage (Zoloft.com) describing how serotonin (theoretically) makes the brain depressed and how “Zoloft can help”.



The web page features two animated nerves, between which bubbles of serotonin move interactively in the synapse, or fail to do so in the illustrated unhealthy brain. Attempting to transform the indeterminate serotonin theory of depression into medical fact, Pfizer declares: “Although the way Zoloft works for Depression, Panic Disorder, OCD, and PTSD is not completely understood, what is understood is that Zoloft is a medicine that helps correct the chemical imbalance of serotonin in the brain.” The simple scientific model, easily comprehended, is meant to stand in as neuropsychiatric “science,” validating the serotonin claim, and collapsing disparate states—depression, stress, panic, and obsessive compulsive behavior—as more or less the same thing: serotonin problems repairable by Zoloft.

Similarly the “recovery” webpage of Prozac.com presents bright purple and yellow animated demonstrations that contrast the healthy brain, sick brain and the brain on Prozac.⁷ These animated displays are accompanied by descriptions that detail the indeterminacy of the script, noting that “many” scientists believe depression works chemically, is “sometimes” helped by Prozac, and finally, admits that “Prozac cannot be said to ‘cure’ depression”. Having noted the instability of serotonin theory, Lilly has deemed itself trustworthy. Cloaked in a veil of authenticity and deploying visuals allegedly illustrating “science” Lilly is thus positioned to deploy biopsychiatric myths, claiming that Prozac, because it targets serotonin directly “...does help to control the symptoms” and allows people to “return to normal functioning,” making it the smarter more accurate antidepressant. The visuals buffer these unsupported claims, presenting normal and depressed brains as dualized opposites, and aligning Prozac with “normal”.

Below you will find links to animations of the serotonin system within the brain.

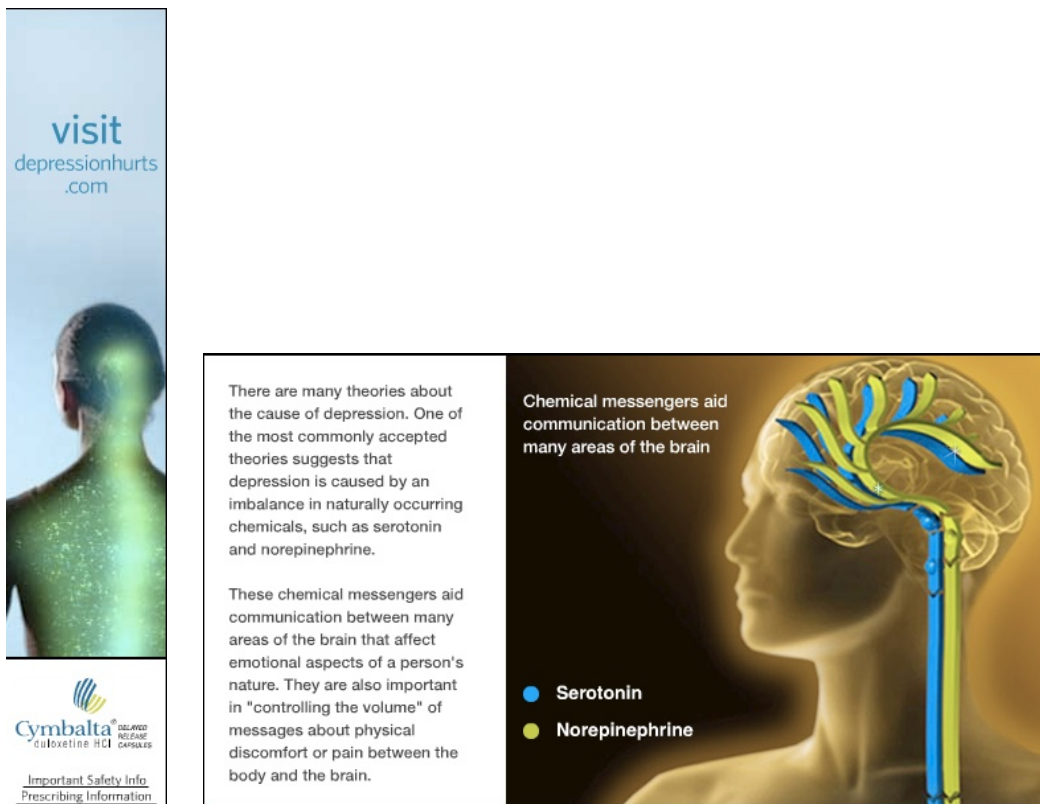


Lilly’s consumer science also includes the aforementioned “Kupver Curve” to demonstrate how recovery proceeds in depression, but which actually provides visual backup for unstable research claims. The visual provides signifiers such as “normalcy” (to indicate a population whose mood remains low for only a few days), while all other mood experiences are grouped as “acute”, “continuation” and “maintenance” phases of depression. In presenting depression and recovery as a scientific process, the graph brings an aura of authenticity to this highly constructed and overly broad “risk” population, which includes all but the few who qualify as normal. The synapse visual also reifies the troubling slippery slope theory, placing mood distress on a continuum with chronic, disabling major depression, during which relapse and recurrence are routine, but apparently mitigated by “maintenance therapy,” or the ongoing consumption of Prozac.

⁷ This model can be found at the following URL: http://www.prozac.com/how_prozac/how_it_works.jsp?reqNavId=2.2

Cyberadvertising

Irony enters into Lilly's depression marketing strategy with the addition of new scientific findings. When research suggested that a new neurotransmitter is also responsible for mood regulation in the brain, Lilly established the new antidepressant, Cymbalta, marketed at a distinctively separate website: depressionhurts.com. This new drug is meant to treat both serotonin and norepinephrine imbalances, in response to what Lilly terms "one of the most commonly accepted theories" of depression origin. Lilly uses descriptions of serotonin similar to Prozac advertisements to sell Cymbalta, but adds the assertion that the addition of norepinephrine reuptake inhibitors helps to address the (physical and emotional) "pain" of depression.



visit
depressionhurts.com

There are many theories about the cause of depression. One of the most commonly accepted theories suggests that depression is caused by an imbalance in naturally occurring chemicals, such as serotonin and norepinephrine.

These chemical messengers aid communication between many areas of the brain that affect emotional aspects of a person's nature. They are also important in "controlling the volume" of messages about physical discomfort or pain between the body and the brain.

Chemical messengers aid communication between many areas of the brain

- Serotonin
- Norepinephrine

Cymbalta[®] duloxetine HCl
DELAYED RELEASE CAPSULES

[Important Safety Info](#)
[Prescribing Information](#)

And yet, the recovery consumer for Cymbalta is not distinguished from other consumers beyond possessing depression plus physical pain; in turn, Lilly's Prozac webpage does not steer consumers to Cymbalta, even through its link to "new advances in the treatment of depression." And like all SSRI's, scientists are (also) unsure how Cymbalta works, when it in fact does "work." The glaring lack of distinction among antidepressant promotions, reveals the utter lack of information or proven assertions in the science of these drugs. At the same time, these absences reveal the blatant consumerized (i.e. dumbed down) science that is meant to side-sweep the actual

medical professional, and reason, and instead flatter the consumer *as* psychiatric expert. Finally, the paradoxical presentation of dueling brain chemical disorder theories as both true, without explanation, reveals the drug companies' intention to gloss fact in the service of depression and antidepressant sale.

Self-Surveillance and Self-Management

Consumer science discourses and visuals reiterate the normative script, making it difficult for consumers to think beyond the science presented. Lilly and Pfizer offer depression as a highly technical discourse based on complex neuroscience that is comprehensible by smart consumers. The companies thus seek to interpolate mood-distressed individuals into the position of intelligent, engaged recovery subject, who is unlikely to contest the message.⁸ And yet, in contrast to this signification, Lilly's more recent "Next Steps" program is presented as an educational package that requires no critical thought on the part of the consumer. Consumers ready for the "Next Steps" are offered a list of questions they can recite to their doctor including, "What kind of depression do I have" and "Is Electro Shock Therapy right for me?" A link entitled "Balanced Living" offers self-actualization tools, including suggestions for recognizing negative thoughts, such as challenging consumers to think of phrases such as "I am a loser," as negative statements.

Finally, both Eli Lilly and Pfizer offer consumers tracking devices and programs, designed to create the subject as expert of her own mood surveillance. The devices refer consumers to ongoing self-surveillance technologies to map her antidepressant consumption. Lilly consumers are meant to use mood-tracking charts to develop a sense of sovereign self-evaluation, though the websites encourage consumers to hand over the completed graphs to doctors in order to receive "professional" diagnosis. Such devices encourage individuals to take on activities of self-reconnaissance and management that mimic the linkages of distress with drug treatment, even as they engage consumers in transferring their interpretive authority to professionals in industry, medicine and advocacy.

Notably, Lilly's webpage over the past two years has crept slowly away from "ad"-type visuals, (though these are available still as web advertisements,) and Lilly has eliminated the tracker service. Instead, today, as evidenced in the above "Next Steps" campaign, Lilly's new

⁸ This suggestion can be substantiated by the mass numbers who consume Prozac as well as in-depth length ethnographic interviews I have conducted with individuals diagnosed with depression. (-- 2003 unpublished.) In ethnographic research studies that I have conducted, depression consumers rarely understand serotonin theory, and in no cases, have been aware of challenges to the theories. The findings suggest that consumers who seek depression information tend to accept, unproblematically, the scientific descriptions of drug functioning and drug testing and instead focus on getting better.

textually dense pages read more like a drug label than a consumer ad, seeking, it seems, to emanate the authority and cultural currency of the former. Lilly, whose name is sotted to depression, is distinct among pharmaceutical companies is its ability to craft visually bankrupt webpages that successfully sell its product to consumers. Nonetheless, the neoliberalist logic articulated above, and in the following, resonates across Lily's current web presence--both its page and its web ads are illustrative of the trends of both Big Pharma and other purveyors of the script.

The Will to Consume Meds

Standards depression discourses employ a moralist undertone to craft distressed consumer as both expert and manager of her care. The National Institute of Mental Health (NIMH) is indicative of this trend; its website provides consumers the usual biopsychiatric depression story but qualifies, it “is not a sign of personal weakness or a condition that can be willed or wished away. People with a depressive illness cannot merely "pull themselves together" and get better. Without treatment, symptoms can last for weeks, months, or years. Appropriate treatment, however, can help most people who suffer...” (NIMH 2007) The NIMH webpage makes the standard linkage of depression with biotechnical treatment, emphasizing antidepressants as the first line of treatment.⁹ Yet, the discourse carefully reifies neoliberalist values of self-determination and willfulness by conveying that the good citizen would want to take care of depression deficiencies, independently. The mythic, willful, self-directed individual is thus steered toward diagnosis and biotechnical treatment.

Pharmaceutical campaigns also employ moralizing as they dub consumers as agents of depression. Pfizer's popular TV ad, featuring a lethargic pill made peppy by Zoloft, appeals to the American consumer embracing the cultural ideology of self-sufficiency and ruggedly individualism. An on-line Pfizer ad (2003) for Zoloft offers an image of restored domestic, heterosexual tranquility—an image intended to signify normalcy in the broader sense of home, mental health, and sexuality.

⁹ The webpage (<http://www.nimh.nih.gov/publicat/depression.cfm#sup5>.) recognizes “medications and psychosocial therapies such as cognitive/behavioral, talk or interpersonal” as able to ease the pain of depression, but then refers to research that recommends drugs or drugs plus cognitive-behavioral therapy as the best treatment for depression, despite that this combination therapy is actually affective only for major depression. Minor depression has been shown to be equally well treated by consuming any or none therapies on the market.



Pfizer routinely couples this type of image with text suggesting Zoloft as path to agency for the mood-problematized consumer: “When you know more about what’s wrong you can help make it right.” Individuals feeling hopeless are addressed as agents of action, again, creating a moralistic imperative to “right” wrongs. “Knowing” Zoloft is presented as the quick fix. Never mind that the symptoms outlined are common and vague--the consumer is presented a decidedly subjective subjectivity by Pfizer. Similarly, Eli Lilly’s “taking control” campaign, discussed earlier, implores consumers “You can and should be an active participant in your recovery from depression. This involves communicating with your doctor about your progress.”¹⁰

This allegedly self-deterministic discourse employs a moralism that transforms self-care into talking to one’s doctor. Were the consumer to do the “right” thing, as per Lilly’s directive, she would request depression screening from her Doctor, and inquire about a Prozac script. Today’s (2007) Zoloft webpage has transformed the “Knowing More” rhetoric into a “program” for already existing Zoloft consumers—direct to consumer communications, via email or snail-mail, encourage maintenance of one’s drug regime, and provides other tips regarding expected progress and healthy lifestyle choices. Like Lilly, Pfizer seeks to maintain its market via discourses that appear invested in consumer recovery, when in fact, the undergirding risk discourse divulges an intention to define depression as indeterminate and yet manageable risk—an ongoing, unstable state, deeming recovery a long-term commitment.

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Docile Brains

Consumer depression discourses, whose rigid script is legitimated by culturally popular myths and assumptions grounded in neoliberalism, not only encourage self-management but also hail consumers to surveil the moods of their selves and others. Similar to pharmaceutical industry tactics, the NIMH arms consumers with (indeterminate) depression “knowledges” with which to employ in mood surveillance. The NIMH depression webpage suggests consumers should surveil

¹⁰ This webpage was accessed in January 2003, from the World Wide Web; its URL was www.prozac.com/diseaseinformation/recovery.

friends and family, helping them to recognize (broad spectrum) depression “symptoms,” accompany them to the doctor, “encourage” the subject to maintain treatment, and even “monitor” their drug consumption. A more significant trend, however, is the creation and distribution, across a vast array of consumer health sites, of consumer-grade depression quizzes that encourage literal mood surveillance.

State Health Campaigns, Pharmaceutical Advertising, Consumer Advocacy Groups, Insurance Programs, Employers, Health Care Providers, both off-line and on-line saturate consumers in depression myths in tandem with self-diagnosis tools. This is akin to the common advertising trope of establishing lack based on the Foucaultian “docile,” inherently flawed, body and then providing consumables to fix the “problem.” The normative paradigm of the “docile brain” suggests brains are inherently unstable, due to flawed neurochemical processes and therefore individuals should assume that mood illness will eventually occur, if left unsurveyed. Like docile bodies, individuals should seek to repair this lack and attend to the brain in isolation of environment. The docile brain is made easily scrutable, however, by the now ubiquitous, consumer-friendly diagnostic questionnaires widely available from State health service and policy organizations, NGO’s and pharmaceutical companies. Depression quizzes are almost impossible to avoid, popping up in doctor’s offices, state-funded clinics, health journals, popular magazines, and the array of (state and industry) consumer health web sites. These user-friendly technologies, such as the 20-question “Zung Depression Inventory,” pose questions that screen for broad spectrum criteria, as below, from Prozac.com.¹¹

Prozac.com
[Zung Assessment Tool](#)

Read each sentence carefully. For each statement, select the response that best corresponds to how often you have felt that way in the last 2 weeks. If you are on a diet, answer statements 5 and 7 as if you were not. Print out this test and discuss your answers with your physician on your next visit.

If your score is 50 or higher, consider printing the results of your test to show it to your doctor. Ask him or her to evaluate you for depression.
Please Note: Only a health care professional can actually diagnose clinical depression.

1. I feel downhearted, blue, and sad
 Not often Sometimes Often All the time
2. Morning is when I feel the best
 Not often Sometimes Often All the time
3. I have crying spells or feel like it
 Not often Sometimes Often All the time
4. I have trouble sleeping through the night
 Not often Sometimes Often All the time
5. I eat as much as I used to
 Not often Sometimes Often All the time

All 20 questions reference common experiences in normally functioning individuals, such as feeling restless, or unattractive or unuseful, while answers are allowed on a four-point scale from “rarely” (designating normalcy) to “all the time”. The tests provide consumers a pre-diagnosis, based on over-determined logic—for example, an answer of “often” to a couple of

¹¹ The Zung tool and other depression quizzes are also available at the World Health Organization, neurotransmitter.net, and the National Institute for Mental Health, to cite a few.

symptoms is pre-diagnosed as moderate depression risk. *All* test-takers are encouraged to show their score to their health care provider, thus assuming risk by virtue of one's willingness to take the test. As such, the quizzes seek to sweep in consumers with minor depression, symptoms and perhaps no depression; it encourages most users to "pre-diagnose" themselves as having depression and its logic again links self-surveillance to the acquisition of "formal" (read biopsychiatric) depression diagnosis and treatment. The risk of disorder, here represented by vague symptoms and overdetermined test results, is diagnosed as disorder itself. The overdetermined, biopsychiatric paradigm and illness model inspire consumers with *any* behavioral or mood distress to view themselves as *ill* subjects in need of biotechnical recovery.

State, industry and advocacy organizations effectively promote depression via on-line scripts, to consumers who find it difficult to imagine or locate alternatives. In turn, the depression script becomes common sense, reflecting a set of normative neoliberal values—namely productivity, efficiency, and rationalization. The ubiquitous script, referencing cultural discourses as the route to the good—to health, and a healthy economy—appears reasonable event to health and advocacy organizations and thus is broadly read and consumed as a path to good citizenship. Hence, in this post-modern age, paradoxical scripts that transform depression risk into illness itself, everyday mood experiences into psychiatric disorder, become sensible and common. As Adam and VanLoon (2000) have suggested, scientific discourses have "advanced" under neoliberalism so the equation of indeterminacy with knowledge, risk with disorder, appears natural and appear to be great. This is particularly the case in a moment when the "risks" —of personal (or national) economic damage or permanent brain disorder— are widely circulated in mainstream culture. A widespread sense of personal risk coupled with citizen imperatives to produce make it possible that industry, policy and nongovernmental groups find themselves strange bedfellows in the promotion of depression.

Researchers both in and beyond psychiatric medicine must make efforts to analyze mood discourses as promotional activities bound up in dominant ideologies, that thereby impact not only practices of health institutions and industrial output, but also practices of subjectivity, consumption and democratic citizenship. Instead, consumer health studies routinely fail to consider the embedded and presentational ideological context of health information, Gunther and Eysenback (2000) contribute to invisibilizing ideology in health discourse in stating:

The greatest contribution of consumer health informatics research to the healthcare sector may eventually be found in its attempts to systematise and codify consumers' needs, values, and preferences; in its research into how information is digested and is best presented to consumers; and in its research into how these variables influence

outcome measures.

Much is at risk. In failing to critique the meanings of depression information in terms of on-line marketing and promotional discourse, we risk becoming consumers tacitly approving of flawed health, productivity and risk ideologies constructed by unstable logics in scientific, government and industry and even advocacy discourse. The extreme embrace of depression as common illness in the brief period of a decade illustrates America's cultural comfort with risk management discourses and our willingness to be passively positioning as biotechnical subjects of neoliberal mandates. As such, highly controversial mood claims are left uncontested by consumers, while Prozac prescriptions increase for grumpy toddlers, exhausted mothers, lonely seniors and the "worried well." Consumers must interrogate the logics housed within this slow discursive slippage to meds, namely: the elision of logic, the casual acceptance of expert authority, passivity presented as self-determination, contingency as knowledge, progress and unfaltering productivity as the good, as well as the moral panic undercurrent of broad-based health risk discourses. Neoliberalist practices, as articulated in the ubiquity of mystified depression discourses encourage docile subjects who behave, accept, self-surveil, and conform in the name of improved productivity— thus distorting the concept of democratic citizenship. By challenging the mainstream depression logics that pivot on the goal of ever-increasing productivity, we begin to disrupt this new, insidious effort in the guise of "health care" to redefine mood management as an act of good citizenship.

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