

# **Re-gendering Depression: Risk, Web Health Campaigns, and the Feminized Pharmaco-Subject**

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*Abstract:* This article analyzes the textual and visual discourse of recent depression campaigns and advertisements generated by state-policy, advocacy, and pharmaceutical organizations, drawing on the work of Anne Balsamo, Nikolas Rose, and Paul Rabinow, among others. A variety of recent Web campaigns are critiqued, addressing the new pharmaceutical strategy of identifying a broad spectrum of depression. These campaigns re-gender subjects by targeting common social and biological factors in the lives of women and girls as risks, while framing male depression as patriarchal opportunity. This analysis of the discourse of gender, risk, and depression in the context of neo-liberalism indicates how health subjects are imagined as consumers and how this situation creates new constrained forms of “responsibilized,” gendered subjectivity.

*Keywords:* Cultural analysis; Discourse analysis; Mass communication; New media

*Résumé :* Cet article analyse le discours textuel et visuel de campagnes et de publicités récentes sur la dépression produites par des organismes gouvernementaux, activistes et pharmaceutiques. Pour ce faire, on se fonde sur l'œuvre d'Anne Balsamo, Nikolas Rose et Paul Rabinow, entre autres. Nous y passons en revue une diversité de campagnes sur le Web en portant une attention particulière sur la nouvelle stratégie pharmaceutique qui consiste à reconnaître un large éventail de types de dépression. Ces campagnes remettent l'accent sur le sexe des sujets en évaluant les pratiques quotidiennes de femmes et de filles comme comportant des risques tout en cadrant la dépression masculine comme occasion patriarcale. Cette analyse du discours sur le sexe, le risque et la dépression dans le contexte du néolibéralisme indique comment maints organismes perçoivent les patients comme étant des consommateurs et comment cette perception crée de nouvelles formes contraignantes de subjectivité « responsabilisée » par sexe.

*Mots clés :* analyse culturelle; analyse du discours; communication de masse; nouveaux médias

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### **The depression script: An introduction**

A reductionist, biopsychiatric mood logic has long been normalized in North America and Europe (Healy, 1997; Kramer, 1993). This logic tends to assume a single-cause model of illness, despite a concurrent reading of the body as a “complex system” informed by both environmental and biological factors. Grounded in a rationale that reduces depression to a brain disorder and overstates its threat, popular discourses directed at consumers have helped make depression one the most diagnosed mental disorders of all time<sup>1</sup> (Healy, 1997). Despite its slippery logic, the script has made a compelling public case that depression resides in sick brains and requires biotechnical treatment. To wit, the website of National Alliance for the Mentally Ill (NAMI) boasts that 75% of surveyed individuals define depression as a chemical imbalance in the brain and recommends medication as treatment (NAMI, 2007e).

This depression script is malleable. If, in the past, the script was directed primarily toward women, in its latest incarnation it normalizes a broad set of distresses as symptoms of new mood illnesses, including subtypes of depression such as dysthymia and depressions that are typified as minor, shadow, postpartum, seasonal affective, pre-menstrual, et cetera. It covers a range of disorders of eating, attention, anxiety, and panic, to name a few. Representing a new trend in managing the health of populations, broad-spectrum illnesses are promoted to consumers via a range of media, from websites to television advertisements to glossy print advertisements.<sup>2</sup> The strength of these campaigns is demonstrated by the now-common consumer practice of using antidepressants alone to treat minor depression, though research shows they are significantly effective only for major depression, and in conjunction with psychotherapy.<sup>3</sup> Problematically, these discourses flatten important distinctions across depression diagnoses and constrain consumers’ abilities to make informed treatment choices (Gardner, 2003; Healy, 2004). The conflation of major and minor depression also rationalizes the script’s snowballing logic, which dubs symptoms as threatening a lifelong illness that will require constant (self-) surveillance and management. The widespread sale of pharmaceutical drugs on the Web only reinforces this tendency.

NAMI’s discourse on depression and the research data they present mirrors that of state health and industry groups<sup>4</sup> (Healy, 1997). Like these other institutions, NAMI defines everyday psychosocial and material phenomena, including sexual abuse and employment, economic, and gender oppression as risks, rather than causes. As shall be shown, these discursive ruptures make it possible for gender to become a symptom of depression and for depression to be reified as a gendered disease.

This discourse relies on antiquated assumptions of gender, capitalizing on unproven essentialist biases, countering the nature/nurture theory, and marginalizing social cause to re-introduce pathology into the lives of women and girls. The script commonly symptomizes depression by everyday body and mood behaviours, but here women, specifically, are called upon to self-scrutinize their hormonal processes. Finally, NAMI recommends that “symptoms” be controlled by biotechnical recovery methods, including antidepressants and short-term psychotherapies; notably, the latter fits within the biopsychiatric paradigm in aiming

to repair behaviour and cognition but ignoring the emotional, social and other root causes of depression.

Also common to the script is NAMI's equation of depression with national economic depression and decreases in the gross national product, so that mood management is referred to as "good economics. . . a return of \$7 for every \$1 invested" by industry (NAMI, 2007c). NAMI contends that depression diagnoses should increase, despite the vast number of researchers who contest the script's slippery-slope logic that links symptoms to chronic illness. The script's broad-spectrum paradigm, in association with risk discourse (pointing to decreased productivity and chronic disease), together establish a generalized risk paradigm applicable to most individuals. Yet, pivoting on the concept of risk, this macro-paradigm provides a mechanism whereby campaigns can logically target gendered social and biological experiences as requiring surveillance for productivity risk/symptoms. NAMI does not offer the sole example of the operation of this complex depression script.

### **Analyzing the script**

Over the past decade, American pharmaceutical, health policy, and consumer advocacy organizations have launched new campaigns designed to encourage the diagnosis and treatment of "broad-spectrum" depression. The expanded marketing strategies are, it would seem, a distinctive retreat from the old-style Prozac campaigns of the late 1980s, which targeted middle-class Caucasian females; new campaigns seek a more egalitarian, less gendered, classed, and raced population of potential users. In addition to the NAMI website, indicative of this shift is the National Institute of Mental Health's (NIMH) "Real Men" depression campaign, which attempts to destigmatize male depression (NIMH, 2007a).

These campaigns seem to redress the discourse of depression as a female disorder by making, and depicting, a more varied range of people "at risk." However, these new campaigns continue to frame gender in a binary manner (Balsamo, 1999) that repositions it as an etiological tenet of depression. To understand the manner in which these mood discourses articulate gender norms, health consumerism, risk, and recovery, I undertake an analysis of this "depression script" that reaches across government, industry, and consumer-advocacy materials. This flexible depression script is naturalized both in drug promotions and in consumer- and state-produced health care information for consumers.

Having tracked pharmaceutical-ad trends, as well as consumer-advocacy discourses and U.S. health campaigns, over eight years and across hundreds of sites, in this paper I target recent depression campaigns by organizations including NAMI, NIMH, and the American Psychiatric Association (APA), as well as advertisements by pharmaceutical companies Eli Lilly, Forest, and Pfizer, to illustrate the complex operations of these gendered promotional strategies and the role played therein by discourses of risk. In particular, I draw upon the Web campaigns that have emerged in the past five years; this realm is important, as it is a much less regulated zone than other sources of promotion. Instructively, Web pages allow for the blurring of health advertisements and promotions, which are in fact presented as objective consumer information. As such, these Web campaigns introduce questions regarding what constitutes reasonable health informa-

tion for consumers and whether the pages' unregulated content constrains agency and rigorous democratic practices that require diverse, contested information.

The method employed to analyze the visual and textual depression "promotions" is a multidisciplinary visual-studies model, blending semiotics with poststructuralism and feminist media and critical studies, in particular the work of Anne Balsamo. To understand comprehensively how these broad-spectrum depression discourses operate, the paper also heeds Nikolas Rose and Paul Rabinow's (2003) call for careful empirical analysis of data across three key axes of biopower: knowledge of vital life processes, power relations that take human beings as their object, and modes of subjectification through which subjects work on themselves as living beings. The depression script that I identify works on all three levels. It espouses a biopsychiatric script, creates gendered recovery subjects, and puts forth the imperative to self-manage. My approach allows for an analysis of how visual and textual discourses together gender mood and make a compelling case for the technological mediation of bodies.

Where numerous advocacy and media organizations and cultural critics<sup>5</sup> have employed political-economy models to critique the creation of new diseases by pharmaceutical companies, this analysis seeks to reveal the logic grounding these practices in culture as well as in social institutions and industry. I examine aspects of this logic in the pages that follow, specifically the establishment of women as the referents for all depression scripts, the narrativization of this script and appropriation of a feminist discourse, the tendency to encourage self-management of social trauma, and the campaign to include men within the script. Finally, I turn to an analysis of the articulation of gender and risk. As I demonstrate, capitalist, cultural, biopsychiatric, and neo-liberal logics together form the broad logic of mood disorders, where risk and gender stereotypes create new recovery subjects and new practices of biopower.

### **Signs of risk: Feminizing the referent of depression**

Pharmaceutical companies have historically referenced woman as the depressive subject, hence making this the norm (Metzl, 2003). My tracking of early ads for selective serotonin reuptake inhibitors (SSRIs)<sup>6</sup> suggests they tended to target a broad population of working and non-working middle-aged women through ads in fashion and other women's magazines, as well as TV spots placed during day- and night-time dramas. An industry trend-setter, Eli Lilly was among the earliest companies to advertise diverse images of working-age males. While Eli Lilly and others have diversified their visual portfolio of subjects, whenever a single image is employed, it is almost always a female, and a female is rarely left out of a group shot unless the target market is male. Despite the broad and targeted marketing directed beyond females, the visual culture of consumer Web pages instructively positions female biology, particular women, or femininity as the primary referents signifying the risk of depression.

This conflation of women and depression has recently taken new forms. In an image from the University of Pennsylvania health care centre ([http://pennhealth.com/health\\_info/tips/depression/what\\_causes.html](http://pennhealth.com/health_info/tips/depression/what_causes.html)) the (documented) differences between male and female brains are employed to imply empirical knowledge of the biological causes of female depression. Great care is taken in the photograph to mimic the orange and red tones of PET scans, to light (unnamed)

pieces of the female brain, and to darken the subject's profile against a lit backdrop to create a romantic silhouette figure. Knowledge of this subject is created through brain rather than facial features. This idealized biotechnical subject is thus "known" without reference to, and despite, her subjectivity.

Pharmaceutical ads have introduced new "risk" factors to market recently created women's disorders that are linked to youth or aging and to a panoply of drugs that will manage the depression likely to occur at any moment in a woman's life. These campaigns provide the dual message that depression, while a risk for the general population, poses a greater risk to females. As well, the campaigns reinforce women as the primary referent of depression, promoting a need for women to undertake new practices of biopower, including auto-surveillance and biotechnical work upon the self (Rose, 2006).

Eli Lilly offers a "Signs of Risk" page, for example, that cites "being female" and multitasking as two risk factors, noting that depression "might" be linked to hormonal changes in women's reproductive systems (Eli Lilly, 2007a). In this way, Eli Lilly has reached to expand its female market to seniors and a success-conscious professional female audience via "new-age" language and techniques. Until recently, these Web pages featured images of professionally dressed women, and the "Finding Balance" online magazine, which was contextualized by smiling senior women and self-help recommendations for diet, exercise, and mind-body balance to augment the pharmaco-aid of Prozac. With Lilly's recent attempts at market-expansion, these Web pages have morphed into pages entitled "Balanced Living" (Eli Lilly 2007b). While "Balanced Living" pages feature a range of gendered images, they retain a focus on feminized discourses, emphasizing self-care in the form of exercise and eating, self-discovery and positive thinking. In total, Lilly's strategic techniques identify new "at-risk" populations within the female population, including functional women engaged in recovery and self-care. These discourses echo mainstream health and media discourses that prescribe life balance for working women, and provide advice on multi-tasking, managing postpartum struggles, and aging well. It is not only middle-aged women or seniors who are now deemed at risk.

Depression campaigns by organizations other than pharmaceutical companies also reach out to youthful female populations. The American Psychiatric Association's (APA) depression page in summer 2007, for example, presented two female teen images to signify general "depression" (American Psychiatric Association 2007). The accompanying taglines relay the script's theory of risk, where untreated minor depression leads to major disorder and individuals are called upon to self-monitor everyday moods and to "control negative thinking," thus reaching into a new everyday mood experience. The positioning of young girls as referents for generalized depression triggered by troubled thinking appears familiar to viewers, given the trend to pathologize common moods. As well, the discourse positions women in a manner common to fashion ads, which tend to shrink, fragment, and ridicule women in a mirror image of cultural pathologies (Schutzman, 1999). In a similar sense, these promotions reflect our cultural obsession with self-management by framing teen girls struggling with emotions as aberrations in need of mood control.

NAMI's depression Web pages (2007a and 2007b) for women and children are revealing in this respect. These pages, and another specialized for policymakers, repeat expert estimates of depression figures from the APA, the latter, for example, stating that depression affects one in ten of the general population and one in four women (NAMI, 2007c). The women's Web page explains that "the gender gap in susceptibility to depression most probably lies in a combination of biological, genetic, psychological, and social factors" (NAMI, 2007b).

While its complex script makes NAMI's discourse appear fair, the group targets women with strategic language. The women's Web page states, for example, that "There *appear* to be important links between mood changes and reproductive health events" (NAMI, 2007b, my italics). On the children's Web page, readers learn, "With adolescence, girls, for the first time, have a higher rate of depression than boys. This greater risk for depression in women persists for the rest of life" (NAMI, 2007a). In this passage, the widely critiqued pathologization of the female reproductive system is employed, paradoxically, to rationalize the cause of depression. As well, NAMI's discourse overstates the status of biopsychiatric research. To date there is no empirical proof that hormones, genes, circadian rhythms, or biochemistry specifically cause depression in women (or anyone else). Most brain chemistry research only suggests biological cause through antidepressant "effect," or as Peter Kramer contends, the drug worked, so depression must exist (Kramer, 1993). As well, Joseph Dumit (2003) has shown that brain-scanning technologies are ambiguous with regard to cause; visual differences between depressed and non-depressed brains are unsurprising, in his view, and provide no empirical evidence of biological cause. Gender thus becomes a pawn of the script made possible by overstatements that appear scientific.

Similarly, the "Say how you feel" campaign by GlaxoSmithKlein (see <http://www.sayhowyoufeel.com>) resorts to a baseline image of a Caucasian woman as the sign of depression, but targets a clearly contemporary audience with a cartoonish postmodern form. This ad deliberately adopts a style similar to artist Roy Lichtenstein's sparse, flat, critical comic forms that were intended to parody gender and other stereotypes. Seemingly ignorant of the polysemous readings of this aesthetic, GlaxoSmithKlein presumably employs the ad to attract a market of both middle-aged and young females and to exploit, with melodramatic effect, the "flat" affect typifying depression. The sparse visual relies on a lack of cultural and social context, making it perhaps the ideal delivery mode for reductionist depression logic and the single-solution sale of antidepressants.

These consumer discourses, which address a broad range of new disorders and women across different age groups, routinely frame female subjects as risky biological entities with disorderly symptoms requiring pharmaco-augmentation. These new feminized depression discourses stress the tipping factor of everyday risks—environmental and somatic issues, including poverty, childbirth, work stress, and multitasking. In contrast, as we shall see, the discourse positions men as facing risks due to work stresses and focuses on restoring them via drug therapy.

In promoting this new depression script to a range of women, Eli Lilly glosses its own core logic, which ultimately blames female biology but also uses



this biology to expand its market, creating a new discursive economy. Here, the history of the drug “Sarafem” is instructive. As its patent for Prozac expired, Eli Lilly launched the same drug formula as “Sarafem” in 2000 to treat pre-menstrual dysphoric disorder (PMDD), a diagnosis feminists have disclaimed as pathologizing common menstrual symptoms, and which was added illegitimately to the American diagnostic manual of mental disorders<sup>7</sup> (Caplan, 1995). Eli Lilly’s TV spots for Sarafem earned it a warning letter in 2000 from the U.S. Food and Drug Administration (FDA) for biased, unbalanced advertising that conflated milder pre-menstrual syndrome symptoms with PMDD<sup>8</sup>. Since then, Eli Lilly has softly marketed PMDD via a “women’s health” Web page that, even while admitting a lack of credible proof of biological or hormonal cause, defines everyday menstrual distresses (i.e., irritability, mood swings, tension, breast tenderness, and bloating,) as symptoms and presents PMDD as a severe risk for reproductive-aged women, claiming it affects 3 to 8% of women (Eli Lilly, 2007). These strategies demonstrate skill in introducing new assumptions into the mood script and embedding risk in both sex and gender, the biological and the behavioural.

Eli Lilly’s savvy marketing strategy extends to its current online marketing of Prozac to treat panic, bulimia, and obsessive-compulsive disorder (OCD). The online ads interpolate young women and teens, inquiring “Are you at risk?” Each page lists statistics that show the female youth bias of these disorders (save OCD), admits a lack of etiological knowledge, and contextualizes the disorders with pictures of recovered young females. Additionally, panic disorder is correlated with depression, alcoholism, and substance abuse, deliberately confusing the distinctive symptoms of each. Drug abuse is watered down as another “psychological condition,” making depression seem less severe and more culturally palatable. As well, alcohol abuse is positioned as a new female symptom requiring mood surveillance. Girls, as such, become framed as keepers of postmodern, disorderly bodies at risk for a host of unforeseen, chaotic symptoms said to require biotechnical mediation.

These pharmaceutical ads introduce new “risk” factors in order to market recently created women’s disorders and drugs old and new. These campaigns provide the dual message that depression, while a risk for the general population, poses a greater risk to females, and reinforce the need for women to undertake auto-surveillance and biotechnical work upon the self. Diagnostic logic is linked to self-management, for example, through consumer mood quizzes and mood-tracking charts available at websites characterized by female referents of depression and feminized at-risk populations. Positioned as managers of their selves, female consumers are invited to employ these overdetermined gauges, to deem mild distresses as symptoms, and to deliver the results to medical professionals. Matching risk and responsibility to biotechnical treatment, self-diagnostic tools contribute to an economy in which it appears normal for vulnerable and worried women to undertake new work upon their bodies/selves.

### **Real stories: Narrativizing depression, appropriating feminism**

Paula Treichler (1992) has argued that a sense of truth is established and sustained specifically by conventions of narrativizing disease, which include as representative elements the use of narrative voice and the promulgation of images

that normalize cultural ideas through repetition (p. 385). The formats common to drug ads and advocacy groups such as NAMI confirm Treichler's contention. Not only does the depression script continue to link women with depression, but narrative tales focusing on posttraumatic stress disorder (PTSD) and anxiety and panic disorders co-opt feminist language to reify stereotypical gender roles. These new forms of depression promotion become effective by mimicking women's cultural practices of telling stories to self-evaluate and drawing upon the empowerment language of feminism.

Intended to make readers comfortable, the narrativized format mainstreams outdated social gender biases by cashing in on female celebrity as well as professionalism. Pfizer's Zoloft Web ads, for example, have included well-known musician Naomi Judd's story, which presented her in a multigenerational female family photo accompanied by a caption that tells us that Zoloft has allowed Judd, who suffers from an anxiety disorder, to return "back to herself once again." Marrying testimonials to risk, Zoloft's Web page also provided stories from ordinary women. "Drucilla" invited us into her self-reflection: "My life is different now—wonderful, free. I'm back to being me. Before, I couldn't go to concerts or. . . food shopping. . . . But on ZOLOFT I can manage my symptoms." Accompanied by a grinning photo, this neo-liberalist narrative equated "taking back" control of domestic and social roles as a "return to herself," characterized as liberation.

In another image on yet another Web page, a laughing woman introduced as "Candyce" accompanied the description of her "symptoms" following rape: trauma, sleep disruption, anxiety, panic, and terror. The discourse re-coded feminist language formerly bound in a social action discourse; Candyce, we were told, "considers herself a survivor" whose "growth" was due to Zoloft and therapy, in addition to her "strong support system." Following in Prozac's footsteps, Zoloft thus becomes a proto-feminist drug—part of a "system" that fights social violence against women one survivor's serotonin at a time. This approach glosses the empirical (social) cause of Candyce's "problem," transforming terror and sexual violence into symptoms requiring behaviour and mood management. This discourse elides the social and demands that the individual survive anxiety or panic by way of mood-altering medication—which are not, in fact, generally recommended to treat these conditions (APA, 2007a).

This peculiar individualizing of depression has been a key aspect of Pfizer's marketing strategy. Pfizer proudly introduced Zoloft as the "first and only" drug approved by the U.S. FDA to treat posttraumatic stress disorder, which, importantly, is the only diagnosis requiring the experience of social trauma as criteria.

One ad featured an alarming visual—an enormous black hand pursuing a terrorized white pill fleeing in evident fear—exploiting biased cultural myths of the Black rapist, while suggesting that the "problem" is the individual possessing panic symptoms. The looming hand, fingers open to apprehend the smaller subject, becomes the primary image of perpetration, arising from the horizon with no apparent source or reason, suggesting a chaotic environment/etiology. The accompanying text linked terrorization to pharmaceutical treatment, asserting "When you know more about what's wrong, you can help make it right." Further causal context was housed in a banner featuring a myriad of disorders, suggest-



ing Zoloft's broad effectiveness and power. Finally, the text described sexual abuse and other social causes of Post Traumatic Stress Disorder (PTSD) as "risk factors," contravening the diagnostic rules of the Diagnostic and Statistical Manual of Mental Disorders itself. With sexual attack reduced to panic made manageable by drugs, this Zoloft advertisement made violence against women consumable and tolerable via biotechnical self-management. In keying in on our personal desires for risk management, Zoloft's advertisements replace social cause with trauma and panic symptoms, effectively erasing the problems that lead to mood disorders.<sup>9</sup> Reflecting society's inability to control violence against women and fearful of this incoherence, Pfizer's individualist, self-managed solution passes as female empowerment—the best one can do in a badly managed world that makes women sick.

Pfizer is not the only company to use this strategy. Eli Lilly likewise manipulates and individuates female trauma, as demonstrated by its 2004 launch of Cymbalta. This new drug technology, said to treat both the physical and mental "pain" of depression, targets not only the brain chemical serotonin (as do Prozac and Zoloft), but also norepinephrine, a new suspect in the causes of depression. Cymbalta ads feature a variety of decidedly young female figures in a neon colour scheme with postmodern appeal, as well as middle-aged Caucasian mothers. A recent online ad, for example, features a mother and her children chatting on a green lawn, articulating the calm that comes from drug enhancement.

Employing depression-narrative practices, the Cymbalta website's "Real Stories" section offers video testimonials of female mood distress managed by Cymbalta (Eli Lilly 2007c). The Web page suggests the objectivity of journalism by using a woman signified as broadcaster, silhouetted by TV screens. This pharma-interlocutor, presented as spokesperson for science and pharmaceutical companies, casts a dual objective-expert glean to the (obvious) biotechnical paradigm. The main page presents eight stacked television screens, the top row featuring middle-aged Caucasian females with taglines identifying name, age, and mood story. Below, blurred images of non-depressed middle-aged men literally support the depressed women.

This framing overdetermines depression as a middle-aged female disease, juxtaposed with non-ill males who include sensitive diagnosticians and pharmacological treatment advocates. The site visitor is positioned to identify emotionally with the subjective testimonials, which are cut with expert doctor advocacy of Cymbalta and contextualized by the alleged objectivity of the broadcast medium. The testimonials' themes reinforce gendered stereotypes—expert/doctor as knowledge source, brothers and husbands as knowledge purveyors, and women as individuals who have learned to trust authorities. Most of the women did not realize they were ill, for example, until a doctor told them, and one trusted her doctor's pharmacological recommendation despite disbelieving the diagnosis. In keeping with new depression trends, the stories make social problems symptoms, pathologizing the inability to care effectively for a child, exhaustion bred by single parenthood, and feeling overwhelmed as the full-time caretaker of an incapacitated husband. The women credit Cymbalta with helping them to cope with divorce, multitask, and manage emotions that otherwise "took over." Through

these persuasive narratives, Eli Lilly marries the gendered depression script—which lauds the expert/doctor/husband/brother/researcher’s knowledge of biopsychiatry and pathologizes social stressors as personal problems—with a biotechnical solution.

This consumer-marketing scheme deems any (Caucasian) middle-aged woman, homemaker or professional, as at risk, given that her messy, postmodern self lives in a world in which environments make women’s brains sick. Eli Lilly’s decision to signify Cymbalta as a drug for everyday women points to the cultural normalization of antidepressant consumption to manage a broad collection of symptoms and risks said to threaten female moods and productivity. As well, the Cymbalta campaign assumes a ready market exists in multitasking women—the traditional unpaid housewife and the professional (paid) female subject equally prepared to take responsibility for their functionality problems by choosing drug enhancement.

Pfizer and Eli Lilly’s campaigns replicate those of NAMI and the APA literature—glossing etiology and overstating, biologizing, and gendering risk. At the centre of these campaigns lies a requirement for women to act upon feminized forms of risk—risks that occur throughout their lifetimes—and the promise of salvation for the female subject who self-scrutinizes to identify broad new distresses of panic, anxiety, and trauma and accesses “expert” (albeit unstable) depression knowledge. The discourse calls upon the will to fix the brain in order to manage the social; as such, drugs offer the hope of coherence to the disorderly female postmodern subject. This representation of women as subjects at risk can be contrasted with the campaigns targeted at men. (Requests were made to reproduce images, referred to in the text, from the University of Pennsylvania Health Center, and from Eli Lilly and Pfizer. Unfortunately no responses were received. As a result, the URL links are provided instead.)

### **New gendered trends: Real men**

Male-targeted campaigns, as illustrated by the Prozac ad discussed below, tend to name depression as a brain illness with unknown causes and social triggers, in contrast with the equation of female biology with depression. Similar to feminized depression marketing, the will is not blamed, but instead, subjects are beckoned to employ willpower to guide them to biotechnical recovery. On the website for Prozac, for example, an African-American male is depicted dispensing the following advice:

It is important for you to accept that depression is a real illness—not a weakness or a character defect. Your friend or loved one can’t “snap out of it” and it won’t go away with time. Clinical depression is thought to be associated with a chemical imbalance in the brain. This imbalance can occur for no apparent reason—“out of the blue” or it can result from a stressful triggering event such as divorce, death of a loved one, trouble at work, or physical illness. (Eli Lilly, 2007d)

The idealization of modernist notions of dualized, gendered subjects is most evident in NIMH’s Real Men campaigns, which are, instructively, circulated and popularized by NAMI. The subjects depicted on the Web pages are identified as

working men of varied races and classes, including traditionally masculine workers (community protectors, including firefighters, police officers, and military men) and culture builders (restaurateurs, art publishers, peer-counsellors). Through these diverse representations, masculinity is re-framed broadly and includes the “courage” to ask for help (NIMH, 2007a). Where female depression is visually signified by hopelessness and sadness, “Real Men” are never characterized as subjected.

While there is an expansion of the types of men who are included as at risk for depression, the discourse carefully distinguishes masculine from feminine symptoms, referencing “scientific” research showing that depressed men present with grumpiness, anger, underproductivity, and other “coping” mechanisms and might abuse substances, “engage in reckless behavior” or become “angry, irritable or sometimes violently abusive.” (NIMH 2007b, p. 8). In this discursive collapse, the assumed brain problem of depression reduces anti-social male behaviours to mere symptoms. “Real men” discourse signifies an active, social male as ideal recovery subject.<sup>10</sup>

Biology is also situated differently in these advertisements than in the ads directed at women. Where women’s hormonal systems are specifically targeted as a cause of depression (and social stressors as triggers), men’s hormones are not noted as problems, and social causes are glossed over. For example, while work stress is alluded to via the problem of underproductivity, the NIMH refrains from addressing the depressed male as victim of any social or biological phenomena, which might risk emasculating men with female depression discourses.<sup>11</sup> Dressed up as a sign of a progressive man unafraid of the stigma (read feminization) of depression, manly “courage” is demonstrated by thwarting guilt and any awareness of the emotional (and social) conditions contributing to depression. This slippage delegitimizes feelings of guilt commonly associated with mistreating others, substituting instead enhanced pride achieved by biotechnical management.

We see this careful division of gender and representation in other advertising campaigns targeting both male and female populations. Lexapro ads by Forest Pharmaceuticals, for example, are binary gendered technologies extraordinaire. Despite Lexapro’s apparent broad appeal, its Web pages offer a glaring mainstreaming of gendered symptoms and risks. With a splash page featuring Prozac-like democratic appeal and expert references, Lexapro sells relief from depression and linked anxiety symptoms to a diverse, grinning population using the tagline “Power to enjoy life” (Forest Pharmaceuticals, 2007). Power here signifies both personal will and biotechnology’s ability to control the brain.

As in Prozac ads, the female subjects in Lexapro advertisements are depicted as happy to return to themselves. Here the images are telling. At the time of writing, one advertisement depicted a woman in her mirror reflection, gazing back at reader-voyeurs as unthreatening inhabitants of the domestic/private sphere and a young girl posing for the camera like a fashion model (Forest Pharmaceuticals 2007a). In contrast, all Lexapro men are busy: an athletic man wears a sweaty towel on his shoulder, a giddy young man cooks dinner with his heterosexual parents, and so on (Forest Pharmaceuticals, 2007b). Hormonally unstable women are presented in evident distress (hunched body, twisted face), in polar contrast with

the confident, repaired male images. Where Lexapro idealizes a female return to home/coherence, for depressed men (represented as having constrained possibilities, rather than sick bodies), pharmaco-repair provides a more active (sex and social) life and is a journey toward narcissistic masculinity. In exploiting outdated gender dualisms, Lexapro campaigns magnify the assumptions of depression risk promotions.

At the time of publication, Forest Pharmaceuticals replaced these dualized images with a broad array of gendered subjects, akin to current Prozac marketing strategies. The new campaign seeks to dress Lexapro as a gender neutral recovery product but continues to link distinctive risks to males and females.

### **Re-gendering depression and articulating the risks**

The gendering of pharmaceutical, NIMH, and NAMI depression diagnosis and treatment across these Web pages supports Anne Balsamo's (1999) contention that contemporary discourses of technology in fact *rely on* the logic of binary gender identity. Gender, for Balsamo, is both a cultural condition and social consequence of technological deployment. As a technology itself, depression promotes various biological and social attributes essential to sex and gender and defines this collection of symptoms as a disorder that is grounded in risk but technologically manageable. Within this logic, a range of girls and women, as well as working-age men, possess bodies/selves that require scrutiny and techno-mediation to ensure productivity.

Pharmaceutical companies meld gender with risk and technologies. Where consumer advocacy and policy discourses tend to avoid visuals, pharmaceutical ads position the docile female body as semiotic subject. Antidepressant ads routinely signify ill and recovered bodies through visuals that demonstrate the science of "knowing" and repairing the female, hormonally flawed body. These bodies also illustrate the depression script's unstable, complex model of causality. Here "natural" (biological) bodies exist in the environment, housing emotions and behaviours that *cross* psychosocial and biological spheres. Different campaigns employ varying tactics to signify the complexity of emotional health as biological illness, slipping from complex mind-body figures to streamlined (generally flattened) figures of "natural" biological sickness. The logical slippages of the pharmaceutical script work to discipline the postmodern, gendered subject/body. Reifying Balsamo's claims, stereotypes of the active (depressed) male subject and biologically challenged, multitasking female subject are vividly employed in pharmaceutical advertising. This re-gendering is articulated to the idea of risk; these discourses accept that while cause is unknown, (gendered) risk is knowable and manageable.

Instructively, social theorist Ulrich Beck (1992) has characterized risk as a byproduct of modernist institutions and industries, which create risks (e.g., environmental pollution) that breed more risks. Subsequently, Joost Van Loon (2000) has argued that risk articulated in mainstream (e.g., policy) discourses can never be "known" or even predicted, but might be managed. Societies, then, continually produce risks, which are unknowable commodities as much as discourses that breed insecurity, providing consumers with no recourse to achieve a sense of safety. Depression risks are similarly qualified: they are bred by health management and policy organizations and are *not* empirically known.

In popular practice, however, gauging risk is commonly undertaken to minimize harm. The script feeds off this desire; it presents depression as a range of risks that cannot be prevented but might be managed. More specifically, it deems symptoms of gender to be knowable risks that can be managed pharmaceutically. Where femininity becomes signified in everyday depression discourse as a risk requiring symptom surveillance, masculinity is rarely signified as at risk, but instead as an entity that requires bolstering. The instability of the causal logic, in fact, creates the opening for risk logic and justifies this pre-emptive, medicative logic. The use of this script in *cultural* practices (beyond social institutions) reifies the reading of symptoms as risks, in turn creating more risks, more fear (than knowledge) in consumers, and gendered practices of biopower. This move away from the language of causality to one of risk is rife across websites that provide information about depression, as we have seen.

A consumer Web page named Healthy Places, for example, republishes APA information, declaring “most environmental changes”—an unwieldy collection of phenomena that includes death, divorce, and new motherhood—to be triggers or “risk factors” of depression (APA, 1994). This discourse functions effectively to reduce what are elsewhere termed social *causes* to triggers and to rename triggers as risks, causing interpolated readers to fear everyday phenomena as likely to instigate a debilitating, deadly disease. Seeking to make this glossing persuasive, the Web page charges that risks “afflict” poor single mothers, who “live with loneliness, financial stress, and the unrelieved pressure of rearing children (alone)” (APA, 1994, p. 3). In this gendered discourse, structural social problems largely impacting women are reduced to disorderly symptoms, made manageable via risk-monitoring and drugs. The logical paradigms of neo-liberalism and gender bias are inextricable here, where the APA targets women—*most* at risk for social harm and neglect—to personalize hardships as symptoms requiring biotechnical management. Nowhere does this discourse critique or even acknowledge the social harm done to women as “social problems.” Instead, the discourse and visuals focus on the personal *impact* of risk and women’s duty to recognize and repair these faults via biopsychiatric technologies. Risk, in other words, is the linchpin marrying gendered depression epistemology to biopsychiatric consumerism.

A decade ago, Richard Sennett (1998) asserted that the new world of corporate re-engineering had dissolved hierarchies and brought a sense of risk requiring personal character, flexibility, and the constant reinvention of self. By the year 2000, the depression script had permeated *broad* consumer health discourses, adding mood as a new site for personal-risk negotiation and self-reinvention. Sennett’s theory is linked to the depression script through the element of productivity; late-capitalist work environments and pharmaceutical discourses each idealize personal thrift, streamlined behaviours, and self-management in workers/multitaskers. The poor functioning typified by depression is easily gendered and pathologized in the competitive business worlds and chaotic domestic environments of North America. This gendering is most evident in pharmaceutical advertisements that stereotype male and female social roles and imbue them with risk. And where depression risk is presented as bred from chaotic systems,

biotechnical solutions (that are actually unstable and poorly understood) are made to appear a reasonable route to improved mood, functionality, *and* productivity. This unsteady linkage requires logical massaging, which is achieved by calling up outdated gender frameworks.

This re-framing of subjectivity through risk is the key to the biopower achieved by depression discourses. In the discourses I have analyzed, new depression promotions are articulated in the guise of autonomized self-scrutiny and biotechnical recovery practices, where “responsibilized” individuals take it upon themselves to curtail their personal risk (Dean, 1991). Replicating centuries of gendered psychiatric bias in contemporary depression, new campaigns target female subjects, selling sweeping new diagnoses, pathologizing common female social and somatic experiences, and re-framing social neglect and abuse as symptoms. Stereotypical gendered roles are thus reconstituted in late-capitalist cloth through gendered risk promotions. Where campaigns, for example, appeal to male subjects as needing respite from capitalist labour demands, female subjects are framed as responsible for career, home, and children, as well as chaotic social problems and unstable bodies. As such, it is primarily women who require techno-augmentation to facilitate multitasking and orderliness.

### Reviewing the economy of depression

In the new discourse on depression by NIMH, NAMI, and the APA, as well as those of drug makers Eli Lilly and Pfizer, the presentation of broad-spectrum depression that can afflict anyone recalls and reestablishes the *feminine* bias of depression. Where “real men” are asked to acknowledge a biologically manifest depression as active, masculine subjects, depressed women are framed as subjected victims of unstable bodies. Where depressed men in recovery are signified as gaining potency and activity, recovering women are laden with multitasking expectations and positioned for a romantic “return” to an (allegedly) coherent self. As a result, new forms of gendered biopower are created in new diagnoses, new risks, and new recovery practices taken upon the self.

Web campaigns accomplish this complex re-gendering of depression discourse by transforming the logic of the discourse from one of causality to one of risk. This move is supported by the cultural lauding of biopsychiatry, which simultaneously reduces depression to a chemical imbalance and expands the category of who is at risk. In so doing, the market for the pre-emptive prescription of these drugs is pried open. “Real men” and re-feminized discourses espouse essentialized notions of gender in tandem with discourses of risk and neo-liberalism, framing individuals as responsible for their symptoms. This discursive strategy refigures specific individuals as managers of populations—a practice, warns Nikolas Rose (2006) that redistributes work formerly designated to the state and social institutions.

As Rose claims, this new form of biopower—management through the body—resides in practices of “translation”: acts of calculation and persuasion by which an actor or force acts on behalf of itself or another<sup>12</sup> (2006). Producing new barometers for health and illness, promotional depression discourses transform individuals into self-managing consumers whose improved functioning significantly benefits society, the state, and industry, at low cost. Depression



campaigns, then, articulate a concerning, gendered subjectivity that is *essentially* linked to economic and social health and sets us on new, less-empowered courses of citizenship. Mood-health logic makes sense only when inscribed in a neo-liberal, late-capitalist model, where the consumer/citizen is defined as one whose actions benefit the economic and social needs of self, society, and, not least, national industrial infrastructures.

As Emily Martin (1994) has argued, complex-systems theory presumes that *small* changes cause massive instability in biological (and industry-organizational) systems and rationalizes a need for flexibility among subjects of late-capitalist culture. The current depression script assumes this need for flexibility and adaptation (even augmentation) among specific depression subjects, vulnerable to a growing set of symptoms. The script garners credulity by producing knowledge both through repetition and logical ruptures—"the rich uncertainty of disorder" lying behind the "visible facade of the system" (Foucault, 1969, p. 76). Because it strategically blames the environment and/or body in a complicated (and problematic) argument, the depression script tactfully employs gender to marry broad-spectrum diagnosis to biotechnical recovery.

A highly constrained diagnostic economy is created through the script's broad-spectrum logic. Despite its illogical statements and contradictions, however, the script works effectively to interpolate consumers, as evidenced by rising rates of minor depression and antidepressant consumption. This (unstable) script has a seductive quality, best understood through the modes by which it transforms social problematics into individual risk and through its creation of fissures in the discourses that result in new knowledge and new practices upon the self. NAMI's script, for instance, demonstrates the slip of a gendered risk logic into the discourse of an organization premised on democratic values—patient empowerment and consumer choice. The resulting new knowledge suggests the script presents reasonable choices, even while it normalizes a binary logic of gender.

In the twenty-first century, pharmaco-technologies become the route to clarified gendered roles and improved personal and work productivity. The unstable script works to essentialize female bodies and to *feminize* self-analysis and multitasking, while it overdetermines capitalism's burden on men and covets male subjects as deserving patriarchs. The discourses of NAMI, the APA, NIMH, and big pharmaceutical companies all tacitly support this gendered framing of mood illness, while fuelling a growing cultural intolerance for disorderly subjects and a need to return to modernist, clarified gender roles. As such, Cymbalta, Prozac, Sarafem, and Zoloft are best described as symptoms of a culture that is fearful of risks—risks of illness, of low productivity, of blurred gender roles, and of post-modern dissolution. In turn, depression reflects our culture's insistence on self-responsibility and symptomatizes women's growing *inability* to function well amid growing demands for self-improvement and for "flexibility" as (overburdened) workers, mothers, and wives.

In depoliticizing social problems and relocating governance burdens onto individuals, depression promotions stymie the (female) recovery subject's possibilities for citizenship. Active democratic practices of questioning, dialogue, debate, and dissent are absent from the diagnostic economy, which instead

restrains comprehensive information and positions female citizens, particularly, as consumers. Within this economy, women are granted *choice* only among biotechnical products, while power resides primarily with experts, doctors, and husbands, who control the discourse. In glossing, re-framing, and invisibilizing social problems and highlighting their negative impact on women's functioning, these discourses create an imperative for women to act upon *themselves*—a practice reinforced by the peculiar character of advanced liberal democracies: “a complex of marketization, autonomization and responsabilization” (Rose, 2006, p. 4).

Depression promotions and advertisements illustrate the deep gender biases that still reside in culture and the extent to which these are exploitable—in this case, hailing distressed women as discursive subjects who should take personal responsibility for broad social dysfunction. Worse yet, the diagnostic economy relieves citizens, particularly men, of the burdens they should shoulder for facilitating structural bias and perpetrating violence against women in the forms of neglect, abuse, and rape. Following the logic of the diagnostic economy and the cycle it perpetuates, women, who are environmentally most “at risk,” are positioned to carry increasing social burdens until eventually we only “function” with pharmaco-augmentation.

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### Notes

1. As I have argued elsewhere, the script houses a number of overdetermined logics. Assuming that depression is a biological brain problem and reading small distresses as symptoms, the script routinely suggests that minor depression will grow into major, and major into chronic depression, if untreated. These claims are not grounded in scientific research and are in fact contested by a range of researchers, but they are nevertheless circulated routinely as the facts of depression in what can be described as a slippery-slope logic (Gardner, 2003).
2. Twenty-one percent of American Internet users have searched for information on-line regarding depression, anxiety, or other mental health issues, according to the Pew Internet and American Life Project (Fox & Fallows 2003). Given that middle- and upper-income individuals typically have Web access, one can assume that depression Web information is a major source of mood knowledge for Web users.
3. Elkin, Shea, Watkins, Imber, Sotsky, Collins, et al. (1989) have authored the most comprehensive study to date comparing the effect upon minor depression of antidepressants, psychotherapy, placebos, and doing nothing at all. They found no difference in the impact of any of these treatments. The importance of this study is further discussed in Gardner (2003).
4. These include the National Institute of Mental Health (NIMH), Healthy People 2010, and the National Depression Screening Day (NDSD), the latter being a government-run coalition of industry, government, health, and advocacy groups.
5. These critics include critical scholars, advocacy groups, mainstream journalists, scientific experts, and journalists.
6. Prozac, Zoloft, Effexor, and other such antidepressants are selective serotonin reuptake inhibitors, which are said to be smart drugs targeting serotonin problems in the brain. Pharmaceutical companies admit, however, they are unsure how the drugs work, why they work on some people and not others, and why they cause some people to become more deeply depressed or even violent.
7. Premenstrual Dysphoric Disorder (PMDD) was added by the editor of the Diagnostic and Statistical Manual of Mental disorders, Fourth Revision (The DSM –IV) appendix as a diagnosis, despite lack of support from the PMDD working group. According to Paula Caplan (1995), working-group members found the diagnostic data supporting PMDD to be flawed and inconclusive. Notably, Prozac is *not* authorized for PMDD in Europe, as the diagnosis is not listed in the European diagnostic manual (the ICD).

8. See <http://www.pharmcast.com/WarningLetters/November2000/EliLilly1100.htm>.
9. Note that Pfizer has, since August 2007, replaced the Zoloft consumer pages including the pages on PTSD, Anxiety Disorder and Panic Disorder, with a disclaimer regarding the suicidal impact associated with Zoloft use in children, adolescents, and adults. This is likely due in part to Pfizer's ongoing legal and regulatory problems. For example, a 2004 US FDA (Federal Drug Administration) ruling required Pfizer to place a "black box" warning noting the suicidal risks associated with Zoloft consumption. That same year, a citizen's consumer protection lawsuit was filed against Pfizer for their failure to abide by the FDA ruling in print ads, and various lawsuits have since been wielded against the drug company, alleging Zoloft was the cause of suicide in adult and child cases.

Some of the referred to Zoloft images and text can be accessed by searching Zoloft.com on the web archive (<http://web.archive.org>). (Search Zoloft and take July 6, 2007 link.) To date, the archive website has not yet banked the PTSD, anxiety, and panic disorder pages. In the past, these pages were accessible by following links to the diagnoses (PTSD, Anxiety Disorder, and Panic Disorder) from zoloft.com.

10. This move to promote a different type of male depression has carved a path for other discourses in recent years on male mental illness and for pharmaceutical ad campaigns that target men with symptoms of obsessive-compulsive disorder, bulimia, and panic disorder, among other diagnoses.
11. Interestingly, this campaign sidesteps research on male depression conducted at the Mayo Clinic, as reported in an article widely available online. Like the "Real Men" campaign, the article describes depression as having psychosocial (risk) factors that lead to brain disease, dualizes male and female symptoms, and symptomatizes anti-social male behaviours. However, the article clearly articulates that men "may be more vulnerable than women to depression triggered by job-related stresses" that include powerlessness at work, lack of job security or good communication skills, performance harassment, and underpaid employment (MayoClinic.com, 2007). The article plainly contends "a profound loss of identity, status and dignity" increases men's risk of depression (MayoClinic.com, 2007).
12. Rose takes this term from the work of Callon and Latour (1981).

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