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**DISPENSING KNOWLEDGE
AND SHAPING EXPERIENCE:
THE ROLE OF POPULAR
MEDIA IN THE LIVES OF
WOMEN WITH
PRE MENSTRUAL
DYSPHORIC DISORDER**

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Dispensing Knowledge and Shaping Experience: The Role of Popular Media in the Lives of Women with Pre Menstrual Dysphoric Disorder

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Abstract

This dissertation focuses on the impact various forms of popular media have on shaping the illness experience in women with Pre Menstrual Dysphoric Disorder (PMDD). In looking primarily at the direct to consumer advertising of psycho pharmaceuticals, and the advent of new media in the form of online support communities, it seeks to show how the disorder has been manufactured and perpetuated as a result of the circulation of lay medical information acquired from various media outlets. It begins with a chapter devoted to the conceptual frameworks that grounded this research: those of social construction of illness and cybernetic theories of information sharing. It moves on to examine the role of media in providing knowledge, shaping women's sense of themselves and their ideas of what constitutes normal versus pathological behavior, and presenting the possibility of a new identity built around the diagnosis of PMDD. The methods used included theoretical literature review, content analysis of advertisements, and narrative analysis of semi-structured interviews and online blog posts. It was found that most women with PMDD self-diagnose as a result of information gleaned online or through advertisements, and that a "consumer demand" has been created around the illness that keeps it from fading into obscurity.

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Introduction

In his book *Mad Travelers: Reflections on the Reality of Transient Mental Illnesses* (1998), the philosopher Ian Hacking questions how a form of mental illness can emerge, take hold, become an obsession in a particular place and time, and then fade away, only to possibly reemerge later under a different name (31). What particular set of conditions or elements need to be in place that will provide a stable home, however temporarily, for certain manifestations of illness? What allows for such illnesses to come and go, lying in wait for their next cultural moment to emerge? In his exploration of these illnesses, Hacking presents the notion of “doxogenic” disorders as those that have been brought about by a belief system cultivated, in part, by the media (ibid., 11). Pre Menstrual Dysphoric Disorder (PMDD) is a contemporary example of such transient illness, which maintains a solid presence in the US, and growing popularity in the UK, despite its controversial status as a legitimate diagnosis.

The disorder, though it has only emerged within the last fifteen years, is a renamed version of the same set of symptoms that have been described by women for centuries. But how, in the current post-feminist, medically savvy climate that exists in the US and UK in the 21st century, is a diagnosis of PMDD, with all of its connotations of “hysterical woman”, able to exist at all? I argue that the increasing amount of medical information available to the lay public via popular media outlets such as direct to consumer (DTC) advertising of psycho pharmaceuticals, blogs, and online support communities are responsible for the disorder’s continued prevalence among women. Even though PMDD remains ill-defined, and it’s existence continues to be highly contested, both among physicians, and within the American bible of mental illness classification, The Diagnostic and Statistical Manual of Mental

Disorders (DSM), women are continuing to seek a diagnosis, due in part to the power of meaning and messages present in certain media outlets that they strongly identify with.

Women with PMDD commonly describe feeling as though they have two personalities: the “nice” one, which is their usual self, and the angry, “crazy”, “evil”, or out of control one, which is their premenstrual self”(Dell 2003: xi). Emotional symptoms such as depression, anxiety or unease (dysphoria) combine with physical symptoms including bloating, weight gain and breast tenderness which can make for an uncomfortable few days for most women. But is it something requiring medical intervention? Prior to the mid 1990’s, such monthly hormonal fluctuations were not viewed as a medical disorder in need of pharmaceutical treatment in any capacity. At that point there was PMS, the less psychiatrically disordered relative of PMDD, which

was not recognized as a medical condition by physicians or by women themselves. It was first mentioned in the medical literature in 1931, little was made of it. A general unawareness continued until the 1970’s, when the lay press began writing extensively about the disorder. As women read magazine stories about PMS, they recognized their own symptoms. As awareness grew, the concept of PMS changed, and what began as a diagnosis became part of the vernacular to describe any woman’s ill-tempered behavior (Dell 2003: xii).

It wasn’t until the summer of 2000 that PMDD found its way into national consciousness. It was at that time when the U.S. Food and Drug Administration (FDA) approved fluoxetine hydrochloride, the chemical compound used for Prozac, as the first drug to be indicated specifically to treat PMDD symptoms (ibid., xiii). PMDD was officially created as a mental illness as a result of the pharmaceutical company Eli Lilly’s desperation over potentially losing a patent on one of the most profitable pharmaceuticals of all time, Prozac. What followed was a public relations blitz in which Lilly sought to familiarize physicians and the general public with the name and make-up of the illness by running television ads that “struck

a note of familiarity for millions of women. While showing realistic portrayals of highly irritated, depressed or bloated women, the ads asked ‘think it’s PMS? Think again.’ And with those five words, the world was introduced to PMDD” (ibid.). Along with the disorder, the public was also introduced to the only treatment specifically indicated for PMDD, Sarafem. Sarafem was the exact same medication as Prozac, but in order to rebrand it for this “new” disorder, Lilly had to change some aspect of the drug so that it wasn’t exactly the same as Prozac. Lilly’s solution was to turn the pill pink.

In its press release, Lilly expressed the hope that the new trade name would “[reduce] confusion about the differences between depression and PMDD” (Kihlstrom 2000). By calling the drug Sarafem instead of Prozac, perhaps Lilly hoped to increase the market for the drug by avoiding the stigma and other negative connotations of mental illness (ibid.). Back in 2000, Laura Miller, a spokeswoman for Eli Lilly at the time, told the Village Voice “women told us they wanted treatment that would differentiate PMDD from depression” (Spartos, 2000). While most women were unaware that Sarafem was an anti depressant, some of those who were preferred the drug especially marketed for their disorder. As one woman elaborated: “my doctor offered me generic Prozac, but I’d rather have my pharmacist fill a prescription for Sarafem. I live in a small town. I see my pharmacist at the grocery store. I’m not depressed” (Dell 2002: 11). By turning Prozac pink, printing a flower on the box, and coming up with a feminine-sounding name, Lilly, along the rest of us, witnessed the birth of a disorder as “women rushed to their physicians and spent \$4.6 million in the first five months the medication was sold” (ibid.).

Conrad and Barker (2010: 68) write that what gets labeled a disease or qualifies as biological is often socially negotiated. If all illnesses are shaped and formed by meaning and

culture as Kleinman (1988) suggests, then it makes sense that a pharmaceutical company, with its endless advertising and public relations budget, would be able to shape cultural response to disease by peddling its supposed treatment. In bypassing physicians and directing targeted “education” campaigns at the lay public, companies like Lilly are actively engaged in shifting the way individuals, women in particular, view themselves and their bodily processes. The medical information they are receiving through popular media is altering their sense of themselves and what they view as being “disordered” behavior. In thinking about how personal identity is constructed, it is important to acknowledge “the power of frequently repeated media images and ideas to establish broad frames of reference, and define the boundaries of public discussion” (Marchand 1986). As ideas about PMDD circulate among communities of women, the disorder becomes validated, reaching the point where women are using their newfound knowledge to demand the diagnosis from their doctors. What began as a pharmaceutical company’s attempt to maintain a profit through the extension of the patent on a popular antidepressant has emerged into a questionable set of symptoms being deemed medical fact. A disorder was created; information disseminated through popular media, and is now perpetuated by women themselves.

Referencing the work of Giddens (1991), Kroll-Smith sees the lay appropriation of expert knowledge as a feature of our late modern times, where individuals are “continually accessing expert ways of knowing, tinkering with them sufficiently to answer a question or make sense of their misery, and fashioning stories that reflect a correspondence between situated biography and abstract, disembodied texts”(2003:627). Faced with decisions, questions and dilemmas:

people are increasingly likely to turn to magazines, books, newspapers, newsletters, and the Internet to acquire new perspectives, facts, explanations and

prescriptions for acting. Personal reasoning and making sense of illness are increasingly tied to clusters of words and images that are detached from local contexts and occur simultaneously in a multiplicity of socially and temporally disjointed settings (ibid.).

So why is this relevant now? One very compelling reason is the imminent publication of the latest version of the DSM. Each successive edition has contained a proliferation of disease categories, with the number of distinct diagnoses reaching in excess of 350 at the time of the most recent edition in 1994 (American Psychiatric Association 1952, 1968, 1980, 1994). “This multiplicity of classifications” writes Rose (2007) “provides a key marketing opportunity, as companies seek to diversify their products and niche-market them, either by making minor modifications to produce new molecules, or by licensing their existing drugs as specifics for particular DSM-IV diagnostic categories”(149). The next installment, the DSM V, will be the fifth book in 60 years and is scheduled for publication in 2013. A first draft was released for public comment in early 2010, an occurrence that reignited discussion surrounding the questionable nature of PMDD as a mental disorder (On the Media 2010). All of the elements leading to the diagnoses that end up in the DSM V need to be examined critically especially given that, as an artifact, the DSM is used by doctors to determine what is normal and what is pathological behavior (ibid.). It is interesting to note that in mid-2003 the agency responsible for pharmaceutical regulation in Europe, the European Agency for the Evaluation of Medicinal Products, put a stop to the promotion of PMDD as a disorder and Prozac/Sarafem as the cure (Women’s Health Watch 2005). Questioning the legitimacy of the disorder's existence, the agency argued: “there was considerable concern that women with less severe premenstrual symptoms might erroneously receive a diagnosis of PMDD resulting in widespread inappropriate short and long-term use of fluoxetine [Prozac]” (ibid.). This is

true, and this is exactly what is happening in the US, where something once more innocuously known as PMS has been relabeled and marketed as a much more sinister psychiatric condition. With its inclusion in the DSM V, the diagnosis stands to become even more prevalent, and regarded as a medical fact.

Numerous feminist scholars (Caplan 2004; Martin 2000; Showalter 1997; Rodin 1992) have devoted entire careers to studying the construction of PMS and PMDD, exploring their roots in hysterical epidemics in the past, and considering the implications for new generations of women facing the continued medicalization of their bodies and behavior. Less common is scholarship devoted to viewing the construction of such illnesses in light of the current consumer culture that medicine is quickly becoming in the US. Sociologists Clive Seale (1994; 2003) and Nikolas Rose (2004; 2006; 2010) have written extensively about the effect representations of health in the media have on our sense of ourselves, with Rose delving deeper into the consequences of the increasing comfort individuals have in using psycho pharmaceuticals as a psychic cure-all. In fusing the current literature in these fields together, I seek to explore a new way of thinking about not just PMDD, but the wider issues of increasing medicalization and shifting perceptions of what constitutes ill health among women, based on information they internalize via popular media.

I begin with a chapter outlining the conceptual frameworks that informed my research, namely theories surrounding the social construction of illness and modes of information sharing as proposed through cybernetic theory. In Chapter Two, I explore the role popular media such as books and DTC advertising of psycho pharmaceuticals plays in shifting conceptions of selfhood, causing women to question what is normal versus abnormal behavior. Chapter Three examines the place new media, in the form of online illness

communities, has in creating and solidifying illness identities in women identifying with PMDD. What I hope to show is that it is the prevalence of health information available through the media which has created the ideal cultural conditions allowing for the existence and perpetuation of PMDD as a transient mental illness.

Methods

The primary methodological approach used in this project was a theoretical literature review, combined with qualitative content analysis of advertisements, blogs and online support groups devoted to women with PMDD. Additionally, semi-structured interviews were conducted with two individuals, and email based interviews conducted with two others. It had been the intention to interview more people, but a combination of factors, including the more theoretical course the project ended up following, and a lack of responses from possible informants led to the smaller sample. As a result, I view this project as something of a prototype, laying the groundwork for related future research in this area. If I were to pursue this research going forward, more time would be devoted to establishing contacts early on. In the case of this project, I wanted to make sure I had a firm grasp of both the nature of the disorder, as well as the theoretical framework in which I was basing my research, before contacting anyone. As a result, late responses, combined with the very limited timeframe, made for a smaller group than intended.

Semi structured interviews were conducted with two women via Skype. The first, Informant 1, is a 34 year-old divorced mother of two residing just outside of London. She is also the creator of a blog devoted to PMDD, not mentioned in this dissertation for reasons of confidentiality. The second, Informant 4, is a physician in family medicine at Boston Medical

Center in the US. I communicated with two other women via email for logistical reasons related to their availability and time differences between the US and the UK. Informant 2 is a married 34 year-old woman with two children, and Informant 3 is married, and in her late-20's. Both are currently living in the US. All of the women interviewed have been suffering with PMDD for at least five years.

The interviews relied on open-ended questions related to the women's own experiences with the PMDD and the support communities they became a part of. They were asked how they first heard about the diagnosis and how they felt on receiving it. Additionally, questions were asked about their experiences gathering and sharing information related to the disorder, the level of support among their family members and physicians, and where else they sought support. There was also an open-ended question asking them to expand in any way on their experience with PMDD. In the correspondence conducted via email, I posed the questions in an initial email, and the women responded with in depth answers. I was able to follow up with any questions or clarifications if needed. The physician interview via Skype was equally as open ended, with additional questions related to the physician's opinion of the direct to consumer marketing of anti-depressants, and the impact that had on her interaction with patients. She was also asked about her experiences specifically treating women with PMDD. Analysis was informed by the content of narratives provided by the women interviewed, pulling out relevant, re-emergent themes and comparing those with what was presented in the literature, as well as within online communities of others with PMDD.

In reviewing the literature, I looked at a combination of sources, including sociological texts devoted to ideas of the social construction of illness and anthropological notions of selfhood, as well as theories related to advertising, marketing and new media.

Advertisements were viewed on television in the US, on YouTube, and in print form from various magazines. Content analysis of the advertisements was used to explore how PMDD is presented in the media, and the way in which treatments are promoted. Close attention was paid to the representations of women in these ads, and the messages regarding normal and abnormal behavior that were being depicted.

There were countless blogs and online support groups that I came across during the course of doing the research. A few of those that ended up playing a larger part in the project included the Facebook groups “Life w/PMDD”, “PMDD Community” and “Living with PMDD”. Additionally, a website called “Experience Project” which has a section entitled “I Have PMDD” was fruitful in being able to read firsthand accounts of women’s own stories of suffering. Blogs such as “Living on a Prayer with PMDD” and “Meet My PMDD” were also used. The mediator of the group “Life w/ PMDD” was helpful in connecting me with women who would be willing to speak with me. All three of the women I was in contact with were members of her Facebook group and made regular online postings about their experiences. The project received ethical approval from the UCL ethics committee.

Chapter 1:

The Social Construction of Illness: Medicalization, Cybernetics and the Manufacturing of a Modern Disorder

Introduction

Where does one's sense of self and identity come from? For psychologists the view might be more of an essentialist vision of human nature, emanating from somewhere deep in the unconscious. In constructing the self, Giddens (1991) writes that modern culture makes available to individuals a great many options and resources, "which might be understood as cultural scripts, or discourses, and modern self identity is formed in a manner that is sometimes quite reflexive" (Seale 2003:514). In seeking to explore the role of mass media in the formation of medical knowledge among women, several things have stood out. The first came when I started paying more attention to the advertisements for antidepressants that are so ubiquitous on American television. It took moving to the UK to realize that a number of the "disorders" that had become a part of my own consciousness while in the US simply didn't exist here, or if they did, not to the same frenzied extent as they did back home.

In looking at the phenomenon of PMDD specifically it is clear that as a disorder which counts only women as its sufferers, it has roots in a long tradition of maladies. It is the way the disorder has been maintained in the medical discourse among women that is of particular interest. Citing Brown (1995), Barker (2010:150) writes of how disease begins with "social discovery" or "the ways in which people, organizations and institutions determine there is a disease or condition". Culture bound and transient illnesses such as PMDD advance the social constructionist claim that illness and disease are something beyond fixed physical realities; they are a phenomena shaped by social experiences, shared cultural traditions and shifting

frameworks of knowledge (ibid., 148). It is my interest in exploring such frameworks that has led me to ground this project in a social constructionist approach; incorporating the related concept of medicalization and the implications such widespread labeling of behaviors as disordered has on women's perceptions of their own physicality. Additionally, I found the theories of cybernetics as expanded upon in Jackie Orr's *Panic Diaries* (2006) an intriguing aspect of the idea of social construction, as the construction and experience of an illness is largely based on the sharing and dissemination of information.

Social Construction of Medical Knowledge

Much of our knowledge of the world is not an extraction of what 'is', but rather "a construction laid atop the world of experience" (Moerman 2002: 68). The social constructionist framework arises out of a diverse set of theories based in sociology, where the founding sociological thinkers, Karl Marx, Max Weber, and Emile Durkheim, each examined the relationship between the ideas or beliefs of a society and the social and material conditions of that society (Barker 2010: 147). Parsons (1951) expanded on this with his theoretical claims for the 'sick role'. Premised on conceptual distinction between biophysical nature of disease and the social experience of sickness, the 'sick role' describes illness as a medically sanctioned form of deviance, where specific rights and obligations are granted to a sick person to make sure that an episode of sickness doesn't disrupt social order and stability (ibid.,148).

The perception that something is wrong, and the guesses as to the cause are always experienced in a social context. The subjective experience of having a cluster of symptoms labeled as illness are shaped by cultural and moral values and influenced by beliefs about health and illness (Lorber 1997: 1). Illness refers to all the "experiential" aspects of bodily

disorder, which are shaped by “cultural factors governing perception, labeling, or explanation of the discomforting experience (Kleinman, Eisenberg and Good 1978: 252). I would argue that such cultural factors include various forms of media, which have achieved a certain power in shaping illness experience through our own increasing reliance on it as a source of medical knowledge. Popular media vehicles such as print and television advertisements, articles and books, and new media such as Internet support groups can be viewed as new foundations in the construction of illness.

Turner (1995:5) wrote that in order to understand the illness of a patient, it is necessary to locate the patient in a social, personal environment. Social constructionist theories argue that the way to comprehend the nature of illness is through examining the society in which the illness exists. Our current society is one in which the amount of information available to the lay public is unprecedented. Given that medical knowledge is produced by and reflective of the culture in which it is formed, it is important to examine various media outlets and the role they play as the main source of medical knowledge for an increasing number of people, and the implications this can have for the place of medical authority. As an example, most women with the diagnosis of PMDD arrive at it themselves, usually after having seen an advertisement with a checklist of possible symptoms, or happening upon an online group devoted to the disorder. Armed with this information, they arrive at their doctor’s office and present their diagnosis, certain that what they’ve seen or read is so in line with their own experience, that there is no doubt this is what they have.

I first found out about PMDD when I began researching mood disorders online. I think one of the sites I first found was on Facebook, called ‘Life With PMDD’. I also ordered the book *The PMDD Phenomenon* and read that from cover to cover. I had no doubt in my mind it’s what I had, so I photocopied out the mood chart in the book and filled it in for three months. I had told my doctor about the disorder and left him some

reading material I'd printed off the web. I went back to see him with the charts and he agreed it was PMDD.

(Informant 1)

As a conceptual framework, social construction “emphasizes the cultural and historical aspects of phenomena widely thought to be exclusively natural, as well as how individuals and groups contribute to producing perceived social reality and knowledge” (Conrad and Barker 2010: 67). In the example above, Informant 1 is actively engaging in the production of her own social reality, and by involving her doctor in the validation of the disorder she discovered through a book and online resources, spreading knowledge about PMDD specifically, and illustrating that no matter how contested or controversial, there is a demand for such an illness to exist.

The assertion that the experience of illness is socially constructed is “grounded in the strong pragmatist underpinnings of symbolic interactionism and phenomenology, which suggest that reality does not just exist out there in the world waiting to be discovered, but rather is created by individuals who act in and toward their world” (Conrad and Barker 2010: 71). Individuals take on the identity of their illness and endow it with meaning. In the case of PMDD, it becomes almost like a membership in an exclusive sisterhood.

Social constructions are not fixed events, rather products of historical incidents, social forces and ideology (Hacking 1999: 2). The way in which illnesses are described and categorized at a particular point in history is of particular interest when looking at the current cultural context that allows a contested disorder such as PMDD to thrive. Hacking (ibid.,104) is interested in how we are affected by the ways in which social constructs are conceived, described and ordained by ourselves and the network of social environments in which we live. He notes that “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”. Advertisements in particular present new ways of classifying oneself, providing a familiarity with symptoms an individual may be feeling, describing a specific condition and providing a name, and assuring them that thousands of others, just like them, have the same problem and are seeking treatment.

Disease categories are highly contingent: each reflects the medical and social attitude of a particular epoch. At the time a particular taxonomy is in use, it seems somewhat inevitable, a perfectly natural way to classify someone with a particular collection of symptoms (Hacking 1992: 111). PMDD was brought a step closer to becoming an official entity in the 1987 revision of the American Psychiatric Association’s *Diagnostic and Statistical Manual for Mental Disorders (DSM-III-R)*. The syndrome was variously referred to as ‘Premenstrual Dysphoric Disorder’ and ‘Periluteal Phase Dysphoric Disorder’ (PPDD), before the responsible committee decided on ‘Late Luteal Phase Dysphoric Disorder’. In the most recent edition of The DSM (DSM-IV 1994), the label reverted back to PMDD. It should be noted that ‘Periluteal Phase Dysphoric Disorder’ “greatly expanded the scope of the diagnostic category; a problem that frequently crops up in psychiatric diagnosis. PMDD was originally intended to cover women who experienced severe mental and behavioral symptoms during a particular phase of the menstrual cycle. But the adjective "periluteal" would permit a psychiatric diagnosis to be made in the case of a woman who experienced particular symptoms at *any* phase of her cycle” (Kihlstrom 2000). Disease categories are not neutral discoveries of facts, but are symbols of successful ‘lobbying’ by their advocates to get the categories accepted and used by doctors (Seale and Pattinson 1994: 103). The advent of DTC

advertising, the emergence of literature specifically devoted to particular disorders and its own category in the *DSM* have all contributed to PMDD settling into contemporary discourse surrounding women's health. The search for treatment and the rendering of PMDD as a medical "fact" does not resolve the larger question of why the subtle or marked physical and emotional changes that accompany menstrual cycles are considered abnormal and not part of normal variations in the rhythm of days, weeks, months and years (Lorber 1997: 67). Individuals seek a label for a vague sense of something feeling "not quite right", and new definitions of what constitutes normal abound, tapping into an increased desire on the part of the lay public to be "fixed". It is as though we have developed a "cultural impatience with discomfort" (Barker 2010: 155).

The Process of Medicalization

Social constructionism is a potent analytical tool in explaining what Barker (2010: 147) calls "a key cultural and historical trend of our time": medicalization. Lay practices, knowledge and the consumer demands they engender are increasingly crucial in advancing medicalization in the twenty-first century. "In societies geared towards open-ended enrichment," writes Illich (2002 [1976]: 73) "people come to believe that in health care, technology can be used to change the human condition according to almost any design." Related to the idea of social construction, and equally as relevant when looking at the different ways people acquire and disseminate medical knowledge, is the concept of medicalization. While some would argue that the expansion of medical knowledge into ever more areas of social life represents some sort of progress (Seale and Pattinson 1994: 109), there are important consequences that need to be highlighted. By defining disease as a

biological disruption residing with an individual human body, the social forces that influence our health and well-being are obscured. As patient consumers, Barker (2010: 152) writes of how “we are increasingly active participants in the medicalization of our experiences as we earnestly seek to resolve and legitimate our suffering.” In viewing the modern tendency to pathologize normal aspects of human behavior through a social constructionist perspective, we are able to make sense of how our problems and complaints come to be defined and treated as medical conditions.

The issue of medicalization warrants increased attention, especially as there appears to be no end in sight to the amount of direct to consumer advertisements plastering television screens in the US, making us aware of new ways things can go wrong. ‘Caffeine Withdrawal’ has now entered the *DSM-IV-TR* (APA 2000: 764) and there are currently medications available to correct “conditions” such as Restless Legs Syndrome, Social Anxiety Disease (currently known as SAD, previously known as being shy) and Shift Work Disorder, for those who find they get tired when forced to stay awake all night. Nowadays we are:

besieged by mental illnesses and wonder which ones are affectations, cultural artifacts, clinician-enhanced, or copycat syndromes...we are confused by this new crop of disorders: symptoms are both nurtured and natural, moral and neurological. Is PMS a disorder or something that a predominantly male profession of psychiatrists has written into their nosology to deal with irritable and irritating female patients? An artifact of psychiatry demanded by culture to medicalize annoyances (Hacking 1998: 8).

Enabled by diagnostic categories, medicalization is the process by which aspects of human existence are assigned to the realm of medicine, to be defined and managed by medicine’s authority (Jutel 2011: 9) and occurs when a social situation or personal experience is made into a medical problem that requires the attention of medical experts (Offman and Kleinplatz

2004: 2). The demand for, or proposal of, a diagnosis may be the first step in casting life's experiences as medical in nature (Jutel 2011: 97).

Although it is located in the body, illness as a social experience goes far beyond physiology. Because illness is socially constructed, physicians and patients may see the same set of symptoms entirely differently. Barker (2010:151) examines how feminist scholars, through drawing on social constructionist tenets, "have demonstrated how women's bodies and experiences have been particularly susceptible to medicalization, one reason being medicine's conceptualization of male physiology as normative." With conditions such as PMDD, the process of interpretation and definition of the situation creates a disorder where none may actually be present (Lorber 1997:10). But what needs to be considered is the fact that while PMDD may not exist in many physicians mind as a disorder, a label for something less stigmatizing than depression is eagerly sought out by many women with a vague and undefined sense that something is wrong. If symptoms are not visible, the physician may infer a psychological cause, which the patient may or may not accept (ibid., 4-5).

A lot of patients are very resistant to me saying 'oh you know that neck pain you've been having? I think you're really just depressed' because you can't say that to someone... it's like saying 'I don't really care about the physical pain that you're having' and then they stop communicating with you. So it's been really helpful for doctors to be able to say 'oh sure, you've got this syndrome that we've got a name for' and in the back of my head I'm thinking it's really depression anyway, but we can call it something else if you want, and we can give you this drug that's for your condition, and particularly the one for PMDD- it has a flower on it and everything, and I think that makes people feel better.

(Informant 4, Physician)

Then you have patients wanting a diagnosis more suited to their ideas about what may be wrong, not content to live with a label that may prove to be stigmatizing.

I was around 26 when I went in for PMDD, and for 10 years, had been assessed and told I was depressed. I had gone through a lot of emotional trauma in my life, and I definitely was very depressed at times, but I knew there was more to it. The extremes of feeling and behavior meant that I was no longer happy with being diagnosed and fobbed off as being depressed.

(Informant 1)

In rooting the diagnosis in something supposedly biological, it becomes less stigmatizing, less about a woman's "crazy personality" and more about the particulars of an illness. When asked how they responded to receiving the diagnosis of PMDD, Informant 2 responded by saying "Actually, I was relieved I wasn't crazy! It was like a weight off my shoulders to know that I wasn't crazy and there was actually something I could do about it". Another woman mentioned how upon receiving her diagnosis:

I was happy I could finally start telling people that I was ill and not a bad person. It was truly sad when people close to me realized that I had been ill all these years, rather than being a person who's difficult to live with...that it was because of a condition rather than being "that way".

(Informant 3)

Rosenberg (2006: 407) writes that "disease boundaries are ever-shifting, as they negotiate where and how deviance becomes disease, feeling becomes symptom, and the stigmatized become value free." Presently the boundaries are becoming increasingly biological, as what appears to be needed to make a disorder less stigmatizing is the knowledge that it is beyond an individual's conscious control.

The transformation of symptoms experienced individually at different points during a woman's childbearing years into medically recognized physiological and psychological syndromes clearly illustrates the social construction of illness (Lorber 1997:11). While women's natural reproductive functions are routinely medicalized, women have themselves been proactive in the process, perhaps, as Barker (2010: 151) suggests, "because it represents

one of the few avenues afforded them to pursue their needs and gain access to resources in a society characterized by gender inequality.” Given that those who suffer, as well as their advocates, push for contested illnesses to be medically recognized and legitimated, such illnesses are examples of conditions for which individual patients and patient groups demand medicalization.

There is evidence that it is the demands of patient-consumers, rather than the professional agendas of physicians that “increasingly underlie medicine’s jurisdictional expansion” (Barker 2010: 154). It is an example of a dual burden of consumer longing and disease classification (Jutel 2011:109). The relation between scientific and social beliefs is strengthened when discoveries about norms and disorders become news stories and are incorporated into common sense beliefs about the world and a person's own relationship to psychological norms (Offman and Kleinplatz 2004).

Engines of medicalization have expanded beyond medical professionals, social movements, and organizations into biotechnology, consumers, and the insurance industry. There is increasing evidence that commercial aspects of medicine, especially the pharmaceutical industry are becoming ever more important in the shaping and dissemination of medical knowledge to promote their products (Conrad and Barker 2010: 74), something which is largely done via DTC advertisements. The most widely prescribed of the new generation of psychiatric drugs advertised treat conditions “whose borders are fuzzy, whose coherence and very existence as illness or disorders are matters of dispute, and are not so much intended to ‘cure’ a specific transformation from a normal to a pathological state as to modify the ways in which vicissitudes in the life of the recipient are experienced, lived and understood” (Rose, 2007: 182). Moerman (2002:70) writes: “the modern triumph of a

universalist biology tends to blind us to the dramatic variation in the ways that people experience their own physiology based on who they are and what they know.”

Cybernetic theory of information:

How do ordinary people respond to media messages about illness and disease? How do they use and respond to health information in books and magazines, on television or the Internet? The relationship between scientific and social beliefs is strengthened when discoveries about what is normal versus what is disordered become news stories and are incorporated into common sense beliefs about the world and a person’s own relationship to psychological norms (Offman and Kleinplatz 2004). In this way, popular media “contributes to social circumstances which leads first to the identification of a particular condition as problematic, and second to its embodiment within a diagnostic framework” (Jutel 2011:114).

The assumption is that information is wanted for making a decision, for selecting one choice among a variety of possible options (Orr 2006: 105), but information is also required to assign meaning to experience. In a conversation, Napier (2011a) observed that meaning is manufactured socially, gathering momentum on its own and self-replicating. Nowhere is this more evident than in the world of illness communities online, where the “distinctions between producers and consumers of media are not always easy to sustain” (Seale 2003: 516). The concept of a feedback loop, in which certain audience members, or consumers of information, are also involved in its production, provides a pertinent analogy (ibid.).

The notion of the feedback loop is at the heart of the theory of cybernetics, a term borrowed from the world of engineering and applied to social science. According to the

theory, humans can occupy any of the three positions in the flow of information: source (input), channel (transmission), or destination (output), and behavior can be promoted through communication (Orr 2006: 105). A catalyst turns individuals into information seekers who, through the process of circulating information via a 'loop', recharge that initial catalyst. Napier (2011b) writes of how in cybernetics "the loop allows for the information to take on a life of its own, to grow exponentially in power, and to re-insert itself 'virally' into an information system". It is in this respect that DTC advertising and online illness support communities are powerful tools used to 'educate' people about specific disorders. Once the existence of a particular set of symptoms is given a name and peddled to the lay public, manifestations of the illness take on a life of their own, steered by a public seeking concrete answers for vague discomforts.

In looking at the construction of illness, the way information is shared is of central importance, especially when viewing the role the media has, given that its primary function is the spread of information. It is clear how theories related to the acquisition and circulation of information can contribute to understanding the continued prevalence of such a specific and gendered disorder as PMDD. Serlin (2010) writes of the expansion of the public sphere of health information (websites, blogs, and ads specifically) and how they all have democratized and transformed the public health directive, which has traditionally been an expert-driven, unidirectional system of communication. The advent of new media outlets such as blogs devoted to specific conditions, and accompanying support groups and message boards can be viewed as cybernetic theory in action.

In studies of the Internet, the blurring of the boundary between audience and producer is particularly evident. The discussion of health matters and promotion of certain health

related messages is within the reach of many people, no longer confined to specialist occupational groups or media producers (Seale 2003:516). Lay people create and join illness-based social movements, generate lay knowledge about their own medical conditions, and forge new communities based on illness identities, reformulating their sense of self in the process (Conrad and Barker 2010: 72). With the expansion of the Internet, laypeople are becoming more actively involved in producing and consuming knowledge about their own health conditions: they are also increasingly likely to create and embrace new illness identities (ibid.). The science of cybernetics, summarizes Norbert Weiner, a mathematician and one of the members of the founding group of cyberneticians, is the study of messages, particularly the “effective messages of control,” where control operates as “the sending of messages which effectively change the behavior of the recipient” (Orr 2006: 110). Direct to consumer advertisements, books, health information websites and online support groups are all well positioned to communicate such messages, shaping the way individuals construct their own ideas about what constitutes ill health, and extending the lifespan of diagnoses including PMDD, which otherwise might have faded into obscurity.

Chapter 2:

The Role of Popular Media in Shaping Medical Knowledge

Introduction

An anonymous woman tries to disentangle a shopping cart from an interlocked row of them, outside a suburban store. She is frustrated and angry. She becomes even more exasperated when another shopper enters the frame, calmly unhooks a cart and glides smoothly on her way. Watching this TV advertisement unfold, it might look like the woman is experiencing little more than a normal bout of tension or stress. But the folks at the drug company Lilly know better. This woman may need a powerful antidepressant because she is suffering from a severe form of mental illness known as Pre Menstrual Dysphoric Disorder. “Think it’s PMS? It could be PMDD,” intones the voiceover.

Moynihan and Cassels (2005).

The direct to consumer advertising of pharmaceuticals was legalized in the U.S. in 1997 based on the outcome of a Food and Drug Administration ruling. As a result, a new genre of health education was born, leading promptly to a barrage of print, radio, Internet, television and radio advertisements that “circumvent the traditional authority of the prescribing physician by appealing directly to consumers’ health concerns” (Ostherr 2010: 77). As the pharmaceutical industry has seen sales of medications, and in particular antidepressants, increase exponentially as a result of advertising, more money has been devoted to their production. As a result, the level of sophistication in the structure of the ads has increased accordingly, with each one presenting a miniature narrative, outlining in one minute the myriad ways the viewer might not be living up to their physical or emotional potential, or highlighting medication as a means to “fix” a problem that, up until that moment, had no name.

The suffering of those who are diagnosed as having PMDD is very real. That is not the issue. What is of interest to me is how a woman suffering might view an advertisement, read a book, or visit a website, and see herself in it, and how once planted, that seed of knowledge about a new condition shapes her interpretation of what is wrong and, ultimately her help-seeking behavior. In looking for women to interview for this project, one of the first places I looked was a support group on Facebook called ‘Life w/ PMDD’. The moderator of the group, a woman named Stef, became helpful in terms of connecting me with women willing to share their stories. She mentioned she herself had been interviewed about PMDD before, and not long after we were in touch, I happened to come across a transcript of an interview she had done with the National Public Radio program *On the Media*. The theme of the segment was on the art of the diagnosis in light of the forthcoming publication of the DSM-V, and how there are many diagnoses set to be included that remain controversial. Stef’s interview is indicative of the power media vehicles such as advertising can have on women and their idea of what constitutes disordered behavior:

Stef: When the Sarafem commercials came out was when I got, you know, the ah-ha.

Host: Stef was being treated for depression, even though she rejected that diagnosis and felt stigmatized by it. When she saw the Sarafem ad depicting her rages and her guilt, she finally felt she had a real diagnosis and was deeply relieved and grateful.

Stef: And immediately I called my doctor and said, this is what I have, I want depression [LAUGHS] taken off the record.

Host: Like so much in the DSM, the diagnosis of PMDD is a judgment call but Stef, who blogs about PMDD, has no trouble passing judgment on whether it should be in the DSM.

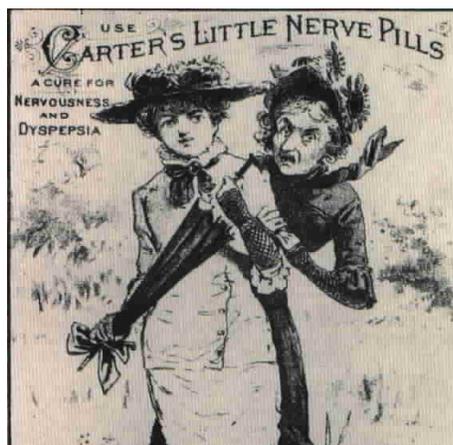
Stef: My answer is yes. Trying to go to work every day and getting the energy to do it, it does, it affects you every single day. And to me, that is a disorder.

(On the Media 2010)

For Stef, the advertisements for Sarafem presented an alternative label for the way she was feeling. While her symptoms were synonymous enough with depression for it to have been diagnosed, the possibility of a disorder with a less stigmatizing background, one that was exclusively “for the ladies” no less, was appealing enough to inform her doctor.

Throughout history, information about health and behavior has been communicated to a lay audience in various ways. But it is popular media that has had the most impact in the creation of new illness categories and the widening culture of medicalization that we in the US and UK currently find ourselves in. Presenting information is one thing, but when it is tied up in pharmaceuticals that can actually alter brain chemistry, and by extension, people’s sense of themselves, the implications are far more severe. This chapter begins by exploring the role early forms of media played in communicating information about health, and moves on to the current issues around the direct to consumer advertising of phycho pharmaceuticals, both on television, and through interactive websites online.

Early Uses of Media in Promoting Ideas About Illness



(Fig.1- 19th century, trade card. Bella C. Landauer Collection of Business and Advertising Art, The New York Historical Society)

PMDD continues to exist as an illness because it offers a less stigmatizing label for a collection of symptoms that, in earlier eras might have earned the patient a diagnosis of hysteria or depression. The media has played a key role in the incorporation of PMDD into current medical discourse, and many scholars (Rodin 1992; Showalter 1997; Lorber 1997) view the disorder as an updated version of hysteria, modernized for the current scientifically based climate of biomedicine. In writing about the ways in which cultural narratives of hysteria “multiply rapidly and uncontrollably in the era of mass media”, Showalter (1997:5) notes how “infectious disease spreads by ecological change, modern technology, urbanization, jet travel and human interaction. Infectious epidemics of hysteria spread by stories circulated through self-help books, articles in newspapers and magazines, talk shows, and the Internet.”

The use of various forms of media in spreading ideas about illness is not a new phenomenon, as an Egyptian medical papyrus dating from around 1900 B.C. illustrates. One of the oldest surviving documents known to medical history, the artifact records a series of curious behavioral disturbances in adult women. As the ancient Egyptians interpreted it, the cause of these abnormalities was the movement of the uterus upward from its normal pelvic position” (Micale 1995:19). Centuries later, a treatise called *The Malleus Maleficarum* (“Hammer of the Witches”) was published in 1486. As a respected source of information, the treatise assumed a major role in disseminating new ideas about witchcraft, including making people more conscious of the “the crime” of witchcraft, and the symptoms to look out for. Having such information in print had the additional impact of making its reality more credible (Seale and Pattinson 1994: 82). Micale (1995:47) writes that the document was “a kind of textbook of medieval misogyny, as the book expounds on the many physical and mental

behaviors in women believed to indicate bewitchment and therefore to require punishment.” These are the same behaviors that, many years later, would be labeled hysterical by “modern, clinically oriented historians” (ibid.).

The power of printed media in the era before television lay in its ability to incorporate popular moral attitudes and beliefs into texts intended as entertainment, as in the case of early novels. As with forms of media that emerged later in history, consumers internalized these attitudes and messages, perhaps unconsciously shifting their sense of themselves accordingly. Micale (1995) speculates on the extent that novels of the 19th century weren't so much modeled by hysteria as much as they generated it (Hacking, 1998: 59). Representations of women in the literature of the 18th and 19th centuries, suggests Heath (1982), “both derived from and contributed to medical expectations, and may have influenced the way hysteria itself was manifested; essentially one had the hysteria one was expected to have” (Seale and Pattinson 1994:86). Given the overwhelming amount of medical information available today, the same dynamic is at play in the way women are able to, consciously or not, shape their own subjective experience of feeling ill with what is presented to them on television, in print, or online. By internalizing the list of symptoms required for a diagnosis of a disorder such as PMDD, women are, just like their historical counterparts, presenting with the PMDD they are expected to have. As history moves on, one taxonomy replaces another. Similar symptoms shape-shift and become new versions of the same illness. An influx of new diagnoses contributed to the doubting of the existence of hysteria that took place in the early 20th century (Micale 1995). Hysteria vanished into “a hundred places in medical text books”, with the miscellaneous symptoms characteristic of the disorder redistributed among a new set of illnesses (Hacking, 1998: 72).

The advent of the advertising industry introduced a new way of informing the public about these myriad new diagnostic labels, with the 1920's presenting "an impressive expansion of the successful application of national advertising to the promotion of a much wider range of products and causes. The notion gained credence that ads could influence public attitudes as well as sell products" (Marchand 1986: 5).

As pharmaceutical companies became aware of the power of utilizing creative outlets as a means to get their message across, there was an increase in unique approaches to marketing not just the medications, but marketing the illness as well. An example of this came in 1961, with the publishing of a book called *Recognizing the Depressed Patient*, by Frank Ayd. At around the same time as he wrote the book, Ayd, an American psychiatrist responsible for introducing the use of antipsychotics into clinical practice, undertook key clinical trials for Merck in which he filed the first patient use of the drug amitriptyline as an antidepressant (Rose 2007:176). Not coincidentally, Merck bought up fifty thousand copies of his book and distributed it worldwide.

Two years later in 1963, in keeping with its creative marketing streak, Merck paid the record company RCA to press and distribute a compilation of blues songs entitled appropriately, *Symposium in Blues*. Included in the sleeve of the album was an insert outlining prescribing information for their latest antidepressant (Greenberg, 2010: 23). As Rose (2007: 177) writes, "Merck not only sold amitriptyline, it sold a new idea of what depression was and how it could be diagnosed and treated. From this point on, it appeared that there was an untapped market for antidepressant drugs outside hospitals."

In keeping with this theme, *The Anxiety Disease*, published in 1981, was a best selling book about a woman who suffers from panic attacks and spells of floating terror. It's author,

Michael Sheehan, was a practicing psychiatrist at Massachusetts General Hospital and composed the novel based on clinical details of his own patients. The re-assembled, fictionalized narrative existed in the realm somewhere between a “medical monograph and a Harlequin romance” which sought to place the idea of anxiety and panic as distinct disorders into both lay and medical discourse (Orr 2006: 213). Over the course of *The Anxiety Disease*, the protagonist and panic sufferer, Maria, is steered by her concerned and helpful boyfriend to a doctor who ‘understands’ her illness, explains the biochemical basis of her disorder, and introduces her to the pharmaceutical medication specifically suited to her particular malaise: Xanax (ibid.. 214). Sheehan was conveniently working for Upjohn, the manufacturer of Xanax, at the time and despite the primary role he played in popularizing the drug as a cure for panic, he never actually came to believe in the existence of panic disorder (ibid., 215).

Knowing exactly who is behind medical information targeting the lay public is an important consideration when looking at the way people become informed about their health. Diana Dell’s book *The PMDD Phenomenon* (2003) is one source that has played a major part in the construction of popular conceptions of the disorder. Women, including one I spoke to, use the book as evidence, presenting information and charts from the book to their doctors in seeking to get the diagnosis. It is interesting to note then that Dr. Dell, the book’s author, served as a consultant both to Eli Lilly and Pfizer as they attempted to get FDA approval for treatment of PMDD with their respective products, Sarafem and Zoloft. She has also openly received grant support throughout her career from a number of sources, including Berlex, GlaxoSmithKline, and Pfizer (Dell 2002: xv). None of this is a secret. The information comes directly from her. But it is the kind of detail that gets lost amidst the barrage of other, more seemingly pertinent information women are looking for.

Selling Stories

We are bombarded by plot lines every day. Inevitably, “we live out the social stories of our time” (Showalter 1997: 6). Books continue to be a major player in the shaping of ideas related to health and illness, possessing the ability to impart a particular brand of medical knowledge. Informant 1 illustrated this in an earlier quote when she listed the book *PMDD Phenomenon* as a determining factor in self-diagnosing. Television advertisements are yet another ubiquitous way that individuals are able to acquire information about illnesses they may not even know existed. Through similar narratives of symptoms, patients learn about the disease from the media, unconsciously develop the symptoms and then attract media attention in an endless cycle (Showalter 1997). As with the earlier examples of books and albums, new information about emerging illnesses depicted in such ads continues to be driven by the pharmaceutical industry that stands to profit by providing their cures. But first they must sell a story.

The early decades of the twentieth century found people with a sense of the quickening tempo of daily life, and with that, new fears arose about the ability to keep pace with such a new array of technological changes. As Roland Marchand (1986:12) explained, “a crumbling faith in communal, ethical, or religious frameworks of meaning had cut many Americans adrift from a secure sense of selfhood.” As a result, an increasing number of Americans pursued their search for a secure identity and self-realization by “seeking clues and advice in those sources most conveniently and ubiquitously available: the mass media” (ibid.,13). Advertisements, according to media theorist Judith Williamson, do not really sell products, or at least not only products: “In providing us with a structure in which we and those goods are interchangeable, they are selling us ourselves. We feel a need to belong, to

have a social place; it can be hard to find” (Williamson 1978: 13). Individual commercials draw meaning from the larger web of collective understanding. But rather than simply reflecting culture, these advertisements also work to shape it by “suggesting new connections between existing ideas and reinforcing particular viewpoints” (Scott 2007: 269). An ad for Midol in the 1970’s (fig.2) is an example of this type of reinforcement.



(Fig. 2- Midol ad from 1974. See jezebel.com)

By encouraging women to view themselves as unpleasant to be around once a month, and using the image of an ideal boyfriend as a reason to take Midol in order to stop being so difficult, the ad is not only reinforcing the stereotype of women being out of control while on their period, but also suggesting that if she doesn't take the drug, she will end up angry and alone.

When confronted with such claims however, marketers deny having the ability to create the necessary social conditions that would result in their own profits. According to their view, advertising isn't capable of "forcing culture in new directions". Instead, those on the marketing side claim it works with and reproduces what is already available, responding to and reflecting broader changes that don't come from the television commercials themselves, but rather the consumers they are targeting (ibid. 270), with 'consumer' being the operative term here.

Direct to Consumer Advertising of Psycho pharmaceuticals

The advertisements for antidepressants shown on American television all seem to begin the same way: A woman, and it is almost always women depicted, stares vacantly out of a rain soaked window. At some point a few seconds later, we will see another woman slumped on a sofa, or staring at a wall in a dark room, while in the background a blurred outline of her small children is visible. While viewing the images, we hear a voiceover, as in the case of an ad for Paxil, first of a woman saying "It's like I can't participate in life", followed by a more official, serious sounding voice who asks us "you know you can feel depression emotionally, but did you know you can feel it physically?" The ad will go on to define the illness being promoted (depression and Social Anxiety Disorder (SAD) are quite prevalent), and proceeds

to mention how “10 million Americans suffer. Do you?” We are told a chemical imbalance may be to blame, and Paxil offers new hope, as the only medication proven affective for depression or SAD. The closing scenes involved a woman looking out a window on a sunny day, engaging with her family, smiling at the office, all the while, a soothing voiceover covers the list of often extreme side effects (a few of which include: anxiety, blurred vision, constipation, decreased sexual desire or ability, bizarre behavior, black or bloody stools, suicidal thoughts or attempts, vision changes; worsening of depression) before encouraging viewers to “ask your doctor about Paxil. Your life is waiting.”

While the Paxil ads define the condition they’re intended for, ads for a newer version of Prozac, Prozac Weekly, don’t specify any condition at all. The brief ad begins, surprisingly, with a woman looking out a window while her voiceover intones, “when I start each morning”. The screen then goes to a bright orange background with the image of a pill and the words “Prozac Weekly is here” superimposed. Next up is the image of a woman jumping through a sprinkler with her children while the voice tells us “when my kids need a playmate”, again, “Prozac Weekly is here”. Finally, a woman receives a kiss from an older relative while she tells us “when I’m celebrating with family” Prozac Weekly is there. “Ask your doctor if it’s right for you”. That’s it. No medical condition is highlighted, no side effects, just the words and images suggesting that Prozac is now an acceptable lifestyle drug, available to help women get through those moments when they really need to be their optimal “self”. Through advertisements, “well-being is re cast as a commodity and as a distinct personal achievement” (Petryna and Kleinman 2007: 3).

In his book *Inventing ourselves: Psychology, Power and Personhood*, Nikolas Rose examines the role the ‘psy’ disciplines (psychology, psychiatry, psychoanalysis and

psychotherapy) as well as other ‘specialists’ (lawyers, economists, accountants, sociologists, anthropologists, and political scientists) have played in shaping the way human beings have come to experience themselves (1996:13). The pharmaceutical industry could be easily added to this list, as it has become the force behind the practice of these advertisements. In terms of how such ads effect the way people come to experience themselves, Hirschman and Thompson (1997: 44) write about the way in which “mass media vehicles sort reality into meaningful social categories that provide a frame of reference from which consumers interpret their daily lives, themes that continually reproduce a particular cultural system of beliefs or ideology.” Knowledge is continually transformed into certain fact while meanings are structured into recognizable images and conceptions. The resulting collective social knowledge and beliefs can then be invoked to encourage certain behaviors (Montagne 2001: 1269-1270), something for which direct-to-consumer ads are a useful vehicle. Through the routine viewing of DTC advertisements, individuals are repeatedly exposed to an ideology in which ideas of what is normal and pathological are redefined, and individual perceptions of selfhood as it relates to mental health and well being is reshaped.

Normal Versus Pathological

Social definitions of ‘normal’ and ‘abnormal’ are based on shared beliefs within a cultural group as to what constitutes the ideal, ‘proper’ way for individuals to conduct their lives in relation to one other, or how to behave in a culturally accepted manner (Helman, 1990:215). Van der Geest (2006), citing a paper by Healy, looks at the ways in which the pharmaceutical industry structures expert and popular understanding of disease, and mental illness in particular, knowing that it needs to sell the disease before it can sell the drugs (309).

As an example, GlaxoSmithKline's confidential plan to 'shape' medical opinion related to irritable bowel syndrome (IBS) was leaked from a medical communications company. It was revealed that the corporate backed plan, classified under 'medical education' as opposed to marketing, was designed to create a new perception of IBS as a "credible, common and concrete disease". According to the document, GlaxoSmithKline wanted to ensure that "IBS is established in the minds of doctors as a significant and discrete disease state. Patients also need to be convinced that IBS is a common and recognized medical disorder" (Moynihan et al. 2002: 887). Once notions such as these take hold, it becomes more difficult to question whether or not mental states such as sorrow or hopelessness are the signs of pervasive disease until (the idea, not the disease) has taken up residence in nearly all of us (Greenberg 2010: 18).

In examining the relation between culture and mental illness, labels such as 'normal' and 'pathological' may contribute to the etiology of certain illnesses, influence the clinical presentation and distribution of mental illness and determine the ways that mental illness is recognized, labeled, explained, and treated by other members of that society (Helman 1990: 215). How do social factors influence the construction of personal and societal knowledge about what constitutes a mental illness? The images and messages communicated in DTC ads could be viewed as contributing to the construction of such ideas, influencing clinical presentation, as well as the ways mental illness is recognized and treated. As Littlewood (2002) writes, "if psychologies are regarded not as value free descriptions of how people actually function so much as part of western societies' definition of the person and of moral agency...the emotions which are recognized and classified may be less an account for how people feel than what society believes they should feel" (148).

In U.S popular culture, cognitive and emotional states that feature “tumultuous and continuous transformations” are undergoing a dramatic change in valence (Martin, 2000:578). For example, the many accounts of manic depression flooding popular culture are in the process of redefining manic depression from being a disability to being a strength (ibid.). On the one hand the reduction of stigma surrounding mental illness can be viewed as a positive development, but what might the consequences be of releasing into the world so many normalized representations of mental disorder? Those who don’t suffer may find themselves questioning their own subjective definition of what is normal, encouraged through messages communicated via the advertising to look a little deeper into their own reality and discover what might not be so normal after all. In viewing ads such as those for PMDD, women are provided with a new framework in which to understand their symptoms, symptoms which many physicians view as being somatic manifestations of depression. The problem lies in the ongoing stigma surrounding depression, or anything that might even suggest mental illness, among many women. What the ads suggest instead is a biological, physical alternative explanation for what feels wrong. What they neglect to mention is that medication being presented, Sarafem, is an antidepressant; Prozac turned pink.

It is interesting to note the way in which these ads mention the small percentage of women who supposedly suffer from the disorder, 3-5 percent according to the American Psychiatric Society (200:772), as opposed to ads for others antidepressants and anti-anxiety medications that seek to increase prevalence rates in an effort to convince people to seek help. It suggests something more exclusive, which many women latch on to in lieu of a diagnosis of depression. PMDD is something just for them, and once the diagnosis is arrived at, a whole support network can be found in which women comfort and advise one another, expressing

relief at not being alone, at finally being heard and understood. But in order to reach this point, women need a narrative they can identify with, that vaguely outlines how such a disorder might affect them.

Manufacturing Illness

Individuals are now relying on Madison Avenue as a provider of health information, learning for the first time about conditions they never worried about before and ask physicians for new medicines by brand name because they saw it on television (Kessler and Levy 2007: 4).

It's very interesting to me how much people trust what they see on TV more than what I tell them, that's always a big frustration. ...But if someone is going to feel better taking a drug from a box with a flower on it labeled Sarafem instead of Prozac with its images of people with depression, then that's what's important.

(Informant 4, Physician)

Psychotropic drug use is embedded in a matrix of social values and expectations. The drug can be used to improve social relationships, by bringing one's behaviors and emotions into conformity with an idealized model of 'normal' behavior (Helman 1990:178).

It wasn't until I went on the medicine (Sarafem/Prozac) that my whole life changed. My personality transformed completely and so did the quality of my life. I was my NORMAL self, the one I was meant to be all these years. It was sad though, when my Parents said they didn't realize I had this (PMDD), and they had thought it was just me all these years.

(Informant 2)

The idea of depression, and its associated images, may not be "normal" for a woman suffering from similar emotional and physical symptoms, but by cloaking the symptoms in a new name, with its supposed biologically based origins, and presenting medication in ads geared to her specifically, complete with its own medication and packaging, there will be more comfort in asking for treatment, which, of course, is the ultimate goal.

The direct to consumer advertisements for these medications are thus responsible for illustrating a set of values regarding what it means to be a well-functioning member of society and instilling expectation through the depiction of disordered behavior and fractured relationships. Inflated prevalence numbers related to a particular condition highlighted in the ads also play a role in shaping the way viewers consider themselves, reminding the viewer that they are not alone, that thousand of others are sexually lackluster/ awkward at parties/ lose their temper in traffic jams, and they are all doing something about it. These prevalence numbers are constructed and have consequences that divide us between categories, transform moral and political judgments into impersonal and technical data upon which they confer the moral authority of objectivity. They legitimate and extend diagnostic categories, creating “disorders without borders” (Rose 2006). The more frequently such messages are put out into the world, the more normalized the narrative becomes, and the harder it is to resist internalizing what is conveyed. In examining the meanings communicated in ads for Viagra, Asberg and Johnson note how they engage in “transmitting cultural scripts which serve as enforcers of normatively gendered expressions of sex and sexuality” According to the international Viagra script, “male sexuality is always active and desirous, the on-demand erected penis is central in its penetrative function” (2009:155). So whether it is the depiction of manhood as instant virility, or a woman engaged and satisfied with the day-to-day life of a housewife, the messages present in pharmaceutical advertising become integrated into our understanding of ourselves and our idealized roles, in everything from sexual practice to housekeeping.

Chemical Coping

“There’s always soma to calm your anger, to reconcile you to your enemies, to make you patient and long suffering. In the past you could only accomplish these things by making a great effort and after years of hard moral training. Now, you swallow two or three half-gramme tablets, and there you are.”

Huxley (1932/2006: 238)

Citing Nichter & Vuckovic (1994), Van der Geest writes that “medicines are vehicles of ideology, they change perceptions of health and construct illness identities, they mark social values and relations, and they are means of both empowerment and dependency and create consumer demand” (Van der Geest 2006: 308). The connection between medicine and the process of social transformation is highlighted, but couldn’t the same connection be made for the advertisements themselves, as the means of transforming the pill into a more concrete, emotionally identifiable narrative? Narratives play a powerful role in shaping individual identities in accordance with social and cultural norms (Samuel and Steffen 2004: 8). As condensed narratives, advertisements exist to send a message about a particular product, to create desire and demand. In depicting scenes of behavior considered abnormal, and even deviant, viewers are encouraged to recognize in themselves similar patterns which, up until considering the message communicated in the ad, had never occurred to them to be anything other than normal. The viewer is quickly reassured that, with the assistance of whichever drug is being advertised, they too can “feel themselves again”. But what seems to be getting overlooked in this search for a pharmacological answer to psychic discomfort is that fact that the medications involved can seriously alter brain functioning. It’s one thing for an individual who is clinically depressed, another for someone with a vague sense of dis-ease.

There are some depression ads that advertise meds that are essentially antipsychotics. And then there’s a woman in the ad saying “oh, I was too depressed to walk my dog, but now I take such and such, and I feel better”, and then the voice over starts in ‘may

cause extra pyramidal side effects, may cause death...and people are being encouraged to ask for this stuff.

(Informant 4, Physician)

The message that accompanies these medications perpetuates ideas about certain levels of accepted emotional stability to which one should aspire, and which the drug will aid in achieving. You can finally “get your life back”(Rose 2010:79). Messages about drugs have become part of who we are and how we live in the global market, with its enormous hold on the transnational and domestic cultural space created by television and other advertising media (Petryna and Kleinman 2007: 16).

In her paper examining ‘The Pharmaceutical Person’, Emily Martin (2006: 273) references a psychiatrist from an educational film on public television called *Drugs in our Culture* who asks the question ‘what kind of person would we be when...the only way we can cope with situations is through a chemical?’ Hellman (1990:139) examines the notion of ‘chemical coping’ as a “new normal”, with individuals increasingly in search of a stress-less, painless utopia as a modern way of life. The emphasis is on removing unwanted feelings and replacing them with feelings that are desired. Treatment is palliative, not curative or preventive. The solution is no longer to seek out those things in life that cause the problems and change them, but to change the person by correcting his or her brain chemistry (Stimson 1974:159). Nikolas Rose (2004) writes about this chemical reshaping of personhood in his paper ‘Becoming Neurochemical Selves’, discussing the shift that has taken place in the way people experience such variations in human emotion such as sadness, anxiety, or mood swings. It now comes down to a treatable chemical imbalance. Many welcome these pharmaceutical developments; no matter how much closer to Aldous Huxley’s *Brave New World* they may appear to bring us.

If 'chemical coping' becomes a more accepted way of existing in the world, then individuals will be conditioned to view themselves in light of this, and those who are not medicated will eventually be in the minority, considered abnormal. It does seem ironic that in a century where longevity in Western societies is on the rise, there is an unprecedented array of mental disorders that we may suffer from. As Nikolas Rose (2010: 79) writes, "now, a lifetime without mental disorder would be somewhat abnormal, abnormality has become normalized, simultaneously a condition to be treated and a mode of existence to be expected". If the assumption is correct that the individual's self image and his interpretation of his own experience cannot be divorced from the concept of the self that is characteristic of his society (Hallowell 1955: 76), then it stands to reason that a society ever more comfortable with the medicalization of certain behaviors, and the normalization of medicating such behaviors, will produce individuals whose own concepts of themselves as healthy or ill are directly shaped by information passed on to them by the likes of those who stand to profit from their disorder.

Ideas of Self-Fulfillment

Self-awareness exists as a cultural as well as social product. As Hallowell (1955: 81) notes, "the nature of the self as culturally defined becomes an integral part of the implicit assumptions that become the basis for the activities of the individual and the interpretation of his experience." Applying labels such as 'healthy' and 'ill' is relevant to an ever-increasing part of human existence (Stimson 1974:159). In exploring the messages put forth in advertisements for psychotropic drugs, Lenard (1971:18-19) explores how ads for such pharmaceuticals are "redefining and relabeling as medical problems, and calling for drug

intervention, a wide range of human behaviors which, in the past, have been viewed as falling within the bounds of the normal trials and tribulations of human existence.”

An individual’s sense of self is very much based on how they exist in and react to the world around them in a specific place and time. Citing feminist cultural scholar Graham Dawson, Asberg and Johnson (2009: 145) discuss the concept of the “cultural imaginary” which consists of “those vast networks of interlinking discursive themes, images, motifs, and narrative forms that are publicly available within a culture at any one time, and articulate its psychic and social dimensions”. It could be said that the advertisements themselves act as a sort of “cultural imaginary”, bringing together and communicating in an emotional way a particular set of values and ideals about normality that can’t help but become ingrained and embodied in those on the receiving end of their message, especially as the ads become more and more frequent and specific in the disorder they are targeting. Rose refers to the ads as:

Pedagogies of self-fulfillment disseminated through mass media, which translate the enigmatic desires and dissatisfactions of the individual into precise ways of inspecting ones self, accounting for ones self and working upon ones self in order to realize one’s potential, gain happiness and exercise one’s autonomy (1996: 17).

There is “much magic in the way pharmaceutical companies target individuals and their bodies, influence the course of therapeutic events, and manipulate collective needs and wants” (Petryna and Kleinman 2007:9) and it is just such a style of manipulation that has the power to shape ideas of what might constitute one’s optimal self.

Knowledge and Meaning

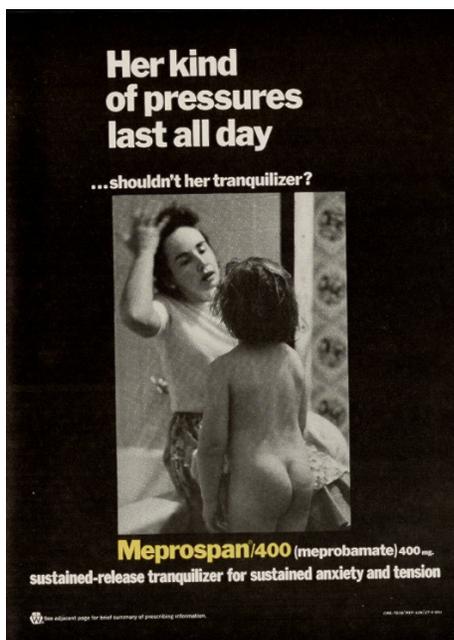
What cannot be overlooked is the influence of consumers’ background knowledge on the meanings they derive from advertisements. Montagne (2001) discusses the role of social

knowledge in individual perceptions about psychoactive drugs. Collective social knowledge, the cumulative knowing of something based on available information and past experiences, has become instrumental in the development and transmission of perceptions about prescription medications. The nature and meaning of drug taking is often described, remembered and transmitted through society in symbolic form, as images, representations, or metaphors (Montagne 2001: 1263). Advertisements for such pharmaceuticals are themselves made up of images, representations and metaphors, providing indications for how the behavior depicted in the ad should be perceived.

Central to this perspective is the realization that consumers often process advertisements for meaning rather than information (Hirschman and Thompson 1997:43). As individuals become more actively engaged in monitoring their own health, the prevalence of DTC ads act as a guide, suggesting conditions that may have been overlooked. Access to medical information invites a certain level of vulnerability on the part of the ‘consumer’, a vulnerability that those involved in the marketing of pharmaceuticals tap into via the tone of the advertisements, and a tone, which increasingly tends towards disease mongering.

Moynihan et al. (2002:886) quote the late medical writer Lynn Payer, who observed that disease mongers “gnaw away at our self confidence.” One group historically targeted in this particular way is women. An example put forth by Rose is that of gendered normality, a “continuous work of modulation of the self in relation to an ideal, desired form of life” (Rose 2010:80), something which is especially relevant in relation to the targeting of women in pharmaceutical ads. Women are prescribed psycho pharmaceuticals twice as often as men, with ads promoting drugs as the solution for women’s life stresses and role conflicts, as opposed to something such as alcohol, which tends to be the main “chemical comforter”

depicted for men (Helman 1990:139). Often in DTC ads, a woman's place in society is shown as one that "generates stress, anxiety and emotional problems". All types of women are depicted, though the harassed housewife, complete with cluttered house, nagging daughter, and pile of dirty dishes seems to be a favorite (*fig.3*). Less represented is the "tired, tearful housewife resentful of her role, subject to pressures virtually unknown to former generations". Gendered role problems are defined in medical terms, and descriptions of the drug always show the individual adapting to the situation with medical help, rather than by changing the situation itself (Stimson 1975:156).



(*Fig. 3- Vintage Meprospan ad. See Practiceofmadness.com*)

In constructing the self, Seale (citing Giddens 1991) writes that "modern culture makes available to individuals a number of cultural scripts, or discourses, and modern self identity is formed in a manner that is sometimes quite reflexive." Drawing on such culturally

available narratives and systems of knowledge, behavior can be formulated in large part from resources drawn from various mass media (Seale 2003: 514). These can include depictions of what it is like to be sick, what causes illness, health and cure (ibid.). Additionally, such scripts can present vague enough depictions of an illness that a viewer is able to take their own experience and successfully map it on to what is being depicted; relabeling themselves in light of how what they've seen on television or the Internet interacts with their own experience.

Nearly all pharmaceutical ads are based on emotional appeals, not facts, and few provide necessary details about the causes of a medical condition, risk factors or lifestyle changes that may be appropriate alternatives to pharmaceutical intervention (Kessler and Levy 2007: 4). Some who market such drugs bypass the fact that what is being sold is a treatment for a supposed mental illness, and instead try and remove all content relevant to the actual medication being sold. Instead the emphasis is on communicating a “feel”, rather than actual medical information. This has been especially apparent in the direct to consumer marketing of psycho pharmaceuticals on the Internet. While an individual may first hear about a possible condition from an ad, the next step nowadays is to go online and find out as much information as possible. Savvy to this behavior, Eli Lilly developed a web presence specifically devoted to Sarafem (*fig. 4*).



(Fig.4- Sarafem Website. See ginaoverstreet.com)

Moving Forward: Interactive Ads Online

As the new prescription medication was launching on the web, Lilly, wanted to “create a place where women who suffer from PMDD could connect with one another, and give them resources that would help promote a relaxing atmosphere and [allow them to] let off steam in a safe environment” (Overstreet 2009). The end result was a website for the drug that was broken down into several sections, including one devoted to “Support and Encouragement” (ibid.). Under that heading, visitors to the site could choose between ‘Soothing Sounds’ (which involved sound clips of ocean waves, crickets and cicadas, a babbling brook, and a “frog solo” among others), ‘Affirmations and Inspiration’ (in which the visitor could sign up to be sent daily affirmations via email), ‘Serene Scenes’ (calming images as your screen saver, no doubt incorporating the Lilly/Sarafem logo somewhere), and finally ‘Letting off Steam’, where viewers could actually play an interactive game called “Supermarket Rampage” (ibid.) (fig.5) .



(Fig. 5. Supermarket Rampage. See micahboswell.me/sarafem)

When marketing Sarafem for PMDD, Lilly decided to promote the brand via “a fun and cheeky game concept” (Boswell 2002). As a member of the design team that worked on the project commented; “we conceptualized, created and developed a campy homage to 80’s first

person shooters (style of video games) with a classy visual style that was edgy but harkened back to the 1950's for its illustrative simplicity and campiness”(Boswell, 2002). The result was “Supermarket Rampage”, where the viewer plays “Sara Femme”, a woman with wild red hair and bulging eyes that, with her jaw clenched and teeth bared, hurls rotting tomatoes at other shoppers who get in her way. Text accompanying the game asks the question:

Have you ever had one of those days where everything goes wrong? A day when you know you'd feel better if you could throw something and relieve your stress? Here's your chance! Supermarket Rampage, the game created especially for women like you, giving you the opportunity to let go of your frustration...and have fun doing it! Imagine you've just arrived at the supermarket, after fighting for a parking space and struggling to get a shopping cart, and everyone seems to be out to get you. Bop them with the groceries in your cart, before they get too close! (Overstreet 2009).

According to the web designer on the marketing team for Sarafem, the “soothing sounds” desktop player and the game "Super Market Rampage" were some options to fulfill the objectives of a calm, safe place for sharing among PMDD sufferers.

The whole concept of a game created as a means to educate women about a mental disorder would be laughable if the product being sold was anything other than a mood altering antidepressant, here being encouraged in a lighthearted manner as something taken to combat a bad day. The information provided on the site isn't targeting the 3-5 percent of the population that supposedly suffer from this disorder; it is very clearly aimed at most of the female population who might find themselves on the site, many of whom, I'm willing to guess, have had days where everything has seemed to go wrong, and might leave the site with a gnawing sense that they too should seek “treatment”.

Hirschman and Thompson (1997:58) write that “the appeal of specific media images is not tied to the literal content of the ‘information’ they convey, but rather the consumer

constructed pastiche into which the images could be concocted.” So, despite Eli Lilly's “pop-psychology marketing, touchy-feely commercials and Oprah-esque website, Sarafem really has little to do with women's physiology. Instead it's about a looming patent loss wrapped up in a vague diagnosis; a diagnosis most women can relate to. And while some women's premenstrual symptoms might “feel better” with Prozac as Eli Lilly claims, so would many things when one is on a mood-altering drug” (Rebensdorf 2001).

Chapter 3: New Media and the Experience of Illness

Introduction

As an illness, PMDD is unique “because there is virtually no other disease that people insist on having”, according to Dr. Nada Stotland, the chair of psychiatry at Illinois Masonic Medical Center back in 2000 (Spartos 2000). With this statement she touched on one of the driving forces behind the continued prevalence of the disorder; the consumer demand that has been created around it. At some point shortly after PMDD became established as a disorder in the minds of American women, the television advertisements for Sarafem were pulled on account of being too vague in the way they were describing PMDD. The number of women who matched the criteria of the illness as presented in the ad was too broad. It would seem that the pulling of the ads would have sent a message that the existence of this disorder of such slippery definition was questionable. And for a number of women, it did. But for countless others, the disorder took on a life of its own and continues to thrive, with women still going to their doctors and asking for Sarafem by name. In viewing this in light of Hacking’s notion of transient illnesses, and the need for a particular social backdrop in which they are able flourish, it could be said that the social context keeping this diagnosis in place is a result of the sustained demand for it; one that continues to be stoked via new media outlets such as online support groups.

The fact that there are new generations of women continuing to discover and self-diagnose with the disorder illustrates the power of how mediated ideas about health penetrate

the subjective realities of women looking to put a name on their emotional discomfort. In doing so, they becoming active participants in the shaping of certain medical discourses, practices and research (Markens 1996: 43).

Interpretation and Identity within Online Support Communities

... this past week I've been straight up lethargic. I've had no ambition. I've wanted to do things, even needed to do things, but I couldn't bring myself to get up and do them. Mom thinks I'm lazy, but it's not that (I just know it's not) but I can't come up with a reasonable explanation. I cry. No reason, I was just sitting with my best friend and burst into tears. I thought it was PMS, but I think it might be PMDD. What do I do now?

(Post on Facebook-PMDD Community, Aug. 15, 2011)

Systems of knowledge are promoted in mass media and influence audiences in various ways. With new media such as the Internet allowing for a new kind of experience (Castells 1996), it too must be taken seriously as an increasingly primary source of medical information; one that can help us to understand illness experience and its rendering in narrative forms (Seale 2003: 513). Serlin (2010: xii) notes how “the phenomenon of self-diagnosis through online research has become so widespread that the term “cyberchondria” has emerged as one of the signposts of the Internet, as it contributes as much to contemporary forms of self-empowerment through knowledge as it does to misinformation, frustration and cynicism.” According to an editorial in *The Economist* (2007), “millions are now logging on to contribute info about various health topics...you could call it ‘user-generated health care’ (cited by Serlin, 2010: xiii).

More and more people are arriving at their diagnosis by seeing an article, or an ad that they are able to relate to immediately, and then plugging the symptoms into a search engine. In turn, they connect to an extensive network of websites that describe their experience as

evidence of a diagnosable disease about which they were previously unaware. Women's own accounts of their premenstrual symptoms, as you find on support group websites, are instrumental in the construction of PMDD as a legitimate medical phenomenon (Markens 1996: 46). This is illustrated by Informant 2 who commented "I first heard about PMDD when I came across some articles online, if I remember correctly, and it was pretty clear that I had all of the symptoms, so I guess I diagnosed myself." While the Internet has helped patients become more active consumers by providing them a means for finding information about illnesses and potential treatments, it has also transformed individuals into producers of knowledge (Conrad and Stults 2010: 181). Even just a quick visit to one of the many online groups will give an indication of how the sites are used:

"New here...just curious what everyone else's symptoms are" (Facebook-Life w/ PMDD, Sep. 6 2011)

"I just want to cry reading some of these posts. I can so relate, and it feels so good to know I'm not the only one that is struggling. I just recently discovered PMDD and although I've not talked to my doctor about it yet, I feel this must be me." (Facebook-Life w/PMDD, May 23, 2011)

My GP has not heard of PMDD (I'm in the UK) however, I really do feel that this is what I have following research. (Experience Project, April 17, 2010)

As the above posts illustrate, open groups on sites such as Facebook or Experience Project are often the first stop after learning what PMDD stands for. In finding online communities, women themselves become the source of information. By communicating their shared experiences and interpreting their own, and one another's, symptoms they are able to create a sense of certainty surrounding their diagnosis. The interactive nature of the sites also allow women solidify their identity as a fellow sufferer, and they are thus provided with a new common language to use when communicating with their doctor or other women seeking help.

the Internet has been the ONLY way to gather information. You can't walk into your doctor's and get the lowdown. It's usually the other way round, with the patient educating the GP.

(Informant 1)

Of the women I spoke to, not one had found out about, or been given their diagnosis by a doctor. Instead, when asked where their initial information about PMDD came from, responses included: “the Internet and other women in support groups on the Internet” (Informant 1), and “ a friend had mentioned it a few years prior, but I never listened. When I started having really horrible days and bad symptoms I looked it up online and then went to my doctor” (Informant 3).

Barker (2010: 157) writes that the interactive quality of contested illnesses “creates a cultural milieu wherein even more individuals, through their brief or extensive encounters with illness support communities, come to locate themselves within these designations.” Such communities create something of a subculture, where membership ensures a level of support that is no doubt enticing to those who might be feeling socially isolated as a result of their symptoms. But while immersing oneself in a community of like-minded sufferers is no doubt a positive experience on many levels, the issue lies in the real-world implications of taking on such an illness identity without medical corroboration. In looking to these communities for medical information and confirmation of self-diagnosis, women may be selling themselves short in terms of getting to the heart of what is really wrong.

Shaping Medical Discourse

Research has found that women's perceptions of what happens in the weeks before menstruation becomes more pathological when they are introduced to the diagnostic

definition of PMDD (Offman and Kleinplatz 2007), and when the language surrounding menstrual cycle-related changes is pathologized, it becomes difficult for women to explain their experiences outside of a medical discourse. Offman and Kleinplatz (2007) write of how the biomedical model validates these feelings, taking women seriously because of their “medical condition” which can be empowering. A diagnosis brings coherence and order to a collection of symptoms that have up until that point been rather vague, and more importantly, the diagnosis validates the sufferer and her suffering after an extended period of feeling ignored and discouraged (Dumit 2006; Barker 2010). It makes sense then that women visiting online communities, by seeking other women sharing similar experiences, would be relieved to come away with a label for their distress. Women feel that their complaints have finally been heard, and that professionals are able to agree that it’s not all in their head. In fact what’s happened is that normal monthly hormonal fluctuations have been deemed mental illness in need of treatment. Many professionals still don’t necessarily believe in the existence of the disorder, viewing it instead as a somatic manifestation of depression, accepting it only within the confines of their relationship with their patient.

The ability to rebrand depression and call it by other names has helped physicians get people on the drugs that they probably really should be on. But its interesting because if you hooked me up to a lie detector and asked me if I believed in PMDD, I don’t know that I’d...I don’t know. I just feel like they’re variations of depression.

(Informant 4, physician)

Caplan (2004: 1) writes that the construction of PMDD as a disorder came out of a cultural climate friendly to the view of women as emotionally out of control. She writes: “from the outset, some women were so relieved to have their physical discomfort and unpleasant feelings recognized that they rushed to defend the label rather than asking for compassion and help that stopped short of diagnosing them as mentally ill.” In discussing the diagnosis of

PMDD in the episode of *On the Media* mentioned previously, Jonathan Metzl, psychiatrist and author of *Prozac on the Couch: Prescribing Gender in the Era of Wonder Drugs*, commented:

If we are in the business of treating PMS with psychiatric drugs, in part what we're saying is that there is a level of insanity to the suffering of PMS. We know that when the industry drives diagnosis, there's a process that happens that Peter Kramer, in *Listening to Prozac*, beautifully described as "diagnostic bracket creep." People start to come into doctor's offices and say, I know this drug is indicated for a particular illness, but I've kind of got that. And the doctor says, that sounds good enough - we'll give you this medication. And what happens over time is that the diagnostic boundaries expand and expand and expand, so that a drug that was indicated for a very small subset of people over time becomes indicated and used for a much wider category (*On the Media*, 2010)

Hacking (1999) was especially interested in labels and classification, and how individuals come to see themselves as having a particular disease and "reorient their symptoms and sense of self in relationship to that disease designation" (Barker 2010:157). By providing an explanation of the symptoms, the individual is able to impose order upon and regain control over the illness experience, as well as assume an illness identity and become part of a larger community (Madden and Sim 2006: 2963). Online groups "move beyond experiential exchange and support to advocate for an alternative interpretation of an illness or the recognition of a previously unknown condition as an illness", in the process becoming something more in line with a social movement (Conrad and Stults 2010:184). The information shared within such groups expands beyond the boundaries of cyberspace, shaping the way women interpret and experience monthly hormonal fluctuations. The ability of a contested disorder like PMDD to hang on, even after countless feminist critiques of labeling women this way, is indicative of the power of the group in shaping medical discourse.

Conclusion

It has become clear in speaking to women with PMDD, and viewing the countless blogs and websites devoted to the illness, that the continued prevalence of the disorder is due in large part to the explosion of online communities offering forth information about the individual experiences of fellow sufferers. It is part of a larger trend that involves the increasing tendency to medicalize normal aspects of human behavior that has take hold in the US, helped along by the never ending barrage of DTC ads, which has reshaped the way individuals view themselves. The increase in lay knowledge about medical conditions, and the rise in numbers of those self-diagnosing, is indicative of the growing trend towards “user generated” health care. The problem with so much specialized medical information being made available to us is that we inevitably end up thinking we’re greater experts than we actually are. Hacking (1998) writes:

We have conceptual confusions that new knowledge seldom helps relieve. Scientific knowledge about ourselves changes how we think of ourselves, the possibilities that are open to us, the kinds of people we take ourselves to be. Knowledge interacts with us and with a larger body of practice and ordinary life. This generates socially permissible combinations of symptoms and disease entities (10).

Through their sophisticated miniature narratives, advertisements for psycho pharmaceuticals are able to tap into potential anxieties women may have about their own mental health, presenting a character and scenario they can identify with, in essence a version of themselves, and labeling the behavior as disordered. People seek meaning when things feel out of their control, and popular media exists as a convenient way to immediately access information and begin to impose some kind of order. Williamson (1978) discussed the ways in which

“ advertisements are one of the most important cultural factors molding and reflecting our life today” (11). This was true in the late 1970’s when she was writing, and it is still true today, though the implications are more sinister when the products being advertised aren’t just appliances and cosmetics, but medication designed to alter brain chemistry. What began as a way to extend the life of Prozac and increase profits for a pharmaceutical company has firmly entered medical discourse as a diagnostic entity.

In looking to the media to answer question about their health, women are putting themselves in a position where they may feel more empowered and in control, but in bypassing traditional routes to diagnosis, they could be missing out on necessary attention to deeper issues, whether actual mental illness in the form of depression, or personal manifestations of societal issues, that would help alleviate some of their suffering. Dr. Nada Stotland, the chair of Psychiatry at Illinois Masonic Medical Center in 2000, was quoted in the Village Voice at the time, saying: “Lilly is targeting almost exclusively OB-GYN’s as Sarafem prescribers, which puts gynecologists in the position of treating mental illness. Lilly’s advertising campaign may convince enough women they need Sarafem, leading them to pressure their doctors to skip the two months officially needed for diagnosis and instead send them straight to the pharmacy” (Spartos 2000). This is just one of the many concerns related to the fact that women are becoming more reliant on media outlets as a means to acquire medical knowledge. The proliferation of online communities brings the experience of illness, something that had once been a private experience, into the public sphere, and the desire to be heard and accepted is no doubt a powerful pull for women who may find themselves overburdened, lonely, and desperately wanting to put a name to their malaise. One of the more common themes to emerge in speaking with women and viewing the support sites

is the relief they felt on finding a community. Knowing they were not alone, and not “crazy” were therapeutic notions in and of themselves. This might help explain why, despite decades of feminists trying to get away from any labels that position women as ‘other’, a new generation is embracing the diagnosis.

Implications

The problem with PMDD is not the women who complain of monthly emotional fluctuations, but the diagnosis of PMDD itself, and the consequences that could arise as a result of this sort of labeling, even if it is due to self-diagnosis. Caplan (2004) cites excellent research showing that women who find themselves with a diagnosis of PMDD “are significantly more likely than other women to be in upsetting life situations, such as being battered or mistreated at work. To label them mentally disordered, and to send the message that their problems are individual, and psychological in nature, hides the real external source of their trouble” (7). The possibility of a diagnosis of PMDD might serve to distract from such trouble, as women might latch on to the diagnosis thinking that it represents something far less stigmatizing in their minds than what may actually be causing their emotional instability. Spartos (2000) found that “some doctors fear that women who have legitimate reasons to be unhappy will be silenced by the diagnosis of PMDD, and that Sarafem could be the Valium of the noughts”. This leads to one of the reasons why it is beneficial to study the impact of the media on women with PMDD; to move away from a purely biomedical view towards a more holistic understanding of what these women are really asking for, and why.

Additionally, the power of the DSM in determining what is normal versus abnormal behavior should be considered. At the moment, PMDD remains in the appendix, marked as needing further study. In thinking about the “consumer demand” that has been created around PMDD as a result of its perpetuation on support websites and popular media outlets, it is important to consider how women may be contributing to their own marginalization, through consenting to their normal hormonal fluctuations being labeled mental illness. To refer back to Hacking’s (1998) thoughts on transient mental illness, I would say the cultural conditions are certainly right for PMDD to be having its moment. But it begs the question of whether or not transient illnesses are possible in this day and age, where various diagnoses are kept alive by communities of the ill who join together online. Perhaps once an illness catches on in some capacity, there is no turning back. It is there to stay, much to the delight of Big Pharma. As pharmaceutical companies continue to manufacture disorders in order to sell the treatment, and communicate the information through advertisements, the cycle will continue with individuals forming online subcultures around the illness, ensuring its continued existence for future generations of sufferers.

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