

ABSTRACT

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 IN THE ANTIDEPRESSANT ERA

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This dissertation is a study of the relationship between antidepressant medications, self-understanding, and the narrative construction of self. The analysis relied upon two kinds of empirical data. First, advertisements for antidepressants in popular magazines, television, and online promotional websites were collected. Second, interviews were conducted with 23 people who were taking or had taken antidepressant medications. It is argued that antidepressants are components of the larger social processes of risk, biomedicalization, and individualization. In contrast to a narrative view, which conceives selfhood as a dialogical and embodied achievement, the antidepressants participate in a set of discourses that sustain atomistic conceptions of the self.

The analysis emphasizes the personal agency that antidepressant users bring to bear upon their use of antidepressants. Chapter one is an introduction to theories of risk, individualization and narrative as well as the ways in which narrative and selfhood are potentially transformed through the use of antidepressants. Chapter two offers an analysis

of three theoretical conceptualizations of the relationship between biomedicine and selfhood: naturalism, poststructuralism and the narrative-hermeneutic perspective adopted in the dissertation. Chapter three analyzes the advertising materials emphasizing the manner in which relationships are constructed between selfhood, biology and antidepressant medications. Chapters four, five and six introduce interview materials in order to examine: a) how people learn to use antidepressants and in doing so come to *split-off* and manage unwanted elements of their selves, b) the ways in which the popular discourse of authenticity (being a “real” self) is transformed in the encounter with antidepressants, and c) the manner in which the antidepressants are taken up in social institutions such as the family. The dissertation concludes with a reflection upon the implications of a shift from a form of selfhood composed in narrative and relationship, to a form of *post-social* selfhood composed through the use of technologies such as antidepressants.

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Dedication

This dissertation is dedicated to my parents, Jerry and Vera Stepnisky, whose continuing love, faith, and support have allowed its completion.

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I am grateful to the 23 people who volunteered their time and stories to this dissertation. In addition, I appreciate the less formal conversations I've had with friends, acquaintances, and colleagues on these matters. They spoke honestly and sincerely about experiences sometimes difficult, oftentimes stigmatized, but always intriguing. I hope that this study captures something of their experience, and offers a meaningful account of their engagement with antidepressants. I am also grateful to the administrative staff in the Department of Sociology who eased my negotiation of the dissertation process. In particular, Wanda Towles was crucial in helping to arrange interview space and tending to unexpected administrative matters. I am also thankful to the family of Milton Dean Havron and the College of Behavioral and Social Sciences who provided funds for completion of this dissertation.

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This dissertation could not have been written without the help of family. My father possesses a love of life which I try to emulate in my work and life. My mother's love, keen intellect, and expertise as a pharmacist have been indispensable in writing this dissertation. The encouragement and interest shown by my brother and sisters – Dave, Laura and Marissa – has helped me greatly. Finally, I thank Michelle Meagher who continues to fill me with joy and comfort. From her I learned the discipline necessary to writing a dissertation. More importantly I have been inspired by her care for others and dedication to a social and cultural theory that can be relevant to life as it is lived.

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Chapter 1: The Challenge of Biomedical Selfhood

The recent explosion in biomedical knowledge and technologies has given rise to a widespread reconsideration of the nature and meaning of selfhood. Where at one time the self was understood through the frameworks of religion, politics, economics, society, or psychology, increasingly theories of the self must reckon with the contemporary belief that in some fundamental way human beings are biological beings, and selfhood is mediated by brain chemistry and genetic heritage. Anthropologist Paul Rabinow (1992) argues that we are witnessing the emergence of “biosocial” subjectivities – selves, identities and communities defined through pathologies already written in one’s genetic heritage. Similarly, Nikolas Rose (2004) asks “How did we become neurochemical selves?” implying that in a world saturated with Prozac, Zoloft, and Paxil subjectivity cannot help but to be recoded within the logic of biomedicine.

I undertook this dissertation in order to learn whether the language and technologies of biomedicine are changing the way that people think about their selves and understand their problems. In particular, I took the development and spread of antidepressant medications – the selective serotonin re-uptake inhibitors (SSRIs) – as an entry point into these discourses. Given the success of medications like Prozac, Paxil and Zoloft these seemed a particularly apt starting point. Only fifty years ago, the theory and practice of biological psychiatry was largely confined to mental hospitals, and the understanding of “everyday” psychological problems was interpreted through the framework of psychoanalytic theory and other psychosocial lenses. Now antidepressants are an 11 billion dollar a year business.¹ Every year 147 million prescriptions are written,² and there are clear signs that people are taking note of these medications and

their applications (Charatan, 2000; Gardner et al, 2003; Mintzes et al, 2002, 2003). Popular images and narratives about the successes, failures and possibilities of antidepressants are also in abundance (Breggin, 1995; Falk, 2001, 2005; Kass, 2003; Kramer, 1993, 2005; Slater, 1997; Wurtzel, 1997). In both professional psychiatric practice and the cultural imagination the biological view of mental health has all but displaced the once dominant psychoanalytic perspective, and with it transformed popular conceptions of mental health. Antidepressants promise not only the restoration of psychological health, but the improvement of human capacities and well-being more generally.

Despite the fanfare surrounding antidepressant medication, this dissertation is conceived as a critique of the biological view of the self and its accompanying technologies. In particular, at stake is a view of self and suffering which conceives of people as fundamentally social, cultural and linguistic beings. Here I follow the work of social theorist Charles Taylor (1985a, 1985b, 1989, 1991) who argues that people are not automatically selves, by biological default, as it were. Rather, people become selves as they struggle to articulate their position within the moral frameworks that circulate within particular cultures and communities. In this respect, selfhood is an ongoing act of embodied, practical, self-interpretation that involves interaction and symbolic exchange with others.

My claim is that the antidepressant medications are a part of a larger trend in which biological views of the person cover over or hide these inherently relational and cultural components of selfhood. I want to show that even when mental illness is conceived in biological terms – problems within the brains and neurochemistry of

individuals – these depend upon a rich set of social psychological and cultural practices. Indeed, antidepressants gain their credibility, appeal and even their efficacy only insofar as they exist within a universe of pre-conceptions, pre-understandings, and practical activities that engage the self and its pathologies. For example, advertisements for antidepressants not only promise relief from seemingly intractable symptoms such as irritability, anxiety, sadness, and sleeplessness, but they also make appeals to ideals such as “authenticity” and “self-control.” Frequently the promotion of antidepressant medications and the debates over their efficacy overlook this aspect and leave unarticulated the complex means through which people make sense of their engagement with antidepressant medications. In doing so these discourses, and the technologies that support them, leave people alone to manage problems that are properly interpersonal, social, and cultural affairs.

In order to examine the impact of the antidepressants on concepts and understandings of selfhood I collected two kinds of data. First, I gathered advertisements for antidepressant medications that appeared in ten popular magazines between July 1997 and May 2005, I reviewed the promotional websites of two popular antidepressant medications – Paxil and Zoloft, and I studied nine television commercials for antidepressant medications (see Appendix 1 for further details). I started with 1997 because this was the year that the American Federal Drug Administration effectively allowed pharmaceutical companies to advertise prescription medications direct-to-consumer. In the process, advertisers *made available* a language of self, psychological suffering, and its presumed relationship to antidepressant medications. These ads and promotional materials provided me with an opportunity to study a widely circulated set of

images and ideas about the relationship between selfhood and biology. Clearly people come across ideas of antidepressants through other sources – friends and family, psychiatrists and family doctors, films and television, and university classrooms, among others. For this reason, I thought of these advertisements as concrete examples of ideas and images “floating” about in a *biomedical* culture.

Second, between January and June 2005 I interviewed 23 people who had taken or who were taking antidepressant medications. The goal was to learn whether the experience of taking antidepressants, and the accompanying language of biological dysfunction, shaped the kinds of stories that people told about themselves and their problems. I recruited participants with posters placed in various locations on the campus of a large American public research university, and at libraries, coffee shops, grocery stores and community centers in a heavily populated, middle class, suburban community (see Appendix 2). The posters requested interviews with people who were taking or had taken selective serotonin reuptake inhibitors (SSRIs) or selective norepinephrine reuptake inhibitors (SNRIs) for any reason. Though the majority of the people I spoke with were taking antidepressants for depression (15/23), there were also people who were taking antidepressants for anxiety (2/23), some for a combination of depression and anxiety (3/23) and others for bipolar disorder (3/23). Ten participants were students at the university and 13 were from the community, three of whom were unemployed and others in professions ranging from real estate, to acupuncture, to teaching, to research psychology. I spoke with five men and 18 women. Four of the people interviewed had used antidepressants in the past for a period of at least three months, but were no longer using them. The remainder were currently taking antidepressants and had been on them

anywhere between three months and 25 years. A key point is that with the exception of one person, the people I interviewed had not been hospitalized for their problems. They were using antidepressants in the context of everyday life. Certainly antidepressants served the purpose of overcoming intractable depression and anxiety, but they were also related to aims such as maintaining self-control and functionality at work, enabling people to pursue relationships with others, and achieving the goal of being a “real,” “normal,” and “authentic” self (see Appendix 1 for further details on method and analysis).

Before providing a history of the development and larger social significance of antidepressant medications I want to say a few words about the theoretical problems that drive this dissertation. As already noted, the most general purpose is to provide a critique and sociological account of antidepressant medication and its impact on self-understanding. More specifically the dissertation is guided by two theoretical problems. First it is conceived as an exploration in narrative theory, and in particular the relationship between narrative, selfhood, and antidepressant medications. Within the last twenty years, as one aspect of the linguistic and cultural turn in the social sciences (Brown, 1987; Gergen, 1982, 1994a; Shotter, 1993a, 1993b), sociologists have increasingly argued that selves are constituted in the linguistic and symbolic activity of story-telling (Bury, 2001; Frank, 1995; Kearney, 2002; Ricouer, 1984; Riessman, 1990; Robinson, 1990). This moves beyond the broad symbolic interactionist claim that human beings are symbol using creatures, and further insists that life is organized and made meaningful through the stories that people tell about themselves with and for others. The self, on this view, is not a natural fact – a human property given in advance of cultural

and social engagements. Rather, selfhood is a dialogical accomplishment that emerges as individuals articulate their position within cultural frameworks. In this sense, the idea of narrative is relevant at two levels of analysis. First, cultures and communities tell collective stories about what it means to be a self. Whether shared or contested these stories define a basic drama and establish the taken-for-granted situation – or “horizon of meaning” – out which life can be lived (Gadamer, 1993: 302). Second, insofar as persons take up positions within larger narratives they come to develop a story of their own. The practical, embodied activity through which people struggle to say who they are in relationship to the narratives of their times forms the basis of personal narrative. I will develop a more complete theory of narrative in chapter two. However, in anticipation of this I’d like to introduce two ways in which antidepressant medications, and the biological discourse that surrounds them, potentially impact the kinds of stories that people tell about their lives and problems, as well as the function that these kinds of narratives serve in managing and making sense of problems such as depression and anxiety.

As new stories about the self and its pathologies circulate within a culture people are provided with a new *content* that can be incorporated into stories. In the case of biomedicine, conceptions of selfhood are deeply influenced by a scientific and naturalist worldview that seeks objective understandings of everyday problems. It introduces people not only to a set of ideas about what it means to be a self, or to be psychologically ill, but it also provides technologies – such as antidepressant medications -- whereby people can, in a sense, bring the idea of biology to bear on the management and organization of their own lives. Indeed, one of the claims of this dissertation is that the

narrative of biomedical selfhood becomes an unavoidable practical reality as larger numbers of people regularly consume and engage their problems with medication. For example, biomedical theories of psychological distress posit an internal realm composed of brain matter, neurotransmitters, and synaptic gaps. Where according to some psychoanalytic theories, depression is theorized as a loss of relationship with an idealized mother (Kristeva, 1989), the biological theory tells a story in which depression is attributed to imbalances in neurotransmitters. So told, the story of depression envisions a new origin of psychological suffering (e.g. the loss of idealized relationships becomes secondary to the damage caused to the brain), but also entails a new assignment of responsibility (e.g. insofar as depression is attributed to biological dysfunction no one person is to blame for the onset of depression) and suggests a new course of action (e.g. the idea that one might overcome such sadness in a psychoanalytic “transference” relationship is replaced by the idea that adequate treatment depends upon a biochemical intervention). Of course, it is too strong a claim that one story is wholly replaced by another, and as I will show throughout the dissertation the understanding of the causes and meaning of psychological distress incorporates both old and new content. Chapter five in particular argues that in addition to introducing a biological understanding of psychological distress, the meaning of antidepressants are frequently articulated with modernist values of self-control and authenticity.

In addition to introducing new content into the story of self and suffering, antidepressants also transform the structure and function of narrative and self. Here the idea of narrative carries a great deal of theoretical weight. It is not merely a medium of communication – a way of describing what people already know about themselves.

Rather narrative is a fundamental constituting structure that makes selfhood – of various kinds -- possible in the first place.³ People acquire identities and a sense of purpose, direction, and “ontological security” as they situate themselves within personal and group narratives. Narratives can open people up to others and purposes that transcend the self. For example, sociologists have long argued that the twentieth century witnesses the disappearance of “grand narratives” (Lyotard, 1979). At one time, and in various communities, selves were constituted through large overarching stories that bound individuals to community purposes and destinies. Christian medieval narratives placed individuals within a religious cosmology and conceived of self-knowledge as the discovery of God’s immanent presence. Nineteenth century Marxist philosophies placed the individual within the context of an historical dialectic driven by the ideal of social revolution and the realization of a socialist utopia. These kinds of overarching stories allowed individuals to transcend the minutia of everyday life and gain meaning through participation in sources greater than themselves. Even if these narratives could not always stave off psychological suffering, they gave suffering a larger meaning.

In contrast, in the contemporary world selfhood and suffering increasingly acquires meaning within individualized narratives. These valorize the life of the self as a good in itself, and see self-fulfillment, and the discovery of one’s own purpose, as crucial to the full development of meaningful selfhood (Taylor, 1989; Guignon, 2004). Here narrative does not constitute selves in an “open” relationship between self, other and larger cosmologies. Rather narrative, is, in a sense, contracted – it closes in around the self and in so doing transforms the role that other people, as well as larger cultural frames play in constituting selfhood. This is a central theme throughout the dissertation. What

happens when selves lose their grounding in larger, shared stories? I will argue that selfhood depends upon relationships with others and in particular, stories that transcend the self and, in a sense, make it bigger than itself. This depends upon a certain understanding of the inherently social and relational character of selfhood, and an understanding of narrative as a medium that can “metabolize” feeling, emotion, and unruly aspects of the self.⁴ Antidepressants enter into this story in two senses. First, they gain their meaning and sensibility within a culture that valorizes individual, atomistic, self-contained selfhood. Antidepressants are part of a discourse that views psychological distress as an internal and individual problem. In their ability to bring mood and feeling under individual control they further reify this ideology. Their seeming efficacy is further proof of the argument that psychological distress really is something that emerges from within the recesses of synaptic gaps.⁵ Second, in their ability to manage and modify mood, antidepressants serve as a kind of antidote, or means of survival, in a culture that individualizes selfhood. In the absence of “good” narratives that can help people to be more than isolated atoms, antidepressants offer an opportunity to handle the fallout of the loss of this kind of self-sustaining sociality.

This engagement with narrative is the first theoretical problem of this dissertation. Now I’d like to introduce the second problem. Early into the project it became clear that many of the people I spoke with viewed depression and anxiety as discrete entities that posed risks to their selves and others. Depression, for example, was a force unto itself that could overtake the normal, everyday self and cause it to lie in bed all day, think loathsome thoughts, attempt suicide, or burden others with its “toxicity.” The discovery that “my sadness is a biological condition over which I have no direct control” led to a

further resolve to manage and contain this “disease” through the use of antidepressants. In this respect, antidepressants acquire their meaning and significance within what some sociologists have called a “risk” society (Bauman, 2001; Beck, 1992; Castel, 1991; Giddens, 1991; Lupton, 1999). According to Deborah Lupton there are three main schools of risk scholarship: risk society, governmentality, and cultural/symbolic. All three perspectives offer insight into the use of antidepressants and their implications for selfhood

The “risk society” perspective originates in the work of Ulrich Beck (1992), Anthony Giddens (1991), and Zygmunt Bauman (2001). In particular it focuses on macrosocial problems associated with late, second, or reflexive modernity. Beck, in particular, has argued that the first, or early, modernity, characterized by industrialization and the bounded management of risk, has entered a new phase in which modern technologies and scientific knowledges have produced unanticipated dangers – unintended consequences. These pose incalculable risks of unbounded global significance – the threat of *ecological destruction* through pollution and the deterioration of the ozone layer, the worry over *financial security* and the potential collapse of financial markets, and the danger of *transnational terrorism*. Lupton (1999a) adds four further categories of risk: lifestyle risks, medical risks, interpersonal risks, and criminal risks (p. 13 - 14). Despite this seeming proliferation of risk at both institutional and personal levels, risk theorists generally agree that the world has not necessarily become a more dangerous place to live. Rather, risk is an interpretive framework, a way of dealing with hazards and dangers which asserts that “something can be done” about the unpredictability and uncertainty encountered in daily life. The “governmentality” perspective, rooted in the

work of Michel Foucault, emphasizes this sense in which risk is a “mentality” and a form of disciplinary power, a means by which neo-liberal bourgeois societies organize and manage populations. On this view, the idea of risk is allied with the goals of a “democratic humanism” that enlists individuals to take responsibility for the surveillance and management of risks posed to them as well as the risks that they pose to others. Finally, the “cultural/symbolic” perspective comes from the work of anthropologist Mary Douglas ([1966]1969, 1992). It details the way in which cultural classification schemes construct particular objects, social groups, and individuals as foreign, dangerous, and risky. Conceived as risky “others” these entities pose a threat to the integrity and well-being of individuals and social groups and thereby organize the conduct of everyday life. Lupton’s (1999c) research on “pregnant embodiment,” for example, demonstrates how modern medical science constructs the pregnant woman as a dangerous, “abject” entity whose body threatens to destabilize the modern values of “containment, autonomy and self-control” (p. 78). So conceived, the pregnant body becomes something that poses a risk to the well-being of the pregnant woman, as well as a risk to normative conceptions of embodied selfhood.⁶

Despite the differences implied by each of these perspectives there are two common themes of relevance to this dissertation. First, risk is tied to processes of individualization. Here a central accomplishment of the risk society is to transform social problems and institutional contradictions into problems for individuals. Beck says “the Western type of individualized society tells us to seek *biographical solutions to systemic contradictions*” (Beck and Beck-Gernsheim, xii).⁷ This individualization thesis, I suggest, holds something in common with a line of critique that reaches back to culturally

oriented psychoanalytic theories of the 1960s and 70s. In particular, theorists such as Phillip Rieff (1966) and Christopher Lasch (1979, 1984) argued that the disappearance of overarching moral tradition and narratives gives rise to a defensive “narcissism”⁸ – a form of selfhood self that has no firm or secure relationships with others, and that seeks some kind of completion and integrity through the pursuit of personal interests and indulgences. This kind of self is characterized by a loss of connection to other people, a growing egoism, a constant feeling of boredom, an ever-present sense of meaninglessness, and a pervasive fear of the threats posed by entities external to the self. In this process, other people, and cultural objects more generally, serve the utilitarian purpose of mirroring the self and its desires.⁹ Here self-understanding and narration cannot find room for the strangeness and difference found in other people. That is, the self-enclosed limits of the self cannot be expanded through an extension of what Hans George Gadamer (1993) calls the horizon of meaning. Rather, others only appear through the illusory projection desired by the narcissistic individual.

More recently, Giddens has developed this theme of defensive retreat in his writing on individualization, self-narration, and the life trajectory of the self. He draws on Rieff, Lasch and other psychoanalytic theorists such as Donald Winnicott and Ronald Laing to suggest that in the risk society the achievement of “ontological security” depends upon establishing a protective “cocoon” around the self.¹⁰ I want to suggest then that the widespread use of antidepressants is a response to the threat of risk in everyday life, further necessitated by the disappearance of theories and stories of the self that transcend the self. Indeed, where previous therapeutic approaches depended upon the relationship between self and other as a means of converting psychological distress into

meaningful self understanding, the biological model transfers care of the self to the individual. Antidepressants emerge, not merely as a response to the pervasive feeling of being-at-risk in everyday life, but also as a defensive aid to the individual who is increasingly left to engage psychological distress on his or her own. Antidepressants protect the self both from the external risks of everyday life, and the internal dangers of depression and anxiety.¹¹

This brings me to the second argument about the relationship between antidepressants, self, and risk. Antidepressants are accompanied by discourses that constitute depression and anxiety in the language of risk. In other words, the cocooning of self is not merely a defensive retreat, but it is also supported by positive images that construct suffering, worry and fear as entities to be feared and guarded against *in themselves*. Indeed, one of the arguments developed in this dissertation is that the encounter with antidepressant medications initiates a process through which the chaos and meaninglessness of depression is converted into a story in which depression and anxiety are thought of as biological things that are not truly part of the self. In contrast to the psychoanalytic narrative that attempts to integrate inexplicable emotion into a story of the self, biological theories, aided by the mood altering properties of antidepressants, maintain a split between behaviors and feelings that are “not me” and behaviors and feelings that are “me.” Conceived as such, depression is set up as a biological problem that operates according to its own laws and rules and, even when treated with antidepressants, remains a presence and threat to the well-being of self. In this respect, the emergence of antidepressants and the individualization of risk are connected to processes of medicalization and biomedicalization. Depression is rendered as something

within the biology of self – rather than in between persons – and at the same time a responsibility of the individual self. Consistent with theories of risk, the antidepressants are part of a discourse that on the one hand constitute psychological suffering as a threat to the self, and on the other hand offer techniques and solutions which suggests that through the technologies and knowledges of medical science “something can be done” about the miseries and dangers posed by biological imbalance.

Finally, I want to be clear from the start that my concern is not with antidepressant medication *per se*, but rather with the sets of discourses that are oftentimes used to interpret the meaning and significance of these medications. Moreover, this is not a study on the cause of psychopathologies such as depression and anxiety. While, inevitably, I discuss some theories of the origin of psychological distress, these are introduced in order to describe the differences between, for example, biomedical and narrative theoretical conceptions of selfhood. This dissertation, then, is about the way that antidepressants and their supporting discourses constitute people’s understanding of their self and suffering. While clearly the significance and meaning of antidepressants for selfhood can vary,¹² it is by and large the finding of this research that antidepressants are bound to logics of individualization, risk and medicalization. This is a problem because it covers over the social character of suffering and selfhood and in so doing it undermines the development of narratives that could conceive of persons as more than isolated, atomistic beings.¹³ It treats narrative as mere talk, and underestimates the power that shared stories have in shaping, healing, and sustaining selves. Indeed, though I do not propose a nostalgic return to the grand narratives of yesteryear, this dissertation is committed to developing a theory of self and suffering that emphasizes the concept of

relational, embodied, practical understanding. This is opposed to what I take to be the dominant view in the social sciences – that of the disembodied, atomistic, self-enclosed self. This is the self assumed in cognitive psychology,¹⁴ rational choice theory,¹⁵ and medical psychiatric science. It seeks the problems of selfhood in individual mental structures and brain materials, and in so doing treats culture and relationship as mere variables, rather than the fundamentally self-constituting media that I take them to be. As a resistance to mainstream social science Taylor, as well as others, are in the process of developing languages of selfhood and social relations which significantly deepen the capacity to describe what is going on in the course of everyday social interaction. Rather than treating the relationship between self and other as a transparent set of communicative interactions – a mere passing of messages to and fro – the space between self and other and cultural meaning systems is treated as a place of embodied practical action. By drawing attention to the way in which the people I spoke with practically engage antidepressant medication, I plan to show where nonscientific narratives enter into or frame their stories, but also how these practical engagements constitute a world rich in activity and struggle. This may not transform the larger processes which encompass biomedical understanding, but it does try to return the story of antidepressants to the realm of language and narrative, thereby countering some of the more neglectful tendencies of the biomedical society.

The Rise of Antidepressants

The idea of an antidepressant medication that targets specific mental illnesses and psychological capacities emerges out of a longer history in which psychology and psychiatry came to dominate the mindset of American and North American culture, more

generally. Rieff, (1966) for example, argues that the emergence of “psychological man” defines a larger shift from cultures organized around religious frameworks, to those organized around the pursuit of individual “well-being.” In this respect, psychoanalysis and the psy-disciplines more generally (psychiatry, psychotherapy) provide both a means of sustaining and supporting the self in an increasingly specialized and industrialized society, but also elaborate a new set of metaphors and technologies indispensable for thinking about selfhood in the 20th and late 20th century (Rose, 1996). As a backdrop for the narrative theory that frames this dissertation I am particularly interested in the historical significance of psychoanalytic theories. Psychoanalysis is relevant not only because of its cultural influence in the early and mid 20th century, but also because it provides a counter example for thinking about the relationship between self and narrative. Diane Bjorklund (1998), for example, demonstrates the impact of psychoanalytic thought on autobiographical writing in early twentieth century America. In contrast to previous eras in which autobiography was informed by religious and then neo-Darwinian thinking, early 20th century autobiography regularly incorporated the language of unconscious conflict, repressed memory, and interpersonal childhood conflict.

Psychoanalysis theory will provide a reference point throughout the dissertation, first because of its widespread influence on 20th century popular consciousness and second because it provides a model of narrative self-understanding that can counteract the kinds of individualizing narratives promoted through biological theories of mental illness. In the mid-twentieth century psychoanalytic approaches dominated office practice, whereas biological psychiatry was largely relegated to hospital practice (Healy, 2002). In particular, psychoanalysis dealt with the “neuroses” of everyday life, addressing

problems of, as Freud suggested, work and love. Indeed, on the psychoanalytic model, “mental illness” was not a problem restricted to a few madmen and women, but rather an inherent tendency of all modern persons. The cost of modern life is the repression of instinctual energies and the subsequent development of repressive psychological structures (Freud, [1930]1989). Even though classical psychoanalysis sought the origins of psychological distress in the internally conflicted spaces of individual persons, these were always mediated by relationships with others. For example, neurotic symptoms emerged in the context of earlier familial scenarios, the most important for Freud ([1905]1977) the Oedipal stage of development in which the child breaks its libidinal bond with a mother and identifies with a father figure.¹⁶ Subsequent theoretical work has placed the climactic moment in childhood development at earlier, pre-Oedipal stages in which the child struggles to overcome a primary narcissism, establish boundaries around the self, yet maintain the capacity for loving relationships with others (see especially the work of the object-relations school of psychoanalysis, e.g. Klein ([1957]2002)). Further, as Jessica Benjamin (1978, 1988) has argued, the capacity to establish reciprocal relationships between self and other is shaped by larger cultural factors. Drawing on the work of Hegel and Frankfurt school critical theorists such as Max Horkheimer and Theodor Adorno, she argues that the instrumental and scientific rationality of modern western civilization militates against the establishment of reciprocal relationships and cultivates relationships of power and domination. In either case the significant point is that in the psychoanalytic approach the development of the self is embedded in relational scenarios.¹⁷

Of course, biological theories also allow for the mediation of internal biological states by social factors. Chemical imbalances are not necessarily something towards which a person is biologically and genetically predisposed,¹⁸ but rather can be a product of a complex interaction with one's social and cultural environment. The difference that matters here I think is the view taken towards resolution of psychological distress. In this respect, the psychoanalytic approach is narrative and social, and the biological approach individualizing. Here the concept of a "talking cure" - introduced in Freud's and Breuer's ([1893]1991) *Studies on Hysteria* - provides a relevant example. First, talking – or self-narration -- provides continuity between inexplicable and intractable symptoms, experienced in the present, and their relationship to earlier moments in one's life-story. In the model of psychic life outlined in *Studies on Hysteria* Freud argues that hysterical symptoms result from a dissociation of affect and memory. "Hysterics" he says "suffer mainly from reminiscences" (p. 58). When affect is not given expression it is converted to bodily symptoms. The resolution of these symptoms occurs when the hysteric is able to recount, or re-narrate, a forgotten moment during which feelings of disgust, hurt, betrayal, etc. were stifled and therefore not permitted to work themselves off. Certainly, Freud's model of psychic life was to change across his career,¹⁹ however the important point is that he was developing a view of the person in which psychological suffering could be traced to disavowed aspects of a personal history. The successful resolution of mental illness, then, depended upon a reincorporation of lost aspects of self into the ongoing narrative.

Second, the talking cure unfolded within an indispensable therapeutic relationship. Here the concept of "transference" and "countertransference", so central to

psychoanalytic thought underlines the inescapably social aspects of narrative self-understanding. At least on this view, narrative understanding must always pass through another person. In psychoanalysis, the analysand unconsciously projects central figures from his or her own past onto the analyst. In this way the analysand is able to actively work through internal conflicts in an interpersonal space. Finally, for Freud ([1930]1989) psychoanalysis was not only a model for the resolution of personal psychological conflict, but it also became a model for social relations more generally. The task of the “civilized” modern society was to provide opportunities for the sublimation of disavowed elements in psychic life. Here cultural expression – shared or collective narratives – become a means of mediating the relationship between self and society.

For the purposes of this dissertation, then, the most significant difference between the biological model and the psychoanalytic model that preceded it is the sense that narrative understanding and interpersonal relationship is indispensable not only to the resolution of incapacitating psychological conflict, but also to engaging everyday life in a world without larger mediating structures such as religion. Indeed, to this end Phillip Rieff (1966) has argued that Freud’s psychoanalytic model is best suited to problems of the modern world – in contrast to post-Freudians such as Carl Jung, Wilhelm Reich and D. H. Lawrence who, according to Rieff, retreat into a nostalgia for religious community – Freud’s approach recognizes the growing individualism of contemporary society and seeks a way of life that can first address the needs of individuals who are, in many ways left on their own to develop a meaningful life, and second retain meaningful and loving contact with the people around them and the social world in which they live. In this

context, the ability to tell a story that both provides a grounding for the self yet reaches out to others seems a worthwhile pursuit.

In contrast, the biological theory of mental illness treats narrative and sociality as a secondary component to successful resolution of psychological conflict. Stories that a person tells about their selves and relationships are in a sense powerless on their own – they are more like inputs into the biological system which do their real work by changing brain chemistry or modifying synaptic connections. In this context, the biological view is increasingly allied with the now dominant cognitive-behavioral therapeutic practices that focus not so much on the telling of a shared story but on the management and control of cognitions. This is a view endorsed by the American Psychological Association, promoted on antidepressant websites in which cognitive behavioral therapy is touted as the most effective means of treating depression and anxiety, and was the dominant mode of therapy reported by the 23 people with whom I spoke.²⁰ It should be stressed, however, that this individualized view of biology is not a necessary component of biological and medical theories of psychological distress. Indeed, numerous critical biologists, including scholars such as Donna Haraway (1991a), Elizabeth Wilson (2004), and Evelyn Fox-Keller (1987) have proposed models of biological understanding that are historically and culturally situated, and that assume a relational conception of human being. I will explore some of these approaches further in chapter two. For now, the important point is that dominant biological and medical models of mental “illness” are quite consistently reductionist and individualist.

Let me then turn the story of the development of antidepressants, and their subsequent move from the backwards of hospitals and laboratories of researchers into

popular medical practice and the cultural imagination. Antidepressants emerge out of a more general social processes of medicalization and biomedicalization (Clarke, Shim, Mamo, Fosket and Fishman, 2003; Conrad, 1975, 2000; Zola, 1972), which, as I indicated earlier, are related to processes of individualization and risk . This includes developments in scientific and pharmaceutical technologies, transformations in way that biomedical knowledges and technologies are circulated and distributed, and the reorganization of medicine within large corporate political economic structures (“BigPharma”). This matrix of social forces creates an atmosphere in which everyday problems, once conceived as moral and social problems, are reconceived within frameworks of illness and health. Familiar examples include alcoholism, post-traumatic stress disorder,²¹ premenstrual syndrome,²² attention deficit disorder²³ and of course the depression, anxiety and vague forms of everyday malaise considered in this dissertation. In this respect, biomedicine does not merely offer correctives to already existing illnesses, it produces new instances of illness and disease that increasingly impinge upon broad areas of life.

The modern story of biological psychiatry, and the subsequent biomedicalization of everyday sadness (depression) and worry (anxiety), begins with the development of the neuroleptic/antipsychotic medication chlorpromazine (Thorazine) in the 1950s.²⁴ Even though psychiatrists had been experimenting with barbiturates since the turn of the century, David Healy (2002) argues that chlorpromazine was the breakthrough drug which drew attention to the possibilities of a biological psychiatry.²⁵ Originally developed as an antihistamine, hospital psychiatrists soon learned that chlorpromazine also had the power to relax violent and withdrawn schizophrenic and manic patients.

Early press reports hailed chlorpromazine as a “wonder drug”²⁶ and “star performer.”²⁷ It lead the otherwise hopeless “mental cases” to “sit up and talk sense.”²⁸ Even so, chlorpromazine and the medications that were to follow its development were treated with caution. Given the continuing influence of psychoanalytic approaches, even strong advocates for the medication argued that chlorpromazine could not “cure” mental illness.²⁹ It merely put patients into a state where they could do the more important work of psychotherapy. Over the next thirty years this relationship was to reverse itself. Medications would come to be seen as a “deep” cure that could get to roots of mental illness, and psychotherapy an adjunct or supporting form of treatment.³⁰

At about the same time, researchers synthesized the first antidepressants--tricyclic medications such as the monoamine oxidase inhibitor iproniazid (Marsilid), and the tricyclic antidepressant imipramine (Tofranil). The term “antidepressant” was coined in 1952 though it would not enter into clinical use until the late 1960s and popular discourse until the 1980s (Healy, 2002: 56). Much more successful, were the minor tranquilizers such as meprobamate (Miltown).³¹ Dubbed a “happy pill,”³² “a peace pill,”³³ or a “don’t give a damn pill”,³⁴ two years after its 1954 market release Miltown was the fourth largest selling prescription medication in the United States, earning the drug industry an unexpected 100 million dollars a year.³⁵ Derived from the muscle-relaxant mephenesin, Miltown, and drugs like it, bridged the gap between hospital psychiatric practice and the treatment of problems in everyday life. In contrast to chlorpromazine which was primarily administered within psychiatric hospitals, Miltown was prescribed on a walk-in basis. It calmed nerves and managed the minor neuroses of an increasingly hectic and economically vibrant post-war America. Despite this initial success, the enthusiasm for

the minor tranquilizers and later the benzodiazepines such as the 1970s wonder drug Valium (“mother’s little helper”) raised increasing concern. Already in 1957 an article in *Time* magazine worried that Miltown might make people indifferent to politics, that it was addictive, and that it had dangerous side-effects such as tremors and drowsiness.³⁶ Given these popular concerns, and limited developments in psychopharmaceutical technology, the period between the late 1950s and 1980s gave rise to few new marketable psychiatric drugs.

The turning point was to come with the development of new laboratory technologies. Up until the 1970s the development of psychiatric medications operated according to accident rather than rational design. However, the late 1950s, 60s and 70s gave rise to a number of technologies and theories that transformed the nature of drug research (Healy, 2002; Valenstein, 1998). In 1955, a machine that could measure neurotransmitters such as serotonin, dopamine and norepinephrine – the spectrophotofluorometer – was invented. A related breakthrough came with the emergence “receptor profiling.”³⁷ Though the idea of the receptor had been present since the late 19th century, in the 1980s with the emergence of radio profiling and PET scan technologies, researchers were able to make distinctions between specific receptors and their binding properties. From this point forward, rather than running lengthy and time consuming drug tests on animals and humans, researchers were able to “directly” observe the action of particular chemicals on the receptors that they argued were involved in specific kinds of brain activity.

More significant for this review, these technologies introduced a new kind of imagery into medical psychiatry. Where previous research had relied upon organic

metaphors which speculated on the impact that medications had on various brain structures, researchers increasingly relied upon metabolic and cybernetic metaphors. These detailed the role of *neurotransmission* and *synaptic communication* in the regulation of mood and behavior.³⁸ This shift in metaphors was also reflected in the popular press. In 1979 *Newsweek* ran a lengthy article introducing the “new era” in psychiatry.³⁹ In contrast to earlier articles which suggested that the action of psychiatric medications were mysterious, this article made specific claims about the relationship between individual neurotransmitters, receptor types and the role that this relation played in mediating specific psychiatric conditions. Significantly, this article also introduced close up diagrams of neurotransmission, thereby allowing a popular audience to envision this new internal life. Along with self-diagnostic checklists, these kinds of images have now become a staple in popular accounts of psychiatric medicine.

This is the context out of which the first SSRI – Eli Lilly’s Prozac (fluoxetine hydrochloride) – emerged in 1987. Relying upon the new imagery of neurotransmitters and receptors, Prozac was promoted as a “targeted” medicine in several senses. First, it was developed using a scientific technique that presumed to match up a particular chemical with a particular problem – it got the heart of the matter. Second, in comparison to the tricyclics and monamine oxidase inhibitors, Prozac was said to be relatively symptom free. Early popular ads for Prozac directly addressed the concerns associated with earlier “everyday” medications, specifically claiming that it is “not a tranquilizer,” that it “won’t take away your personality” and that its side effects are only “mild.”⁴⁰ Furthermore given the relative safety of SSRIs psychiatrists and increasingly family

physicians were able to test a range of medications on single patient, with no worry about adverse side effects.⁴¹

Soon thereafter Prozac was joined by GlaxoSmith Kline's Paxil (paroxetine hydrochloride, 1992) and Pfizer's Zoloft (sertraline hydrochloride, 1993).⁴² The emergence of these competitors also signified the growing role that market forces played in the design and promotion of medications. Prozac, like the tranquilizers before it, had been marketed as a medication that could address problems of everyday life. In particular, it cornered the market on depression. Paxil was also promoted as an antidepressant, but distinguished itself as a medication best suited for the treatment of chronic and social anxiety disorders. Indeed, as Healy (1997) suggests, the marketing focused not so much on the promotion of the medication but on the promotion of these previously unfamiliar disease types. In this respect, antidepressants did not merely treat already existing conditions, but they operated within a discourse that transformed previously "normal" worries and anxieties into biological illness traceable to an abnormal imbalance in neurotransmitters.

At present, depending upon the specific medication, antidepressants are approved for treatment of at least eight different DSM-IV defined conditions: major depressive disorder (MDD), social anxiety disorder (SAD), generalized anxiety disorder (GAD), panic disorder, posttraumatic stress disorder (PTSD), premenstrual dysphoric disorder (PMDD), obsessive-compulsive disorder, and bulimia nervosa. This does not include the numerous unaccounted "off-label" prescriptions written by primary care physicians.⁴³ Indeed, as Metzl and Angel (2003) argue, the relative ease with which these medications can be prescribed contributes to a "diagnostic bracket creep." Metzl and Angel borrow

this term from philosopher Jaqueline Zita (1998) and describe it as a process in which “novel medications catalyze a process whereby diagnostic category distinctions become less clear as different conditions respond positively to the same drug” (Zita, quoted in Metzl and Angel, 2003: 577). As it was learned that antidepressants were effective in treating a large range of symptoms, diagnostic category distinctions became less clear, and began to include “symptoms” of everyday life. In particular, emphasizing the gendered construction of antidepressants, Metzl and Angel traced a transformation in the way in which the popular magazine articles depicted the problems addressed by Prozac. Where earlier articles (back to 1985) relied upon DSM diagnostic terminology, more recent articles (up to 2000) implied that SSRIs dealt with the problems of “marriage, motherhood or menstruation” (in the case of women, p. 582), and problems with “aggression” (in the case of men, p.582). Metzl and Angel’s study demonstrates that the presumably neutral efficacy of antidepressants is firmly embedded in larger culture narratives – in this case, narratives about gender.⁴⁴

Prozac, and the antidepressants more generally, was also introduced to the popular imagination through a growing set of memoirs and public debates. In addition to numerous magazine articles about the medications, Elizabeth Wurtzel (1997) wrote *Prozac Nation*, Lauren Slater (1997) *Prozac diary*, and Persimmon Blackbridge (1997) *Prozac Highway*. This was followed by a male perspective on the drug when in *Esquire* magazine John Falk (2001) detailed his experience as a war correspondent on Zoloft. More recently this has been published as book length account *Hello to All That: A Memoir of War, Zoloft, and Peace*. In contrast to previous memoirs of mental illness, these books made the medication – Prozac or Zoloft – a central character in the story.

Slater outlined her up and down “love affair” with the medication. Blackbridge examined the relationship between psychiatric medications and Internet chat rooms. Falk treated the medication as an integral component of his experience in Bosnia. In these accounts antidepressants were presented not only as an antidote to in-born chemical imbalances, but as normal and perhaps necessary feature of everyday life in the late 20th and early 21st century.

Furthermore, the widespread use of antidepressants have given rise to a series of public debates which directly address the relationship between the medications, psychological suffering and human selfhood. Peter Kramer (1993) is most famous for his claim that antidepressants are not merely chemical correctives, but also means of modifying and improving selves. In the same way that people are able to improve themselves through cosmetic surgery Kramer considers the possibility that Prozac offers the opportunity for “cosmetic psychopharmacology.” Under the auspices of the President’s Commission on Bioethics Leon Kass has aggressively worried about “what new knowledges of brain function and behavior will do to our notions of free will and personal moral responsibility” (2003: 5). This concern about the moral dilemmas posed by biomedical technologies is echoed in popular articles. As a backlash to the widespread use of antidepressants a 2002 article in *Self* magazine insists that “depression can be a healthy response to an unhealthy situation. It can be a mistake to try to medicate it away”,⁴⁵ and in a special report on children and antidepressants *Time* contributor Walter Kirn (1999) wonders “What if Holden Caulfield had been taking Prozac?” In contrast to the concerns over addiction, side-effect, and political participation raised by the tranquilizers of the 1950s, contemporary worries seem to regularly return to the problem

of authentic selfhood (Elliot, 2003). For some, antidepressants help people to realize their true selfhood or to create the self that they have always wanted to be. For others, antidepressants stifle selfhood. They treat problems that should be handled by people on their own, and they too easily relieve suffering that would otherwise contribute to the strengthening of character and self.

Finally, antidepressants have been widely discussed in terms of the risk that they pose to self and others. High profile news stories including the Columbine high school massacre,⁴⁶ and Christopher Pittman's murder of his grandparents suggest that antidepressants,⁴⁷ such as Luvox and Zoloft, caused these people to kill others. This creates the fear that in solving one problem – replenishing mental health – antidepressants create another problem – unleashing murderous and antisocial rage. Furthermore, recent studies indicate that antidepressants increase the likelihood of suicide in adolescents. This news has been accompanied by warnings in antidepressant advertisements. Beginning in 2005 all Zoloft ads cautioned that “those starting medication should be watched closely for suicidal thoughts, worsening of depression, or unusual changes in behavior.”⁴⁸ This is one of the contradictions of the antidepressant discourse. It conceives of depression as a disease that poses a risk to the self. At the same time it introduces risks of its own – unintended consequences. Antidepressants can both heal the self and destroy the self, and the decision to take medications depends upon a calculation of the amount of one kind of risk the individual is willing to accept (the risk the medications pose to self and other) in order to overcome another kind of risk (the risk that mental illness poses to self and other).⁴⁹

The story of antidepressants, then, is not merely an account of scientific progress and discovery. It is also the story of an expanding set of discourses and their interconnection with sophisticated technologies, advertising techniques, and political economic interests. The influence of the antidepressant story is not only marked by the flurry of commentary and concern about the drugs, but its power over the material resources and social networks that allow for the development and distribution of technologies and ideas. The biological model of mental illness exercises a near stranglehold over not only the means of treating psychological suffering, but the means of defining self and suffering more generally. People are presented with a richly articulated narrative, tied to claims about scientific progress, supported by stories and anecdotes, and accompanied by offers of untold possibility. Indeed, antidepressants are not merely the discovery of a new psychiatric treatment, but the invention of a way of thinking about selfhood and its problems. In their broad scope, antidepressants present a powerful narrative that at least in theory, makes sense of everyday suffering, and at the same time promises to correct the problems of everyday life. In this respect, it pushes to the side older stories (e.g. religious and psychoanalytic accounts of psychological distress) and replaces them with a new set of stories about the self. The impact that antidepressants have upon narratives of self – especially at the level of the individual self – is a concern at the heart of this dissertation.

Teresa's Story

In anticipation, then, of the chapters that are to follow, consider some elements from Teresa's narrative. Teresa is 26 years old. She holds a master's degree in graphic design and has worked as a web-designer, though when we spoke, she was unemployed.

When studying for her Master's degree Teresa was overcome by what she now calls mild depression, or dysthymia. She didn't understand where the depression came from or why she could not overcome it. She was having problems functioning in everyday life. She was overwhelmed by a pervasive feeling of "emptiness." She hated herself, she couldn't sleep, she always felt sad, and she didn't want to be around other people. Teresa comes from a comfortable background and she fondly remembers Italian family gatherings and the joy that came from that sense of community. Teresa also says that she has always been a little bit sad. However, until she talked with counselors and psychiatrists she thought of this as a normal part of her personality – to be a little bit sad was a part of Teresa. She had never considered otherwise. Indeed, her encounter with counselors and psychiatrists lead her to consider her sadness in a different light. The past now became evidence of an illness that had always been lingering in her biology. Teresa now came to think that she had always been ill – that is, she had suffered from a chemical imbalance in her brain from a young age. She considers the possibility that this may have been caused by social isolation she experienced in her early school years, but given the present intractability of her sadness Teresa doesn't entirely believe this psychosocial account. In her mind, the idea of biological imbalance is the only explanation that really makes sense of her ongoing suffering.

The idea of biology entered into Teresa's story in two senses. First, Teresa thinks of her depression not as a product of interpersonal or psychological processes but as something that originates from within her brain. This is a common belief. Twenty-two of the 23 people I spoke with attributed their problems to a biological imbalance, oftentimes referring to the neurotransmitter serotonin. For some, the idea of biology is elaborated in

imagery that tries to depict and describe the inner life. Teresa talks about articles she read that “said that certain antidepressants start building new brain cells.” Or she told me about how scientists, using brain scans, are able to take pictures of depressed brains. Teresa wondered what a picture of her brain would look like – would it be covered with “black splotches” like those she had seen in magazines? When I asked her what her healthy brain would look like she said “there would be no black, and it would all kind of be like a mixed rainbow thing.” This biological imagery, then, is capable of instilling both fear – “What are the medications doing to my biology?” and hope – “maybe they’ll give me a rainbow brain?” However, while Teresa and others clearly rely upon biological stories and imagery to make sense of what is happening inside of themselves, these are often peripheral to the main story.

More importantly, in trying to figure out how antidepressants work on them people enter into an antidepressant “lifeworld” characterized by its own particular feelings and rhythms. This leads to both an intimate involvement with antidepressants, and a re-structuring of selfhood. Before Teresa started to take antidepressants she had learned from friends that this could be the beginning of a long process that required experimentation with different medications and doses of medication. In her first attempt to find an antidepressant, Teresa took Celexa, which caused her to sleep 21 hours of the day. She then tried Prozac and, though Teresa remained on that medication for several years, she never really knew whether it was helping her or not. For example, even after Teresa has been taking Prozac for three months, she didn’t notice any significant changes in feeling or mood until a co-worker pointed out to her that she was acting differently. Where previously she had been patient, kind and caring now she was impatient,

distracted and aggressive. Even though antidepressants modify brain chemistry, it quickly became clear that they do not enable a straightforward transformation from illness to health. Rather, Teresa struggled for years to find the right medications, and even when she finally settled on Prozac it was never clear to her that it was making her feel better. Instead, she told me, the act of taking the antidepressants made her feel like she was doing something to help herself. This ritual gave her the hope that one day the medicine might build-up enough in her system to provide the relief that had so far evaded her.

The experimentation with medications and the introduction to the language of biology also leads to a restructuring of self. Teresa started to distinguish between parts of herself that are “me” and “not me.” In this respect, antidepressant narratives are also “splitting narratives.” They distinguish between qualities of the “real” self, and behaviors caused by biological dysfunction. In contrast to the psychoanalytic narratives described above, this is a striking form of self-understanding. The psychoanalytic perspective attempts to re-integrate inexplicable symptoms and psychological pain into the life of self. From this view, hysterical symptoms or inexplicable sadness have their origins in unresolved conflicts, and restoration of psychological health depends upon the narration of these as parts of the self. In contrast, many of the antidepressant narratives I heard put aside psychological distress as something, for the most part, attributable to biology. Certain experiences and feelings are, in a sense, cast-out of the ongoing narrative of self, where they acquire a story of their own that operates according to biological rules and laws. As biological dysfunction, depression and anxiety become “reified” things-in-themselves -- “real illnesses with real causes.” In this, they also acquire a personality of character in the story of self. Teresa fears depression not only because it makes her feel

so loathsome, but now, conceived as internal pathology, it is also something that lies in wait. Even when the antidepressants provide her with a modicum of relief, Teresa fears what will happen once she stops the medication. Depression, held at least partly in check, might return with a monstrous force. In this respect, the antidepressants don't heal or cure Teresa's depression, they merely put it aside. In this story, then, antidepressants become tools that, as some people told me, "put a skin between the self and the world."

Complementing the social processes of individualization and risk, these medications both allow people to take personal responsibility for their suffering and, further, create protective skins around their selves – separating it both from risky internal pathology and external environmental threats.

In putting depression or anxiety aside some space is cleared for the self and people are freed-up to realize modern aspirations such as *self-control* or *authenticity*. Though Teresa did not find the kind of relief she expected from the medications, she nevertheless gained a sense of accomplishment in the knowledge that she was taking control of the depression. The medication became part of a routine: "I felt like sticking with it just to see if anything would happen and it was almost routine, you'd wake up, you'd take your antidepressant and you'd go throughout your day." And in sticking with this routine Teresa felt like she "was doing something to help myself." In this respect, the antidepressant are also a tool that Teresa learns to use in fighting depression. When properly used, it stands between herself and depression allowing her to proceed with a semblance of normalcy. So too, Teresa's narrative is informed by ideals of authentic selfhood. I already noted that she believed the Prozac turned her into a new kind of person – someone that she didn't like. However, her encounter with biomedicine had also

convinced her that her depressed self was not a normal self. Indeed, in this respect Teresa comes to see that she had misperceived or misunderstood fundamental aspects of her life. The encounter with biomedicine teaches her something about herself, and potentially reveals a part of herself that is more real than the self she has ever known. She wonders, for example, whether there is a medication that will help her to overcome depression and at the same time allow her remain a kind and caring person. Or, at another point she wonders whether she even knows what her real self is like. Since she has always been depressed it suddenly becomes possible that beneath all of the layers of depression and medication there is another *more real* self. Would she like this person? Would she recognize this person? Would others like or recognize this person?

Finally, Teresa's narrative also shows how antidepressants introduce new relationships between self and others. Through her encounters with psychologists, psychiatrists, and the medications themselves, Teresa learned to "recognize" herself as someone who has a biological condition in need of treatment. Yet, Teresa also wants her family to recognize this new identity. In some ways, this is for practical reasons. After completing her Master's degree, Teresa returned to her family home, because she could not find work. Once her university insurance plan was terminated, Teresa also had to stop taking the medications. She wanted her parents and sister to accept her condition, so that they would support and finance her therapeutic work and her prescriptions. Teresa received this support only grudgingly. Her mother felt that Teresa's problems were really caused by poor sleeping habits. In contrast to Teresa's newfound biomedical identity, her mother's explanation falls short, and Teresa felt unrecognized – still alone in her suffering. She wants her family to see her suffering as she has come to see it. The gap

between her own self-understanding and her families image of her cause her further pain and sadness. Teresa feels alone in another sense. She sees depression as something that emanates from within her self. In this respect, it is also something that she fears could be a risk and danger to others. While certainly she has the help of counselors and psychologists, ultimately she is faced with a responsibility to get her chemistry under control, both for her own sake and for the sake of those around her. She must therefore learn to watch out for her depression, learn the way in which it manifests in her feelings and behaviors, and know when it can be a risk to self (disabling pain and suicide), other (being a downer), and the relationships that hold self and other together.

Teresa's story, then, is one among the 23 people with whom I spoke. Other narratives depict similar experiences, struggles and conceptions of self. For example, while Teresa now sees herself as someone who has always been ill, other people I spoke with experience their depression or anxiety as something that came upon them suddenly and out of the blue. Or where Teresa was not able to find perfect relief through medications, others seem able to recover selfhood – the medications help them to return to a selfhood lost to depression. And while Teresa understands her depression as a relatively mild condition, even something that can be handled without medications when she needs to, others – such as those who suffer from a bipolar condition – depend upon the medication in deeper ways. Indeed, for some, it becomes a matter of life and death.

I develop these relationships between antidepressants, self, and suffering in greater detail in the chapters that follow. In chapter two, I engage some further theoretical problems. In order to better clarify the significance of narrative theory for this dissertation I compare it to two other theoretical perspectives and the way that these have

conceived of the relationship between selfhood and biotechnology. The “naturalist” perspective attempts to reduce social and psychological problems to biological explanations. The “poststructuralist” perspective takes issue with biological reductionism, but also critiques the narrative view of self I am developing in this dissertation. In contrast to the poststructuralist perspective I argue that the idea of “agentic selfhood” remains an important resource for interpretive and critical social science, even when engaging the challenges of biomedical technology. I then introduce a narrative theory of selfhood grounded in hermeneutic theory. The narrative theory of self consists of three important elements: narrative as structure, narrative as expression, and narrative as embodiment. I describe how these elements constitute an “ideal” theory of selfhood and then describe some ways in which the encounter with antidepressants, and the biological language of self and suffering, potentially transforms the way that stories about the self are told.

In chapter three I analyze the advertisements and promotional materials for antidepressant medications. This analysis provides an understanding of the kinds of images and stories of self made available not only to people who are taking antidepressant medications, but to the contemporary culture more generally. Like the people I interviewed, these ads make appeals to modern notions of selfhood – namely self-control, authenticity and the desire for wholeness – but they also make antidepressants out to be a straightforward, and almost magical solution to problems that for many people are not so easily overcome. The ads depict persons as “punctual” (that is, abstract and disembodied, Taylor, 1989: 159), rational actors, constituted in the moment that they choose to take antidepressant medications. Though the ads tell a story

of hope and self-recovery, they are also simplistic “before-and-after” narratives. In this, they considerably overlook the rich set of social practices and interpretive strategies people rely upon to make sense of the relationship between self, suffering and antidepressants.

Chapter four is the first of three chapters to discuss the interviews that I conducted with people taking antidepressants. In chapter four, I describe people’s efforts to learn how to use antidepressants. In experimenting with antidepressants people learn to think of themselves as biologically disordered, and seek means of establishing a balance or equilibrium between positive effects of the medication, side effects of the medications, and idealized images of “normalcy.” Furthermore, this encounter with antidepressants leads to a restructuring of self. Drawing on psychoanalytic theories I argue that people use the language of biological dysfunction to distinguish parts of themselves that are “not me” from parts of themselves that are the “real me” (Grotstein, 1981). Insofar as antidepressants play a central role in helping people to split-off unwanted aspects of themselves, and manage mood more generally, they take over psychic functions that would have once been performed by the psyche alone. In this respect, I argue that antidepressants can be conceived of as “ego-prosthetics” – technologies that supplement or extend functions once assumed by the psyche.

Chapter five asks after the kinds of narratives of self that emerge after depression, anxiety, and other symptoms have been engaged with antidepressants. In particular, I am interested in the way that the valued modern concept of “authenticity” is transformed through its encounter with antidepressants. Both in the ads and in the interviews, people often say that the medications help them to feel like themselves. Examining this theme, I

consider two narrative types: the *return-to-self* narrative and the *always-been-ill* narrative. In return-to-self narratives, the medications allow people to re-inhabit a remembered and idealized image of self. In always-been-ill narratives people say that they have always been ill and as a result the medication can never return them to a previous state of selfhood. Rather, the medications, when they work, allow people to experience their “selfhood” for the first time. Even though, in both narrative types, authenticity becomes an individualized form of self-understanding I conclude the chapter by arguing that authenticity can be an important concept for understanding contemporary selfhood, as long as it is understood in a dialogical context. This leads me to the final empirical chapter.

The final empirical chapter turns to the kinds of relationships that antidepressants both open-up and close-down. Again emphasizing the dialogical and relational character of selfhood I show that even as individuals are required to take individual responsibility for their suffering, these unfold within social processes. Self-knowledge must always pass through the other. In particular, I emphasize the role that “recognition” plays in the development of antidepressant narratives. I draw both on Taylor (1994) and the psychoanalyst Jessica Benjamin (1979, 1988) to argue that the desire for recognition is both an important feature of contemporary selfhood, and a source of contention and conflict. In the biomedical era, individuals seek recognition for their biological identities and are often saddened and frustrated in their failure to be seen by others (especially family) as they see themselves. Furthermore, in some cases, people are required to assume biomedical identities in so that they can be recognized by social institutions such as the legal system and the family. I conclude with a discussion of how these social

practices are related to a broader set of contemporary themes, especially those associated with self-surveillance and risk.

In the conclusion, having introduced empirical examples and theoretical interpretations, I turn to some broader problems. How are these antidepressant narratives informed or framed by other narratives? What do these narratives tell us about practical, embodied selfhood and its relationship to psychiatric technologies? Is there value in the modern ideals of authenticity and self-control, so central the narratives that I heard? Or should we, as postmodern and poststructuralist critics argue, refuse these as oppressive and outdated forms of self-knowledge? Finally, having considered the various ways in which antidepressants control, contain, and put aside depression and anxiety, I ask whether the idea of “depression,” not as disease, but as a form of relationship and self-engagement is of any value? Is something important to psychic and interpersonal life lost when depression becomes an entity to be feared and eliminated, rather than understood?

Chapter 1 Notes

¹ IMS Health, 2004, “Leading 20 therapeutic classes by U.S. sales, 2004.” Accessed November 23, 2005 on-line at IMS Health:

www.imshealth.com/ims/portal/frton/articleC/0,2777,6652_49695983_69891394,00.html.

² IMS Health, 2004, “Leading 20 therapeutic classes by Total U.S. Dispensed prescriptions, 2004.” Accessed November 23, 2005 on-line at:

www.imshealth.com/ims/portal/frton/articleC/0,2777,6652_49695974_68914714,00.html.

In Canada 15.7 million prescriptions were written for SSRIs in 2003. IMS Health Canada, 2004.

“Estimated number of SSRI prescriptions written in Canada. Accessed January 14, 2004 on-line at: http://www.imshealthcanada.com/htmen/1_0_14.htm.

³ The kinds of stories that groups and individuals tell about themselves change across time and place and reflect the values, ideals and even needs of persons at a given time. For example, much has been made in the social sciences of the loss of grand narratives – large, overarching collective stories that impart a sense of directedness to entire communities (Lyotard, 1984). These older, what we might call “traditional” forms of narrative, are increasingly replaced by individualized narratives – stories that begin and end with the life of an individual.

⁴ In this sense I join a host of social and psychological theorists who critique the individualistic ideology of self that has become a defining feature of modern western selfhood. This includes Charles Taylor (1989, 1991), Kenneth Gergen (1982, 1994a), and John Shotter (1993a, 1993b) among many others.

⁵ As I will claim in chapter 4, even when antidepressants don’t work “perfectly” the fact that they provide some relief often leads to the conclusion that depression, anxiety, bipolar disorder is a chemical problem.

⁶ Lupton further distinguishes the epistemological stance that various social theories take on the reality of risk. They vary from realist positions in which risks are seen as real threats “out there” in the world, to constructionist positions that see risk more as a mentality constructed through classification schemes, institutional organization, and media hype. The epistemological stance taken in this dissertation will be addressed in chapter two. At present, suffice it to say that I adopt a position somewhere in between. On the one hand, the people I spoke with encounter inexplicable anxiety and sadness. These threaten the well-being of self and get in the way of everyday life. On the other hand, the biological account of depression and anxiety – adopted by many who take the antidepressants – transforms sadness and worry into biological problems – diseases – that are then viewed as risks to self and other. These become problems to be solved and guarded against in the future.

⁷ Bauman puts it like this: “In our ‘society of individuals’ all the messes into which one can get are assumed to be self-made and all the hot water into which one can fall is proclaimed to have been boiled by the hapless failures who have fallen into it. For the good and the bad that fill one’s life a person has only himself or herself to thank or to blame. And the way the ‘whole-life story’ is told raises this assumption to the rank of an axiom” (2001: 9)

⁸ Rieff (1966) argues that the “psychological man” emerges as a response to the disappearance of religion as a source of social solidarity and self-understanding. The “new center” of social life he says “is the self” (p. 5). This “narcissistic” individual pursues its own interests and indulgences, rather than those of a transcendent moral framework, as a means of preserving meaning and integrity. This kind of self is characterized by a loss of connection to other people, a growing egoism, a constant feeling of boredom, and an ever-present sense of meaninglessness.

⁹ In this sense the narcissistic self is not merely pleasure seeking, but more fundamentally retreats into itself in a bid for psychic survival. Cultural images of self-fulfillment, self-improvement and self-completion are conceived here as symbols that serve a defensive and protective function. It is this latter point that I want to emphasize because this is increasingly relevant in articulating the relationship between individualization and the risk society.

¹⁰ Coming from a Foucauldian perspective Jackie Orr (2004) captures something similar in her concept of the “militarization of inner life.” Though Orr places this in the context of risk and “panic” more generally, she is more literal in her use of the concept of militarization, and traces the structure of contemporary selfhood to its articulation with the militarization of life in late 20th and early 21st century America.

¹¹ I want to be careful however not to suggest a causal theory of depression, anxiety or the other psychological pains addressed by antidepressants. It is too simplistic and does not capture the complexity

of the stories that I heard to say that people are depressed or anxious because they feel at risk and alone in the contemporary world. What is more important is the way in which, for example, depression is conceived and managed in the language of risk.

¹² It is conceivable for example that the discourse of antidepressants could be unpaired from the logic of illness and disease that currently frames their use. Peter Kramer (1993) hints at this when he places antidepressants in the context of broader strategies of self-control and empowerment. Here the antidepressant is not necessarily viewed as a corrective to a deficient brain, but a supplement or add-on, to an already normal personality – a way of creating super-humans. This was not a sentiment expressed by anyone with whom I spoke, though certainly the sample set is limited.

¹³ It also undermines the view that mental illness is a product of social-structural inequality. While not a central concern of this dissertation, the socio-structural bases of psychological distress are well-established. See William Cockerham's (2006) *Sociology of Mental Disorders* for a broad introduction.

¹⁴ The field of cognitive psychology is too massive to cite all of the relevant scholarship. In Thomas Kuhn's (1970) terms, it has become a paradigm unto itself. This said, foundational statements include Ulric Neisser's (1967) *Cognitive Psychology*, Donald Broadbent's (1958) *Perception and Communication*, Kahnemann, Slovic and Tversky's (1982) *Judgment Under Uncertainty: Heuristics and Biases*, and Nisbett and Ross' (1980) *Human Inference*. The cognitive psychological perspective was a rejection of both phenomenology and psychoanalytic psychology, which it viewed as non-scientific and subjectivist. It also sought to replace behaviorism which, according to cognitive psychologists, crucially overlooked the importance of mind and cognition in human behavior. Cognitive psychology takes as its central metaphor the human being as information processor. Using this metaphor it employs experimental methods to examine internal psychological processes including perception, categorization of information, memory, language, and problem solving, among many others. It has also made significant inroads into psychological social psychology treating human interaction as problems in information exchange and processing. More recently, cognitive psychology has merged with the neurosciences to create the interdisciplinary field of cognitive neuropsychology. Cognitive neuropsychology seeks the basis of human cognition in underlying brain processes. One of the most influential scholars and popular authors in this field is the neuro-linguist Steven Pinker (2002).

¹⁵ Rational choice theory is an extremely influential approach in sociology, political science, and economic theory. In sociology its foremost proponent has been James Coleman (1990) and is derived from neoclassical economics, utilitarianism and game theory. Like cognitive psychology, rational choice theory assumes the primacy of the thinking, choosing and calculating individual. Indeed, rational choice theory puts aside the sources of the values, goals and aspirations that individuals pursue, and only investigates the decision-making processes in which people engage to achieve preferred ends (though recent work in rational choice has sought to make room for culture, see for example, Adams (1999) and Lichbach & Seligman, 2000). From this view, human beings are rational decision-makers seeking to maximize gains and minimize losses (see also Coleman, 1986; Coleman & Fararo, 1992).

¹⁶ The Oedipal conflict describes a distinctive phase in the maturation of the young boy. For young girls, Freud posited the controversial "Electra complex." The key point for this review is not the adequacy of Oedipal or Electra stages of development, but the more general point that for Freud self-understanding 1) depended upon coming to terms with events within one's early life and 2) that psychopathology as well as therapy was always embedded in relationship.

¹⁷ I recognize that psychoanalytic theory, especially Freud's classical psychoanalysis is often viewed as a theory of the individual human psyche. This is apparent, for example, in Rieff's (1961, 1966) study of Freud, and has been a criticism offered by contemporary theorists (Rose, 1996). My view, however, is that even in his most thorough treatment of the structures of the psyche Freud's theory always pointed outward, toward the role that other persons and socio-cultural structures played in mediating psychic life. Even as Freud's work (and subsequent psychoanalytic work) deepens the interior of the self, it also always deepens the relationship with the external world of objects and people. At various points in this dissertation I rely upon psychoanalytic ideas. When I do so I will continue to emphasize these relational aspects of psychoanalytic theory. For further discussion see Chapter 2, pages 86-87 and 88-90; Chapter 4 pages 170-172 and 197-201; and Chapter 6 pages 282-285.

¹⁸ At least in theory. However in practice, biological theories continue to push further back into the "self" seeking genetic structures that wholly determine the life course of the individual.

¹⁹ The transformations in Freud's psychoanalysis are too numerous to detail. He was constantly developing and revising the theory of psychoanalysis across his lifetime. Some significant transformations are: the abandonment of his early reliance hypnotic techniques in favor of a "talking cure," the transformation of his theory of mental structure from a division between unconscious, preconscious, and conscious to a division based on the faculties of id, ego and superego. In particular, in his later work Freud began to study the ego in greater detail with particular interest in narcissism. These later interests have been particularly influential in later psychoanalytic formulations.

²⁰ This though must be qualified. I had no way of assessing the kind of therapy pursued by the people with whom I spoke. When people told me that they participated in psychotherapy, I depended upon their brief descriptions in order to get a sense of the kind of therapeutic approach they relied upon- a few explicitly labeled their therapy cognitive behavioral. This is further problematized by the fact that many did not really know what to call the kind of therapy they relied upon.

²¹ For discussion of the introduction of post-traumatic stress disorder into the classificatory scheme of biological psychiatry see Wilbur Scott (1990), "PTSD in DSM-III: A Case in the politics of diagnosis and disease." Scott emphasizes the way in which the biological idea that PTSD is a natural thing that emerges from within the biology of persons covers over the social forces that contribute to its articulation as a treatable medical illness.

²² See Jane Ussher's (1992) *Women's Madness*, in particular chapter 6 "The routes to madness" (pp. 244 – 286) for a discussion of the way in which biological psychiatry essentializes and pathologizes experiences such as childbirth, menstruation and menopause. Within the biological model these presumably "normal" aspects of women's experience are treated as potentially dangerous and risky aspects of the life course.

²³ In a foundational essay on medicalization Peter Conrad (1975) describes the social construction and medical treatment of "hyperkinesis," a forerunner of more contemporary conditions such as attention deficit hyperactivity disorder (ADHD) and attention deficit disorder (ADD). Here he describes medicalization as a form of expert, medical control that individualizes deviant behaviors.

²⁴ At the time of its discovery chlorpromazine was not thought of as an antipsychotic. It was referred to as a neuroleptic and sometimes more broadly as a tranquilizer. In the latter respect, it was placed along a continuum of more popular tranquilizers such as meprobamate (Miltown). Healy (2002) and Valenstein (1998) provide full discussions of these historical transformations.

²⁵ Of course, biological models of selfhood and mental illness are not new to the 20th century. They reach as far back as classical Greek medicine (see Simon, 1978) and, in various forms, have influenced medical and psychiatric practice throughout western history. Hippocratic medicine was based in a theory of the four humours: blood, cholera, phlegm, and melancholy. These humoral theories persisted into the middle ages and Renaissance and, according to Roy Porter (2002, p. 52) climaxed in Richard Burton's 1621 book *Anatomy of Melancholy*. Rene Descartes' 17th century distinction between mind and body contributed to theories of mental illness that relegated disorderly and unruly behavior to the realm of the body, as opposed to the more pure and spiritual realm of the mind. Descartes theory of the "reflex" also informed future work on the relationship between the nervous system and mental illness (Porter, 2002, p. 124). The modern "psychological" conception of mental illness only gets off the ground with empiricist philosophers such as John Locke and David Hume, both of whom developed theories of mental perception and the association of ideas. In this vein, madness was attributable to disorderly associations in the mind. Throughout the 18th and 19th centuries both the somatic/biological and psychological theories vied for place of pride and continue to influence contemporary thinking. See Porter (2002) for a more complete review.

²⁶ Time. 1954. "Wonder Drug of 1954?" June 14, p. 79.

²⁷ Ibid., p. 82.

²⁸ Ibid., p. 82.

²⁹ Time. 1955. "Pills for the Mind: New Era in Psychiatry." March 7, p. 63;

³⁰ Metzl (2003) says much the same in his analysis of advertisements from psychiatric journals. Advertisements from the 1950s and 1960s pictorially emphasized the relationship between psychiatrist and patient, and medications were depicted in the background – a supplement to the psychoanalytic relationship. From the 1970s forward the psychiatrist dropped out of the picture and the relationship between patient and medication was foregrounded.

³¹ See Mickey Smith (1985) for a history of the "minor tranquilizers."

³² Time. 1957. "Happiness by Prescription." March 11, p. 59.

³³ Newsweek. 1956. "Pills vs. worry-How goes the frantic quest." May 21, p. 68.

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- ³⁴ Time. 1956. "Don't-give-a-damn pills." February 27, p. 98.
- ³⁵ Newsweek. 1956. "Pills vs. worry-How goes the frantic quest." May 21, p. 68.
- ³⁶ Time. 1957. "Happiness by Prescription." March 11, p. 59.
- ³⁷ In *Blaming the Brain* Valenstein (1998: 82-84) provides a history of the idea of the receptor and receptor profiling. See also Healy (2002) *The Creation of Psychopharmacology* chapter 5 "twisted thoughts and twisted molecules."
- ³⁸ This is similar to a shift that Donna Haraway (1991b) argues occurred in the biological sciences more generally. Comparing the work of biologists Robert Mearns Yerkes and E.O. Wilson, Haraway suggests a widespread transformation from holistic, organic approaches tied to goals of human engineering, to cybernetic approaches emphasizing information transmission and tied to the larger project of sociobiology.
- ³⁹ Clark, Matt. 1979. "Drugs and psychiatry: A new era." *Newsweek*, November 12, pp. 98 – 104.
- ⁴⁰ Prozac advertisement. *Time*. 1997, July 21, 150, 3: 18 – 20
- ⁴¹ In contrast to MAOs, which could cause death if taken in combination with food items such as cheese and red wine, SSRIs did not present any immediate physiological danger.
- ⁴² Luvox (fluvoxamine maleate) was introduced in 1994, Effexor (venlafaxine hydrochloride) in 1997 and Lexapro (escitalopram oxalate) in 2002.
- ⁴³ "Off-label" refers to the practice of prescribing medications for conditions and problems for which they are not FDA approved.
- ⁴⁴ In *Prozac on the Couch* Metzl (2002) conducts of similar analysis of gender and antidepressant advertising. He argues here that even though the medical model parades as a neutral, scientific depiction of psychological distress and treatment, it is deeply underwritten by longstanding gender dichotomies. In particular, he suggests that the patriarchal model that informed early psychoanalytic theory emerges in hidden form in modern biological psychiatry.
- ⁴⁵ Casey, Nell. 2002. "Are We Happy Yet? Rethinking the Prozac Revolution." *Self*, January, p. 100.
- ⁴⁶ Wilgorn, Jodi. 1999. "Terror in Littleton: The Investigation: Marines reject high school gunman for taking antidepressant, Pentagon says." April 29, Retrieved on-line January 4, 2006: <http://query.nytimes.com/gst/fullpage.html?res=9F0DE7DA133DF93AA15757C0A96F958260>. The leader of the Columbine tragedy was Eric Little who was taking the antidepressant Luvox (fluvoxamine hydrochloride).
- ⁴⁷ Meier, Barry. 2004. "A drug on trial: Justice and science: Boy's murder case entangled in fight over antidepressants." August 23, Retrieved online January 4, 2006: <http://query.nytimes.com/gst/fullpage.html?res=9A03E0DD143EF930A1575BC0A9629C8B63>. Christopher Pittman was taking Zoloft at the time he killed his grandparents.
- ⁴⁸ Zoloft advertisement, *Self*, 2005, June, pp. 147 - 48
- ⁴⁹ Giddens (1991), Beck (1992) and Lupton (1999) agree that the calculation of risk is central to the mentality of a risk society. Persons are perpetually engaged in efforts to balance out the risks posed by different forms of action. There is no risk-free life. Rather, this kind of calculation is an effort to minimize risk. Though these theorists place preeminent importance on this calculative rationality, in the interviews I conducted, I found little evidence to suggest that individuals engage in this kind of calculation when deciding to use antidepressants. The use of antidepressants emerges out of a more desperate need for relief from intractable suffering. The desire to get one's life back on track overwhelms any tendency toward rational calculation.

Chapter 2: Meta-Theoretical Possibilities

The purpose of this chapter is to lay out assumptions in my approach to this topic. It addresses the philosophy of science behind this dissertation, and the stance I take on issues such as: the goal of social science research, the relationship between biological science and social science, and the various ways of understanding the self. In other words, this chapter provides a metatheoretical analysis of paradigms that inform the study of the relationship between antidepressants and self-understanding. Ritzer (1991: 2) defines metatheorizing as the systematic study of the underlying structure of theory. In particular, he describes three varieties of metatheorizing: metatheorizing as a means of attaining a deeper understanding of the theory, metatheorizing as a prelude to theory development, and metatheorizing as a source of perspectives that overarch sociological theory. The three approaches overlap, but, in particular, the analysis in this chapter is driven by the first variety. The goal is to understand not only the basic assumptions that underlie different metatheoretical positions, but also the implications that these positions have for method of analysis, and theories of self in particular.

In this respect, metatheories, theories, and methods are bound together by taken-for-granted assumptions. In his analyses of the social sciences (1982, 1994a), and psychological science in particular, Kenneth Gergen has shown that metatheory, theory and method are overlapping and mutually supporting discourses. The success and influence of a particular theory of human and social behavior depends not simply on the adequacy of empirical data, in itself, but rather the degree to which the interpretation of empirical data shares in the dominant metatheoretical climate of a given time and place.¹ For example, Gergen argues that behaviorist theories dominated the social scientific

landscape of the early and mid-twentieth century because they resonated with the logical empiricist metatheories of the time and were complemented by the experimental method incorporated from the natural sciences.² Ritzer (1991), in outlining three metatheoretical paradigms in sociology, has also noted the correspondence between “image of the subject matter,” “methods,” and “theories.” He describes three sociological paradigms: the *social-facts* paradigm which unites the study of large scale social institutions with interview questionnaire methods, and encompasses structural-functional and conflict theory perspectives; the *social-definition* paradigm which unites the study of the way that social actors define their situation with interview-questionnaire methods and theories such as symbolic interactionism, phenomenology and existentialism; and the *social-behavior* paradigm which unites the study of the unthinking behavior of individuals with the experimental method and theories such as exchange theory and rational-choice theory. Beyond the discursive and practical realm of social science, theories and scientific practices are also sustained by related political ideologies and economic structures. To this end, critical theorists, feminist science scholars, and postmodern scholars have argued that scientific research is always articulated with ideological projects.³ For example, the atomism and individualism assumed by behaviorism, and now more recently cognitive psychology, rational-choice theory and cognitive neuroscience, resonates with the atomism and individualism that largely defines contemporary western cultures (Gergen, 1994, Taylor, 1985e).

For the purpose of this dissertation, I am concerned with the implications that particular metatheoretical perspectives have in constituting selfhood, and in defining the relationship between selfhood and biomedical technologies, such as antidepressant

medications. I am also interested in the implications of different perspectives for the understanding of risk, and the relationship between theories of self and risk. I do not intend to review all metatheoretical possibilities, but only those which highlight distinctly different conceptions of selfhood. I describe three contemporary schools of thought: naturalism,⁴ poststructuralism,⁵ and hermeneutics.⁶ The “naturalist” perspective largely holds to neo-positivist philosophies of science, experimental methods, and atomistic/individualistic theories of the person. It places much faith in the idea that scientific theory is a neutral and objective representation of reality. It adopts the view that at least at some level, to properly understand selfhood, requires that sociologists draw on cutting-edge research in the biological sciences, especially cognitive neuroscience and evolutionary theory (as in sociobiology or evolutionary psychology). Most famously, this perspective is championed by the sociological theorist Jonathan Turner (2000). He and others⁷ make regular use of the work of neuroscientists such as Joseph LeDoux (1996, 2003), Steven Pinker (2002), Antonio Damasio (1995) and Michael Gazzaniga (2005, 2000). This neuroscientific research seeks the neurophysiological underpinnings of human behaviors in the structures and activities of the brain, as well as genetic make-up. In the section on naturalism, I provide a number of critiques intended to combat the atomistic/individualist and reductionist underpinnings of this naturalism. The purpose is to show that biological knowledge always depends upon practices inherent to a scientific community, and to its position within cultural and historical frameworks.

The second school I call the poststructuralist school though, in its broader assumptions, it shares much in common with the deconstructive impulse of postmodernism. The category captures a concern with the relationships between

knowledge and power, disciplinarily practices, and the technological apparatuses that produce subjectivities. It depends upon a method of critical deconstruction that reveals the ways in which stable subjectivities are regularly produced and reified through institutional structures and supporting ideologies. This perspective has been influential in challenging neo-positivist science, and hence offers a starting point for critique.

Knowledge, as Nietzsche claimed, is always *perspectival*, it is always an exercise of power, and it can never lay claim to neutrality or objectivity. Most importantly, the post-structuralist perspective de-centers and deconstructs the concept of the self and argues that selfhood is a social construction and an effect of power relations. At the same time, recent work in poststructural theory has engaged cutting-edge research in the biological and life sciences in order to construct new metaphors of human subjectivity. This demonstrates one way in which biological theory and its technologies can be conceived more broadly within the framework of critical social theory.

Finally, I adopt a hermeneutic perspective, with particular attention to the idea that selfhood is constituted through *narrative* understanding. This provides both a baseline understanding of what it means to talk about selfhood, but also a critique of the other two perspectives. This critique is woven throughout the chapter. Like the poststructuralist, the hermeneutician holds that selves exist within historical and cultural contexts. However, while poststructuralists place central emphasis on the discourses and practices that construct and discipline persons, hermeneuticians prioritize the goal of understanding, and describe the social, historical and cultural structures that make such understanding possible. Furthermore, hermeneutic theory offers a view in which biology is recognized as an undeniable origin of human subjectivity, but also always incomplete

without the cultural frameworks and interpretive practices that give expression to otherwise chaotic and unintelligible feelings, emotions and bodily activities (see Geertz, 1965).

Drawing on the social theorist and philosopher Charles Taylor (1989, 1985c) and narrative theorists (Frank, 1995; Gergen, 1994c; Kearney, 2002; Ricoeur, 1984), I develop the view that persons are “self-interpreting animals” who continually struggle to make sense of their lives within the context of cultural frameworks. I review the assumptions of hermeneutic philosophy and in particular its attention to the “fore-structures,” and cultural knowledges, that frame and make possible the activity of narrative self-understanding. Further, I draw-out three aspects of narrative theory that are of particular relevance for the analysis of antidepressants and selfhood. First, through plot, narrative organizes social action by positing valued endpoints and structuring the relationship of selves to these endpoints. Second, by way of a cathartic mechanism, well-told stories have the capacity to convert unruly and chaotic emotion into meaningful self-understandings. Third, narratives are viewed as embodied forms of self-understanding. This said, the narrative perspective also enters into dialogue with the findings of naturalism and poststructuralism. Though I prioritize the narrative emphasis on agentic, embodied self-interpretation, narrative theory must also recognize the ways in which identity and selfhood is increasingly mediated through technologies that modify brain neurotransmission. In the closing section of the chapter I describe how narrative theory can learn from and develop the insights offered by both naturalism and poststructuralism.

Nature's Self

Despite decades of critique, the naturalist position exercises a strong hold on the social sciences, and on our collective imaginations. It is well established that, in the late 19th and early 20th centuries, the natural sciences provided a methodology for the emerging social sciences (Gergen, 1982; Danziger, 1990). Though this scientific method has undergone significant transformation across the 20th century, it continues to guide mainstream social science research. What is even more interesting is that in recent decades the natural sciences, especially the biological or life sciences, have produced visions of human beings that increasingly shape the content of social science research. These not only influence the kind of research conducted in sociology and psychology, but also operate as knowledges that circulate more widely in the popular culture. Popular accounts of cutting-edge science promise to reveal the neurophysiological basis of, for example, moral judgment (Gazzaniga, 2005), emotion (LeDoux, 1996), and the self (LeDoux, 2002). Joseph LeDoux puts this view most radically when he argues that: “your ‘self,’ the essence of who you are, reflects patterns of interconnectivity between neurons in the brain” (2003: 2). Through his research he seeks “the essence of the person in the brain” (p. 13). Ethnographers, such as Joseph Dumit (1997, 2004) have also traced the way in which representations of biology and scientific technology move far beyond the scientific laboratory and influence popular conceptions of human selfhood through newspaper accounts, expert testimony in courtrooms, and television programs.

The naturalist perspective is frequently allied with neo-evolutionary theories that conceive of contemporary human behaviors as “natural” adaptations to environmental circumstances. For example, Gazzaniga’s (2005) recent *The Ethical Brain* offers a

challenge to humanistic theories of moral reasoning. Rather than locating moral decision making within the realm of cultural frameworks, political concerns, and interpersonal engagements, Gazzaniga argues that human *brains* make ethical and moral decisions before people become aware of what they have done.⁸ The biological basis of ethical judgment is the product of a process of natural selection. Or, in his now classic book, *The Selfish Gene* (1976), Richard Dawkins argues that “we...are machines created by our genes” and that “such a gene” shaped by the exigencies of natural selection “is ruthlessly selfish” (p. 2). Certainly, Dawkins allows that human beings can act against these so-called natural impulses. However the force of his argument depends upon an atomistic view in which human beings are self-enclosed entities whose behavior is largely shaped by genetic forces located deep within the individual, and furthermore, accessible only through expert knowledges and technologies. On the one hand, this suggests an intriguing challenge to existing notions of justice and responsibility, and in some ways even overlaps with, for example, psychoanalytic theories which grant unconscious motivation a tremendous explanatory power. On the other hand, neuroscientific research is frequently informed by individualistic and reductionist theories of human behavior, and therefore runs the risk of shifting too much weight to biological accounts of human behavior and occluding the social, cultural and linguistic aspects of selfhood prioritized in this dissertation.

I argue that the brain cannot bear the burden of helping us to understand what it is to be and to have a self. As social scientists grant greater primacy to biological theory, they become incapable of speaking about ourselves in ways that matter. As sociological theory turns to biological research it translates psycho-social problems into biological

problems, and thereby loses its capacity to speak meaningfully about what it is to be a person among others. Another way of putting this is to say that the concept of the brain is *underdetermined* in regards to social life, and that it can't carry the explanatory weight demanded by lived experience. Explanations offered through the brain always fall short of communicating the subtlety and implicit character of our lives and problems. Such a perspective overlooks the long social and cultural traditions through which the very ideas of individuality, autonomy and even selfishness (as well as their many refined and subtle variants, see Taylor 1989) have become possible to imagine from the start. This critique is not a rejection of the findings of biological science, nor the accomplishments of modern neuroscience and its contributions to the development of medicines and technologies, such as antidepressants. Instead it is a call for perspectives that are more reflexive and critical about human behavior and the variety of ways in which biological theory can be articulated with cultural, social and linguistic practices.

I want to argue that even the seemingly most transparent and certain biological representations of selfhood are constituted in social and linguistic practices. In this, I challenge the central neo-positivist assumption that theoretical knowledge can be derived from observation of "raw" facts in the world. This view of theory is grounded in what Taylor (1985d) calls a "designative" view of language. According to the designative view, language points to a reality which exists in and of itself, independent of language. Theoretical propositions can either accurately represent states in the world, or fail to reflect states in the world. The test of the validity of a theoretical proposition rests on whether it matches what scientists observe in the scientific laboratory, or even in the social world, through surveys, participant observation and other methods. By testing

theory against reality, scientists are able to discard faulty propositions and slowly work toward a body of law that gradually comes to resemble the way that things really are.

To take an example relevant to this dissertation, consider the problem of locating depression in the brain. Psychiatric science hopes to locate the areas of the brain responsible for mood and thereby develop technologies that can intervene in the course of mood disorders such as depression and bipolar disorder. In such research, there are at least two important objects of observation. First, the researcher must be able to observe depression as it is evidenced in everyday behavior – in the activities of a person. Second, the researcher must be able to connect depression with an image on a brain scan.⁹ The first goal – observing depression – would seem easy enough, and a researcher/clinician should be able to decide, based on commonplace observation and a few psychological tests, whether a person is depressed or not. By many definitions, a depressed person is someone who has a depressed mood, trouble with sleep patterns, and has lost interest in activities that once brought him or her pleasure (to take three of the signs of a depressive episode – see DSM-IV, 1994: 327). However, as we try to make an assessment of depression, we are quickly confronted with a number of questions such as: Is this depressed mood, and trouble with sleep, caused by a recent loss in the family? If so, then the researcher answers that it is likely not depression but “normal” grieving and sadness. Is this trouble with sleep caused by anxiety about general life circumstances? If so, then maybe we’re not talking about depression, but some more general life problem, like a really bad job. Has this depressed mood persisted for more than six months? If not, then it isn’t yet real depression, but something more like a life funk.

As these questions suggest, an assessment of depression cannot be easily read off of the body, as it were, of an individual. It is not, as a positivist scientific model would presume, a simple matter of *seeing* the person exhibiting depression, or even having them “triangulate” their depression by answering questions on a psychological test. In order to know how we are to account for a person’s persistent crying we must ask them for more information about their general life circumstances, and this draws us into a field of language and culture, which is filled with qualifications, reassessments, and reinterpretations. Indeed, I have found in interviews with people who are taking antidepressants that it is very possible for a person, at one moment, to be convinced that they are depressed, in the clinical sense, but then five months later, on re-examination, to have reinterpreted depression as a “difficult period” in their life. Further to this point, many people I have spoken with say that they now know that they have been depressed from an early age, but that they just didn’t know it at that time. To become depressed, in a more technical sense, these people first had to come upon the interpretive schemas provided by the community of psychologists, psychiatrists, and increasingly, television advertisements. As numerous social constructionists, hermeneuticians and other critical theorists have argued, we can only know ourselves and others through the languages common to a community (Gergen, 1994a; Shotter, 1993a, 1993b; Taylor, 1985d). Knowledge is always mediated in language. Along these lines, Taylor (1985d) opposes a “constitutive” conception of language to the “designative” theory adopted by neo-positivists. Attempts to directly observe a reality “out there,” that would finally settle the matter of what people are, what their behaviors mean, or how their behaviors can be transformed, are always complicated and potentially overturned by the fact that as people

speak about the world, they are also giving form to and organizing that world. The world that we seek to *simply* describe keeps slipping from beneath our fingertips.¹⁰

Perhaps the “surface” signs of depression are easily confused and open to ongoing interpretation and reinterpretation, but take the second object of observation – the brain itself. Isn’t it the case that neuroscientists and brain researchers are now able to “photograph” the brain, and to show that people who are clinically depressed have different brains than those who are not depressed? Even if depressed persons changed their mind about whether they were depressed, wouldn’t brain scans prove that, despite what people have to say about themselves, they really are depressed, in some fundamental biology way? The medical anthropologist and ethnographer Joseph Dumit (2004) followed positron emission tomography (PET) images as they circulated through research laboratories, conferences presentations, public lectures, journal articles, patients lives, and the mass media. Dumit’s work suggests both a critique of the view that brain scans simply reveal the inner workings people, and a theory of the way in which biological research is embedded in social processes. He shows that the seemingly incontestable pictures of psychologically healthy brains and depressed brains that are regularly exhibited in news magazines (e.g. *Vogue* and *Newsweek*), television dramas, and courtrooms are highly contestable images, none of which actually say what we usually think they show.¹¹

Even in the scientific laboratory, Dumit demonstrates, the production of a PET image is never a simple matter, but rather a complex organizational and interpretive problem that involves social judgments, and the development of certain ways of seeing.¹² I’ll take two of Dumit’s most compelling examples. First, the production of a PET image

involves sorting through noise in the data so as to “make visible” the phenomenon of interest, for example, depression. Since all human activity in some manner influences brain activity the list of confounding variables is seemingly limitless: race, gender, ethnicity, handedness, level of nicotine or caffeine in the blood, level of urine in the bladder, or even movement of the body during the scan can create noise which would interfere with attempts to locate depression. This process, though, assumes that there is some discrete entity called depression that resides somewhere in the brain, and furthermore that it is possible to “shut down” some behavioral and brain activity such that the depression will show itself in a pure form. This conception of depression is not depression as it is normally experienced, but rather a constructed image evoked under a very controlled situation.

Second, researchers regularly seek to produce “generalized human brain” images – composites of many individual brains which show an ideal-type of, for example, depression. To create generalized brains researchers engage in processes of “subtraction” and “averaging” (Dumit, 2004). In one procedure, researchers compare activity in individual depressed brains to activity in normal brains, and subtract from the depressed brains those features which also appear in normal brains. However, even among this collection of depressed subtracted brains, there may still be differences between each individual brain. The final act, then, in creating a generalized image involves averaging across all of the depressed brains, to find those regions of activity which overlap, in all cases. Presumably, this final image will get us closest to depression’s location in the brain. What is striking is that the final product of this averaging technique can in itself create a composite image that is *qualitatively* different from any one of the individual

brains.¹³ In the end, composite images – the generalized brain – may look different from individual brains. Indeed, the entire process of sorting through data, as well as subtracting and averaging differences, is driven by the assumption that there is in fact a real generalized brain, and that it is possible to extract (or locate) the region in a generalized brain that produces something like depression. The images are not built into the brain, as it were, but reflect prevailing theoretical assumptions that depression is a discrete entity that can be regionalized or localized in the brain. Or to say it another way, these ideas about the relationship between brain and behavior are not learned from the raw data of the scan. Rather they must be assumed in order that the search for depression in the brain move forward in the first place.

The point of both these examples – observing depression in a person and locating depression in the brain – is to show that it by no means a simple task to move from raw observables to theories about depression and the self. These observations are always mediated by the standards and practices of interpretation inherent to any linguistic community. This is not because science has yet to develop the tools that would allow it to investigate the brain, unhindered by language, as it were, but rather that the interpretation and understanding of human activity is always embedded in language. Prevailing attempts to locate the self and its psychological capacities in the brain are guided by the idea that selfhood can be separated out from the linguistic and symbolic activities that make up the meaningful spheres in which people live their lives.

A social theory of the self, then, should address the related problems of *how* people come to interpret certain observables as evidence of, say, depression, and also *why* people value certain forms of interpretation and understanding above others. Taylor

(1989) argues that the commitment to science, and more particularly to reductionist theories of selfhood, is deeply embedded in the culture of *modern* selfhood. Most basically, the modern view assumes that the “self” is a stable, continuous and ultimately knowable¹⁴ entity that can be studied and observed both personally (in self-reflection), but also scientifically (in the laboratory).¹⁵ Taylor (1989) traces the origins of the modern western view of self to an “inward turn” developed in the 5th century writings of St. Augustine. Here the self became an object of contemplation and reflection in itself. However, the features of modern stable, reflective selfhood most fully emerged with the scientific Enlightenment and the romantic counter-Enlightenment. Romanticism and its impact on the concept of “authentic” selfhood will be further discussed in Chapter 5.¹⁶ For the moment, it is important to point out the significance of modern Enlightenment thought for naturalist conceptions of self.

According to Taylor, the writings of philosopher John Locke introduce the possibility of “disengaged reason” and the ability to step outside the self and view it from an objective distance. In particular, this view laid a foundation for Enlightenment philosophies that took the “mind” (and later the brain, as correlate of mind) as if it were a mechanism that could be studied through empirical observation and experimentation. Taylor (1989: 159) also calls this a “punctual” view of the self, insofar as it conceives the self as an abstract, disembodied entity that can gain control over itself through reason. In this respect, Enlightenment philosophies of the self dovetailed with the larger modern hope that scientific knowledge would bring progress and order. For Taylor, then, the problem with the naturalist approach is not that it studies biology and introduces new technologies for the elimination of illness and disease, but rather that it is unreflective as

to the cultural and moral traditions that make its view of self, and its investigation of internal workings, possible in the first place. This unwillingness to acknowledge the historicity of its own practices gives naturalism its argumentative strength and claim to mastery. Insofar as science, and its accompanying laboratory method, are seen to be “value-free” it capitalizes on the modernist aspiration to perfect the world through disengaged reason. However, Taylor argues that in disavowing these historical sources, the naturalist position mistakes the cultural ideal of individualism (a modern ethical standpoint that valorizes the cultivation of independence, autonomy and self knowledge) for a theory of human agency. Where Taylor insists that human beings are always dialogical agents, embedded in language, culture and interpersonal relationship, the naturalist perspective assumes that persons are first and foremost isolated individuals that must engage in acts of utilitarian, calculative reason in order to co-ordinate their activities with others.

For these reasons, even as it claims modern mastery of its subject matter (or at least the eventual hope of such mastery), naturalism is not an acultural pursuit of transparent truths about self and suffering. Rather, this quest for selfhood is grounded in historical and cultural narratives that inform the sense of what the self is, and how that self might best be sought. In particular, this search for the self in the brain is enabled by a commitment to atomistic and individualistic theories of the person. These theories, which manifest in the natural sciences as neuroscience and sociobiology, in the social sciences as cognitive psychological and rational choice theories, and in political life more generally as liberal individualism are products of a long history that internalizes selfhood. This internalization of selfhood is not only a necessary predecessor to the modern sense

that persons possess internal psychological spaces, but also to the view that through scientific knowledge it is possible to gain increasing control and mastery over both selves, and the risks to self newly constructed in the biomedical society.

The Deconstructed Self

In this section, I group a range of theoretical perspectives that I loosely call postmodern or poststructuralist. I group these theories together in order to highlight trends in contemporary social theory, and to draw attention to a particularly intriguing understanding of biomedicine and subjectivity. I emphasize Foucault (1965, 1988a, 1988b) and neo-Foucauldian approaches because these have been central in shaping contemporary theories of selfhood and subjectivity, especially as these are constituted through what Nikolas Rose (1990, 1996) has called the psy-disciplines. However, the perspective also gains sustenance from its connection to other postmodern and poststructural theories. In contrast to the modern understanding of the self as stable, autonomous, and ultimately knowable, poststructuralist and postmodern theory deconstructs the very idea of selfhood, and all of the efforts to authoritatively define and map its potential and problems. Jean-Francois Lyotard ([1979]1984) introduced a central tenet of postmodern theory when he argued that postmodernism is characterized by the “incredulity” toward grand narratives, and in particular the incredulity toward Enlightenment aspirations of totalizing forms of knowledge. Similarly Jacques Derrida’s ([1967]1974) concept of “deconstruction” challenged the structuralist effort to reveal the fundamental linguistic and symbolic structures that underpinned social life. Rather, through concepts such as *differance* and *deferral* Derrida demonstrated that the meaning of any sign system is always constituted in a play of absence and presence. From this

perspective, the goal of postmodern analysis is not to find a deeper meaning hidden within the “text” (or society, see Brown, 1987; or the self, see Gergen, 1991), but rather to continually engage in acts of deconstruction, always leaving meaning unsettled.

Postmodernists have also sought to destabilize established boundaries, and open social life up to new hybridities and relational mappings (Jameson, 1991). In *Anti-Oedipus: Capitalism and Schizophrenia* Gilles Deleuze and Felix Guattari ([1972]1983) challenged the self-enclosed, “fascistic” theory of self that they found in Freud’s psychoanalysis, and proposed a model of social life that valorized the “schizophrenic process.” Humans were to be seen as desiring “machines” constituted within “rhizomatic” structures and “machinic assemblages.” Here the critique of modern social and psychological theories is also an effort to free-up desire, and realize new “lines of flight” – an idealized form of anarchistic creativity that has no master or leader.¹⁷ Further developing the postmodern emphasis on hybridity and transformation Donna Haraway (1991a), has drawn attention to the relationship between emerging scientific technologies and the breakdown of established, taken-for-granted boundaries (see also Best & Kellner, 2001). Haraway’s concept of the “cyborg” – a being that combines both human and non-human elements¹⁸ – challenges the distinction between human, animal and machine, but more radically the modernist dichotomies that underwrite contemporary science and social life. Though, like the other theorists mentioned here, Haraway recognizes that these emergent forms of subjectivity are often regulated within capitalist markets¹⁹ and governed through new forms of discipline, she also holds that in its emphasize on, playfulness, irony, and transformation, postmodern theory can liberate subjects from rigid and oppressive identities.

For all these theorists, the grand narratives of modernity are replaced by a vision of selfhood and subjectivity that is socially constructed in language and discourse, but also through material technologies. The pretense to certainty and the hope for a final, transparent truth is replaced by a project in which identity is playfully engaged, on the one hand to demonstrate the contingency of knowledge and identity, on the other hand to open up new possibilities of practice and relationship. In their emphasis on language and discourse postmodern theories meet up with hermeneutic concerns. Both participate in what has been called the linguistic, and more recently, the cultural turn in the social and human sciences. However, while hermeneutics emphasizes the concepts of *understanding, narrative, and self-interpretation*, the post-structuralists emphasize that language (more broadly conceived as discursive technological apparatuses) is the medium through which power is exercised and human subjects are made. In the remainder of this section I draw out the implications of a poststructuralist approach for understanding the relationship between selfhood and biomedicine. I draw attention to two concepts which are particularly influential in the post-structuralist theory of self. The first emphasizes the Foucauldian concern with systems of power/knowledge relations, classification, and, returning to a theme introduced in the opening chapter, risk. The second returns to the poststructuralist critique of stable identities and the challenge it presents to hermeneutic conceptions of the self. I complete the section with a discussion of some recent “post-Foucauldian” trends that highlight an especially intriguing understanding of the relationship between biological science and social theory.

Poststructuralists, especially those in the neo-foucauldian vein, show that modern selfhood is constituted within power/knowledge systems that define normalcy against

pathology. In *Madness and Civilization* Foucault (1965) demonstrated how the category of Madness was constructed against visions of the modern composed, collected, autonomous and productive self. Madness became Reason's unspeakable Other, and psychiatric systems of diagnosis and classification were emerged to firm up the distinction between normalcy and pathology.²⁰ Insofar as madness was kept locked up in the asylum, it did not immediately impact persons as they lived their everyday lives.²¹ However, since at least the time of Sigmund Freud's psychoanalysis, psychiatric theories of the self have gained greater ground in more common place self-knowledges (Lunbeck, 1995).

Sociologists have been much influenced by Foucault's account of disciplinary regimes and power/knowledge structures. This has given rise to numerous studies that trace the emergence of 20th century classificatory systems that have sought to distinguish normalcy from pathology, and establish normalcy as a common ideal (Bowker and Star, 1999). Dumit's analysis of PET scans provides an account of how biological knowledge, and its accompanying technologies seek a firm ground for establishing differences between normal and pathological persons. Pictures of depression, set alongside pictures of normalcy, underwrite the longstanding intuition that there is really something different about the depressed person. Legitimated by a narrative of scientific progress, biological evidence is used to confirm existing classificatory systems.

But the effect of these biomedical technologies is much more significant than this. As classification systems expand, and psychiatrists invent more precise diagnostic techniques (always finding a newer version of depression, or a type of illness that people did not even know they could have), the range of possible illnesses rapidly expands.

Insofar as these “biosocial subjectivities” (Rabinow, 1992) are circulated through the popular culture, older sources of identity are, in a sense, squeezed out as resources for self understanding. Everyday anxiety, once understood as mere “nerves,” or perhaps just a unique temperament, is transformed into generalized anxiety disorder (GAD) and opened up to psychopharmaceutical interventions (Healy, 1997). Mental illness, once the sole possession of the mad person in the asylum, is distributed as a potential identity for all persons. Gergen (1994b) refers to this as the spread of “deficit discourse” and implicates the growing ranks of the American Psychiatric Association, and ever-expanding size of the APA’s Diagnostic and Statistical Manual (DSM).²² Jonathan Metzl and Joni Angel (2004) argue that the increasing use of antidepressants contributes to what philosopher Jacqueline Zita (1998) and psychiatric historian Edward Shorter (1997) call a “diagnostic bracket creep.” As psychiatric medications are found to be effective in the treatment of a larger range of problems than initially conceived, the problems in living considered pathological, and in need of medical care, significantly expands. In their analysis of popular articles about antidepressants Metzl and Angel found that where in the early 1980s Prozac was promoted as a medication intended to treat problems defined through DSM rubric, increasingly SSRIs were promoted and discussed as medications that treat problems with “marriage, motherhood or menstruation” (for women) and problems with aggression and self control (for men). In addition to pathologizing what were previously viewed as “normal” everyday concerns, Metzl and Angel show that the presumably neutral language of psychiatric medicine is underwritten by culturally defined gender stereotypes. Furthermore, the realization that people can improve their functioning by modifying levels of bodily chemistry establishes a desire for “lifestyle

drugs” that can better help people achieve the ideals promoted by a culture (Mamo and Fishman, 2001). Psychiatrist Peter Kramer (1997) coined the term “cosmetic psychopharmacology” – the practice of perfecting one’s self through psychiatric medication -- to describe this phenomenon.

This pathologization of everyday life contributes to the sense that selves are always potentially at risk of psychological/biological breakdown and disruption. Here Lupton (1999a) identifies neo-Foucauldian scholarship as one of the central contributors to critical theoretical conceptualizations of risk.²³ The Foucauldian approach identifies risk management as a new form of “governmentality” allied with the interests of neo-liberal societies and capitalist economies.²⁴ Focusing on transformations in the practice of “mental medicine and social work,” Robert Castel (1991: 281) traces a historical shift from the management of “dangerousness” the management of “risk.” Early, asylum based, psychiatric science studied *individuals* in order to assess the dangers that they presented to society. Danger was embodied in the mentally ill person, who by virtue of some inherent predisposition could become dangerous. The risk discourse displaces the study and assessment of individuals with a statistical, demographic, and epidemiological analysis of populations and population traits. The relationship between patient and psychiatrist is displaced by an administrative focus on the characteristics of large groups and the likelihood that individuals in those groups could be at risk for illness or psychological collapse. In this context, the risk of individuals is imputed from a combination of abstract factors – observations made at the level of the population rather than the individual, and a new mode of surveillance, “systematic predetection” (Castel, 1991: 293), is created that has the impact of increasing the number of people potentially

at risk, or always already at risk. Expert knowledges are no longer concentrated in the hands of authorities, but are distributed to all members of a society through mass media and advertising, interaction with health professionals, and community awareness programs.²⁵ This contributes to the formation of neo-liberal subjects who are expected take responsibly in managing risks in their own lives, as well as the danger that the risk within one's self poses to the well-being of others. In short, as contemporary subjects are constituted within the language and technologies of biomedicine, they are always constituted as potentially pathological subjects, and hence recruited into techniques of self-discipline and management intended to control against dangers that may or may not emerge in the course of one's life.

I want to turn then to a second aspect of poststructuralist thought and consider its implications for conceiving of selfhood and subjectivity, and in particular the challenge that it presents to the hermeneutic and narrative perspective I am developing in this dissertation. Poststructuralism offers a critique of the stable, autonomous self assumed by modern theories (and further developed in the contemporary naturalist perspective) and in so doing shifts the language of selfhood to the language of subjectivity. Here, subjectivity is a more comprehensive concept than self. It draws attention to the way in which identity is produced in multiple and diverse ways through configurations of ideologies, embodied practices, and interlocking technological apparatuses (Rose, 1996). Another way of putting this is to say that while older approaches asked the metaphysical question: What is a self? The poststructuralist deconstructs the very notion of selfhood and focuses on the questions: How are persons made into particular kinds of selves? This move conceives of selfhood as an effect of interlocking systems of power, rather than a universal aspiration

or possession of all human beings. It takes aim not only at those technologies and ideologies that seek to dominate and regulate persons, but even critical theories that rely on any notion of selfhood to launch social critique. It is not enough, for example, to show that biomedical science, pharmaceutical companies and well intentioned psychiatrists discipline and control persons through classificatory systems and technological practices. Rather, from the Foucauldian perspective, the critic is encouraged to see that any attempt to speak for the self, and to establish it as an agent with its own powers, is an effect of interlocking discourses and technological apparatuses.

For this reason, hermeneutics, and its reliance on concepts such as “experience,” “understanding” and “intelligibility” often come under attack by poststructuralists. Nikolas Rose (1996) traces the influence of the psy-disciplines (psychiatry, psychology, psychotherapy, psychoanalysis) on 20th century subjectivity. Here the “self” emerges as a concept tied to the aspirations of western liberal democracy and its demand for autonomous, stable, free-thinking subjects. Rose, then, argues that Taylor’s concept of a self-narrating interpretive human agent reproduces the modern regime of self (Rose, 1996: 6). This is not only a critique of Taylor, but a critique of all social theories which make some kind of appeal to expressive identities or lived experience. For Rose, like Foucault, it is impossible to transcend systems of power. People can only become subjects and persons through the various techniques of self control and regulation exercised within disciplinary regimes. Even if people somehow find a means of escaping one configuration of power, they are merely re-constituted within another set of discourses and technical practices of self management. For the Foucauldian, freedom from power is always elusive, and understanding is always distorting. Perhaps, on this

view, the only conceivable way of slipping from under the thumb of power (if such a thing is desired) is to continually engage in acts of self-deconstruction.

Something like this emerges in Rose's "thin" or "weak" theory of the "human material" upon which history writes:

We are not concerned here with the social or the historical construction of the person or with the narration of the birth of modern self-identity. Our concern, rather, is with the diversity of strategies and tactics of subjectification that have taken place and been deployed in diverse practices at different moments and in relation to different classifications and differentiations of persons. (p. 37)

Rose goes to a lot of work to avoid saying anything that would pin him to a particular understanding of selfhood, persons, or human beings. Readers are warned against "thick" description of the histories (Geertz, 1973), contexts, and cultural spaces in which persons and members of various communities presumably forge meaningful identities. Rose develops a language which keeps him at a distance from the everyday sense in which people constantly try to say something meaningful about who they are and what it means to be in a particular position, or in the midst of a troubling dilemma. I understand the critical importance of such a move. Grand narratives which assert the primacy of one metaphysical conception of persons over others – as atomistic individuals, as biological creatures, as beings seeking creative self expression – have often been the basis for modern projects of assimilation, symbolic violence, and the denial of difference. I don't want to underestimate or overlook the political and epistemological necessity of such a critique.

However, as Taylor (1985f) points out in his critique of Foucault, there is also something troubling here. For one, the Foucauldian position puts people at odds with the languages that many have historically used to make meaning amongst themselves. Even if these meanings are contested, and identities open to ongoing critique and re-interpretation, it seems impossible to think of persons independent of the content that shapes their interpretive efforts. But Taylor goes further in his critique, and argues that even though poststructuralists like Foucault and Rose try to deconstruct modern concepts of the self, they still find themselves embedded in distinct traditions of thought. In the same way that naturalism is grounded in atomism many poststructuralists are committed to the influential ideas of 19th century philosopher Friedrich Nietzsche. This seems to undermine the fundamental poststructuralist view that we can radically deconstruct and think of ourselves outside of inherited cultural frameworks. Indeed, as Taylor insists, the poststructuralist perspective (even as it refuses to sit still and assert transcendent theories of self or the moral good that these theories appeals to) depends upon, a commitment to Nietzsche's deeply influential "theory" of human subjectivity.²⁶

Nietzsche's style of scholarship, largely written in aphorisms, influences the aspiration to flexibility and openness of textual interpretation influential in postmodern and poststructuralist thought. In this Nietzsche also challenges the grand narratives of modernity, particularly in their assertion of a scientific worldview and the accompanying rationalization of social life. Indeed, connecting the organization of modern society to *ressentiment*, and the slave morality that he finds in Christian Protestant asceticism, Nietzsche ([1887]1969) offers an anti-modernist philosophy that demands the assertion of irrational energies and aesthetic practices. Here, Nietzsche's focus on the body and the

way in which it is rationalized and controlled in modern orders is developed in Foucault's (1977) work in *Discipline and Punish* and the accompanying power/knowledge critique. Indeed, poststructuralism and postmodernism place the body and its various social and historical constructions at the center of analysis. Against the body rationalized through science and medicine, poststructuralism, following Nietzsche, envisions a body powered by uncontainable forces that assert difference and undermine stability at every moment. Closer to the interests here, Nietzsche's emphasis on creative, primal energies inspires a poststructuralist theory of subjectivity based in a theory of vitalism – the assertion that human life is driven by deep, quasi-biological forces.²⁷ To draw out the importance of this view of the subject for contemporary research on the biosciences I turn to recent “post-foucauldian” work.

Patricia Clough (2003, 2004) argues that social theory has now moved into a post-Foucauldian era. By this, she does not mean that the key insights of poststructuralism – the critique of discipline, the de-centering of self, the analysis of knowledge/power relations – no longer offer sustenance. Rather, the rapid development and global circulation of biomedical knowledge and technology requires a shift in critical focus. Whereas traditional Foucauldianism studied the ways in which discipline and power operate on the “surface” of bodies, post-Foucauldianism studies technologies that operate at the sub-organic level. For example, genetic scientists explore and modify the microscopic make-up of the human genome, and psychopharmacologists investigate the structure of neuronal synapses and neurotransmitters. Clough argues that previous forms of discipline, which worked at the psycho-social level of representation and narrative, now take on a more direct and brutal form of control. It is no longer necessary to shape

practical activity through education, discipline, and coercion, because modifications performed on the material body can act more quickly and efficaciously. Put in another way, power no longer need appeal to people's sense of their selves and their projects of self-making, because technoscience enables what might be called an "unmediated" contact and communication with the material stuff of life itself. This interest in biotechnological practices also draws poststructuralism into a working relationship with the biological sciences. Elizabeth Wilson (2004) argues that the social constructionism of the 1980s and 1990s was, rightfully, wary of the essentializing tendencies of biological science. Biological science naturalized and reproduced social systems of power and domination, especially at the levels of race, class, gender and sexual orientation (Fausto-Sterling, 2000; Fox-Keller, 1987; Haraway, 1991a; Lancaster, 2003; Martin, 1987). However, for Wilson this wariness also kept poststructuralists from recognizing the ways in which biological discoveries could offer new metaphors to feminism in particular, and social theory in general. In contrast to the naturalist approach, which interprets biological research within the framework of individualist and atomist theories of the self, the poststructuralist tradition frames biological theory in the language of vitalities, flows, and creative potentialities.²⁸

Take, for example, Wilson's reading of psychiatrist Peter Kramer's (1997), now famous, book *Listening to Prozac*. She focuses on his discussion of a "kindling" theory of biological depression. The kindling theory conceives of depression not merely as an inborn neurological disorder, but also as something that can be imprinted in the nervous system by environmental and social stimuli. Constant exposure to stressful situations cause changes in the synaptic connections in the brain that, at first, are not overtly

recognized. Over time, the changes to the nervous system will become irreversible and the individual primed for a mood disorder. Where first there was an environmental stimulus, now there is a permanent depression in the nervous system. Through this example, Wilson aims to establish a more “intimate” connection between psycho-social determinants of depression, and the nervous system. She criticizes older poststructuralist theories which argue that economics, history and culture unilaterally shape the nervous system. She also criticizes biological theories which suggest a unilateral determination of biology on economics, history and culture. Instead, developing Kramer’s metaphor of “listening to Prozac” she argues that the nervous system can “speak” to us about depression. For her, the nervous system becomes a kind of agent-in-itself that enters into relations with social forces.²⁹ Her goal is to open up a “multivalent” and constantly unsettled mapping of the origins and causes of depression – depression is social, economic, historical, cultural and biological, all at once. For my purposes, however, something even more interesting happens in Wilson’s re-reading of the nervous system. She establishes greater intimacy, and direct communication, between the nervous system and the Foucauldian systems of discipline and control (history, culture, economics), but the person who is experiencing depression is absent. The self, in other words, is bypassed. This is not just an oversight, but a consequence of the poststructuralist view that selves are, firstly, constructions and effects of power.

In this critique of biology, Wilson articulates a view of subjectivity echoed by other contemporary theorists of science, technology, and medicine. The self of experience is absented for a collection of forces, energies, drives, affects and lines of movement of diverse social and material origin. These forces are put into contact with one another,

behind the back of the person, as it were. This does not simply describe a new form of social organization, but it rallies around an especially exciting view of subjectivity. Most importantly “life” is celebrated for its uncontainable vitality. This position is both a critique of bioscience, and an image of possible subjectivity enabled through these emergent conditions. Insofar as biomedicine and techno-science contains and represses “life,” it is challenged. On the other hand, these technologies offer the promise of putting life energy into constant movement. The promise of this critical perspective is to unleash energy, to realize “creative” potentials inherent to life-itself, to assume subject positions which enable unceasing connectivity, flow, and, I think, some kind of freedom.

The important point is that this critique is not offered in defense of the agentic, narrative self. Unlike modernist critiques of technology (Heidegger, [1954]1977; Horkheimer & Adorno, 2002), it does not seek to protect human beings from the dangers of technology. Instead the poststructuralists argue that the biosciences open up a new ontology (Clough, 2004) – in some fundamental way personhood is restructured within radically new ways of being. Rose (2004) has described this as a shift from “psychological” individuals to “somatic individuality.” Rabinow (1992) argues that we are now “biosocial” beings.

While taking these claims seriously, I also want to suggest that this “radicality” cannot be conceived outside of the frameworks that have been important to self-understanding throughout the 19th and 20th centuries. Even if people are now entangled in new forms of being, these cannot help but to enter into dialogue with existing images of what it means to be a person or a self. It is not so much that the biosciences radically recast personhood so that persons are dislodged from previous kinds of self-knowledge. Rather, the images of the subject enabled through bioscience become one more framework -- one more

possibility of self understanding -- among others. As the terrain of self expands, the hermeneutic problem: “How do people orient and make sense of their lives within these changing cultural spaces?” becomes all the more urgent.

The Hermeneutic Self

Up until this point, I have presented two important areas of research that engage the relationship between selfhood and biomedicine. The naturalist perspective promises to ground the self in biology. It is reductionist and it is allied with individualist and atomistic theories of the self. I have also demonstrated that these are not “natural” facts about human selfhood, but are views of selfhood made possible within modernist frameworks that prize autonomy, individuality and the transparency of self-knowledge. Nevertheless, as poststructuralist critics have argued, the research and findings of the life sciences open up new ways to understand the relationship between biology and selfhood. On the one hand, poststructuralists show that the life sciences invent new forms of classification and discipline. These are also articulated with neo-liberal problematics of risk and risk management. On the other hand, read through a postmodern appreciation for flexibility, flow and the vitality of “life itself” the biological sciences open up new conceptualizations of subjectivity. While I am enthused with the ideals of vitality, flourishing and liberation that underwrite recent poststructuralist encounters with bioscience, I am not convinced that this is the best starting point for thinking about selves, or even their encounters with biomedical culture. In this section I want to develop the perspective this dissertation takes toward the relationship between biomedicine and selfhood. This benefits from the poststructuralist approach and the critiques of naturalism

described above. However, in order to retain a focus on the agentic self-interpreting agent, I position myself within a hermeneutic and narrative tradition.

Narrative theory is an interdisciplinary field that recognizes narrative as a ubiquitous feature of social life. In literary theory, the Russian formalist and narratologist Vladimir Propp ([1928]1968) anticipated the anthropological structuralism of Claude Levi-Strauss when he sought the universal features of Russian folk tales. In an analysis of hundreds of folk tales Propp found that folk tales are regularly defined by basic structures or functions. These deep structures persist despite surface variations in folk tales. Though Propp's work did not extend far beyond the structural analysis of folk tales it established a form of narrative inquiry in which scholars seek general patterns of narrative over specific instances of narrative (Smith, 2001). Another Russian literary theorist, Mikhail Bakhtin advanced the study of narrative through his introduction of a "dialogical" view of narrative. Sometimes described as a postmodern theorist, Bakhtin challenged what he called the structuralist approach and the "monologic" view of narrative proposed therein. In the structuralist view the reader of a text was viewed as passive, and the text was taken as a homogenous and totalizing mind set. Bakhtin studied the work of Rabelais (1965) and Dostoevsky (1984) to provide a dialogical model in which narrative was seen as a back and forth process of open-ended exploration and questioning. The meaning of the text was not found in the text itself, but in the historical and culturally situated relationship between a reader and the text. This Bakhtinian view of narrative has been influential in the work of critical psychologists who provide a dialogical model of the self (Gergen, 1994a; Shotter, 1993a, 1993b; Hermans, Kempen and van Loon, 1992). Similar to symbolic interactionist perspective, the dialogical model sees selfhood as an unfolding

communicative process. Here the narrative of one's life is never one's own story or possession, but a co-construction that unfolds in relationship between individuals and between the individual and cultural knowledges.

Within the last twenty years sociologists have begun to explore and incorporate the narrative approach. Here narrative is viewed as a method which challenges the dominant neo-positivist approaches to sociological research. Both David Maines (1993) and Laurel Richardson (1990) argue that though sociology has been dominated by a neo-positivist epistemology and method, narrative's time has come. For Maines narrative is appropriate to sociological research because, he argues, most of what sociologists study are the stories that people tell about themselves in relationship with others. Even quantitative survey methods, and associated demographic techniques, assume an intentional actor whose life is organized within story-like structures. This goes beyond the broader symbolic interactionist claim that human beings are constituted through symbolic exchange, to the more precise argument that human behavior and intention is mediated in narrative. Most of what count for explanations of human action have a plot-like structure that "confers structure, meaning and context" on events, and a temporal sequencing through which narrative elements acquire their "tempo, duration, and pace." (Maines, 1993: 21). Furthermore, narrative is not merely an organizing structure but it is also a *social act*. Narratives posit valued endpoints, and sequences of action that lead to the realization of those endpoints. In this, narratives provide direction for individual conduct, but they also enjoin others to participate in the story. Furthermore, in contrast to the neo-positivist emphasis on neutrality, objectivity and the uniformity of knowledge, advocates of a narrative perspective prioritize the diversity of narrative knowledges

(Richardson, 1990). Though narratives necessarily have an origin in shared culture, the precise manner in which these are incorporated into individual biography reflect the contingency and situatedness of experience. Hence, feminist scholars (Smith and Watson, 1998), medical sociologists (Bury, 1982, 2001; Frank, 1995), queer theorists (Plummer, 1995), and scholars of race (McKay, 1995), among others have turned to narrative and autobiography as a means by which the experience of the disempowered and voiceless can stand as a challenge to dominant narrative constructions.

The approach that I take to narrative is grounded in a hermeneutic conception of narrative and selfhood. The hermeneutic approach to narrative shares much in common with the theories described above. Like the structuralist approach, it recognizes that narratives possess stable features that transcend momentary action. In this sense, narrative is not simply a story told by an individual but it is linguistic structure that organizes social life. In addition, like the dialogical and symbolic interactionist perspectives, contemporary hermeneutic theory emphasizes that narrative is a social practice that unfolds in relationship between persons as they are situated within cultural knowledges. Indeed, Charles Taylor (1989) argues that because narratives are constructed in language, self-interpretation cannot help but to include others and refer back to others. However, beyond the dialogical and symbolic interactionist perspectives, hermeneutics provides a more comprehensive view of the relationship between narrative understanding and the “pre-predicative” or “fore-structures” of understanding that condition narrative knowledge. The notion of self-interpretation is seen as part of a problematic of contemporary western culture that presumes a dialectic between the temporal structure of everyday action, and the aspects of action that are explicitly articulated in narrative form.

Furthermore, though contemporary hermeneutics is sometimes allied with the pragmatic philosophies that underwrite symbolic interactionist theory, interpretation is never viewed as a mere “language game,” but rather an “expressive” activity that integrates and structures selfhood. This establishes language and interpretation not merely as a means of co-coordinating actions with others in the world,³⁰ but also as an impulse or even “craving” that speaks to the way in which selfhood has been historically constituted (Taylor, 1989: 44). Thus, though hermeneuticians like Taylor speak favorably of the work of theorists such as George Herbert Mead, the concept of self-interpretation is grounded in a more inclusive historical and cultural perspective.

Before outlining the features of what I take to be a hermeneutic conception of narrative, I must say a few words about the hermeneutic perspective more generally. Narrative will be seen as a concept that flows out of prior hermeneutic philosophies, and in Charles Taylor’s (1989) term, an “inescapable” feature of the self-interpreting agent. The term hermeneutics has many meanings within the social sciences. Most broadly, hermeneutics refers to the art and science of textual interpretation. Eighteenth and 19th century hermeneutics was largely a *specialized* hermeneutics dedicated to the interpretation of particular kinds of texts, most notably the interpretation of obscure biblical passages, but also legal texts and medical symptoms (Grondin, 1994: 47). The 19th century theologian Friedrich Schleiermacher is generally regarded as the originator of modern hermeneutics. In developing a rigorous method of biblical interpretation Schleiermacher laid the ground for a *universal* hermeneutics – a theory of interpretation not limited to specific kinds of texts, but one that conceives of human life, more generally, as an interpretive enterprise. Schleiermacher distinguished between the

“grammatical” and “technical” aspects of interpretation (Grondin, 1994: 69). The grammatical referred to the supra-individual structures of language, and anticipating 20th century semiotics, the goal of interpretation was to place a text, or specific statement, within the context of the possibilities of a language. The technical side of interpretation referred to the “special art” that an individual author employed in writing a work (p. 69). The goal of technical interpretation is to understand the spirit or the intention of the author that is expressed in the meaning of the surface text. In distinguishing between the grammatical and technical aspects of the text, Schleiermacher retained an older distinction between “spirit” and “word.”³¹ Texts, and linguistic expressions more generally, were taken to be surface phenomena (word) that pointed toward a more comprehensive meaning that lay beneath the text (spirit). In Schleiermacher’s work, the spirit beneath the text increasingly became associated with the psychological characteristics of the author. This “psychologistic” bias, later criticized by 20th century hermeneuticians and poststructuralists, also served as a foundation for Wilhelm Dilthey’s influential formulation of a hermeneutic method.

Hermeneutics also refers to the methodological distinction that Wilhelm Dilthey made between the methods of the natural science – *naturwissenschaften* -- and the human or cultural sciences (or more recently, the social sciences) – *geisteswissenschaften*. This, perhaps, is the view of hermeneutics most influential in contemporary sociology – a method of research that assumes a distinct character for social knowledge. At the end of the 19th century, Dilthey responded to the growing influence of mechanistic, and experimental approaches of the natural sciences to argue that the social sciences required a method unique to their subject matter. In contrast to the

natural sciences which sought causal “explanations” of their phenomena, the social sciences depended upon “understanding.” Drawing on Schleiermacher’s idea that interpretation required an understanding of the intention of the author, Dilthey contributed the concept of “lived experience.” Here through a method of *verstehen* (understanding or systemic intuition) the goal of hermeneutics was to grasp the intention of an author as a whole unit of meaning, irreducible to component parts. Moreover, Dilthey argued that the social sciences could gain access to these authorial intentions through the historical study of cultural expressions. Combating positivist fears that the study of psychological intentions was merely a subjective procedure compromised by personal biases and prejudices, Dilthey argued that cultural expressions were historically situated, and thus possessed an *objective* character uniquely accessible to the interpretive sciences. Here Dilthey problematizes his original emphasis on a direct access to lived experience, and contributes to the 20th century view that lived experience is always linguistically and culturally mediated. For Dilthey, though he never completed the project, a rigorous study of the historically and culturally situated basis of lived experience would provide a grounding for the social sciences (Grondin, 1994).

Hermeneutics only becomes truly universalized in the 20th century, with the increasing focus on language and symbol systems as the medium and ground out of which people live (Taylor, 1985d). In this respect, the term hermeneutics comes to refer to a fundamental feature of human subjectivity. Here hermeneuticians assume that all human activity is grounded in linguistic and symbols systems, and that language use requires an ongoing process of interpretation – clarifying misunderstanding, overcoming obscurity, and reaching agreement on intended meanings.³² Furthermore, while earlier

hermeneuticians focused on the methods and rules of textual interpretation, 20th century hermeneuticians studied the “originary phenomenon”, or underlying structures of Being, that made possible interpretation or understanding in the first place (Grondin, 1994: 18). In this, hermeneutics shifts from being a science of textual interpretation, to a phenomenological and existential examination of the character of human beings as language using creatures. For example, in *Being and Time* Martin Heidegger ([1953]1996) distinguishes between statements articulated in language, and the pre-predicative intuitions that always come before, and condition, explicit speech statements or actions. He calls these pre-predicative intuitions the “fore-structures” of understanding and argues that they ground everyday, practical, human activity. Heidegger argues that the fore-structures of understanding are determined by the temporal character of Da-sein (Being). Insofar as life ends in death, Da-sein always experiences itself in time. This inevitability of death contributes to the care-structure of Da-sein. That is, all statements and practices, even the most neutral and scientific, gain their intelligibility and sense as human activity from the more basic fact that they are oriented within a structure of Care. By pointing to the temporal character of Da-sein, in which it adopts an attitude of care for itself, and the world around it, Heidegger also draws attention to the narrative structure of human life. Taylor credits Heidegger when he writes:

Heidegger... described the inescapable temporal structure of being in the world: that from a sense of what we have become, among a range of present possibilities, we project our future being. This is the structure of any situated action, of course, however trivial. (1989: 47)

This centrality of narrative to interpretation has been further developed by hermeneuticians Paul Ricoeur (1981, 1984) and Richard Kearney (2002).

Ricoeur (1981) extends the hermeneutic metaphor of textual interpretation to include human action more generally. Human action is like a text, he argues, because its meaning is not limited to the immediate situation in which an action is undertaken. As such, action is freed from the moment and opened up to interpretation and re-interpretation in varying social contexts. Ricoeur (1984) further develops this approach to hermeneutics in his influential *Time and Narrative*. Here Ricoeur provides a theory in which narrative is described in three moments. Relying upon the Aristotelian conception of *mimesis* (imitation) Ricoeur calls these three moments *mimesis*₁, *mimesis*₂, and *mimesis*₃. *Mimesis*₁ refers to the fore-grounded field of practical action that makes narrative understanding possible in the first place. This field is structured by an implicit cultural stock of knowledge,³³ but more basically, it is structured by the temporal character of human life described by Heidegger. Insofar as everyday action is situated in time, it presses for a more articulate configuration in language. In this sense, everyday life implies a story that it yet to be told. *Mimesis*₂, then, is the act of narrative composition that explicitly articulates this foregrounded relationship with time. It draws out specific elements of action and organizes these in a narrative sequence, thus further conditioning the relationship with time. In this respect, narrative at once gives expression to that which is taken for granted in the field of everyday action, and in turn feeds-back to shape the practice of everyday action. Narrative, Ricoeur says, at once presupposes and transforms action. Finally, *mimesis*₃ is the moment of narrative composition that anticipates the reception of narrative. The reception of narrative depends at once on its

ability to describe that which is already assumed in the cultural stock of knowledge, and at the same time to transform that implicit understanding. In hermeneutic terms, Ricoeur says that mimesis₃ closes the “hermeneutic circle” elevating the individual and particular to a more holistic meaning captured in the story told, and re-inserting it into the practice everyday life.

In all cases, pre-predicative understandings (fore-structures) exist in a dialectical relationship to the explicitly formulated descriptions and accounts of human life and society. In contrast to earlier hermeneutics, which held out for interpretive methods that could secure a final and authoritative reading of a text, these phenomenologically and existentially oriented hermeneuticians depict narrative as an ongoing act of interpretation. The character of pre-reflective experience is always such that it exceeds final acts of interpretation. What is distinctive about hermeneutics, in contrast to the poststructuralist perspective, is that it sees value in the ongoing efforts to clarify the meaning of human expressions, even if these are always open to further negotiation. This is perhaps best expressed in Hans Georg Gadamer’s (1993: 302) concept of the “horizon of meaning.” While on the one hand, life is lived out of an established set of pre-conceptions which set the limits on understanding in the here and now, these can always be expanded and re-interpreted to reflect encounters with unfamiliar and unanticipated meanings. Here hermeneutics has the practical advantage of allowing us to understand the interpretive process that unfolds in the encounter between self and other. While the understanding of the “other” always proceeds from within the framework of existing horizons, these horizons can be extended and transformed in the efforts to better understand the experience or life-world of those from different backgrounds.

In the context of the present dissertation, Charles Taylor's hermeneutics is particularly instructive because it explicitly engages the concept of selfhood, not as a universal trait of all human beings, but as a deeply influential historical and cultural articulation of the problem of interpretation. Taylor (1985c) assumes from the start that human beings are "self-interpreting" animals. Narratives of self and identity have become central elements in the modern, and now late-modern, activity of interpretation. Here the self is not a universal feature of all human beings, but rather a particular, historically situated form of interpretation that assumes the integrity and self-constituting powers of individuals. Even as postmodern and poststructuralist critiques of the stable, authentic self challenge this modernist aspiration, the idea of selfhood remains a constituting feature of everyday life. Here selfhood is a valued possession of many members of western cultures, and at the same time a framework for the interpretation of one's position in the world and relationship to others. This resonates with Heidegger's notion that everyday life is oriented in structures of self-care. Taylor is also deeply influenced by the phenomenologist Merleau-Ponty's (1964) insistence on the embodied character of interpretation. Self-interpretation is a practical activity that involves the entire human organism in the context of its lived experience of its body, its relationships to others, and its participation in a larger shared world, always made intelligible in language. In this respect, self-understanding is an engagement with culture and history as it is embodied in space and lived in the body. Something similar is connoted in Pierre Bourdieu's (1977, 1984) concept of the habitus.

Furthermore, Taylor argues that self-interpretation is not relativistic or arbitrary, but rather that it is oriented within *moral* spaces. This, in fact, is Taylor's central

contribution to hermeneutic theory (Smith, 2004).³⁴ We cannot think of being selves without some orientation to deeply valued endpoints - distinctions of worth - and as such, people cannot help but to want to be certain kinds of selves and to pursue a particular kind of life. “We are only selves insofar as we move in a certain space of questions, as we seek an orientation to the good” (Taylor, 1989: 34). And furthermore, in narrative terms: “in order to have a sense of who we are, we have to have a notion how we have become, and of where we are going” (p. 47). This narrative character of selfhood can refer to the way in which everyday mundane tasks are organized and engaged, for example, to borrow from Taylor, a walk to the drugstore is situated in a drama, however uninteresting, that moves action forward. More importantly, for Taylor, narratives of the self are grounded in deeper currents that reflect larger social and cultural concerns and values. In his historical review of the “sources” of the self, Taylor (1989) describes the moral sources that he argues informed modern conceptions of selfhood and continue to serve as valued endpoints for late-modern selves. The invention of an “inner self” as a place worthy of cultivation and development emerges in the writings of St. Augustine, and was elaborated through Enlightenment and Romantic philosophies that sought the source of selfhood within the person, rather than an overarching cosmology. The Protestant Reformation contributed a valorization of the “everyday life” of family and work as realms worthy in themselves, and Enlightenment science introduced disengagement and self-control as ideal forms of self-knowledge. Finally, 18th and 19th century, Romanticism depicted the act of artistic expression as a place for the realization of *authentic selfhood*. Since that time, Taylor argues, authenticity, though much contested in postmodern and poststructuralist critiques, has become an ideal advocated by cultural

spokespersons and psychological health professionals (especially in popular culture, e.g. Dr. Phil McGraw and Oprah Winfrey; see Guignon, 2004 for further discussion), but also an ideal embraced in everyday efforts to discover and cultivate one's "real" self.

In this respect, even though selves are constituted in language, they are not arbitrary social constructions, as some postmodern thinkers conclude (Gergen, 1991, 1994a). Rather, they possess a certain historical and communal weight that bear upon the way people formulate their sense of who they are, what matters most to them, and the story of their life in regards to their proximity to these valued endpoints. Taylor's emphasis on the moral element in self-understanding communicates the fact that people cannot help but to orient their self understandings in particular ways. It establishes self-understanding as a drama in which people struggle with themselves, and others. In this respect, it is possible for people to be conflicted in the way that they live their lives, to feel guilt about their decisions and actions, to fall short in their self understanding, and their obligations to others. In short, it situates people in an ever-changing field of problems and dilemmas which are not simply "out there" in language, but a part of the phenomenological structure of selfhood.

I want to conclude this section by drawing attention to three aspects of narrative that will be particularly important in the analysis undertaken in this dissertation. First, I return to the idea that narrative structures action, in particular through plot, and consider some of the narrative "types" that narrative theorists have proposed to understand contemporary narratives of self. Second, I want to draw out the "expressive" elements of narrative understanding and in particular its significance for conceiving the relationship between narrative and emotion – a topic of special concern given the mood altering

properties of antidepressants. Third, I want to describe the relationship between narrative and the body. Though narrative is articulated in language, it is also always realized in embodied practical action. In this respect, stories told about selves inform the relationship between selves and bodies. In particular, as narrative sociologist Arthur Frank (1995) has argued, medical narratives (found for example, in the naturalist discourses that surround antidepressants) can colonize the body such that it is treated as an object of distanced engagement and control, rather than the lived expressive entity prioritized by hermeneuticians and phenomenologists.

Plot: Narrative as structure

One product of the narrative turn in the social sciences is a proliferation of typologies of the kinds of narratives that circulate in popular and scientific discourse. Sociologist Arthur Frank describes narrative analysis as an attempt to discern “the most general storyline that can be recognized underlying the plot and tensions of particular stories” (1995: 75). This focus on the structure of narrative should not overshadow the fact that narrative also informs, and is informed by, the actions of individual agents. Rather, it provides an outline of the kinds of frames that people can rely upon when orienting their selves within the moral spaces and valued endpoints of a given culture or community.

Kenneth Gergen’s (1994c) work on narrative is frequently cited in the discussion of narrative typologies. He describes four rudimentary forms of western narratives, or basic plots, that link events in a story, over time, in relationship to valued endpoints. *Stability* narratives link “events so that the individual’s trajectory remains essentially unchanged in relation to a goal or outcome” (p. 195). *Progressive* narratives depict an

incremental and positive development in a story. Central characters rise above their initial situation in order to achieve a valued endpoint. In contrast, *regressive* narratives depict a downward slide so that the distance between characters and valued endpoints increase over time. Furthermore, Gergen suggests that these rudimentary forms can be combined in more complex arrangements. The *tragic narrative* combines the progressive narrative with a regressive narrative to depict a sudden and unexpected reversal of fortune – a tragic fall. The *comedy-romance* narrative reverses this tragic form. An initial fall is compensated by a reversal which, usually at the last moment in a story, restores proximity to the valued endpoint. When a progress narrative is followed by a stability narrative this is referred to as a *happily-ever-after myth* (p. 197), and when a narrative combines a series of progressive and regressive elements this is described as a *heroic saga*.

In his study of illness narratives, Arthur Frank (1995) depicts three kinds of narrative structures. While these share in Gergen's basic structures, they are also conditioned by the narrative encounter with illness. Indeed, Frank suggests that encounters with life-threatening and chronic illnesses can create "narrative wreckage" in which the narrative backdrop of one's ongoing life is called into question and requires radical restructuring (see also Bury, 1981, 2002, for further discussion of chronic illness narratives).³⁵ In this context, the taken-for-granted story of one's life is overcome by chaos and confusion. Here illness narratives can restore order, enabling people to get on with their lives once again. However, certain kinds of narratives can deepen the confusion and chaos presented by illness. Frank distinguishes between three narrative types. The *restitution* narrative is the preferred story in contemporary western encounters

with illness. It is, he says, highly medicalized, and seeks quick closure. These stories project full recovery and a return to selfhood, as it was once known, as a valued endpoint. Though Frank recognizes the powerful appeal of restitution narratives, he is critical because these narratives “attempt to outdistance mortality by rendering illness transitory” (p. 115). In this critique, Frank reveals his commitment to existential and phenomenological philosophy. Rather than reflecting on mortality, these narratives, and the culture that sustains them, continue to pursue an inauthentic immortality, and perfection of self. Second, Frank describes *chaos* narratives, in which the story is “sucked into the undertow of illness and the disaster that attends it” (p. 115). Here Frank reflects on the occasions in which narratives are unable to restore selfhood, in any sense. The threat of illness overwhelms the self and leaves persons in a perpetual state of fear and confusion. In these instances, narrative cannot organize and communicate the dread that accompanies the encounter with mortality. Third, Frank identifies *quest* narratives as a kind of story that converts the chaos of illness into a journey. “Quest stories meet suffering head on; they accept illness and seek to use it. Illness is the occasion of a journey that becomes a quest” (p. 115). What also becomes clear in Frank’s account, as well as other accounts of illness narratives, is that people rely upon narrative self-construction in order to secure a basic “ontological security.” Narrative here is not merely the story that a person tells about his or her life, but in orienting selves within shared structures of understanding, narrative has the capacity to hold a self together and provide people with a basic and secure grounding out of which life and its problems can be engaged.

Narrative types, it must be underlined, reflect the social structure and cultural climate of a given time and place. Though, as hermeneuticians argue, narrative understanding is likely a feature of all human societies, required by the temporal character of life (Kearney, 2002), narrative is also organized within existing social structures. In this dissertation, as I have indicated in chapter one, the themes of individualization and risk occupy a central position. Here it is worthwhile to distinguish two further kinds of narrative – *interpersonal* and *individualized* narratives.

In his *Mind and Madness in Ancient Greece*, the psychoanalyst and classicist Bennett Simon (1978) compares 20th century psychiatric theory to models of narrative indicated in Greek Antiquity. In particular, he argues that the Homeric epics demonstrate a form of narrative that conceives the self in an open field of relations. In these interpersonal narratives ‘the self is not encapsulated, but is an open field of forces’ (p. 284) and is amenable to the influence of others, including mythological characters such as the gods. Simon recognizes a similar form of narrative in the interpersonal field theories developed in early 20th century psychiatry. These interpersonal field theories, reflected for example in the work of Harry Stack Sullivan (1953), placed their understanding of self and psychopathology in the context of the spaces between self and other, rather than within the individual psyche. In the context of this dissertation, the important point is that Simon recognizes that narrative is more than the mere reporting on a person’s life, but it can also be a form of social ritual that provides sustenance and strength for selves.³⁶ This view of narrative is, I think, implicit in the 20th century hermeneutic theories described above. Insofar as shared cultural narratives provide what Taylor calls an orientation in moral space, they can also provide selves with meaning and

direction, and thereby hold selves together. In the individualized culture, described by theorists such as Ulrich Beck, Anthony Giddens, and Zygmunt Bauman, stories that conceive of selfhood as an individual possession proliferate at the expense of stories that see selves as inevitably bound to others, and mediated in cultural and social rituals. The problem in the individualized culture, then, is that it treats narrative self-construction solely as an individual project and responsibility, and thereby underestimates the “healing” power of shared, ritualized narratives. Moreover, this diminishment of narrative has a significant impact on the structure of the self, as I hope to demonstrate in the dissertation. No longer “held” in relationship to others through shared narrative understanding, selves are encapsulated, or in Giddens’ (1991) term “cocooned,” and forced to rely upon non-narrative mechanisms (e.g. antidepressants) to organize and structure the life of the self and its pursuit of valued endpoints.

Catharsis: Narrative as expression

Implicit in what I have said above is the view that narrative is not merely a means of communication – it is not solely a cognitive act – but it is also a form of expression bound to feeling and emotion. The kind of hermeneutics I am drawing on grows out of 18th and 19th century Romantic philosophy. This is especially the case with Taylor’s hermeneutics which explicitly contrasts two western traditions of self-knowledge. The first, indebted to the Enlightenment focus on science, reason, mastery and control views the self as an object to be studied and managed from an objective distance. The second, indebted to Romantic philosophy especially as articulated by Jean-Jacques Rousseau and Johann Gottfried Herder, sees the self as a holistic creature constituted in its expressive and creative activities (Taylor, 1985d) . Here Romanticism responds to Enlightenment

reason with an emphasis on the depth of feeling, the cultivation of moral sentiment, the creative imagination, and the position of selves within communal activities. In this context, the hermeneutic account of narrative sees self-narration as an activity that has the capacity to transform powerful, overwhelming and even unrecognizable, feeling into cultural expressions that make selves available to others. This is captured in the concept of *catharsis*.

The romantic view runs the risk of slipping into a doctrine of self-absorbed hedonism. This, as many have argued, is the central impact (or contribution) that Romanticism has had on contemporary consumer culture (Campbell, 1989). However, from another angle, if narrative is viewed as a shared medium – always constituted within cultural and interpersonal contexts – it can play an important social function of “metabolizing” and making intelligible feelings and emotions that individuals cannot make sense of themselves. Here narrative depends upon the Aristotelian depiction of catharsis as “purgation by pity and fear” (Kearney, 2002: 137). Kearney writes that in the Aristotelian view “stories could offer us the freedom to behold all kinds of unpalatable and unliveable events, which by being narrated have some of the harm removed” (2002: 137). More recently, this concept of catharsis has shaped the psychoanalytic view of narrative. Joseph Breuer and Sigmund Freud ([1893]1991) first introduced the cathartic method in their *Studies of Hysteria*. Though catharsis was closely bound up with the hypnotic techniques employed by 19th century psychiatrists, it gained its significance for narrative in its later articulation with the psychoanalytic “talking cure” (Laplanche & Pontalis, [1967]1973). For Freud, hysterical and, more generally, neurotic symptoms develop when affect is “strangled” and is unable to find adequate discharge. Rather

than finding expression in the moment that it is experienced, affect is “diverted into bodily innervation,” hence the conversion of psychological conflict into hysterical bodily expressions. In talking and “working-through” repressed memories, strangulated affect is restored to its proper place in the narrative of a person’s life, thereby providing, if not a final cure, then at least an improved self-understanding.

More recently, group psychoanalysts have articulated the relationship between emotion, individual narratives, and group narratives. I am especially interested in the theory of narrative and emotion developed by group psychoanalyst Claudio Neri (1998). Neri draws on psychoanalyst Wilfred Bion’s concept of the “alpha function” to introduce a theory of “effective narration.” The alpha function refers to the earliest relationship between a child and its mother. In this state the child is unable to “metabolize” the sensorial and emotional stimuli which occupy its body in early life. Through love and understanding, but more importantly, through bodily contact in the form of rocking, holding, and caressing, the mother *takes responsibility* for the child’s experience. She thereby transforms, metabolizes, or digests these experiences into something more tolerable for the child. Neri relies upon the concept of the alpha function to describe the role of narrative in group life. Here narrative is not a possession of the individual, but rather develops in a “group field” that is irreducible to any single member of a group. It “is beyond individuals and does not correspond to their relationships, and yet conditions both individuals and relationships” (p. 61). The field is a repository of those elements of self that individuals cannot handle or make sense of on their own. For Neri, narrative can play many roles in group and individual life. On the one hand, it can transform collective energies into a “psychotic” force that overpowers individuals and submits them to the

work of a mass mind or group mentality. On the other hand, he offers the idea of “effective narration” as a form of group activity that can metabolize and digest – i.e. make emotional and narrative sense of – an individual’s life. Effective narration recognizes the interconnectedness of self and other and goes beyond “what is only and exclusively the narrator’s experience or personal feeling” (p. 131). In this, a narrative can be seen as something that is not simply an individual possession but that belongs to, and sustains, all members of a group.

While Neri’s work emerges out of a group psychoanalytic context, I believe his view of narrative offers insight to cultural narratives more generally. While, in mainstream social science (including naturalist theories of the self) narrative is viewed as a mere communication of already existing individual facts and feelings, in Neri’s view narrative is recognized as a shared medium that can process emotion, make the self whole, and at the same time draw attention to the necessity of viewing selves in relationship to others. In contrast to the individualized society that transfers the responsibility for self-narration and risk management to the individual, this is a view in which narrative can and must become a shared responsibility.

Embodiment: Narrative as embodied activity

A theory of narrative also requires an understanding of the relationship between narrative and the body. I want to develop the significance of this relationship in two directions, each of which is relevant to the study of antidepressants and selfhood. First, stemming from the work of Michel Foucault (1977), contemporary scholarship draws attention to the numerous ways in which bodies are socially constructed and disciplined. Insofar as bodies are disciplined through power/knowledge structures they become

“docile bodies” – sites upon which prevailing social classifications are written and realized. Feminist theorists, as well as theorists of race and disability have used this concept to demonstrate how social distinctions are naturalized – they come to be seen as inherent properties of the body.

Similarly, science studies scholars show that presumably neutral biological theories carry within them culturally conditioned theories of bodies. Emily Martin (1987), for example, argues that biological theories portray the female body as a factory, naturally intended for the reproduction of the human species. In this, processes such as menstruation and menopause are portrayed as dysfunctional moments in a woman’s life. Similarly, Deborah Lupton (1999c) has described how women’s experiences of pregnancy are shaped by medical science. Drawing on Foucault’s theories of discipline, but also anthropologist Mary Douglas’ work on social classification and risk, Lupton argues that pregnant women frequently see their bodies as dangerous, risky and abject entities that are to be feared and controlled. This patrolling of the body is intended to protect both mother and foetus against the dangers and risks viewed to be a central element of pregnancy. More broadly, the management of the pregnant body serves to subdue the cultural threat posed by the idea of a pregnant body. Lupton writes:

Central to the ‘risk’ of pregnancy, therefore quite apart from concerns about the foetus, is the potential threat imposed by one’s own body to a sense of containment, autonomy, self-control. So too, in its liminal two-subjectivities-in-one-body state, the pregnant body comprises a symbolic threat to others. It stands as Other to notions of acceptable embodiment. (1999: 78)

Here scientific narratives reproduce and naturalize distinctions that have tremendous cultural and political significance. They maintain social classification systems and protect against deeper fears presented by bodies that are thought to be out-of-control, unusual, or abnormal. Further, these narratives frequently attribute properties of risk and danger to bodies and selves – this will be particularly significant in the analysis of the biomedical narratives that accompany the use of antidepressants. Increasingly, depression is rendered as a biological entity – something in the body -- that opposes and threatens the integrity of self.

However, these social constructionist accounts of the body are sometimes found wanting by phenomenologically oriented theorists. Especially in Foucault's early work, the body is treated as something akin to a blank slate, disciplined through knowledge/power structures but never disciplining these structures in turn (Shilling, 2001).³⁷ In response, phenomenologists rely upon the concept of lived experience. In the *Phenomenology of Perception*, Merleau-Ponty (1962) demonstrated that early 20th century psychological theories did not address the lived experience of the body. These approaches, which presumed the Cartesian distinction between mind and body, valorized the supremacy of an abstract, disengaged psyche and self. The body was merely a biological container for the higher functions sought in the experimental study of the psyche. Merleau-Ponty argued that psychological investigation should begin with a phenomenology of the body, in which the body was not viewed as distinct from the mind, but rather a pre-condition for linguistic, symbolic and narrative expression. The body, as lived experience, was not merely the possession of an individual, but a form of

subjectivity entangled in pre-discursive relationships with the surrounding cultural and physical environment.

In a similar vein, Pierre Bourdieu (1977, 1994) has contributed the concept of *habitus*.³⁸ Bourdieu developed the idea in order to overcome modernist sociological distinctions between object and subject, individual and collective, or structure and agency. For Bourdieu habitus is conceived as a form of bodily intelligence; a pre-reflective practical engagement with the material world. Where in modernist, Cartesian-inspired, theories, the body was viewed as a kind of counter-intelligence – a mechanical container that got in the way of clear and unhindered cognitive and linguistic representation – for Bourdieu the body makes everyday practical engagement with the world possible. Furthermore, the body is what, drawing on Bourdieu, Taylor (1995) calls a background understanding. The body carries and encodes “components of our understanding of self and world” and in so doing becomes a mode of understanding that cannot be separated out from linguistic, cultural, and narrative aspects (Taylor, 1995, p. 170). For example, Bourdieu (1984) has described the way in which class distinctions are incorporated into individual bodies. These become a part of the “natural” embodied background of everyday life and allow people to carry-out appropriate actions, without second thought. The ease with which individuals can unthinkingly fit into the world in which they live provides them with a kind of cultural capital – a status that derives from the body’s “know-how.”

In his work on illness narratives, Arthur Frank (1995) has developed a theory of the body that combines both the disciplinary critique of the body, and the phenomenological theory of the body as a form of pre-understanding. Frank’s central

thesis is that the body can “speak” and, in so-doing, transform narrative. This is particularly the case when people are confronted with chronic and life-threatening illness. Here the taken-for-granted narrative of everyday life is confronted by a body that refuses to conform to familiar habits. The body, in this sense, falls out of the narrative of one’s life as it has always been told, and presents experiences that call for new forms of interpretation. Frank favors a theory of narrative that would allow the body to speak for itself – so that narrative can express and cultivate the needs of individual bodies, making them available to others. He calls this the communicative body, and says that: “the communicative body realizes the ethical ideal of existing for the other.” (1995: 49). However, Frank argues that within contemporary medical science, the ill body is frequently disciplined and closed down upon itself. The body becomes a symptomatic body; a body that is engaged from an objective distance and studied for signs of internal disease and illness. In sociologist Bryan Turner’s (2004) sense, the vulnerable body, which opens its suffering up to communication with others, is silenced and disciplined. It becomes an object of individual surveillance and control. In this context, the body, and hence the self, becomes “monadic,” cut off from others and unable to tell stories that speak to its need for interpersonal forms of care and understanding (Frank, 1995: 49).

A theory of narrative, then, recognizes that the stories told both by groups and individuals are always embodied. On the one hand, this means that the body becomes a habituated carrier of social and cultural meanings. Shared stories hold people together not merely as abstract psyches, but as selves that acquire a “feel” for a story, and a common trajectory within material spaces. Even stories told by individuals, gain their meaning from the embodied location within shared cultural spaces. Indeed, here the relationship

between selfhood, narrative and embodiment is not merely a metaphor, but as Charles Taylor remarks, the “disorientation and uncertainty about where one stands as a person seems to spill over into a loss of grip on one’s stance in physical space” (1989: 28). Stories are incorporated into the body and, as such, provide orientation within the spaces in which selves live. On the other hand, in order to maintain its stability in space, selves depend upon narratives that can conceive of selves as more than isolated atoms, but as beings that share a common embodiment, or at least the capacity for embodied relationship.³⁹ Here we see a further relationship between embodiment and space. The body of the self is not merely located within the borders of the physical body, but insofar as it is a linguistic and cultural being, constituted in moral space, the body is also constituted within larger, shared spaces. Scientific and medical narratives not only disavow the embodied character of selfhood, but in offering mechanistic and disengaged accounts of illness and suffering, they proliferate narratives that contribute to a widespread disorientation.

This review of the relationship between narrative and the body suggests two ways of investigating the relationship between antidepressant medicines and self-understanding. Both of these will be utilized in the analysis to follow. First, as poststructuralist critics point out, biomedical technologies provide opportunities to modify the body at sub-molecular levels. New forms of feeling and embodiment are introduced that bypass traditional forms of narrative embodiment. While poststructuralists maintain their focus on the relationship between these technologies, the disciplining of bodies, and the circulation of new forms of subjectivity, I retain the emphasis on lived experience to suggest that by transforming the balance of brain

neurotransmitters, antidepressants introduce new feelings into the realm of bodily lived experience. Thus, in addition to the narrative destabilization experienced in encounters with illness, antidepressant medications introduce their own kind of chaos and destabilization, including medication side effects, or the feeling of, what some people I spoke with called, being a “normal” self. These feelings do not come automatically interpreted – transparent to experience (as naturalists might suggest) -- but rather require larger cultural narratives to make sense of them. Here the encounter with antidepressants introduces the challenge of finding a habitus suited to the experience of taking antidepressants. The “antidepressant user” will need to learn how the practice of taking antidepressants can be integrated as a part of everyday agentic practical activity. Second, following on the critiques of biomedicine offered by theorists such as Frank, it is necessary to analyze the kinds of narratives made available for understanding the feelings introduced by antidepressants. If medical narratives are colonizing narratives – as Frank suggests – then how do they impact the narrative of self in its encounter with antidepressants? I’ve already suggested that these antidepressant narratives are individualizing narratives. Given the embodied character of selfhood, individualization and the accompanying processes of risk will be viewed not as processes that unfold in abstract psychological or social space, but rather as processes realized through a practical engagement of both self and body.

Conclusion: A Narrative Theory of Antidepressant Medications

In this chapter I have provided a metatheoretical analysis of three ways to understand the relationship between biomedicine and the self, or more specifically, antidepressants and the self. Naturalism is the most influential perspective in the

contemporary life sciences and increasingly the social sciences. It assumes, from the start, that selves are individual creatures and that psychological suffering is a product of biological imbalance. Nevertheless, the life sciences contribute the seemingly inevitable view that human beings are biological beings and in some ways the balance of neurotransmitters must inform our understanding of self and suffering. Poststructuralists deconstruct the self, but also show how the life sciences enable new forms of discipline and subjectivity. In particular, they call attention to the need for a reconceptualization of the ontology of subjectivity and selfhood. I rely upon a hermeneutic theory of narrative which holds that self-narration is a socially and bodily embedded activity. According to the hermeneutic view, self-narration is always grounded in fore-structures of understanding. These are given in advance of self-interpretation and carry within them cultural knowledges and moral frameworks that orient selves in time, space and relationships to other people. Even when not explicitly articulated in everyday life, cultural frameworks posit valued goods for selves and structure the way in which these can be articulated in personal stories. Here the embodied sense of being a self, moving through time with others, meets up with the cultural narratives that enable people to give expression and form to an otherwise taken-for-granted sense of being in the world with others. I have also suggested that in ideal instances narrative is something that can transform affect. It can make the unruly, chaotic and inexplicable aspects of life into a story that both makes sense of selfhood for the storyteller, but also for other people.

However as I have also suggested, this ideal view of narrative is frequently undermined in a culture that disavows the embodied, dialogical character of selfhood. The valorization of the individual, independent autonomous self not only places

increasing responsibility on individuals for the management and care of self and feeling, but it also works against theories that would place narrative and self in interpersonal fields and cultural frameworks. Here, in fact, Taylor (1991) and other social critics such as Robert Putnam (2000), argue that the growing individualism of western culture leads to a more general *malaise*. While I hesitate to diagnose the causes of depression and anxiety in contemporary cultures, the individualism, loss of orientation within space and relationship, as well as the discursive creation of a risk mentality seem to indicate some broad social factors. It should be clear however that Taylor's critiques of individualism and the accompanying malaise is not a rejection of individualism *per se*. Unlike postmodern and poststructuralist scholars who critique the language of individuality, authenticity and selfhood, Taylor argues that these have become central aspirations of many contemporary western persons, and as such cannot simply be thrown off. The problem for Taylor, then, is to re-embed these ubiquitous languages and selfhoods within larger historical frames. Here individualism and authenticity should be seen as dialogical accomplishments – achievements situated within unique historical situations, and valuable resources in ongoing debates about the character of selfhood and social life more generally. Indeed, the goal of *Sources of the Self* is to provide a larger story of the self that reveals the background assumptions and historical aspirations that orient everyday self-knowledges in the first place. In part, this dissertation is an attempt to fill-in the background knowledges and practices of self-interpretation that go into making sense of the use of antidepressant medication. The goal is to show that even though antidepressants are frequently treated as merely a chemical intervention, whose effects

are more or less transparent, their engagement is always informed by implicit knowledges and self-understandings.

This said, it should also be clear from the review of naturalism and poststructuralism that a purely linguistic or symbolic theory of narrative will not be able to fully address the significance of antidepressant medications. Biomedicine introduces technologies that modify the body at “sub-molecular levels” therein bypassing the acts of representation and self-narration so central to the constitution of selfhood in modern frames. Indeed, in emphasizing the linguistic origins and character of selfhood, hermeneutics and narrative theory have frequently opposed views in which technology could be recognized as a worthwhile means of achieving human betterment. Here the hermeneutic critique decries technology as a form of instrumental reason that, in Jurgen Habermas’ (1987) term, “colonizes” the lifeworld of everyday human experience. Such perspectives oppose the essentially human expressive and interpretive character of narrative to the manipulative and totalizing character of scientific technology (Heidegger, [1954]1977; Horkheimer & Adorno, 2002). The poetry of language is opposed to the distancing, theoretical attitude presumed by most modern technologies. This provides an appealing critique of new technologies, especially those which attempt to supplant creative and expressive activity, and as I have suggested above requires an analysis that would embed the use of such technologies within larger social and cultural frameworks.

However, given recent work in poststructuralist science and technology studies there is also reason to hesitate in this critique. For one, the critique of technology is oftentimes related to a disenchantment thesis. Taylor (1991) elaborates this theme when he argues that contemporary social science, and especially those perspectives that

embrace evolutionary and biological approaches, misconceive selfhood as something to be explained through objective and abstract theories. Parading under the authority of science, these perspectives displace the lifeworld of everyday self-understanding. From this perspective, the widespread use of antidepressants, and the biological theory of the person that they bring with them, have something inherently disenchanting built into them. Where, according to Taylor, selves and their problems are properly conceived in relationship to meaningful cultural frameworks and everyday practices, the biological perspective relocates the entire problem to an unfamiliar realm of neurotransmitters and dysfunctional brain structures. Furthermore, these perspectives ask, in some cases require, that people understand themselves in languages that, by definition, come from somewhere outside the realm of everyday life.

Yet, numerous contemporary social scientists suggest another possibility. They argue that the life sciences no longer abide by rational and abstract principles. Instead they suggest that contemporary biology has become more “postmodern” and that it now offers complex, non-reductive models of *life itself* (Best & Kellner, 2001; Clough, 2003, 2004; Haraway, 1991a; Rabinow, 1992; Rose, 2003). In this very complexity biological science potentially re-enchants narratives of the self, or at least opens up new realms of meaning and relationships. Karin Knorr Cetina (2001), like some of the poststructuralist thinkers I described above, has argued that western societies have passed from social to postsocial forms of organization. Each of these forms of social organization sustained and constituted certain human capacities and views of self. Social theories of self emphasized a self embedded in social and linguistic activity, and known through its relationship to others. These theories lament the increasing individualism and the liquidation of

relational forms that constituted the social and political environment of modern societies. The self is at a loss, and empty, when it loses face-to-face inter-subjectivity. Postsocial theories, however, emphasize the increasing role that non-human objects, especially machine technologies, play in constituting selves. Such objects are always “incomplete” and call out for practical human involvement, thereby enabling new forms of imagination and relationship, in which inter-subjectivity no longer plays a central constituting role. In this respect, technologies like antidepressants can be viewed not merely as medicines that combat deficit and restore lost selfhood, but as new forms of self-engagement.

While I am not prepared to argue, as some poststructuralists do, that we now bear witness to the emergence of a radically new ontology of being, I aim to explore the ways in which narrative is conditioned by this postsocial environment. In addition to the way in which self-interpretation unfolds within older traditional frameworks and interpersonal encounters, the narrative approach must understand how self-understanding is transformed by its engagements with biotechnology. I anticipate three ways in which biomedical science impacts the act of self-interpretation and narrative formation. First, *biomedical science introduces a new content into the story of self*. Increasingly the scientific knowledge controlled and deployed by experts – scientists, medical doctors, psychiatrists – enters into everyday life and becomes a kind of knowledge that can be incorporated into people’s life stories. As I will examine in chapter three, one central way in which these knowledges are circulated is through antidepressant advertising and promotional materials. Here, I will suggest that biology becomes an actor in itself – a new character -- potentially inserted into the story of self. Second, *through technologies that modify affect, bioscience potentially transforms the function of narrative*. For

example, as I argued earlier, narrative theory assumes a relationship between affect and narrative. Narrative transforms affect, converts chaotic feelings and fear into comprehensible experiences that can make sense of suffering and enjoin the life of self to the life of other. This, I suggest, is potentially transformed in the biomedical era. As medicines enable people to manage and control affect, narrative serves a secondary function in the transformation of affect. No doubt people continue to tell stories about themselves, and stories remain a central way of making meaning and engaging the world with others, but here the story is not a primary means of transforming and making affect available – the medication takes over from narrative. In a similar fashion, I will examine how biomedicine transforms the relationship between self and body, as well as self and other. Third, *biomedical technologies, such as antidepressants, participate in a larger process wherein narrative is individualized and constituted through the lens of risk*. This moves narrative from the realm of interpersonal relationships and shared evaluations into to a realm of personal self-management. The narrative of self increasingly involves the story of one's struggle to overcome, or avoid, either environmental risks or risks posed by one's biological make-up. In this context, antidepressants become meaningful as technologies that allow people to negotiate risk and realize aspirations such as authenticity, self control and individual empowerment.

Chapter 2 Notes

¹ In this claim Gergen develops the influential work of Thomas Kuhn (1970). Focusing on research in the natural sciences, Kuhn argued that science does not progress through a slow and steady accumulation of knowledge determined by experimental observation, but rather it is shaped by dominant interpretive paradigms. Major changes in scientific theory, then, do not wholly emerge from the observation of new empirical facts, but are also conditioned by the readiness of a scientific community to recognize and account for “anomalous” findings.

² Logical empiricism assumed the possibility of objective, distanced knowledge determined through a hypothetico-deductive method. This view also informed the behaviorist view of the human subject. In early behaviorist theory human activity was conceived as a series of adaptive responses to an external environment. In later neo-behavioral theory the notion of the human being as a rational-calculator was developed through the notion of “hypothetical constructs” (Gergen, 1994, p. 18).

³ Evelyn Fox-Keller (1987), for example examines the relationship between gender and science. She argues that the “engendering of scientific knowledge...has served to order the sphere of epistemic power.” Insofar as a masculine science pursues ideals such as unity and coherence it also excludes difference. Theoretically this denigrates the entire “realm of the feminine” and the possibility of a feminist science. Practically it is realized as an exclusion of women scholars from science.

⁴ I borrow the term naturalism from Charles Taylor (1989, p. 4) for whom naturalism is a deeply seeded modern ethical stance which treats moral reactions as instinctual impulses. Taylor is critical of this perspective because it ardently denies the cultural and linguistic origins of moral sensibilities, but more broadly, and closer to my concerns, it also denies the cultural, social, and in Taylor’s terms, moral, character of selfhood. I describe naturalism as a metatheoretical perspective in the sense that it is a deeply seeded set of assumptions that guide the way some scholars and researchers think about selfhood and the relationship between selfhood, psychological distress and biomedicine. Further I use the term naturalism rather than the term biological or biologism in order to emphasize the idea that biological theory is not necessarily positivistic, or reductionistic. As will be argued in the section on poststructuralism, biological theory can be conceived in non-reductionist languages. In addition to feminist critical biologists – Evelyn Fox-Keller (1987), Donna Haraway (1991a), Anne Fausto-Sterling (2000) -- Best and Kellner (2001: 104) provide a list of biologists who are more “postmodern” than naturalist: Stuart Kauffman, Ilya Prigogine and Brian Goodwin.

⁵ Here I choose poststructuralism rather than the more inclusive category of postmodernism in order to emphasize 1) Foucault’s work on power/knowledge and the technological apparatuses that produce subjectivity and 2) because much of the “cutting-edge” social theoretical work on biomedicine and subjectivity that I discuss in section two describes itself as post-structuralist. I will further comment on the relationship between postmodernism and post-structuralism in section two.

⁶ This division, it will be noted, differs from Ritzer’s (1991) distinction between a social-facts paradigm, social-definition paradigm and a social-behavior paradigm. One of the main reasons for this difference is that Ritzer bases his distinction on an analysis of sociological theory, whereas my concern is conceptions of selfhood across the social sciences more generally. This said, the division between naturalism, poststructuralism and hermeneutics does share some similarity to Ritzer’s breakdown. Insofar as naturalism emphasizes experimental methods and is frequently allied with cognitive psychological, rational-choice and neo-Darwinian theories of human behavior it offers a theory of self that loosely overlaps with Ritzer’s social-behavior paradigm. Insofar as hermeneutics emphasizes the experience and self-interpretative activity of the agentic actor, its theory of self overlaps with Ritzer’s social-definition paradigm. However, in addition to emphasizing the self-interpreting activity of actors in everyday life, the hermeneutic perspective also gives weight to the cultural structures and frameworks that make self-interpretation possible in the first place. In this sense, hermeneutics bridges both the social-definition and social-facts paradigm. Insofar as poststructuralism emphasizes the analysis of cultural constructs and institutionally articulated forms of power, it also overlaps with the social-facts paradigm. However, this perspective clearly goes far beyond the structural-functionalist and conflict theory perspectives that are the exemplars in Ritzer’s depiction. Indeed, recognizing the recent importance of postmodernism (and poststructuralism) in sociological theory, Ritzer (1997) suggests that these perspectives themselves constitute a fourth sociological paradigm, despite the fact that, as Ritzer notes, postmodern theorists would likely refuse any

attempt to categorize or seek a final definition of the variety of positions that are called postmodern or poststructuralist.

⁷ See, for example, recent issues of *Sociological Theory*: Smith & Stevens, 2002; Hammond, 2003; Machalak & Martin, 2004; Horne, 2004; Savage & Kanazawa, 2004.

⁸ Here the brain becomes the central actor rather than the self or the human being.

⁹ A third observable includes blood tests that measure levels of serotonin and other neurochemicals in the body. For the sake of space I don't address the problems associated with those theories, though Valenstein (1998) provides a book length critique of contemporary scientific theories of personhood. See chapter 3 footnote 7 for further elaboration.

¹⁰ Unless, of course, great efforts are taken to secure that language from such slippage, which on many critical accounts is precisely what the medical and psychiatric sciences have sought to do with depression.

¹¹ In describing the ways in which brain images are socially produced, Dumit shares in a tradition of science studies scholarship. In particular, Dumit's work draws on scholars such as Bruno Latour (1988, 1999) and Michel Callon (1986) who study how scientists "create" objects in the laboratory. Furthermore in creating scientific objects scientists also forge connections between objects created in the laboratory, and larger political and economic concerns. For example, in his study of Louis Pasteur's influence on 19th century France, Latour (1988) shows that science does not work through isolated laboratory work, but rather requires that scientists translate social problems into scientific problems (e.g. the designation of an anthrax microbe as a potential harm to cattle), capture the interest of actors outside of the laboratory (e.g. the anthrax microbe becomes interesting to farmers and the French government because it promises to solve a pressing problem in agricultural production), and move the science of the laboratory into the realm of everyday life (e.g. so that farmers can reproduce the lab conditions that allowed Pasteur to control anthrax). In this, Latour breaks down dichotomies between society and science, as well as the distinction between the "inside" of a laboratory and the "outside" social world. The two are never distinct from one another.

Similarly in his influential essay "Some elements of a sociology of translation" Michel Callon (1986) describes the process by which a group of scientists addressed the problem of declining scallop production in St. Brieuc Bay, France. Here he argues that the *translation* of scallop farming problems into a scientific solution depends upon process of *problematization* (by which actors, including the scallops are defined in their relationship and relevance to one another), *interessement* and *enrollment* (i.e. in which the relationship between defined actors is stabilized and actors come to see their mutual interests – including the interests of the scallop). What is unique about Latour's and Callon's "actor network" approach is the agency that they give to non-human agents – scallops or anthrax microbes.

A concise review of this history of social studies of science can be found in Michael Lynch (2005). Social studies of science has origins in Robert Merton's research on institutional scientific structures and the philosophical writings of Thomas Kuhn, Paul Feyerabend, Peter Winch and other critics of positivism. Lynch describes four developments in the social studies of science: 1) the strong programme in the sociology of knowledge, which emerged from the Edinburgh School of science studies and in particular the work of David Bloor (1976). These argued that even what appeared to be the most universal and invariant entities in the mathematical and natural sciences were shaped by social and cultural factors; 2) social, historical and ethnographic work, which took historical cases and ethnographic studies as a basis for understanding the social and cultural forces that guided scientific research and constituted scientific knowledge; 3) the very influential actor network theory, which sought to articulate laboratory practices with wider chains and networks of knowledge production; and 4) constructionism, which combined critical work in feminist theory, deconstructionism, postcolonial theory and postmodernism to demonstrate the constructed character of all social knowledge as well as its, oftentimes disavowed, ideological underpinnings.

¹² A PET scan provides an image of activity in specific regions of the brain that is correlated with particular cognitive and behavioral tasks (such as looking at words) or psychological conditions (such as schizophrenia or depression). To produce these images persons/patients are injected with radiotracers that resemble the activity of molecules that are normally used by the brain (e.g. oxygen, glucose), and then placed in a PET machine. The radiotracers are absorbed into different regions of the brain and, as they decay, emit positively charged electrons -- positrons. As positrons collide with electrons they emit two gamma rays which shoot out approximately 180 degrees apart. A ring of crystal detectors surrounding the patient detect the presence of these gamma rays, enabling the computation of the location from which the

positron was initially emitted. The collection of large masses of emissions allows researchers to produce an image of activity in the brain.

¹³ Dumit (2004) writes: “Turning back now to the example figure... another conceptual abstraction can be discovered. The five subtracted brainsets each have a fairly lateralized activation in the visual cortex. Meaning that the left side is significantly more active than the corresponding right side, or vice versa. The average brainset, however, is prominently bilateral, with both the left and right side of the visual cortex showing high (white) subtracted activity (p. 86)

¹⁴ See also Kenneth Gergen’s (1991) *The Saturated Self* where he distinguishes between the romantic self that emerged in the 18th century (see this chapter, footnote 16 for further discussion and chapter 5), the modern self which was bound to scientific developments in the 19th and 20th century, and the postmodern, or relational self, which emerges in light of structural transformations in communication and information technology. For Gergen the postmodern self is fragmented and fractured by the proliferation of roles, relationships, and possibilities for identity formation in a postmodern world.

¹⁵ In addition to the question of modern definitions and attitudes toward the self, there is also the question of modernity as a historical period. This periodization of modernity, as well as its sometimes presumed predecessor, postmodernity, is contentious.

¹⁶ Briefly though, while Taylor points to Augustine as an initiator of the inward turn, the theme of inwardness is not significantly engaged again until the 16th century, at which time philosophers such as Michel Montaigne and Rene Descartes sought the self within the person. Montaigne’s (1533 – 1592) ruminations in his *Essais* explored the idea of self discovery and a self in flux, even anticipating postmodern claims that the self is neither stable nor a consistent entity. Descartes (1596 – 1650), Taylor argues, marks a significant departure from the Augustinian view of self not only because he describes the division between body and mind, so central to modern scientific thought, but also because he relocates the moral sources of the self from a cosmological realm (influenced by neo-platonic philosophers, Augustine sought the self in a realm of ideal forms, Taylor, 1989, p. 127 - 179) to an internal realm. The modern trajectory of self is further influenced by the Protestant Reformation and its rejection of Catholic dogma. From this point of view, evidence of heavenly salvation could be discerned through success in everyday production and reproduction (see also Max Weber’s ([1904-05]1998) *The Protestant Ethic and the Spirit of Capitalism*). This marks a point at which the virtues of “ordinary life” – work and family – became a significant feature of western selfhood (Taylor, 1989, p. 211). The 17th century sees the development of two further features of modern selfhood. The notion of “disengaged reason” was developed in the work of John Locke (1632 – 1704). The idea that persons could step outside of themselves and view themselves from an objective distance played a significant role in the development of Enlightenment thought. In particular it laid a foundation for philosophies that engaged the “mind” as a collection of perceptions and associations that could be studied using the empirical method of natural science. Finally, Taylor traces the influence of the counter-Enlightenment and romantic philosophies of the self (pp. 368 – 392). This 18th century “expressivist turn” challenged the hegemony of scientific reason. It sought to bring persons into contact with nature and heal the division between reason and sensibility that was believed to be the product of Enlightenment science. Further, Romanticism claimed that the real or “authentic” self could be found in a deep, mysterious interior. The expression of one’s self through art became a central means of coming into contact with this “deep” selfhood. This view – that the true self is found in aesthetic representation and soul searching – continues to influence contemporary views of self, especially in the private realm where coming in touch with one’s authentic feelings is a central means of finding meaning, and a condition for intimate relationship with others.

¹⁷ As an example of the desiring being and the possibilities of the schizophrenic process, Deleuze and Guattari ([1975]1986) point to the literary work of Franz Kafka. In particular, Deleuze and Guattari are interested in hybrid beings, most famously, the man-cockroach at the center of Kafka’s *Metamorphosis*. These represent creatures that are never contained within their own boundaries, and like the mythological figures in Ovid’s *Metamorphosis*, constantly undergo radical change and transformation. Deleuze and Guattari, and the postmodernists who follow in their tracks, have been criticized for their valorization of the schizophrenic process. To be schizophrenic even in a metaphorical sense, is also to lose contact with communal reality. James Glass (1989) explores the interplay between delusional inner states and communal, consensual reality. His discussion stands in contrast to Deleuze and Guattari’s celebration of the schizophrenic process. He describes delusion as the experience of being isolated and ejected from community.

¹⁸ More precisely a cyborg is “a cybernetic organism, a hybrid of machine and organism, a creature of social reality as well as a creature of fiction” (Haraway, 1991: 149).

¹⁹ Indeed, according to David Harvey (1989) and Frederic Jameson (1991) the postmodern aesthetic, in its embrace of hybridity, transformation and flexibility merely reflects the underlying structure of a post-fordist capitalism that has become more flexible. For Harvey and Jameson the postmodern aesthetic – and frequently accompanying postmodern social theories – do not liberate people from the forces of capitalism but cover-over the material practices that guide their production.

²⁰ Jane Ussher (1992) further develops this Foucauldian critique through an analysis of “women’s madness.” She argues that Madness is not merely the Other to Reason, but it is also the Other to Man. In this set of dichotomies and associations Woman is always aligned with Madness, and therefore in the western cultural imagination more incomprehensible, more unreasonable, and more prone to breakdown and disorder than Man.

²¹ Though as Foucault and other historians of psychiatry (see Porter, 2002) note early asylums served a pedagogical purpose for the interested public. For example, members of public could pay a small fee to watch the antics of the mad in London’s famous Bedlam asylum. In this, the public learned the dangers of sloth, laziness and the unproductive life.

²² Given the predominance of the psychoanalytic model in American Psychiatry, the first edition of the DSM (DSM-I, 1952) was hardly recognized in professional psychiatric practice. By 1974, as the medical model gained ground, the third edition of the DSM (DSM-III) was 150 pages in length. The fourth edition, published in 1994 (and due for expansion as DSM-IV-R in 2010) has been the most successful edition to date. At 885 pages, it provides approximately 300 diagnostic categories for mental illness, and has been translated into 13 languages. In the United States a DSM-IV diagnosis is required by insurance companies for reimbursement of psychiatric treatment (Spiegel, 2005).

²³ As indicated in the opening chapter the other two schools are the “risk society” school developed by Ulrich Beck, Anthony Giddens, and Zygmunt Bauman, and the “cultural symbolic” school that grows out of the work of Mary Douglas.

²⁴ In Foucauldian language, governmentality is a form of social control that operates at the level of populations rather than individuals. It relies upon statistical, demographic and epidemiological methods and accompanying administrative techniques to maximize the ideals and interests of a particular social order.

²⁵ Though as Dean (1999) and Ewald (1991) have argued the language and knowledge of risk is certainly not homogeneously distributed, but rather interact with forces on the ground, as it were, to generate varying forms of risk rationalities.

²⁶ Taylor’s critique of poststructuralism is summarized in the following passage from *Sources of the Self* “Oddly enough-or ironically-the neo-Nietzschean theory is open to the same kind of criticism as that which we both, it and I, level against mainstream moral philosophy: that of not coming quite clean about its own moral motivations. Only here the problem is not that it denies having any, as with modern meta-ethical theories which claim only epistemological grounds, but that it accords them a false status. It claims a kind of distance from its own value commitments, which consists in the fact that it alone is lucid about their status as fruits of a constructed order, which lucidity sets it apart from other views and confers the advantage on itself of being free from delusion in a way that the others aren’t.” (pp. 99 -100).

²⁸ See for example Fraser, Kember and Lury’s (2005) introduction to the *Theory, Culture and Society* theme issue on the “new vitalism.” They combine 19th century biological theory (including Nietzsche’s vitalism) with contemporary theories of social process and relationality: “The significance of relationality in process thinking in this collection is that it acts as a ‘lure for life,’ an enticement to move beyond the confluences of life with the (life) sciences, to conceive life as not confined to living organisms, but as movement, a radical becoming. In process thinking, relations and relationality cut through and across all spheres, regardless of the distinctions that are drawn between them (between the cultural, the natural and the artificial for example). Indeed, distinctions are themselves an aspect (an effect) of the differentiation of processes. In this way of thinking, it is not enough to see nature as an effect of culture or vice versa. The existence of changing distinctions, or ontological differentiations, between nature and culture is instead an effect of particular relations.” (p. 3)

²⁹ Here Wilson's work resonates with practitioners of Actor Network Theory who also work to deconstruct clear-cut distinctions between human, animal and machine. This also builds on the work of critical biologist Donna Haraway.

³⁰ For Mead this was expressed in a quasi-behaviorist theory of stimulus and response. At a most basic level all animals coordinate activity through *gestures* – back and forth signals that condition interaction. In addition to communicating through gestures, humans coordinate activity through meaningful signs (*significant symbols*). These allow people to take themselves as objects of reference, and therefore coordinate activity at a more abstract level. This capacity for abstract signification also contributes to the development of complex social structures. Mead's pragmatism is also taken up in contemporary social constructionist accounts of human interaction. Social psychologist Kenneth Gergen (1982, 1991, 1994a), for example, argues that language is a means of coordinating action, and the concept of the self enters as one means of organizing relationships with others. To refer to one's self, and its various attributes, is to call out behaviors in others that would allow for the smooth flow of interaction. Gergen's enthusiasm for this linguistic pragmatism leads him to the conclusion that selfhood can be transformed through the invention of new language games.

³¹ In fact, as Grondin points out, this distinction goes far back into the "pre-history" of hermeneutics. For example, it is found in Ancient Greek and Jewish attempts to provide a method for the interpretation of "allegories" (Grondin, 1994: 26) and it is further articulated through St. Augustine's work in which inner thoughts were believed to reveal the more fundamental will of God (p. 32). Heidegger ([1953]1996) argues that this distinction between word and spirit characterizes the western philosophical tradition. His goal in *Being and Time* is to deconstruct the ontology of Being that informs this distinction, and shapes the western tradition.

³² This view that interpretation can lead to a more accurate, or truer account of an expression is much contested. Postmodern and poststructuralist scholars argue that there is nothing but the text and that the attempt to discern a deeper intention is a modernist conceit.

³³ Here, in emphasizing a cultural stock of knowledge, Ricouer shares much with phenomenological sociologists such as Alfred Schutz (1967) and Peter Berger and Thomas Luckmann (1967). Schutz, in particular, developed the idea that cultural backgrounds provide people with "recipes" for the negotiation and co-ordination of their interactions and activities in everyday life.

³⁴ In a discussion of Taylor's position within hermeneutic philosophy Nicholas Smith (2004) writes "The distinctiveness of Taylor's voice in the hermeneutic tradition owes much to the explicitly moral perspective he brings to the post-Heideggerian thesis that human beings are self-interpreting animals. We have to bring such as perspective, Taylor argues because self-interpretations are conducted in languages that cannot but instantiate distinctions of worth" (p. 43).

³⁵ Leslie Irvine (1999) has extended the concept of narrative wreckage to include the kind of narrative collapse that can follow on the break-up of a long term intimate relationship. In particular, Irvine emphasizes the extent to which personal narratives are always embedded in relationship. The collapse of relationship can lead to the collapse of the individual story of self.

³⁶ Of course, sociologists have also suggested the same. For example, in *Elementary Forms of Religious Life* Émile Durkheim ([1912]1965) described the relationship between "collective effervescence" and "collective representation." For Durkheim, the ritualistic gathering of individuals at select times of the year stimulated great emotion and feeling in individuals. These unnamed energies assumed concrete representation in totemic symbols. I do not explicitly rely upon Durkheim because he does not formulate this problematic in narrative terms, though further work on a Durkheimian theory of narrative could prove fruitful.

³⁷ Though Foucault's (1988a, 1988b) later work on the "care of the self" suggests a turn toward understanding the body as an agency realized in situated forms of practical activity.

³⁸ Though popularized by Bourdieu, the concept, habitus, had previously been employed by sociologists and anthropologists (Jenkins, 2005). Norbert Elias was the first to extensively use the term to refer to an "automatically functioning self-restraint, a habit that, within certain limits also functions when a person is alone (Elias, quoted in Jenkins, 2005, p. 352). Habitus was also employed by phenomenological and symbolic interactionist scholars such as Berger and Luckmann and Erving Goffman. In anthropology Marcel Mauss ([1936]1972) introduced the concept of habitus in his influential essay "Techniques of the body." Mauss argued that the capacities and abilities of the human body were not naturally given, but rather were taught and incorporated through, culturally specific techniques of the body. For example, he argues

that the way people swim, walk or hold their hands changes across time and place. These habits do not emerge from the body itself, but rather emerge as “physio-psycho-social assemblages” – a series of actions that allow the individual to unthinkingly, yet meaningfully, engage the surrounding cultural space.

³⁹ In contemporary social theory, the idea of a “common embodiment” will necessarily be a contentious idea. On the one hand, it combats the naturalist and individualistic view that bodies are entities that begin and end at the borders of the flesh. On the other hand to suggest a common embodiment is to undermine the manner in which individual bodies of various types can be radically distinct and contribute to different forms of embodiment. While this dissertation recognizes the importance of theories of “difference,” the hermeneutic perspective, focused on problems of self and interpersonal understanding also suggests that the experience of the Other, though always irreducible to the sameness of self, offers opportunities to imaginatively participate in the experience of another.

Chapter 3: The Language of Antidepressant Advertising

Since 1997, when Eli-Lilly launched its first major direct to consumer advertising (DTCA) campaign for Prozac, antidepressant advertisements have circulated widely in magazines, on television, and through the Internet. In the United States, DTCA for prescription pharmaceuticals has been used since 1981 (Wilkes, Bell and Kravitz, 2000). However, early campaigns were burdened by Federal Drug Administration (FDA) regulations that required extensive listing of contraindications, side-effects and effectiveness of medications. This proved especially difficult and costly for television and radio advertising (Wilkes et al., 2000). In 1997, the FDA relaxed these regulations requiring that broadcast ads list only the most serious risks, and provide a statement directing viewers to a more complete description of the medication. Between 1996 and 2003 spending on DTCA increased fourfold, from 791 million to 3.2 billion dollars.¹ Though clear causal claims cannot be made, the growth of DTCA has been accompanied by an increase in consumer awareness of prescription brand names. Mintzes et al (2003) report that people who were exposed to prescription medicine advertising were more likely to request advertised medicines from their doctors.² Antidepressants medications, in particular, have been widely advertised and consumed. Eli Lilly spent \$15 – 20 million on its 1997-1998 Prozac print campaign (Gilbody, 2004). GlaxoSmithKline's 1999 Paxil television and print campaign cost 30 million dollars (Goetzl, 1999), and \$65.1 million in 2002 (Advertising Age, 2002). The antidepressant Zoloft has also been widely advertised, costing \$50 million in 2000, \$51 million in 2002 (Sanders & Thomaselli, 2003), and \$75 million in 2003.³ Since 2000 SSRIs and SNRIs have been the second most highly

prescribed medication the United States.⁴ In 2000, 98 million prescriptions for SSRIs/SNRIs were filled,⁵ and in 2004 this number was 147 million.⁶

Pharmaceutical companies rely upon DTCA as one of the most efficacious means of educating a broad public about medications, but also about the scientific theories, and evidence, that support their use. In particular, antidepressant ads proclaim that depression, anxiety and other forms of psychological distress are biological conditions, the product of chemical imbalances in the brain. They fend off older folk and psycho-social theories of mental illness, and promote a view that rigorously links psychological suffering, biology, and antidepressant medication. Indeed, once depression and anxiety are reconceived as biological imbalances, antidepressants become a necessary and non-negotiable solution to psychological distress.

Despite their reliance on scientific imagery and authority, I argue that these advertisements are more like myths than the factual educational resource that pharmaceutical companies make them out to be. The advertisements oversimplify the character of depression and anxiety, as well as the science behind these medications (Valenstein, 1998). For example, it is unclear that serotonin is the neurotransmitter implicated in depression and anxiety, either alone or in conjunction with norepinephrine and dopamine – the other usual suspects.⁷ Yet, the “serotonin story” continues to animate scientific research, and inform advertisements and promotional materials. Even more striking, it is not clear that people who suffer depression and anxiety have chemical imbalances, or that their brain chemistry is different from “normal” brain chemistry.⁸ Though the advertisements claim that depression and anxiety are caused by changes in levels of neurotransmitters, consumers are not told that neuroscientists (and physicians)

have no way of directly measuring neurotransmitter levels in the brain, either in the physician's office, or in a scientific laboratory.

As myths, antidepressant advertisements claim a totalizing knowledge of self and suffering. They participate in, and clarify, a kind of *cosmology* that offers a narrative framework for understanding the self and its suffering. This cosmology is made up of biological elements (neurotransmitters, synaptic gaps, brain structures, antidepressant medications), assertions about the relationships between those elements, and claims about the powers that inhere in those elements. It also transforms the character of the self, which, equipped with a new set of technologies and self-surveillance devices acquires a set of responsibilities in relationship to its biological material (see also Novas and Rose, 2000). Finally, as cosmology, the biological story attempts to replace, or absorb, older representational systems. Antidepressant ads challenge competing accounts of psychological distress and self-understanding. For example, talk therapy, so central to the psycho-social view of mental illness, is re-conceived through the lens of biology. The PaxilCR website claims:

Psychotherapy is more than 'just talking.' Just as the process of learning changes the brain, psychotherapy can change the way the brain functions.⁹

Once the biological argument gains ground, psychotherapy – as mere talk -- becomes a liability, and its efficacy must be interpreted within the universe of biological understanding. All psychological healing must pass through the brain.

The purpose of this chapter is to describe how this biological myth is developed in antidepressant advertisements. I am interested in the stories told about selfhood and psychological suffering, and the “characters” and images constructed within the ads to

support these stories.¹⁰ I develop this analysis in three sections. First, I describe how the ads construct depression and anxiety as disease, but more specifically I talk about how biology is introduced as a character in its own right. Through the use of metaphor, the brain becomes an object of sympathy and care, and as such available for integration into stories about the self. Here, following Knorr-Cetina's (2001) suggestion that in a postsocial world human agents are increasingly constituted in relationship to non-human agents, I argue that selves are constituted in relationship to an active biological internal space, and the antidepressants that allow interaction with that biology. In the second section, I show how the medicalization of psychological distress constitutes the self as a disengaged "punctual" agent, that must confront the risk of psychological distress in a moment of individual choice (Taylor, 1989: 159). This builds on the critique of disengaged, abstract selfhood introduced in chapter two. Taylor uses the concept of "punctual selfhood" to describe the philosophy of self that derives from John Locke's valorization of disengaged self control, as a form of self-knowledge. Antidepressant ads assert the primacy of expert knowledges in the recognition and treatment of psychological distress. Depression and anxiety are engaged as "things-in-themselves" essentially unintelligible within the frameworks of everyday understanding. As such, people are encouraged to abandon explanations and accounts of their suffering that emerge from within the sphere of everyday understanding (e.g. "I am to blame for my depression" or "My anxiety is a product by my inability to resolve events from my past"), and to assume the attitude of naturalism. Here the notion of punctual selfhood is further articulated with ideals of rational choice, and consumer choice. In social and economic theory, rational choice refers to the assumption that human beings are fundamentally

rational economic calculators, and that a study of social life requires an analysis of the way in which individual actors make calculated decisions about their own well-being.¹¹ Here, larger social and cultural values assume the position of mere “preferences” that establish the background interests of individual rational choice. The depiction of selfhood in antidepressant ads resonates with this theory of social action: even when in the midst of overwhelming psychological distress and delirium, individuals retain the ability to make a rational choice in the interests of their own well-being. Ironically, this choice depends upon a move in which individuals relinquish accounts of self and suffering embedded within the ongoing story of their life, and “hand-over” self-understanding to the “objective” accounts provided in expert psychiatric knowledges. Individuals assert their agency at the moment they conceive of themselves as powerless over their biological condition, and then make the choice to “get well.” The portrayal of selves as free to choose in favor of their own well-being, despite their biological condition, is central to the promotion of antidepressants and the proliferation of a market for antidepressant medications. The choice for wellness is the choice for antidepressant medications which is also the choice for selfhood.

In the final section, I draw these elements together in a discussion of the most common narrative developed in antidepressant ads -- the *before and after* narrative. This narrative depicts a path to recovery through a biological treatment that restores complete and unitary selfhood. Though this narrative shares much in common with Kenneth Gergen’s (1994c) *happily-ever-after* narrative (in which a period of suffering is followed by a lifelong period of stabilization), and Arthur Frank’s (1995) *restitution narrative* (in which illness is put aside so that people can become their selves again) I call it a *before*

and after narrative to emphasize the “magical” transition from illness to wellness implied in the ads. In this formula, the antidepressant medication acts as a magic pill that moves the self from an intractable past, full of suffering, into an idealized future where the self is happy and complete.

I conclude by comparing the view of self offered in antidepressant ads, to the view of self developed in narrative and hermeneutic accounts. The hermeneutic perspective emphasizes the depth of self-understanding that comes from ongoing efforts to situate selves within changing life circumstances. In this perspective, narratives of self remain open to an ongoing process of re-interpretation and self-clarification. The dynamic and depth of selfhood rests in this space between that which is unclear and confusing, and the efforts to provide a more integrated and complete self-understanding. In contrast, the antidepressant narrative, featured in the ads, emphasizes closure, and the cessation of self-interpretative activity. Insofar as selves are portrayed as punctual agents, disengaged from their own suffering, and constituted in a moment of decision, the antidepressant narrative remains distanced from the dialogical and interpretive activities that ground selves in larger cultural and interpersonal spaces.

Disease, Biology, and Antidepressant Medications

The major antidepressant advertising campaigns emerged in three, more or less distinct, waves (see Figure 1). Each period is characterized by an increased frequency of advertising, dominated by a particular brand: Prozac (April 1997 – 1998), Paxil (1999 – 2003); Zoloft (2001 – May 2005). The other medications advertised during this period were Serzone, Effexor and Wellbutrin. In all, there were 21 unique ads for six different medications. Of the nine magazines reviewed, ads appeared most frequently in *Glamour*

(25%), *Self* (19%), *Time* (19%) and *Sports Illustrated* (16%) followed by *Esquire* (9%), *Reader's Digest* (8%) and *Essence* (5%). There were no advertisements for antidepressants in *Men's Health* or *Psychology Today*. (see Appendix 1 for further details). Though the distribution of the advertisements suggests a targeting of the women's audience of *Glamour* and *Self*, it is also clear that the medications are promoted to a wider audience through *Time* and *Reader's Digest*, a men's audience through *Sports Illustrated* and *Esquire*, and an African-American women's audience through *Essence*.¹²

All antidepressant ads provide a means for identifying and defining psychological distress as a disease condition. They list common symptoms, provide checklists for self-diagnosis, but most importantly, transform what could be interpreted as a set of unrelated phenomena into signifiers of an underlying disease state. In short, the ads divide the self into a series of discrete symptoms, and then unite these under a common theme of depression or anxiety.

The early Prozac campaign listed these symptoms: trouble sleeping, unusually sad or irritable, hard to concentrate, loss of appetite, and trouble feeling pleasure.¹³ The symptoms are united by imputing a common source of the symptoms in an underlying biological condition – clinical depression. As such, what were once conceivably discrete problems (attributable to a diversity of sources) are provided a unity and coherence, that can be acted on, at the source, with Prozac. These kinds of symptoms are also described in later ads. A Paxil ad for depression asks “What's standing between you and your life?” and then lists depressed mood, loss of interest, sleep problems, difficulty concentrating, and restlessness as the signs of depression.¹⁴ The “thing-like” quality of depression is also visibly represented. In the central graphic, the symptoms are listed so that they form a

kind of body which stands between a woman and her family. Depression becomes an object identifiable as a thing-in-itself, separable from the woman, and hence vulnerable to treatment with Paxil.

In later ads, the line between feelings and behaviors that are commonly recognized as signs of psychological illness, and those which could be interpreted as problems in everyday life, began to blur. Philosopher Jacqueline Zita (1998) and historian Edward Shorter (1997) describe a process of “diagnostic bracket creep.” As new psychiatric medications are found to impact a growing range of unanticipated symptoms and conditions, the original definition of an illness broadens, and the use of medications expands into new realms. While Zita and Shorter suggest that this bracket creep is driven by practical experimentation with medication, David Healy (1997) draws attention to the marketing dynamics that drive the definition and construction of psychological illness in advertising. Healy argues that prior to the 1980s, pharmaceutical development was primarily driven by the agenda of laboratory scientists, physicians and institutionalized psychiatry. However, starting in the 1980s, especially with the discovery of Prozac in 1987, advertising executives and big pharmaceutical companies began to play an increasing role in shaping the research agenda and defining the character of psychological suffering (see also Angell, 2004 and Valenstein, 1998).

Healy, for example, argues that until the 1980s the diagnostic category “panic disorder” was relatively unknown and rarely used in the diagnosis and treatment of psychological suffering. However, in an effort to secure a market position for antidepressants, marketers promoted panic-disorder to physicians and psychiatrists. Similarly, Paxil’s campaign for social anxiety disorder was intended to distinguish the

medication from the Prozac, which had already cornered the market on depression. As such, the first Paxil advertisement focused on educating the consumer public about the disease “social anxiety disorder” rather than the medication itself.¹⁵ Marc Worman of McCann-Erikson Consumer Health says “This isn’t just about creating a competitive preference for a brand...It’s about defining a condition as well as to promote the Paxil name” (Worman quoted in Goetzl, 1999: 82). The ads provided checklists and further normalized social anxiety by stating that “You are not alone. Social anxiety disorder affects over 10 millions Americans.” They claimed that people who “blush, sweat, shake” and “even experience a pounding heart around people they think may criticize them” may have social anxiety disorder.¹⁶ This not only introduced a new psychiatric concept (social anxiety disorder) into the popular vocabulary, but it also blurred the boundary between normal social worry and clinically dangerous anxiety. A 2003 ad for Effexor asks the reader: “not involved with family and friends the way you used to be?” and “not motivated to do the things you once looked forward to doing?”¹⁷ In both ads the symptoms of illness reached further into everyday life. In particular, the Effexor ad reduces the specificity of symptoms, and broadens the set of signs that point toward an inner, previously unrecognized illness. This creates an interesting paradox. Even though the symptoms of depression and anxiety are increasingly vague and open to interpretation, the biological foundation becomes more precise. The Effexor ad, and other ads that ran from 2002 onward, provides readers with more information about the biological material involved in depression than were featured in earlier ads. “Effexor XR works on both serotonin and norepinephrine—two chemicals in the brain linked to depression.” In this, Wyeth pharmaceuticals distinguishes its medications from all the

run-of-the-mill SSRIs, and elaborates, for readers, the languages available for describing their biological workings.

The ads isolate symptoms and link these to specific diseases, but they also ground these diseases in biology. These biological claims are especially important to the antidepressant narratives. For one, they establish scientific credibility and authority. More importantly for my purposes, they introduce readers to a new language of self, and a new set of explanatory tools. The importance and the meaning of the medications does not simply rely upon the promotion of the medicines themselves. It is not enough to say, for example, that antidepressants restore happiness, or cure depression. Rather, in these ads the credibility of medications depends upon an elaboration of the biological cosmology, which explains the operation of the medications, and grounds them in a world that clearly distinguishes them from the worlds of folk psychology and psycho-social theories. In its ad for Prozac Eli-Lilly asserts that “depression is a real illness with real causes” and adds “when you’re clinically depressed one thing that can happen is the serotonin (a chemical in your body) may drop.”¹⁸ The Paxil ads say: “once-a-day Paxil helps correct the chemical imbalance that may be associated with social anxiety disorder.”¹⁹ And Zoloft: “while the cause is unknown, depression may be related to an imbalance of naturally occurring chemicals between nerve cells in the brain.”²⁰

As they elaborate these internal mechanisms, the ads make available a new “inner life.” In contrast to psychoanalytic theory, which imagined an internal conflicted psyche, or earlier romantic worldviews which experienced the inner self as well of powerful feelings and creative energies, the new inner life is populated by biological material. Pfizer’s Zoloft campaign is most striking. It utilizes the basic techniques developed in the

other ad campaigns. It lists a set of symptoms characteristic of depression: tired all the time, feeling sad and hopeless, feeling anxious and not able to sleep. It also includes feelings and behaviors that are open to wider interpretation: “when you’re not feeling like yourself” or “when you just don’t feel right.” Like other ads, the Zoloft campaign unifies this disparate set of elements under the common theme of depression, anxiety, or in the case of one ad, posttraumatic stress disorder. Symptoms point inward toward a biological imbalance. “While the cause is unknown, depression may be related to an imbalance of naturally occurring chemicals between nerve cells in the brain.” However, the Zoloft campaign is particularly important because it introduces biology not merely as a so-called scientific fact, but as a *sympathetic* character. For this reason I want to spend some time with the Zoloft campaign.

Zoloft is an SSRI which has been FDA approved to treat major depressive disorder, social anxiety disorder, panic disorder, posttraumatic stress disorder, premenstrual dysphoric disorder, and obsessive-compulsive disorder. It is particularly well-known for the cartoon “bubble” character that is featured in its ads. Indeed, this bubble has acquired something of a cult status. It has become the subject of social satire (The Onion, 2003), and at one time had its own online fan club.²¹ Many of the people I interviewed were familiar with this character. Some thought that it was foolish and demeaned the experience of people who suffered depression. Others adored it, and felt that it expressed their suffering well. The bubble has been the center of the Zoloft campaign since the ads started in 2001. The early ads featured the bubble in various states of distress. When depressed, the bubble cries in the moonlight or under a rain cloud. When overcome by PTSD it is haunted by a dark shadow figure, its face expressing

shock and terror. When anxious, it is shaking and blushing in a spotlight, or alienated from other more jubilant and gregarious bubbles.

The bubble is especially striking because it contrasts with the seriousness of the message conveyed in the ads: “depression is a serious medical condition, which can lead to the risk of suicidal thoughts and behavior.” Why would Pfizer make light of this serious situation? Most obviously, one could argue that the Zoloft bubble provides a gentle introduction to the difficult and stigmatized topic of mental illness. Indeed, this is how many of the people I spoke with interpreted the use of cartoon imagery in these ads, as well as the use of cartoons in the Prozac ads. As cartoon, the bubble is a point of entry into this new and foreign world. I want to emphasize something different, however.

Following Judith Williamson (1978), advertising is effective when it translates between systems of meaning. “Advertisements” Williamson argues “provide a structure which is capable of transforming the language of objects to that of people, and vice versa” (p. 12). I want to suggest that the Zoloft advertisements provide linkages between otherwise inert biological matter and the human agent tasked with the use of antidepressants.²² The ads make Zoloft intelligible as a form of treatment not merely by asserting that depression is caused by a chemical imbalance, but by establishing a relationship of *care* between the person diagnosed with depression, and his or her imbalanced nervous system. Through this imagery the act of taking an antidepressant is no longer viewed as an abstract enterprise (swallowing a pill), but it is seen as an activity that has material consequences visualized through the narrative of the Zoloft bubble. Indeed, the Zoloft bubble is a perfect mediator because it can at one and the same time become: (a) a little white pill, (b) an analogue for the neurotransmitters that the human actor wants to goad into action,

or (c) a humanized subject.²³ Point (a) speaks for itself. I will expand upon the significance of points (b) and (c).

(b) The meaning of the bubble depends upon its relationship to the other centerpiece of Zoloft ads – a cartoon image of neurotransmission. In the magazine ads, neurotransmission is represented in two panels that sit side by side. These panels tell a *before and after* biological story. The first image features a synaptic gap relatively empty of little bubbles – the neurotransmitters. In the after picture, Zoloft blocks re-uptake of the bubble neurotransmitters. As a result, the synaptic gap is no longer an empty space, but is filled with many bubbles. In deciphering this image, sorting out its meaning and its relationship to depression and Zoloft, we are already involved with this “inner life.” The agency of the reader is in part constituted in relationship to the problems and solutions posed by this image, as well as their significance for the reader’s own psychological well-being. The biological story is one in which neurotransmission is slowed, or scattered, and in need of rejuvenation or direction. This depiction of an inner life composed of neurotransmitters in various states of activity and deficit is not unique to the Zoloft image. In recent years, all promotional websites feature some kind of animated journey into the brain. GlaxoSmithKline’s Depression.com (which feeds into both Paxil and Wellbutrin sites) provides a particularly detailed narrative that moves viewers, and takes a first person perspective, from the outside of a human body, through the outer layers of the brain, through neuronal bundles, and to the edge of a synaptic gap, where they are able to watch neurotransmitters cross the synaptic gap, both with and without the help of an antidepressant. The central difference in the Zoloft ads is that the relationship between the human agent and the biological material is more ardently constructed. The bubble

character becomes an analogue for the neurotransmitters in the cartoon synaptic gap. Here the bubble also starts to double for the human agent. In the same way that the human agent is caught up in the midst of everyday dilemmas, and crises of movement (e.g. depression as a slowing down of one's life, or anxiety as an inability to move forward) the Zoloft bubble is caught up in dilemmas defined within a biological narrative – it struggles to move across synaptic gaps and to complete a journey necessary to the functioning of the system as a whole. By putting a familiar face on the activity of neurotransmission, the bubble acts as a bridge between the dry, abstract world of the scientific laboratory, and the world of everyday life.

(c) A relationship to biology is also established in metaphors through which certain brain states become desired states. These brain states are not desirable in themselves, but rather acquire their significance within larger social and cultural narratives. Here the story of biology is embedded within problematics that originate in the background experience of contemporary social life, most notably the dilemmas of communication and information exchange that contemporary social theorists argue are central to the concerns of “postmodern” society (Best & Kellner, 2001; Gergen, 1991, Haraway, 1991a; Lyotard, 1984). The Zoloft website provides an exemplary account:

nerve cells in the brain and the rest of the nervous system use chemical messengers. These messengers help cells send messages to each other. One of these messengers is called serotonin.... The tie between depression and serotonin led scientists to an interesting find [*sic*]. Scientists believe people with depression could have an imbalance of serotonin in their brain. That means the level of

serotonin is ‘off.’ So the nerve cells can’t communicate, or send messages to each other the right way. This lack of contact between cells might cause depression.²⁴

This description operates at many levels. It achieves legitimacy through an appeal to scientific authority. It introduces the character of serotonin, and it connects depression to serotonin. However, this kind of description is not merely a handy metaphor intended to communicate a dry science to a consumer public. As narrative, it also acquires its significance because it *expresses* and *structures* concerns central to contemporary society. In this “mimetic” function (Ricoeur, 1984, see chapter 2), the narrative acquires its relevance for life. Through our sympathy for the bubble, we have already established a relationship of care with the “chemical messengers.” We want them to get their job done, not only because we are interested in their happiness, but because our own happiness is at stake. They are “helpers” who require our help to get the job done. In this respect, the person who chooses to take antidepressants enters into an alliance with their neurochemistry. The meaning of neurotransmission is further thickened through its association with computers and telephone systems. As a communication system, the synapse can either be “on” or “off.” And when the synapse is off it is inoperative and lacks energy. This is an all or nothing system – on or off. The off also refers back to the felt symptoms of depression: “you know when you’re not feeling like yourself.” When you feel a little bit “off” this might be depression. The “offness” of the synapse” is equated with the “offness” of feeling and selfhood. Finally, the metaphor of communication builds upon popular psychologies, which place openness and communication at the center of psychological well-being (Guignon, 2002). Just like psycho-social relationships, the brain is healthy when it communicates freely and

transparently. Depression and anxiety are the opposite of communication. They are isolation of the suffering individual and the bubble/neurotransmitter.

In particular, I want to draw attention to the images of *plenitude* and *wholeness* in these ads. In addition to opposing communication and non-communication, or happiness and depression, or sociality and isolation, the ads regularly return to a contrast between depletion and plenitude. The synaptic gap is empty or depleted when not operating correctly. Zoloft restores energy and happiness by filling-up the empty space. The imagery is most striking in the animated sequence featured in Zoloft television ads (also seen at the website zoloft.com). The animation begins with a more or less empty synaptic gap. Bubbles emerge out of “Nerve A” in slow and directionless movement, few reaching the destination of “Nerve B.” One can almost feel the malaise of these shiftless neurotransmitters. Many return and are reabsorbed into Nerve A. Zoloft enters the picture and erects barriers so that the bubbles from Nerve A cannot be reabsorbed. They are forced (encouraged? helped?) to move through the synaptic gap. The result is not merely *forward, directed, movement* (a progress narrative, see Gergen, 1994c) but a sudden and exhilarating increase in bubbles in the synaptic gap. In the animation, both the density and the speed with which bubbles move through the gap is increased. The gap is filled-up, energized, and active – a modern image of the good and productive life, now duplicated at the level of neurotransmission.

The plenitude of neurotransmitters enabled by Zoloft, is an important image because it resonates with themes developed across the antidepressant ads and the contemporary consumer culture more generally. Against the malaise, meaninglessness, emptiness and sense of fragmentation that many argue characterizes life in our times

(Cushman, 1990; Lasch, 1979, 1984; Taylor, 1991), the ads promise energy, wholeness, completion and direction, both at the level of biology and at the level of the self (as will be demonstrated in the section 3). Williamson (1978), building on the work of psychoanalyst Jacques Lacan, argues that advertisements regularly appeal to the emptiness or lack of self, and promise idealized satiation. Products depicted in ads acquire a powerful meaning and significance because they give a feeling of completion, or of finally being filled-up. Indeed, this is the fundamental relationship between consumer and product in the consumer society. The self is constituted in a continuing and repetitive relationship of lack, desire, and momentary satisfaction. Certain products acquire the ability to give us the feeling of satiation, but insofar as they lack substance they inevitably deepen the feeling of emptiness.²⁵ The unique “contribution” of the antidepressant ads is that they constitute lack at a level that, by definition, cannot be addressed through remedies that might be found in everyday life. In antidepressant ads, most crucially the Zoloft ads, satiation is realized through the metaphor of biology. Where in other ads food, clothing, jewelry, or vacation getaways promise satisfaction, in these ads emptiness occurs in the recesses of the brain, and satiation is achieved only with Zoloft. Where, for example, committed consumer hedonists, suffering malaise, might learn that they can find deeper meaning in a return to nature or change in lifestyle (as, for example, advocates of “voluntary simplicity” propose), people constituted through the antidepressant, deficit, discourse have no choice but to seek a solution for their problems in antidepressant medications. Indeed, conceived as such, the antidepressant promises the satisfaction that no other products in the consumer society are able to provide. The brain, and its state of activity becomes extremely interesting to reader’s and those suffering

everyday malaise because it comes to stand for the ultimate feeling of satisfaction. A full, active, communicating, chemically rich brain is also a full self.

The Punctual Self in Antidepressant Advertising

I have argued that, in these ads, the brain, or more specifically neurotransmitters and synaptic gaps, are introduced as characters in their own right. The ads tell a story about these parts of the brain and how they can get stopped up, and how antidepressants can put them into motion again. In this respect, the depiction of biology is a narrative within the greater narrative of the ad space. I will return to the role that this little narrative plays within the bigger narrative at the end of this chapter. For the moment, I turn to the way in which the self is depicted in ads, because even though biology is given a crucial position in antidepressant advertising, the force of the argument still depends upon modern notions of the selfhood: authenticity, freedom, independence, and wholeness. Indeed, as Williamson points out, the trick of all good advertising is to place the reader of the advertisement within a story that has an outcome already written by the advertiser, while at the same time constituting the reader as a free subject who is able to make his or her own choices, as a consumer. The ethic and spirit of market capitalism depends upon this ideological move. This is especially relevant to antidepressant ads that redefine vast areas of human life and suffering as biologically determined behaviors and feelings, definitely beyond the control of the individual. The problem becomes: How do antidepressant ads create agency for individuals, even as they threaten them with biological determinism? I argue that even as the ads depict selves as beings at risk of biological dysfunction and loss of self-control, they also retain an image of the self as punctual, choosing agent. The punctual self is constituted in a moment of disengaged

reason. Even when overwhelmed by the distress or delusion of mental illness, this kind of self still possesses the fundamental ability to choose the well-being promised through biological psychiatry and the antidepressants.²⁶

I have already indicated a few ways that audiences are addressed as particular kinds of subjects. In some cases advertisements call out to people who already know, or suspect, that they are depressed or ill. They list symptoms that many will recognize as feelings that they experience. In other cases, especially as pharmaceutical companies try to introduce unfamiliar illnesses such as social anxiety disorder, the ads address people who suffer some kind of everyday misery, but do not know that they are clinically and biologically ill. They teach people a new language and form of self-observation. This is quite explicit on GlaxoSmithKline's PaxilCR website. They question the reader:

Am I suffering from social anxiety disorder? Take a moment to consider how you've been feeling lately. Do you experience persistent fear and avoidance of social or performance situations?²⁷

And the same with depression:

Am I suffering from depression? Take a moment to consider how you've been feeling lately. Have you experienced feelings of sadness, loss of interest, sleep problems, or difficulty concentrating?²⁸

In effect, for attentive readers, it becomes possible to discover that "*I am ill and simply did not know it.*" Reframed as clinical anxiety or depression, distressing psychological states become biological imbalances.

Antidepressant ads regularly pose the possibility that the reader is in a *deluded* state of mind. Even as antidepressant ads operate through the promise of scientific

authority and honesty, they play off older stereotypes and fears of the out-of-control madman, subsumed and overtaken by alien forces (Foucault, 1965). Indeed, in most advertisements mental illness is depicted as madness, a state in which individuals cannot recognize the truth of their condition. Defined as biological illness, madness poses a growing *risk* to the self. Risk is located internally, within the unbalanced neurotransmitter system. Psychological illness becomes an entity, at first originating within the recesses of the brain, but then growing outward in scope. If left unattended, the ads suggest, biological imbalance can proliferate and spread, deepening its hold on individuals and submitting them to greater risks, including the possibility of suicide. The Paxil ads for social anxiety disorder depict anxiety as an entity that causes feelings of embarrassment but also spreads so as to impact everyday activities: dropping out of school, refusing to date, and turning down job promotions. The ad summarizes: “People with social anxiety disorder are at higher risk for depression, alcoholism, even thoughts of suicide.”²⁹ In these instances, the person who suffers social anxiety (or in other ads, depression) are fundamentally out of contact with life-saving, and self-constituting, forces. Though implied by most, some ads explicitly depict the suffering individual as someone overwhelmed and caught-up in a swirl of symptoms and misperceptions. As madmen and women these people cannot see beyond the cloud of their illness. They pose a risk to self and others because the illness has gained control over their thoughts, feelings and perceptions. The first page of a two page Serzone advertisement features a middle-aged woman, in bed, in the middle the night, wide awake with worry and sadness.³⁰ Words: “feel on edge,” “can’t concentrate at work,” “nothing matters anymore” crowd around her, illustrating the ad slogan “Serzone: calms the chaos of depression.”

SmithKline Beecham uses a similar technique to depict a male character's delusion in a Paxil ad.³¹ In the first image, titled "What It Is," he is pictured as the center of attention at a board room meeting. His colleagues look at him with curiosity and interest, as if awaiting an answer to a question. In the second image, titled "What It Feels Like" the character sits inches beneath a glaring lamp, like those depicted in television police dramas. He is bound by tight ropes, and confronted with the glares and accusations of his colleagues. The message of the ad is that this man's misperception is a product of a chemical imbalance. This imbalance is the source of confusion and fear that are far beyond his control. Furthermore, because he does not know that these feelings are really symptoms of disease, he is unable to help himself. He lingers in a state of disease, misunderstanding, and misrecognition, and as a result not only his psychological well-being, but his capacity to perform at the workplace is under threat. Paxil, then, does not only relieve the symptoms of illness, but it also restores the man to a state of self-transparency. Once working, the Paxil not only relieves the symptoms of anxiety, but it also allows this man to distinguish between himself and his illness.

In this kind of maneuver, the individual is robbed of one kind of agency and introduced to another. He or she is robbed of control over certain domains of his or her life, and expected to become a passive participant in a process governed by biological entities and expert knowledges. Because depression and anxiety – and the broad range of symptoms associated with them – are products of biological imbalance, there is nothing that individuals can do by themselves to clear the problem away. They cannot turn to talk therapy because that does not clear-up the imbalance (it is, as we learned from the Paxil website, "just talk"), and they cannot simply will it away. Thoughts and wishes are made

up of a different material than brains and neurotransmitters. They may be comforting, but ultimately they have no causal efficacy. In short, depression and anxiety speak a different language than human beings, and the recognition of depression and anxiety as biological entities requires an acceptance of laws outside of normal human control.

GlaxoSmithKline's depression.com website suggests: "even after you've learned that you have depression and sought treatment for it, you won't feel better right away. Depression can be frustrating, because recovering from it takes time."³² The Zoloft website echoes this sentiment "expect your mood to improve little by little, not overnight. People rarely 'snap out' of a depression. Feeling better takes time."³³ The people who have recognized their suffering as biological imbalance also recognize that they can only sit back and wait for the antidepressant to do its work on its own *biological time*.

Here, the hermeneutic view, that narrative structures time, becomes especially important (Ricoeur, 1984; Taylor, 1989). The organization of narrative and self in everyday life emerges out of an effort to get hold of the basic rhythm of day-to-day activities. Present suffering is placed in the context of personal memories, imagined futures and meaning-making cultural frameworks. These "everyday" narratives are also mediated by technologies, such as clocks and calendars, that provide a further structure for the engagement with everyday life (Zerubavel, 2003). In contrast, where these conventional time-management strategies refer back to the social world, antidepressant narratives assert the primacy of a time that refers to an internal, biological world. The antidepressant user has no intuitive, or "folk" (Bruner, 1990), knowledge of this other time, but rather must depend upon expert knowledges to discern its rhythms, and control its movement. In these cases, narratives that would try to get a hold of depression or

anxiety through everyday languages are rendered impotent. The time of the self, and the course of one's suffering, sits alongside the time of biology, unable to change its movement, except through the use of mediators such as antidepressants.

In this universe, the medical professional – the doctor or psychiatrist – is placed in a new relationship to self and suffering. In earlier models, the psychiatrist gained an authoritative knowledge of a patient's unconscious memories, life concerns, and relational dynamics, thereby helping individuals to get hold of suffering through self-narration. In contrast, biological psychiatrists cannot enter into dialogue, as it were, with depression or anxiety. They too are mere witnesses to the actions of medications and chemical systems that “we are only beginning to understand.” Or, if they enter into dialogue, it is with the help of medication. Peter Kramer (1993) captures this ethos with the phrase “listening to Prozac.” Psychiatrists look past the narrative of self, and try to understand the biological changes caused by antidepressants. They “listen” to antidepressants in order to learn what they are telling us about the biological make-up of individuals and, more broadly, the manner in which antidepressants can transform aspects of behavior unanticipated by theory alone. Psychopharmacological expertise, then, comes in knowing which drugs are available, how they interact with other drugs, how they have worked in the brains of other patients, and which side-effects they might have.

In this context, the only kind of agency left to the subject comes with the *choice to get well*, and subsequently the choice to manage one's “wellness.” In her discussion of individualization and risk, Lupton (1999) indicates that human agency is increasingly defined through moments of choice and decision:

as a consequence of modernization and individualization, increasingly more aspects of life are considered to be subject to human agency. The contemporary self, therefore, is placed in a position of making choices about a myriad of aspects of life, such that ‘choosing is the inescapable fate of our time.’ (p. 106)

This is the central message of all antidepressant advertisements and promotional materials. On the depression.com website, GlaxoSmithKline emphasizes the decision to get treatment

Depression can make you feel hopeless and helpless. But just taking the first step – deciding to get treatment – can make all the difference.³⁴

And again on the Paxil website

most patients, even those with severe depression, show improvement after they seek treatment.³⁵

Here, the decision to get treatment becomes an existential choice. This is emphasized in most ads which equate the decision to seek medication as a choice to “feel more like ‘yourself’.”³⁶ This decision to become one’s self does not require reflection on the life that one has lived, or the life one hopes to live. Indeed, it is a choice in which individuals, in a sense, are expected to withdraw from their life; to recognize that they have no control over certain areas of their being. In this respect, antidepressant promotional campaigns rely on the narratives developed in organizations such as Alcoholics Anonymous, and the popular self-help culture. Freedom comes in the decision to recognize oneself as a person with disease. In this choice to get well, the individual becomes the only kind of agent he or she can be.

In addition, ads and promotional materials provide consumers with a large array of things to do – ways to make the choice to get better. Most provide symptom checklists. Some offer cut-away materials and suggest “you may want to cut this out and show it to your doctor.”³⁷ These checklist and self-diagnostic materials are multiplied on websites. The opening page of the Zoloft website asks viewers to take a quick poll: “Why did you *decide* to choose Zoloft?” [emphasis added]³⁸ Here individuals are recognized for their decision to choose Zoloft, to get help, to choose themselves. This choice also joins them to a community of other people who have chosen their selves through Zoloft. This image of self as free-agent is more explicitly depicted in moralizing slogans. Some of this advice hardly makes sense if studied too closely:

You might not be controlling your reaction to the anxiety, but you’re still in control of your actions.³⁹

On first reading, the sentence leads to a distinction between two kinds of behaviors. Those that are out of control, a reaction to chemical imbalance, and those that, despite biological imbalance, remain under control of the self. However, on further reflection, it’s not clear which of a person’s actions are a reaction to anxiety, or which actions are a product of one’s freely taken decision to be one’s self. Indeed, isn’t it possible, even likely, that the decision to seek treatment is a product of anxiety caused by learning that one may have a disease called social anxiety disorder? The point however, is that, despite the constant threat of biological determinism – the possibility that “everything I do is caused by my biological condition” -- these “activities,” and directives, give the self something to do, and thereby affirm the fact that at it’s core, no matter what, the self has the freedom to choose itself. In fact, anticipating the next chapter, several of the

people that I interviewed thought that antidepressants made them feel better, not for medical reasons, but because in deciding to take medications they were doing something to help themselves.

More than depicting suffering as biological imbalance, antidepressant ads provide an influential technique for affirming selfhood. To clarify the significance of this cultural phenomenon it is helpful to distinguish between two possible visions of the self. Very broadly, the hermeneutic and narrative perspective takes the self as a phenomenon that exists in its expressions, its symbolic relations to others, and its position within a social and moral community. Indeed, in this view, people become selves by articulating and speaking about their understanding of their life circumstances, and their position within a shared symbolic universe.

In contrast, the self assumed in antidepressant advertisements is more like what Taylor calls the “punctual” self (1989: 159). This is the self whose essence resides in its ability to step outside of life, and manage itself through disengaged reason. Instead of the narrative self that is “distributed” across its own life, and across social and cultural institutions, the punctual self always exists in a moment of disembodied choice or decision. It is punctual, in the sense that all of the qualities that matter to it exist at a single abstract point. It does not constitute itself through language, or ongoing activities of self interpretation. It does not create itself from within its own narrative and time. Insofar as the punctual self is disengaged from itself, it can act only upon itself from outside, from an objective distance. Though certainly not a new or unfamiliar view of self (as many argue, this is the form that modern selfhood, shaped by the ideals of science and utility; see also Horkheimer & Adorno, 2002; Habermas, 1997), the punctual

self acquires new tools for self management and control in the biomedical age. It knows itself, not by slipping into its own narrative skin, as it were, but through “objective” symptom checklists. Responding to question such as “Does an unreasonable fear of embarrassment cause you to avoid most social interaction?” the individual only knows who he or she is by responding “yes” or “no”.⁴⁰ As a system of thought and practice, then, antidepressant advertisements constitute the self as a disembodied essence, hanging in mid-air, waiting to be offered its choices.

The Before and After Narrative

In the previous two sections I have drawn attention to elements constituted in the antidepressant ads. In the first I showed how depression and antidepressant medications are constituted as biological entities that operate under their own power according to their own laws. These are made intelligible and available for narrative through various metaphors that give them life and meaning. In this, the well-being of the self is bound to the well-being of neurotransmitters, a relationship mediated through antidepressants. The qualities of specific brain states are given further meaning through their resonance with background social dilemmas involving information transmission and communication, as well as the modern aspiration toward a complete and energized selfhood. In the second section, I argued that even though the biological argument threatens the self with biological determinism, the people addressed by advertisements are constituted as agents insofar as they can make the choice to get well. In contrast to a narrative view that sees selves as embodied within ongoing acts of self-interpretation and narration, the biological model is articulated with a theory of individual, punctual selfhood. In this section, I want to show how these elements fit into the larger narratives developed in the

ads. I characterize these as *before-and-after* narratives, and emphasize the way in which antidepressants provide a kind of “magical” passage from illness to health. In so doing, they once again turn our attention to the ideal of complete or whole selfhood.

Before and after narratives are visibly built into the formal structure of ads. I have already indicated how the Zoloft image of neurotransmission introduces this narrative as a story about the changes in brains treated with antidepressants. This before and after story is duplicated in advertising narratives about the self. They rely upon a formula first popularized through cosmetic, fitness, and diet ads. The ads distinguish two discrete conditions: *before*, in which a person is caught up in depression or anxiety, and *after* in which happiness, health, and selfhood have been restored. For example, the first Prozac magazine ads covered two pages. Page one pictured a cartoon metaphor of depression. In one ad this was a dark rain cloud, underneath which appeared the phrase “Depression Hurts.”⁴¹ Another ad pictured a shattered vase with the phrase “Depression Shatters.”⁴² Page two of these ads introduced a state of restoration: a shining sun, or a vase with a flower in it. This state of restoration was paired with the phrase “Prozac can help,” and the product logo and campaign slogan “Welcome back.” Darkness is opposed to brightness, fragmentation is opposed to completion, and restored selfhood is visually associated with the antidepressant medication.

In 2002, Paxil used a similar technique in ads for both chronic anxiety disorder and depression. This time, before and after were depicted with images of people, rather than cartoons. The ad featuring chronic anxiety was divided into two panels.⁴³ The top panel featured a middle-aged woman, lost in a crowd, overwhelmed by anxiety symptoms – her body is drawn inward, her arm held across her chest tightly holding a

bag, the muscles in her face and neck are drawn tight. She looks afraid, tense, reactive, and unable to show herself to the world. A graphic “millions suffer from chronic anxiety” cuts across the woman’s body. The second panel opens with the claim “millions can be helped by Paxil.” It is accompanied by a second image of the woman, smiling, bright eyed and open to the world. The picture is framed by the product name “Paxil” and the campaign slogan “Your life is waiting.” Anxiety, or depression, as the second ad in the series says, is the thing that is “standing between you and your life.”⁴⁴ Paxil removes the barrier and restores selfhood. This pattern, is repeated in numerous ads. Where depression or anxiety are constituted as real things that get in the way of life and selfhood, antidepressants come to stand for revived selfhood, happiness, activity, and social involvement.

The medications take on the properties associated with happiness and good health, and therefore are associated with the after stage of selfhood. However, they also play a crucial role in *bridging* the move from the before state into the after state. This is most obvious in the television ads for Zoloft. Unlike the stories told in magazine ads, television commercials are able to depict transformation as it occurs over time. Take for example Zoloft’s “cave” commercial.⁴⁵ This commercial unfolds in three parts. In the first part, the bubble character is found facing the back wall of a cave. It is turned away from the cave door. A horizon and blue sky can be seen through the door in the distance. These, of course, are all images of wide-open possibility; the undefined future. The bubble seems unaware of the butterfly which flutters near the entrance, and when it finally turns to catch a glimpse, the butterfly disappears. Happiness is just within reach, but the bubble is always slightly out of synchronicity with these possibilities. The second

part of the ad switches to the neurotransmitter image discussed in the first section of this chapter. Zoloft's restorative properties are introduced. Consistent with the theme of choice introduced in the last section, Zoloft is presented a solution ready-at-hand.⁴⁶ It is something that can bring the bubble into synchronicity with the world outside the cave. The Paxil ad for depression catches this sentiment as well. This nearness of a solution – the ease with which the self can be put back to rights – is captured with the phrase “feeling balanced, more like ‘yourself’ is *within reach*” [emphasis added].⁴⁷ Indeed, the choice is simple, and miraculous. When we return to the bubble character, it is no longer inside of the cave, but outside, near the entrance, smiling, and looking around. The butterfly is there, hardly able to contain its fluttery excitement, and the bubble follows it, bouncing, to meet up with other bubbles who are happy to see it.

I'm interested in what happened while we were watching the neurotransmitters cross the synaptic gap. How did the bubble get out of the cave? Where did its courage come from? How did it overcome his fear of other people (and butterflies)? How did it find it in itself the ability to finally turn around? Perhaps it remembered some moving words told to it by its mother. Perhaps it realized that it did not want to die before seeing the sun again, and this desire was more powerful than its fear. Perhaps it remembered a friend outside of the cave and the desire to be with this friend drew it out, or at least to a decision to take Zoloft. We'll never know for sure. In this ad – and all antidepressant ads -- some time has been lost, and with it, the ability to begin to answer my questions.

Indeed, in this respect, the Zoloft solution is magical. In *Decoding Advertising* Williamson (1978) studies the magical properties that advertising bestows upon products. Oftentimes, this magic plays with the laws of time and space. Products loaded

with meaning and feeling, allow people to satisfy nostalgic longings by returning to a lost place, or to imagine themselves as the people that they would like to be, but in reality could not be. In antidepressant ads the magic of antidepressants are most obviously highlighted in contrast to older narratives that valorized suffering and despair, as central to personal growth. Or put another way, religious, and even psychoanalytic narratives, made sense of suffering and despair by narrating them as central components of personal development. For the Biblical figure Job, suffering was a test and lesson from God, important to the affirmation of faith. To the neurotic, burdened by anxieties and compulsions, confrontation and interpretation of a difficult and shocking past was crucial to the development of self-understanding, even if cure was not always assured. Thus, for good or for bad, something seems to be missing from antidepressant narratives. A piece of the story, once filled-in with more elaborate explanations of the purpose of suffering, is snipped out, or bypassed. In this sense, antidepressant medications allow the self to move from the past to the future, unhindered by the need to say more about the source of suffering experienced in the present. In these stories, the only semblance that we have of a present is the moment in which the self makes a choice for well-being. The medicine and the punctual self are united as a kind of fulcrum around which the antidepressant narrative turns.

If there is any doubt that antidepressants are a kind of magic pill, consider the way in which the pills are fetishized in the ads. I am using the term fetish in both the Marxian and the psychoanalytic sense. The pill is both a commodity which stands in for and covers-over social relations, and it is an object that stands in for fantasies of wholeness and completion. The latter will become more clear in a moment, but first, consider a

television commercial for Paxil CR.⁴⁸ Like the Zoloft commercial, this one is divided into three segments. The first segment depicts people in anxious states – their identity is overtaken by the illness, and this is symbolized by nametags worn by each character: “fearful,” “nervous,” “self-conscious,” “anxious” and “panicky.” As these people begin to realize that they can become the “real me,” the camera cuts to a full screen product shot, and Paxil’s “controlled release” properties are demonstrated. The pill changes from white to pink. It begins to sparkle and release evanescent, glowing energies. This is the controlled release of the medicine inside the pill. The pill also assumes a central narrative position in the television commercial for Wellbutrin XL.⁴⁹ Though not as spectacular as Paxil, mid-commercial, the camera zooms in on the palm of a hand displaying the medication. The choice has been made. The medication is in hand, and the future beckons. Clearly, the pill comes to embody a wide range of values and meanings. It builds on historical conceptions of medications, magic tonics and love potions. It also, as I have been arguing, bridges past and future through a choice made in the present. Finally, it stands in for happiness, sociality, and as I want to now argue, complete and full selfhood.

Perhaps more than anything, antidepressant narratives promise the restoration of selfhood. Depression or anxiety destroy selfhood, and antidepressants bring selfhood back. This is implied by most campaigns, and explicitly captured in some slogans: Prozac uses the phrase “Welcome Back,”⁵⁰ Paxil asserts “Your life is waiting,”⁵¹ and Effexor brings you “Back to me.”⁵² I want, however, to take a closer look at the 2004 Wellbutrin campaign, which also promises to make people “feel like themselves again,” but illustrates this recovery process through an extensive use of mirrors.

The Wellbutrin campaign features a television commercial and a print ad. In the television commercial, each character (four in total, represented through four separate vignettes) is introduced as they walk up to, or sit down in front of, a mirror. These are the climactic moments of the commercial, the moment at which the individuals come to themselves, and see themselves clearly. Under the influence of medicine they are able to see themselves for the first time in a long time. Now, however, there are two “selves” in the story: one in the “real” world, and the other reflected in the mirror. As viewers, we only see the back, or the blurred shoulder, of the real character. The focus of attention is the mirror image which primps, prepares, and smiles for the evening ahead. At once, the self in the mirror is contrasted with the blurry self in the world – the self before Wellbutrin. The mirror image is also a glimpse into the undefined future – the character, now herself again, is ready to go out into the evening, and into life ahead. And given the placement in bedrooms and family homes, the images are richly intimate, suggesting, as the ad slogan prepares us (“an antidepressant with low sexual side effects”), sexual possibility.

The Wellbutrin ad draws attention to the two themes which circulate in antidepressant discourses: the desire for complete selfhood, signified through the mirror, and the risk of sexual side-effects popularly associated with the drugs. We have not seen the problem of sexual side-effects directly addressed in previous advertisements. Indeed, Wyeth pharmaceuticals distinguishes Wellbutrin from other antidepressants through the claim that it is a medication with low sexual side-effects. In this respect, Wellbutrin provides an interesting contrast to advertisements for sexual impotence drugs such as Viagra and Cialis.⁵³ Where Viagra and Cialis address male audiences, Wellbutrin and

other antidepressants primarily address female audiences (though the main character in the Wellbutrin print ad is a woman, the television commercial also includes a male character). This difference is suggestive, though I will not discuss it in greater detail here. Instead, in anticipation of interview chapters to follow, I will say that, when discussed, the problems of sexual side-effects were a secondary priority to the people I interviewed. For example, even though Mary experienced a diminished sexual drive when she took Lexapro, she was willing to tolerate this in order to achieve the stability provided by the medications. In order to even consider sexual activity, Mary first needed to be assured of some more basic stability. Like the characters in the Wellbutrin ad, Mary prepares her self for social activity in what Goffman (1959) would call the “backstage” of everyday life. Here the self is viewed as something that is composed and constituted even before it arrives on the scene of social life. The “presentation of self in everyday life”, to use Goffman’s (1959) phrase, depends upon a prior activity in which individuals, with the help of antidepressant medications, make themselves whole, and thereby capable of presenting some semblance of a self to others. This stands in striking contrast to symbolic interactionist (Blumer, 1969; Goffman, 1959; Mead, [1934]1962) dialogical (Gergen, 1994a; Hermans et al, 1993; Shotter, 1993a, 1993b), and narrative (Ricoeur, 1984; Taylor, 1989) views that see the self formed in the process of social interaction.

Indeed, the problem addressed by antidepressants is related to more primary questions and narcissistic self-completion. This points to a line of argument developed by social theorists (Putnam, 2000) and psychoanalytic social critics of 20th century American society (Alford, 1988; Cushman, 1990; Lasch, 1984, 1979). Putnam (2000),

for example, demonstrates that Americans are becoming more disconnected from friends, family and neighbors. This in part is mediated by the gradual disappearance of civic community organizations and democratic social structures. Christopher Lasch (1984), introduced the idea that the loss of community, traditional family structures, and attachment to place, leaves individuals without interpersonal support and shared narratives. In Lasch's view, The self is "besieged" by the growing threats and risks encountered in everyday life, and at the same time is thrown back upon itself for psychic survival. This leads to the formation of a "minimal" or "narcissistic" self contrasted with the self that finds meaning through narrative and relationship. Unable to openly "trust" this unstable and risky environment, the self is contracted into a smaller and smaller space, the nature of which is captured in Anthony Giddens (1991) concept of the "cocoon" – a self protective barrier necessary to functioning in the contemporary world. This siege mentality is further entrenched in contemporary risk societies (Beck, 1992; Lupton, 1999). For one, everyday social activity is increasingly defined in terms of the threats and risks that wait around every corner: financial collapse, environmental degradation, and terrorist attack. Further, through medical narratives, risk is constructed as an entity that potentially lives within persons: cells waiting to become cancerous, genetic predispositions that may or may not emerge as full blown medical conditions, and, of course, unstable neurotransmitter systems threatening to turn against the self in the form of anxiety and depression.

The antidepressant ads, then, suggest a development in this mentality of besiegement. On the one hand, the ads valorize and promote the ideology of individualism, thus making it appear natural that individuals are left alone to handle and

manage a proliferating number of risks. Contrary to the arguments developed by symbolic interactionists, dialogical theorists, and narrative theorists, the ads suggest that the self can be complete without others, indeed that it is realizing its greatest aspirations, when it can handle its problems on its own. The individualism is further constituted through the idea that the health of the self depends upon an individual *choice* to get well. Here people can compose themselves simply by taking a medication. On the other hand, antidepressants enter into this story as a kind of last-ditch effort to prop up the self threatened with disintegration and emotional instability. Indeed, when the narcissistic defensive strategies described by psychoanalytic theorists (Alford, 1988; Lasch, 1984, 1979), and the more general hedonistic love of self, fostered in the consumer culture, fail to work, antidepressants are introduced as a means of restoring the capacity to hold oneself together and thereby to become available for others.

The paradox and inadequacy of this kind of solution should be clear. While selfhood inevitably depends upon the other, individuals are increasingly thrown upon themselves for self-definition and coherence. Here the restoration of selfhood is divested of all social qualities. The self is required to gain coherence and emotional stability long before it enters into relationships. Relationship is no longer a means to self understanding, but an end pursued only after the individual has pulled him or herself together. This further requires that persons attribute their suffering not to the social or interpersonal dilemmas that sociologists have argued are central to the contemporary situation of the self, but to problems that only concern the brain of the individual. In the Wellbutrin ad, the blurry figure of the past self that stands in front of the mirror, in all of its problems and complexities, is forgotten – as if those experiences of fragmentation,

chaos, depression, sexual impotence and anxiety are only a part of the illness and therefore not really a part of one's life and relationships with others. As illness, they can, in a sense, be put into the category of "other." This is the central danger of the ads. They promise selfhood, but they lack narrative depth - a sense in which both self and suffering always emerge in cultural and interpersonal spaces that require an ongoing interpretive engagement in order to cultivate a rich, and I would argue, embracing narrative of self. The biological view of depression and self, covers over the sense in which interpersonal, interpretive activities can be more than mere storytelling. While I do not want to be naïve and suggest that well-told stories can overcome desperate forms of suffering,⁵⁴ it seems clear that the biological perspective effaces a whole realm of self-knowledge and practice that could better ground people in their lives and relationships. The biological model has no conception of the symbolic universe in which selves are lived and formed, and as such it offers a solution that avoids the larger dilemmas and dislocations faced by contemporary persons.

This is also where ideologies of self and the exigencies of the market economy meet up with one another. I began the chapter by talking about the enormous amount of money that went into promoting antidepressants, and even though I have not explicitly addressed these material economic concerns for the bulk of this chapter, I return to them now, if only briefly. Even as these antidepressant images of illness and selfhood appeal to certain psychological needs for wholeness and completion, they also make selfhood into a commodity, something that can be bought and sold in a free market. Indeed, in these pictures selfhood is represented as something that a person can either have or not have. The yes/no choice to get well is also the yes/no choice to have a self. In the ads, selfhood

is not an ongoing accomplishment, a product of social relationships, or a cultural position, assumed through self narration. Most clearly, selfhood has become something like a feeling state, and well-being is equated with the capacity to *continually* live in a state of wholeness, completion, readiness, and availability to others.⁵⁵ The capacity to be in this state of selfhood is something, the ads suggest, that most “normal” people are born with – it is, as the naturalists would argue, in the genes. When people have not been born with the capacity for realizing complete selfhood, or at least have lost the capacity for selfhood, the ads argue that it is possible to restore that capacity through medication. Antidepressant medication stands in for many things, but in particular it carries with it the possibility of selfhood.

Conclusion

In this analysis I have described the myths of self and suffering created through antidepressant advertising. They constitute a universe populated by neurotransmitters, synaptic gaps and chemical agents and thus introduce a new way of situating and potentially relating to oneself. These acquire meaning not merely as cutting edge scientific knowledge, but also through metaphors which emphasize their ability to restore the communicative capacities of the brain and to fill it with serotonin; that is, to make the brain whole again. In this way the images of the brain are linked to larger concerns of the contemporary self. Besieged and under threat, the self seeks wholeness and completion, and when these cannot be found in interpersonal relationship, or within the psychic structures of the self, they are supplemented through antidepressant medications.

In addition to describing some of the languages that the biological view of self and suffering introduces into the popular culture I have also started to develop an

argument in which the antidepressants are seen as the solution to larger social dilemmas in which people are increasingly left alone to handle their problems. This is not to say that people no longer have a social life – indeed antidepressants are frequently advertised as the means by which people can restore their capacity for relationships -- but rather that the relationship between the self and others is transformed. At least in these ads, the self and its problems are relocated to an internal biological realm which, in theory, requires no interpersonal understanding, but only biological intervention. Here people are granted the individual choice to get well and thereby expected to take responsibility for their biological make-up, and the risks that it poses to both the self and others. They are asked to watch out for and check up on their behaviors to see if they are really just examples of everyday malaise, or whether they signify an underlying biological disease state. I have also suggested that this is a dangerous solution, not only because it denies the social and interpersonal needs of the self, but also because it suggests that antidepressants can do a better job of making people into selves and preparing them for social interaction than earlier approaches which, more than anything, relied upon the mediating powers of narrative.

But is the antidepressant solution so mistaken? Is language and narrative so important to selves? This is hardly a problem for commentators like Peter Kramer (1993) who speculates that Prozac allows people the ability to pick and choose their personality, to become the kinds of selves that, until this point, the consumer culture has only promised, but never been able to fully realize. Here antidepressants seem to offer new possibilities of meaning and self-control. The punctual agent understands his or her illness as something outside of narrative, but in this very recognition is able to gain a

sense of satisfaction from the decision to do something about the illness. In this sense, the antidepressants not only offer relief from suffering, but also offer people membership in a community of those who have recognized their illness and decided to do something about it. They become members of a “biomedical community” and acquire a new identity as what Paul Rabinow (1992) has called “biosocial selves” Of course, the stories told in the ads do not necessarily transfer to the way that people use antidepressants in their everyday life. As such, a more complete answer to this question will have to wait on further discussion of the interviews.

For the moment, I’ll close by introducing a few of the most important ideas that the ads make available for the incorporation into personal narratives. First, they offer before-and-after narratives that emphasize closure. These are stories that have a clear beginning, middle and end. This narrative closure supports the images of wholeness and completion depicted in other elements of the ad, but, very practically it creates a simplistic expectation about what the medications do, and how they work. Depression is a biological imbalance. Antidepressants correct the biological imbalance. Antidepressants restore selfhood. In this respect the antidepressant narrative is clean and uncomplicated. Indeed, in contrast to the stories that I will begin to tell in the next chapter, these advertising narratives assume that most of the hard work is done once one decides to take antidepressants.

As will be argued, however, the use of antidepressants require acts of practical self-engagement and self-interpretation. Indeed, while the ads describe the way in which antidepressants modify brain chemistry (albeit in a cartoonish and simplified manner) they do not say anything about the way in which antidepressants modify the lived

experience of the body. This transformation in the body, I will argue, is a central component to the antidepressant narratives told by the people with whom I spoke. While the people I spoke with frequently describe the hope of progress and self-transformation (e.g. Frank's restitution narrative) depicted in the ads, these are not straightforward before-and-after narratives. Rather, many of the narratives that I heard include a challenging period during which people learn to live with the unfamiliar feelings and side-effects introduced by the medications. As such, while the stories told in the advertisements portray individuals as a passive, disengaged, punctual observers of antidepressant action, I will demonstrate the numerous ways in which people become active agents in the practice of taking antidepressant medications.

A second important point is that these ads introduce depression and anxiety as real and natural things. They are separated and distinguished from the self, and made available as a sort of character that people can imagine, describe, get a feel for, and do battle with. As real things, depression and anxiety also start to live on their own time. They have their own laws and stories to tell, independent from the story of the self. These representations of biology, I will argue, enter into antidepressant narratives in at least two ways. First, they provide content for the unfolding narrative of self. Nearly all of the people I spoke with held the belief that their suffering was caused by an imbalance in brain neurotransmitters. This biological thesis was offered as an explanation for both the intractability of their depression and anxiety, and in some cases it led to more elaborate descriptions of what people imagined was happening inside their brain when they took antidepressants. Second, the idea of biological imbalance came to serve as a "holding area" for those elements of self that were inexplicable and threatening. I will explain

what I mean by this in the next chapter. For the moment, suffice it to say that this leads to a separation or split within the self – those parts which are attributable to biological imbalance, and therefore outside the realm of normal narrative interpretation, and those parts which remain within the realm of everyday life, and a part of the valued story of self.

Finally, the ads introduce a conundrum which shapes the kinds of narratives told by the people I interviewed. The claim that depression and anxiety are diseases seems to come into conflict with attempts to normalize and destigmatize mental illnesses as mere biological imbalance. Furthermore, the redefinition of depression and anxiety as biological disease constitutes psychological distress as a risk and a threat to self and others. In the process of taking antidepressants, people frequently redefine themselves within this language of disease and risk. Why would the medication work, unless there was really something wrong with me? The logic of the biomedical worldview is such that the act of taking antidepressants implicates one in a discourse of individual disease and dysfunction. The paradox here is that most of the people I spoke with did not think of themselves as diseased or disordered before taking antidepressants. Rather, in order to make sense of the kind of support and “psychological” treatment that they received, they also had to accept the idea that *there is something wrong inside of me*. As indicated through this chapter’s analysis, the advertisements (and I suggest, biomedical accounts more generally) are incapable of resolving the contradictions and tensions introduced by this disease model. Rather, this becomes an interpretative problem for the individual who struggles to understand their encounter with antidepressant medications.

Chapter 3 Notes

¹ IMS health “Total U.S. Promotional Spend by Type, 2003.” Accessed November 23, 2005 on-line at IMS website: www.imshealth.com/ims/portal/frton/articleC/0,2777,6652_44304752_44889690,00.html.

² Gardner et al (2003: 426) summarize “There is ample evidence that DTCA has increased consumer awareness of advertised prescription products, and that this has affected consumer behavior and physician prescribing practices, but very few new drugs have demonstrated advantages over standard therapies.”

³ Adweek “Agency report cards 2003.” Accessed February 6, 2006 on-line at: www.adweek.com/aw/industry_reports/report_cards/2003/arc2003_national.jsp#Kaplan.

⁴ Based on numbers provided by IMS health.

⁵ IMS health “Leading 10 therapy classes by U.S. total dispensed prescriptions, 2000.” Accessed November 23, 2005 on-line at IMS website:

www.imshealth.com/ims/portal/frton/articleC/0,2777,6652_49695974_68914714,00.html.

⁶ IMS health “Leading 29 therapeutic classes by total U.S. dispensed prescriptions, 2004.” Accessed November 23, 2005 on-line at IMS website:

www.imshealth.com/ims/portal/frton/articleC/0,2777,6652_40054611_1004878,00.html.

⁷ In a critical review, Valenstein (1998) traces the development of the serotonin hypothesis. It emerged in the 1960s as one version of the biogenic amine theory of depression. This theory held that depression was caused by a depletion in biogenic amines, either serotonin (an indole amine) or norepinephrine (a catecholamine), and that antidepressants worked (at that time tricyclics and monoamine oxidase inhibitors) by modifying biogenic amine levels. There was debate over whether serotonin, norepinephrine or some combination of the two was responsible for depression. Research by Joseph Schildkraut and Seymour Kety favored norepinephrine and hence the catecholamine theory of depression was victorious. However, the debate is unresolved and the development of SSRIs in the 1980s demonstrated the continuing relevance of serotonin for a biological theory of depression. Despite this 50 year old debate, there is extensive evidence which brings into question the accuracy of a biogenic amine theory of depression. According to Valenstein “the theory cannot explain why there are drugs that alleviate depression despite the fact that they have little or no effect on either norepinephrine or serotonin,” (p. 99). Biogenic amine theories also cannot explain why antidepressant drugs sometimes take three to four weeks to elevate mood, even though they “produce their maximum elevation of serotonin and norepinephrine in only a day or two” (p. 99). Furthermore, given the wide range of “secondary, tertiary, and even more remote” changes caused in the brain by antidepressants, it is not clear that it is the changes in biogenic amines produce that lead to a therapeutic effect (p. 99).

⁸ Valenstein: “It is now not possible to measure norepinephrine and serotonin in the brains of patients. Estimates of brain neurotransmitters can only be inferred from indirect evidence, which has a number of weaknesses. Several investigators have attempted to approximate this information by measuring biogenic amine breakdown products (metabolites) in the urine and cerebrospinal fluid. The assumption underlying this approach is that the level of biogenic amine metabolites in the urine and cerebrospinal fluid reflects the amount of neurotransmitters being used. However, attempts to find abnormal metabolite levels of norepinephrine and serotonin in depressed patients have not been encouraging.... Although some depressed patient do have low levels of either norepinephrine or serotonin metabolites or both, the majority do not. Estimates vary, but a reasonable average from several studies is that only about 25 percent of depressed patients have low levels of these metabolites. Some depressed patients actually have abnormally high levels of norepinephrine metabolites, while the levels of biogenic amine metabolites of the majority of depressed patients are well within the range of the normal population. Moreover, some patients with no history of depression also have low levels of these metabolites. In any case, there are serious problems with what is being measured, as less than one-half of the norepinephrine and serotonin metabolites found in the urine or cerebrospinal fluid comes from the brain. The other half come from various organs in the body.” (1998, p. 100-101)

⁹ www.paxilcr.com/Antidepressant_Medications.jsp; retrieved September 30, 2005.

¹⁰ While the ads certainly tell other stories about the medications, this analysis is guided by an interest in the relationship between selfhood, antidepressants, and the biological theory of mental illness. Another analytic framework would reveal other kinds of stories. For example, the advertisements also present stories about gender and family relationships. Metzl (2003) has provided such an analysis in *Prozac on the*

Couch. Other analyses that could prove fruitful would investigate: the relationship between work, productivity and mental health (these include ads that depict depression and anxiety as diseases that stand between an individual, and productive involvement in the workplace), and the manner in which race is storied in antidepressant ads (most of the ads for antidepressants focus on middle-class white characters, though advertisements for the medications that treat attention deficit hyperactivity disorder in children are frequently addressed to an African-American audience in magazines such as *Essence*)

¹¹ See further discussion of rational-choice in chapter 1, footnote 15.

¹² The analysis presented here focuses on the way that the self is represented in general across all of the advertisements. As such I have not attempted a rigorous analysis of the relationship between magazine type, and the depiction of self, as well as its interaction with factors such as gender and race. This said, a few general observations are warranted. I coded the gender of the central character (the individual suffering psychological illness) in each advertisement. Both Prozac and Zoloft campaigns feature *non-gendered* cartoon figures (though a closer analysis, such as conducted by Jonathan Metz (2003) might reveal gendered characterizations of self and suffering, even in presumably neutral advertisements). Paxil ads feature both male and female protagonists. While the ads centered around the female characters only appeared in women's, men's, and general audience magazines (*Glamour*, *Self*, *Essence*, *Time*, *Reader's Digest*, *Sports Illustrated*, *Esquire*), the ads that featured a male character appeared exclusively in male magazines (*Sports Illustrated*, *Esquire*) and in one women's magazine (*Glamour*). Ads for Effexor, Serzone and Wellbutrin featured female characters. The distribution of gender in the advertisements was: non-gendered character (e.g. the Zoloft bubble) – 64/132 = 48%; female character – 46/132 = 35%; male character – 22/132 = 17%. Finally, a quick review suggests that when depicted, the relationship between gender and psychological suffering reproduces conventional gender stereotypes, as suggested by Metz & Angel (2004) in their analysis of popular magazine representations of gender and Prozac. For example, female characters are frequently depicted in relationship to family and motherhood. In contrast, the one of two Paxil ads that featured a male character, portrayed him overwhelmed by anxiety in a boardroom.

¹³ *Time*, 1997, July 21, 150, 3, pp. 18 – 20

¹⁴ *Time*, September 30, 2002, Vol. 160 (14), p. 83-84.

¹⁵ *Time*, 1999, September 27, Vol. 154 (13), pp. 28-9

¹⁶ *Time*, 1999, September 27, Vol. 154 (13), pp. 28-9

¹⁷ *Self*, 2003, June, pp. 154-55

¹⁸ *Time*, 1997, July 21, 150, 3, pp. 18 – 20

¹⁹ *Time*, 1999, September 27, Vol. 154 (13), pp. 28-9

²⁰ *Time*, 2001, July 23, Vol. 158(3), p. 37

²¹ <http://users.bestweb.net/~aisle9/zoloft/>; retrieved November 27, 2004.

²² This notion of linkages derives from the work of actor-network theorists such as Bruno Latour (1999) and Michel Callon (1986). For Latour, scientific knowledge moves from laboratories to everyday life by means of “translation” and “linkage.” Human and non-human agents are related to one another as “assemblages” or “mobiles” that come to be seen as necessary formations for particular kinds of social activity.

²³ In this ability to take on many forms the bubble exemplifies what semioticians call polysemy – an image or word that has multiple meanings. I have only listed three possible interpretations of the Zoloft bubble. Others proliferate in the popular culture.

²⁴ http://www.zoloft.com/zoloft/zoloftportal?_nfph=true&_pageLabel=how_zoloft_works; retrieved September 30, 2005

²⁵ For a structural analysis on the insubstantial character of contemporary consumption see Ritzer (2004a), *The Globalization of Nothing*. Ritzer argues that increasingly consumer commodities, settings, services and people are “devoid of distinctive and substantial context” (p. ix). This “nothing” is contrasted with “something”: commodities, settings, services and people that have a distinctive and substantive context. Ritzer attributes the expansion of forms of nothing to the growth of capitalism. In particular Ritzer argues that commodities and settings that are devoid of substantive content are easier to globalize – insofar as they are devoid of particular content they do not conflict with aspects of particular cultures around the world. While Ritzer does not examine the psychodynamics of “nothing,” it seems that the growth of commodities and settings that pretend to possess substantial qualities (e.g. the spectacle and excitement of shopping centers, Ritzer, 2004b), yet, in fact, are without substance would contribute to a confusing feeling of emptiness amidst consumer riches.

²⁶ As noted in the introduction to this section, the emphasis on punctual selfhood also resonates with rational choice theories. In both cases a part of the self remains outside of the influence of cultural variables, and as I suggest here, even madness. Furthermore, this image of the mentally ill self as fundamentally rational is a product of the efforts of the antipsychiatry movement and mental health consumer movements of the 1960s and 1970s. A particularly influential critic was Scottish psychiatrist, and 1960s guru figure, R. D. Laing. Taking schizophrenia as his central example, Laing (1959) argued that what at first appeared to be unreasonable and bizarre behavior could be understood on its own terms. Applying existential and phenomenological philosophies, Laing proposed that the schizophrenic was a feeling, rational being who had become deeply alienated in late capitalist society. On this view, psychotherapy should strive to engage schizophrenics as agents in and of themselves, who, given time, could account for their suffering in their own terms. Though it is clear that Laing valorized the irrationality of schizophrenia, his work also implies a view in which the “mad” are seen as agents capable of giving expression to themselves, and capable of making choices for themselves. This last point is particularly important for the development of the mental health consumer rights movements in the 1980s.

While the more radical anti-capitalist and anti-authority components of the anti-psychiatry movement faded in the early 1970s (Crossley 1998), the idea that the mental patient could act as an agent in his or her treatment was elaborated through the mental health consumer rights movement in the 1970s and 1980s. At its most basic, consumer rights movements called for increased access to treatment options. To these ends, the National Alliance for the Mentally Ill (NAMI) “worked to improve mental health services for severely ill persons, to increase research, and to advance training...” (McLean 2000: 828). NAMI positioned itself against psychiatry as an alternative source of knowledge production, and a force that continually challenged psychiatry to develop innovative and effective treatments for all forms of mental illness. Closer to the point, consumer movements argued for greater consumer choice and fought to empower patients in their relationships with their doctors. By providing an extensive consumer support network, including citizen’s boards and policy making committees, the mental health rights movement established the grounds out of which an ethos of partnership emerged (McLean, 2000: 829). The mad person is no longer a child, or unreasonable fool, who must submit to the diagnosis and treatment demanded by physician. The mad person, reconstituted as mental health consumer, could work alongside psychiatrists and physicians to choose from a growing array of treatment options.

²⁷ http://www.paxilcr.com/Social_Anxiety_Disorder.jsp; retrieved September 30, 2005

²⁸ <http://www.paxilcr.com/Depression.jsp>; retrieved September 30, 2005

²⁹ *Time*, 1999, September 27, Vol. 154 (13), pp. 28-9

³⁰ *Glamour*, 1997, November, pp. 336-37.

³¹ *Sports Illustrated*, 2000, September 25, Vol. 93(12), p. 95.

³² http://www.depression.com/day_by_day.html; retrieved September 30, 2005

³³ http://www.zoloft.com/zoloft/zoloftportal?_nfph=true&_pageLabel=mang_plan_depr; retrieved September 30, 2005.

³⁴ http://depression.com/treating_depression.html; retrieved September 30, 2005

³⁵ <http://paxilcr.com/derpession.jsp>; retrieved September 30, 2005.

³⁶ PaxilCR ad, *Time*, September 30, 2002, Vol. 160 (14), p. 83.

³⁷ Paxil ad, *Time*, 1999, September 27, Vol. 154 (13), pp. 28-9.

³⁸ http://www.zoloft.com/zoloft/zoloftportal?_nfph=true&_pageLabel=default_home; retrieved September 30.

³⁹ http://www.zoloft.com/zoloft/zoloftportal?_nfph=true&_pageLabel=anxiety_myths_facts; retrieved September 30.

⁴⁰ Paxil ad, *Time*, 1999, September 27, Vol. 154 (13), pp. 28-9.

⁴¹ *Time*, 1997, July 21, 150 (3), pp. 18 – 20

⁴² *Time*, 1997, October 13, 150 (15), pp. 94-95.

⁴³ *Time*, 2001, October 15, 158 (17), p. 55

⁴⁴ *Time*, September 30, 2002, Vol. 160 (14), p. 83

⁴⁵ This commercial ran on television in 2004. I viewed it at www.ad-rag.com.

⁴⁶ This of course overlooks the fact that a Zoloft prescription is expensive and requires the support of an insurance company.

⁴⁷ *Time*, September 30, 2002, Vol. 160 (14), p. 83

⁴⁸ This commercial ran on television in 2004. I viewed it at www.ad-rag.com.

⁴⁹ This commercial ran on television in 2003. I viewed it at www.ad-rag.com.

⁵⁰ *Time*, 1997, July 21, 150, 3, pp. 18 – 20

⁵¹ *Time*, September 30, 2002, Vol. 160 (14), p. 83

⁵² *Self*, 2003, June, pp. 154-55

⁵³ For analysis and discussion of advertising for impotence medication see Mamo & Fishman (2001)

⁵⁴ Indeed, the narrative perspective puts the question of health and well-being on a different footing. Rather than prizing an idealized form of psychological health and well-being, it makes the difficult, and increasingly controversial suggestion, that certain forms of sadness and suffering may be necessary features of self-development necessary to the formation of interpersonal relationship. Arthur Frank (1995) captures this when he valorizes narratives that allow the body to communicate its vulnerability. He also suggests that some forms of suffering may be unavailable to language. However, this is different from the biological refusal to tell certain parts of the story. Instead, the unspeakability of certain experiences gives rise to ethical debate over the role of narrative in life. Perhaps there are some experiences that cannot, and should not, be put into words? For example, Kearney (2002) discusses the debate over films and movies about the Holocaust. Should these be made, or does the attempt at narrative expression always fall short of communicating the significance and depth of those events, and therefore risk simplifying and demeaning the experiences of those who died, or lived through, the Holocaust? The point is that the biological perspective is frequently allied with images of human perfection and completion that do not even allow these kinds of questions to be asked. As a medical problem, suffering and sadness is not a problem for narrative, but an element of self to be eliminated.

⁵⁵ To this end PaxilCR says “life can feel difficult ALL DAY. That’s why you need relief ALL DAY.” (*Time*, September 30, 2002, Vol. 160 (14), p. 83)

Chapter 4: The Practice of Using Antidepressants

In chapter two I introduced a theory of narrative. Narratives were described as a form of individual and cultural expression. They give expression to pre-reflective experience, structure relationships with time, and organize the activities of embodied, self-interpreting agents. I also identified three elements of narrative that were of particular importance to the study of the encounter with antidepressants: narrative as structure, narrative as expression, and narrative as embodiment. As structure, narrative was seen to have numerous forms, including Gergen's (1994c) characterization of progress, regress, and stability narratives and Frank's (1995) introduction of restitution, chaos and quest narratives. I further indicated the significance of the structural differences between interpersonal and individualized narratives. Interpersonal narratives place the self in relational space, and realize the cathartic potentials of narrative understanding. Stories told together have the capacity to transform chaotic and confusing experiences into shared understanding. Individualized narratives can also be shared – they are stories about one's life that can be told to others – but in their formation they depend upon strategies developed by the isolated atomistic individual. In chapter three, I analyzed the narratives developed in antidepressant advertising. These introduced depression and anxiety as biological entities that require treatment with antidepressants, and, in so doing, replaced views that locate psychological suffering within the realm of narrative understanding. The ads constructed selves as punctual agents who, even when overwhelmed by depression or anxiety, are able to realize freedom in the individual choice to take antidepressants. The antidepressant advertisements were also shown to develop simplistic, magical, accounts of a *before and after* transition from illness to

health. In depicting this relatively clean transition, the advertising narrative spliced-out moments of the encounter with antidepressants, granting a powerful agency to the medications, and leaving the self-interpreting agent, who uses the medications, out of the narrative of recovery.

In this chapter, as well as chapters five and six, I turn to the interviews that I conducted with people who are taking, or who have taken, antidepressants. In contrast to the advertisements, which assume that antidepressants simply work by modifying chemicals in the brain, here I argue that the antidepressants cannot work, let alone acquire any meaning within a narrative, independently of the interpretative frameworks and practices that accompany their use. This argument is not necessarily new or unique but builds on demonstrations made by sociologists such as Howard Becker (1953, 1967), who showed that the subjective experience of marijuana and LSD depended upon interpretations provided by social groups, Erving Goffman (1961) who argued that the experience of mental illness was created in the total institution rather than given through biology, and more recently David Karp (1993) who describes the encounter with antidepressants as a process akin to religious conversion.¹ The experience of what happens to one's suffering, body and self when taking antidepressant medications is not an automatic or unmediated achievement, directly induced by changes in the chemical make-up of the brain. Indeed, when I asked participants to comment on ads for Prozac, Paxil and Zoloft their most frequent complaint was that the ads made the practice of taking antidepressants seem too easy, as if the medication simply transformed a person from morose and withdrawn individual, to happy and complete self. The ability to feel the effects of antidepressants, then, requires an attunement to body and self, an ability to

distinguish side-effects from positive effects, an ability to recognize “brightening” of mood, an ability to distinguish the way “I felt before” from the way “I feel now.” In short, the success of antidepressant treatment, and the restoration of selfhood, requires new forms of self-recognition and self-understanding.

Consider the variety of metaphors that the people I spoke with used to describe the action of antidepressants: they *lift* depression off of the self, they *unclog* the brain, they *re-center* or *balance* the self, they *cut-off* the tops and bottoms of emotion, they *repress* feeling, they *put a skin* between the self and the world, they make a person *passive*. These describe the phenomenological-experiential aspects of antidepressant action. They are attempts by people to say what it feels like when antidepressants begin to relieve depression or anxiety.² Though I do not claim that the effects of antidepressants are, in any simple sense, a social construction, they have acquired an incredible range of meanings and uses within practices of self interpretation. Antidepressants, though promoted as “targeted” drugs with specific effects, do not determine the languages or metaphors used to describe their actions – such meanings emerge somewhere in between the bodily “feelings” induced by antidepressants, and the effort to articulate the significance of those feelings within a developing narrative of self and suffering.

In contrast to chapters that follow, which focus on the kinds of selfhood enabled by antidepressants (chapter 5), or the social dramas that shape antidepressant narratives (chapter 6), this chapter describes the period during which people start to take antidepressant medications, and learn to re-think their selves and bodies through the experience of taking antidepressant medications. In this process – of saying “what I think I felt” – certain features of experience are constituted and made available for narration.

Here, narrative self-understanding is never a transparent depiction of what *actually* happened. Narrative theory refuses the positivist view that language merely depicts a world “out-there,” and instead argues that the act of narration constitutes the self in time and space. In the encounter with antidepressants, this self-narration meets up with feelings introduced by antidepressants to form the basis of an antidepressant “lifeworld” (Berger & Luckmann, 1967; Schutz, 1967) – an embodied sphere of experience that has its own particular rhythms, poses unique problems to people, and can also serve as a resource to make sense both of psychological distress and the effects of the medications. The attempt to negotiate this sphere, much like the story of a life, becomes a mini-drama in itself, a slice out of time, during which people try to get a handle on the experience and practice of taking antidepressants.

I was struck by the enthusiasm and energy that some people brought to this drama. For example, to college sophomore Jeremy, the changes in sensation and mood induced by antidepressants were the center-piece of his narrative. Jeremy did not have much to say about childhood memories or the life events that had shaped his self. Instead, Jeremy, who had been on Zoloft for four months when I spoke with him, talked about the miraculous and “ecstatic” experience of taking antidepressants. This was not merely because Zoloft brought him relief from depression and social isolation, but also because it provided an opportunity to experience his self in a particularly intimate manner. It drew his attention to his body in a new way. When the medicine caused him to constantly, and unwittingly, clench his jaw, he was not so much upset as curious about this side-effect. He would catch himself walking down the street and suddenly realize that he had been clenching his jaw for the last few hours. At least in our two conversations, the mini-

drama of taking antidepressants was truly a story unto itself, disconnected from any larger sense of personal development. It was a “suspension” of time in which Jeremy could be with his self in some kind of comfort and relief. Jeremy’s story is exceptional, but illustrates the more general point that antidepressants can draw individuals into a unique relationship with body and self. This requires a re-learning of the relationship between “self, biology, and body” and the demand for a new kind of self-understanding (Bury, 1982).

This chapter advances the theory of narrative, introduced in chapter two, by demonstrating the ways in which antidepressants enter into the process of self-interpretation. As a starting point, I retain the view that human beings are embodied self-interpreting agents. However, in contrast to extant narrative views that emphasize the role that language, and symbolic systems more generally, play in mediating the formation of narratives, in this chapter I emphasize the way in which antidepressants supplement important functions that would otherwise be served by narrative. In other words, whereas most narrative theories emphasize the way in which human agents constitute themselves through linguistic self-narration, I “bracket” this assumption and argue that antidepressants play an important role in constituting the self-narrating agent. This is especially the case in antidepressant narratives, where the capacity for self-narration is overwhelmed by depression or anxiety – the story of life is disrupted and individuals lose the ability to speak for themselves. People still tell stories, and as will be shown in chapter five, these stories have tremendous importance for the life of self, but the manner in which those stories are told depends upon new narrative structures, new forms of emotion management, and new forms of embodiment. In the biomedical society, the

relationship between technology and selfhood is of increasing importance in the development of narrative self-understanding (Knorr-Cetina, 2001).

This also must be understood in the context of a more general process of individualization. Where in other times, and contexts, the interpersonal dimension of narrative provided means of “processing” emotion,³ and grounding the self in relationship to others, in the stories that I heard, antidepressants allow people to “do it for themselves.” This is a self-perpetuating phenomenon. For one, as was demonstrated in the discussion of naturalism (chapter 2) and the analysis of the advertisements (chapter 3), the biomedical view treats people as individual atoms who simply have and possess selves – both healthy and pathological – in advance of social relationships and narrative self-articulation. These dominant discourses push people back upon themselves and require that they take personal responsibility for psychological distress, thereby squeezing out resources for interpersonal self-narration. At the same time, the biomedical culture fills the gap left by this loss of interpersonal narrative. Left without interpersonal resources for understanding and expressing unruly and inexplicable emotion, antidepressants allow people to control and manage these feelings on their own.

At the same time, the process of understanding and telling a story about the antidepressants is individually crafted. Certainly, the stories draw on resources that circulate in the popular culture, especially the view that psychological suffering is a “real illness with real causes.” However, as noted in chapter three, the advertisements say very little about the period between the “before” stage of suffering, and the “after” stage of healthy selfhood. In the interviews, I learned that this in-between period was of central importance not only to the story of taking antidepressants, but also to the reconfiguration

and restructuring of selfhood. Indeed, in learning how to use antidepressants, people come to structure their self-understanding in ways that have far-reaching consequences. For one, narratives are individualized in the sense that they tell the story of an individual's struggle to learn how to use antidepressants. These encounters are no doubt guided by advice and input from psychiatrists, counselors, and Internet sources. However, in the day-to-day routine of taking a medication and learning how it feels, people are left to themselves to discern the meaning and significance of feelings introduced by the antidepressants. This individualizing aspect has implications for the structural, expressive, and embodied elements of narrative. In the end the self is constructed and maintained as a self-enclosed unit, that manages unruly aspects of its internal life (e.g. depression and anxiety) with antidepressants. In using antidepressants, the body-self is transformed from an expressive entity, caught up in webs of relationships with others (though oftentimes distressing, painful and overpowering) into an object of scrutiny and self-surveillance. The antidepressants provide individual freedom from depression and anxiety, but only at the cost of splitting parts of the self off from the realm of everyday understanding, and submitting those pathological elements to biomedical strategies of control and management.

This chapter is divided into three sections. First, "disruption and relief" describes the collapse of self which leads to a search for relief, and eventual decision to take antidepressants. This crisis in the story of self can manifest as a total loss of the self – a feeling in which the self is overcome by inexplicable and overpowering forces – or a more general disorientation and loss of self-control. In either case, antidepressants provide relief from otherwise intractable symptoms, and the ability to gain some control

over the unfolding story of self. This allows people to proceed with further experiments with antidepressants. Though clearly there are instances when people take antidepressants for a short period of time and then decide to stop taking them, in many of the stories that I heard, the initial encounter with antidepressants led to a search for a better medication with fewer side-effects, or that provided a better approximation of “normalcy.” Second, “the use of antidepressants” describes the process by which people learn that depression, or anxiety is a biological condition, separate from their self. I emphasize this learning process in order to show that facility with antidepressant medications is not automatically achieved once a person takes an antidepressant. Rather it requires a series of experiments and tests in which people use antidepressant medications to confirm and test the limits of the biomedical claim that depression, or anxiety, are products of biochemical imbalance. In the process people sort out the differences between biology, medication, and their “real” selves, thus establishing the basis for a re-structuring of selfhood.

Third, in the “splitting narrative,” I describe the structure of self that emerges from the encounter with antidepressants. Here the antidepressants are seen to come to the aid of a splitting mechanism. In psychoanalytic theory, splitting refers to a universal defense mechanism “by which the ego discerns differences within the self and its objects or between the self and its objects” (Grotstein, 1981: 3). Though it is not clear whether antidepressants take-over or merely supplement this ego function, it is the case that these medications provide a means by which people can make, and maintain, distinctions between feelings and behaviors 1) that they attribute to biological dysfunction, and 2) that they discern as parts of their real selves. Insofar as antidepressants become integral components in maintaining splits within the self I characterize them as “ego-prosthetics”

– technologies that aid or extend the functions once attributed to the psyche alone. This splitting procedure provides some freedom for the self, but it also constitutes the self within a timeless drama. The depression, now conceived as a thing operating according to its own biological laws, potentially (though not in all cases) becomes a constant companion. In this, depression is constituted as a risk inside the self that provokes new kinds of fears and anxieties. Indeed, in the process of redefining self and suffering within the language and technologies of biomedicine the *danger* posed by once incomprehensible suffering becomes a *risk* to be managed and controlled.

Disruption and Relief

I start, then, at the beginning of the drama, the moment when the taken-for-granted narrative comes undone, when the desire for wholeness, integrity, or more pragmatically, self-control, begins to unravel. *Disruption* is a common element in narratives of all types. It indicates crisis, and demands resolution. In her study of the “codependent self” Leslie Irvine (1999) argues that when long-term intimate relationships suddenly end, people lose the shared narratives that shaped self-understanding for so long. They must develop new narratives, both to understand the reason for the unsettling break-up, and to provide direction, and hope, for future action. Medical sociologists have shown that disruption is a central element in chronic illness narratives. The unexpected onset of cancer (Frank, 1995, 1991), rheumatoid arthritis (Bury, 1982), or multiple sclerosis (Robinson, 1990), for example, calls into question established hopes and expectations, and requires a rethinking of an individual’s relationship to others. The self is reconstructed in relationship to illness, and also within new patterns of dependency and vulnerability.

Antidepressant narratives are not reducible to chronic illness narratives, but I was struck by the resemblance between the two. The similarities suggest the extent to which psychological distress has become medicalized—rendered in a pattern common to illness narratives. When chronic illness first emerges, explanations for everyday aches and pains “lose their grip” and appear inexplicable and distressing (Bury, 1982).⁴ Antidepressant narratives follow a similar pattern, and for the most part are marked by an inexplicable collapse, or loss of control in the self. Problems such as weeping, suicidal ideation, angry outbursts, and lethargy are met with no explanation:

I just didn't know that I was crying everyday because I was depressed. I just had no idea what was going on. (Joanna, student, age 21)

I don't really know what happened, but I would just completely withdraw, and it would only last about a day. I would just go in my room myself, and I don't want to see anyone, and we really couldn't pinpoint anything that caused that. (Jeremy, student, age 20)

Being eight years old, I didn't know what was going on. I have this sense that my family didn't know what was going on, didn't know how to help me. I mean, literally, I would hyperventilate. I had stopped eating, my family threatened to put a feeding tube in my stomach, and they didn't know what to do. (Emma, University Administrator, age 25)

In contrast to chronic illness, in antidepressant narratives, people do not only lose the narrative thread of their lives. In addition, the self and its very capacity for meaningful narration is disrupted. Though I spoke with people who suffered from what they characterized as a variety of conditions including depression (15/23), anxiety (2/23), a

combination of depression and anxiety (3/23) and bipolar disorder (3/23), common to all narratives is the feeling that the self is overtaken by an unknown, inexplicable, and intractable force. No doubt, the way in which people understand their suffering is shaped by the specific diagnosis that either their psychiatrist, family physician, counselor or they themselves have specified. As such, Zareen is able to recognize that her “dysthymia” is not nearly as disabling as Angela’s “bipolar disorder.” However, the concern in this dissertation is not the characterization of pathology in itself, but rather the way in which the encounter with antidepressants, and their accompanying biomedical narratives, shape self-understanding.⁵ Here the problem of psychological suffering is not merely the feeling of sadness, anxiety and social isolation, but it resides this inability to explain or make sense of what is happening. This is captured by what one participant, Barbara, called “illogical” depression. “It’s illogical. Everything in your life is good but you’re still unhappy. That to me is what depression is. Depression is you’re unhappy for no good reason.” Illogical depression has no clear relationship to events in the present, or the past. It is disproportionate to any reasonable emotional response. In this inability to explain – to narrate – what is happening to one’s self, people are also beset with a feeling of disorientation. The self that they have known is left without a stable grounding. The tension in the antidepressant narrative comes in experiencing this disruption and disorientation, and then struggling to overcome this disruption. There are varying degrees in the extent to which the self is lost and disoriented.

Some people describe disruption as a total *loss of self* – under the sway of depression and anxiety people become unrecognizable to themselves. Joanna remembers suffering from anorexia and depression.

For a long time I got lost in this thing that was so skewed, and to me that was like the truth, everything I was doing, everything I was thinking and I guess that, I'm not sure, I'm not too educated on mental disorders or disease, but you think that the way you're feeling is normal, and that it's always going to be like this, and you get lost in your thoughts and your head the way you think and these truths that your mind is telling you which are just so wrong. (Joanna, student, age 21)

And Jennifer feels as if she lost herself to depression every few days:

I was trying to stay focused and I was like "I don't know why I feel bad" and I was like "things are so pretty, I love people, I love books" and then two days later I'd be like "what was I talking..." It was like two different people, seriously, this one person who is myself: active, going out, having fun, and this other person who doesn't want to do anything, just sits, sleeps, and doesn't sleep, and I didn't know what was wrong. I was starting to freak out. (Jennifer, student, age 20)

For people like Jennifer, this loss of self is also accompanied by aggression and anger directed toward herself. The self she has known is not only lost to an unidentifiable force, but this force poses a *risk* to the life of self. For example, on her birthday, a time when Jennifer thought that everything should be perfect, she took a razor blade and, for reasons she still does not understand, cut her arm. She sought counseling only after she had heard of an acquaintance who had committed suicide. Jennifer was afraid that if she could cut herself then she might do other things that she did not want to do, like kill herself. In retrospect, she says that the depression made her do it, but in the moment she was confused and overwhelmed. Jesse, Samantha, Peter, Teresa, and Louise, among others, were faced with repetitive thoughts of self-loathing and suicidal ideation. From the

moment he awoke, to the moment he fell asleep, Jesse could not stop the “broken record,” and had no understanding of why he could not stop it or will it away.

Joanna, Jennifer and the others described here are overtaken by something that blinds them to themselves. They cannot gain an “objective” distance on their situation, and they mistake their actions in these moments for the actions of what they will later call their *real selves*. Part of the process of taking antidepressant medications is naming this inchoate, confusing, and terribly frightening moment as depression or anxiety and placing it in a narrative structure that makes sense of this disruption. This distinguishes these dangerous aspects of one’s behavior from the real self that would not do harm, and would see things more objectively and reasonably.

Some people experience disruption as something less threatening. It isn’t an eclipse of the self or violent threat against self (though most people are at least haunted by the phrase “you suck” or “why are you such a loser” or “why can’t you be better”). Instead it is a disorientation that comes from a loss of control, an inability to deal with the present moment. These people do not withdraw from the world, but rather, find themselves unable to withdraw from a world that is spinning out of control. Mary says:

I was anxious and angry because my life was so out of control. I felt like things were just happening to me, and that I had to react. The financial thing was happening to me. The kids coming over or ending up staying later, or not having the things they needed when they came to the house, was happening to me. My frustrations at school were happening to me, and I didn’t feel like I had control over what was going on. (Mary, teacher, 37 years)

Mary was being crowded out by all of the people and events in her life. She was losing control and freedom, and the loss of control threatened to “spiral” downward into depression. There is nothing she could do to stop it once it started coming. She described the coming depression as the cloud of locusts that she remembered from an episode of the television program “Little House on the Prairie”:

I would see that cloud out there, and I could see that it was coming, but there was nowhere to run. You just kind of wait and it comes.

And later

It’s coming, it’s like watching a tornado coming. You can protect yourself but there’s nothing you can do.

Like some of the others I spoke with, Mary did not feel a desperate need for relief. Her life was not at stake or under threat of suicide, but she was thrown-off by events in her life, and she went to her family physician in order to gain some control, so that she could hold herself together despite the stress of everyday life.

Finally, in contrast to people who experience depression and anxiety as something appearing suddenly and out of the blue, others narrated disruption as a long-term understanding that something is fundamentally amiss in their life. This is a feeling that “I am at a disadvantage,” and even the pre-cognition that “one day I will need to get help.” Barbara had lived with mild depression all of her life. She had many disruptive moments throughout, most notably her father’s early suicide. From that point on she knew that she was in a “different category of person” and from that point forward her life was disrupted. The only thing that kept her from taking antidepressants sooner was her fear about the stigma attached to these medications.

In general, then, I emphasize the power, intractability and inexplicability of the affect that disrupts life, and initiates the drama of antidepressant narratives. In the next chapter, I will describe how antidepressants allow people to realize idealized and valued versions of selfhood. For the moment, however, I stress that the decision to take antidepressant medications emerges out of a confusing and threatening disruption within the narrative of self. At its most mundane, it slows people down, and makes them tired and lethargic, so that they do not want to get out of bed or leave the house. Insofar as a part of the self is disrupted, the narrative can't move forward at a steady or reliable pace. At its most dramatic, the disruption appears as a total loss of self, and the threat of imminent dissolution. More than anything, disruption cries out for relief. Even though I spoke with a range of people who suffered in varying degrees of severity, I did not talk with anybody who sought medication for the purposes of what Peter Kramer (1993) famously called "cosmetic psychopharmacology" – an almost playful and vain effort to use medication to craft a better personality. This is not to say that people don't try antidepressants out of curiosity, or the promise of a better self. Indeed, once we start to talk about the discourses that surround antidepressants, the line blurs so that not being a complete self, not being the self promised by the advertisements or consumer culture, can in itself become a source of terrible distress. But for the moment, I focus on the idea that antidepressants come to the rescue in the midst of troubling and confusing times.

In Arthur Frank's (1995) terms, this is a chaotic period during which persons cannot get a distance from their self and body, and as such they live in a confused present. He writes that:

the body is imprisoned in the frustrated needs of the moment. The person living the chaos story has no distance from her life and no reflective grasp on it. Lived chaos makes reflection, and consequently storytelling, impossible. (p. 98)

This incommunicability can overshadow an entire life so that all a person can do is withdraw from the world and relationships – stay in bed, refuse to see friends and family, hide their head from people in the street, stew in one’s own self loathing. In the face of chaos, the challenge for Frank (1995) is to provide room for the development of narratives that can allow the body, and the self, to speak, and give form to its chaotic experiences. So too, in her study of melancholia and depression, psychoanalyst and semiotician Julia Kristeva (1989) seeks means by which the unspeakable hole within the self can be given some meaningful expression. As noted, the people I spoke with did not all suffer from depression, and it is not clear that even those who suffered from depression suffered from the melancholic depression addressed by Kristeva. However, I want to say a few words about her analysis because it points to the way in which psychological suffering, in general, can be conceived in narrative and linguistic terms.⁶

For Kristeva, depression is outside of speech and narrative, not because it is better explained within the realm of biology, but because depression is a response to the unspeakable elements in human life – “an impossible mourning for the maternal object” (p. 9), and “the non-representability of death” (p. 25). Even though, as Kristeva suggests, there is an element of depression that always remains outside of language, the task of psychotherapy is to find means for articulating the character of this “negativity.” She therefore examines psychoanalytic discourse, and artistic expression, as efforts to signify a mourning for the lost object.⁷ Here the space of interpersonal relationships

(psychoanalytic therapy) and cultural expressions (painting, poetry, and writing) offer a medium in which a “depressive discourse” – a form of expression that maintains the ambivalence and negativity of depression,⁸ yet frees it from the unbearable attachment to a lost object - can be discovered and cultivated as a means of alleviating and giving meaning to suffering more generally.

It should be noted that Kristeva also sees a role for antidepressant medication in the treatment of depression. She posits a relationship between the capacity for linguistic representation and physiological disturbances in the brain, and writes that “the facilitating effect of antidepressants is then required in order to reconstitute a minimal neurophysiological base upon which psychotherapeutic work can begin, analyzing symbolic deficiencies and knots and reconstituting a new symbol system” (p. 38). However, Kristeva warns against an understanding of depression that rests solely on the work of antidepressants. She proposes a psychoanalytic-semiotic theory of depression as “counterdepressant” (1989, p. 25). Antidepressants, she suggests merely neutralize depression, whereas psychoanalysis, and other expressive forms, elucidate the character of “depressive discourse,” as well as its position within larger interpersonal problematics of mourning and forgiveness. Where Kristeva envisions antidepressants as a means toward the ends of enlarged interpersonal narrative understanding, the biomedical model envisions the antidepressant treatment as an end in itself. As I have argued in the analysis of antidepressant advertisements, medications are portrayed as technologies that offer relief from intractable suffering, but when this relief is provided, the story comes to an end. This marks a split in the road – two ways of making sense out of disruption and chaos. The narrative approach seeks to give expression to chaos, and locate its meaning

within interpersonal and cultural stories. The biomedical approach prioritizes the relief of suffering, and leaves the experience of chaos aside, as mere disruption, rather than a challenge for further narrative articulation.

What, then, is relief? The metaphors used to describe antidepressant action provide a number of characterizations, most of which are mixed throughout all of the stories. Antidepressants can

bring me up from the bottom. (Barbara, real-estate agent, age 34)

take me out of this hole, where I never even thought that I could ever get out of it.

(Joanna, student, age 21)

But relief is not merely the lifting of suffering, it is also a positive accomplishment.

Antidepressants provide emotional stability, a “baseline”:

Just be stable about it, and logical about it, and not freak out, and it kept my mood very stable. (Joanna, age 21)

It controls your system. It controls so you're not all over the place, highs and lows, but then it... it clears the cloudiness in your head, you can think clearer, and instead of someone saying something to you, and you going haywire it's more like “oh.” (Jennifer, student, age 20)

And with emotional stability comes the capacity for objective, reasoned thought:

I am able to carry on my tasks throughout the day with a sound mind. (Peter, student, age 33)

I can definitely think a lot clearer .. I'm a lot more realistic now than I was...a lot more aware of what's going on around me. (Samantha, student, age 20)

I begin to rise past the depression, to understand these things more clearly and when I can understand those things more clearly...it becomes more rational.

(Michael, computer programmer, age 43)

The antidepressants are defined against unruly emotion as medicines which bring control. They bring an ability to step back from oneself and one's disordered, extreme emotions, and to see the world from a more realistic, and less overpowering viewpoint. They allow people to get back into the world of everyday activity, leaving behind the chaos that overcome them during periods of disruption. Though as I have suggested, the biomedical view closes down on the formation of further narratives of self, this is not necessarily the case in practice. Indeed, for most of the people I spoke with, the individual relief provided by antidepressants was only a starting point in the development of a new kind of self-understanding. This new kind of understanding does not emerge out of the interpersonal and narrative articulation of self and suffering depicted by Frank (1995), Kristeva (1989) and narrative theorists more generally. Rather, it is a kind of understanding that unfolds in a relationship between individuals and antidepressants. It is a story in which people struggle to redefine their selfhood in biomedical terms – as selves that have biological imbalances, and as selves that need to learn how to use antidepressants.

The Use of Antidepressants

Despite the fact that the biological theory of mental illness is widespread in the contemporary culture, in the beginning, most of the people I spoke with did not think that they were suffering from a biological condition. Before concluding that he was biologically depressed, Jesse asked his doctor to test him for diabetes. For months after

the terrorist bombings of 9-11 Duyen wandered around the city lost and disoriented. Only several months later did she begin to think of her disorientation as an onset of a bipolar disorder. Others interpreted their suffering as personal failure. Barbara and Louise thought that they were simply lazy. Jeremy and Jennifer felt guilty when they did not want to be around others, or could not supply the good humor and jokes that their friends expected from them. In this respect, an important aspect of the relief that comes with psychiatric diagnosis is the belief that “I am not to blame for these behaviors. It’s not me it’s biology.” In some cases, this relief comes when a psychiatrist, therapist, or doctor diagnoses a person with a chemical imbalance. In other cases, people, such as Zareen, tentatively diagnosed themselves with an illness that they had heard about through acquaintances, friends, in the university classroom, or on television. They were relieved not only when their self-diagnosis was confirmed by doctors or psychiatrists, but more importantly, when the medication seemed to work, thus trumping all doubt that “it is my fault,” or that it is “just in my imagination.”

In cases where antidepressants bring relief, they also bring the revelation that disruption is something a person could not have handled without the help of medication. The relief provided by antidepressants, reveal that depression or anxiety is something beyond everyday forms of control and understanding. Zareen puts it best:

The biological part is the part that you can’t control...Before you figure out that it’s depression, or whatever it is that you have, you always think...that you have the capability of controlling that emotion, or you have the ability to react to something. But there comes a time when you’re like “Ok, no matter what I try I know I shouldn’t react this way, but I just do,” and you can’t fix it. So that’s the

biological, when you realize it's sort of, it is beyond your control, you don't really understand why it's beyond your control, and then when you go on the medication and you see how you react differently when you're on the medication you're like "Oh, well obviously there was something that I couldn't control 'cause the medication helps." (Zareen, student, age 33)

Or Wanda says

I think it taught me that I was depressed because suddenly I was able to be not depressed. It taught me that I felt like I was a, um, you know, alien. I hadn't realized how alienated I was until I went on the antidepressant and felt like I had joined the human race. (Wanda, research psychologist, age 38)

Here antidepressants have the ability to *teach* people something about themselves that they did not know before going on medications. They are the medium through which a new kind of self-understanding starts to emerge. Given the transformative power of the medication Zareen equates loss of control with biological imbalance, and in experiencing her transformation, the medications show Wanda that she was alienated from humanity.

I am pointing here to a form of self-knowledge that firstly does not emerge in personal reflection or in conversation with others, but through the encounter with technologies that modify mood and feeling. The idea that antidepressants restore a biological imbalance may be accepted in word, but it is confirmed, and refined, *in practice*.⁹ This illustrates what Knorr-Cetina (2001) has in mind when she says that we are living in a postsocial world. This is a world in which self-knowledge is derived through relationships with technologies and non-human entities rather than through inter-subjective relationships. As "teachers," antidepressants not only introduce new ideas

about the self, but they offer a means of examining and exploring the self. In part, this teaching capacity inheres in the material fact that, as most people told me, antidepressants don't automatically, or easily, cure illness. Indeed, in taking medications people are introduced to a lengthy process wherein they learn how to use antidepressants, and in so-doing, learn to orient their selves in relationship to the new feelings introduced by antidepressants. These practices may eventually become routine so that, as Barbara says, Prozac becomes like a "multivitamin." However, especially in the beginning of treatment, people must remember to take their medications at the right time of day, they must learn to sort out side-effects from normal effects, they must see that diet and exercise allow the antidepressants to work, and they must struggle to determine whether the antidepressant is working, or whether it can work better.

In other words, the use of antidepressant medications generates a set of experiences that call for a reconceptualization not only of the origin of one's distress, but also of the relationship between body, self and illness. This experience of taking medications draws attention to the body and feelings aroused by the medications. The body becomes a signaling system which indicates the efficacy of the medication and potentially serves as proof for the biological theory of mental illness. Ideally, as Zareen says, the effects of antidepressants would be unnoticeable. They would return the self to its "normal" state without provoking change at other levels. In practice, however, people are oftentimes drawn into an antidepressant lifeworld with its own rhythms and patterns.

Three sets of examples describe practices of antidepressant use. These show how antidepressant medications are used by people to teach themselves about the biological character of their suffering, and its relationship to their self. First, through Tara's story, I

further describe the ways in which people use antidepressants to learn about themselves. Indeed, when faced with a decision as to whether she is living her life “correctly,” Tara does not turn to family or acquaintances to work the problem out, but rather experiments with Zoloft in order to decide whether her anxiety is pathological or just a part of herself. Second, I discuss the ways in which antidepressants are used to make distinctions between different parts of the self. By experimenting with different doses and different kinds of medications people come to conclusions about the nature of their illness – they start to discern parts of the self that are attributable to biological pathology, and parts of the self that are their “real self.” Third, I describe how the ideal of “normalcy” enters into these experiments with antidepressants. While the concept of normalcy and normalization is central to neo-Foucauldian discussions of knowledge/power systems here I show how the use of antidepressants is articulated with the practical problem of achieving a “feeling” of normalcy.

Tara’s example

Tara has suffered from anxiety most of her life. She left the home of her abusive father when she turned eighteen, worked her way through an undergraduate university degree, and is now preparing for marriage and a challenging graduate degree in the medical sciences. Tara believes that her success is attributable to her anxiety. It has given her an “edge.” Even though it is persistent, keeps her awake at night, and never allows her to enjoy her success, Tara values the anxiety as a central and defining aspect of herself. Yet, Tara also has doubts, and she wonders whether her anxiety is abnormal or pathological. Indeed, in the midst of a stressful move, the anxiety threatened to get out of control and Tara began to wonder whether the anxiety was indeed pathological,

something caused by a biochemical imbalance, rather than a property of her real self. She talked to her physician and the physician prescribed Zoloft. When I asked Tara what she hoped Zoloft would do she said:

I just didn't know what, but I wanted to see if...maybe I was living my life incorrectly up to that point. Maybe I had been too anxious, so I just needed to see if I need a change. (Tara, student, age 22)

In this example, Tara does not rely upon personal reflection or conversation with friends or acquaintances in order to decide whether she needs a change. Indeed, she transfers the power of moral decision making – an assessment about the *correctness* of her life – to the effects of the medications. She sees the antidepressant Zoloft as a kind of tool that will enable her to make some decisions about her anxiety: “Is the anxiety something I need to live with?” “Is it good to live with this anxiety?” or “Is it pathological, something that controls me and gets in the way of my life?”

Tara took Zoloft for three months. It relieved her chronic anxiety, but she didn't like the person she became when taking the medication. The Zoloft made her feel “passive” and “lost.” “It felt like I was just sitting back taking everything in.” In contrast to the self that was always engaged, on the “edge,” and continuously doing things, Zoloft made her into a person who was too relaxed, and too at ease. The constant, unrelenting, involvement with the external world – also described as an “edginess” and “doggedness” were the qualities that had allowed her to survive her difficult upbringing, against all odds. As a result, when she lost that edge, she lost a part of herself. Tara, then, used the antidepressant to experiment with different ways of feeling, and thereby to distinguish between parts of herself that were pathological, and those that were truly herself. She

learned that her anxiety was not pathological, but a valued part of herself. In this sense, Tara confirms a longstanding view of herself, namely, “despite the trouble it brings me, my anxiety is an important part of me.”

This however, is not entirely clear-cut. As a student dedicated to the natural sciences, Tara speaks the language of neurochemistry, and she holds a biological view of self. She imagines and talks about the way in which different aspects of her behavior and feeling are regulated by neurochemistry.

as a scientist I would have to say that self is not anything [other] than the creation of all the chemicals confined in my body, and then I ingest things that cause a chemical difference or allow me to function.

As a result, even though the Zoloft didn't give Tara the results she liked, she considered the possibility that the Zoloft, which she believes normalizes her serotonin levels, was revealing her real self. “Maybe it did work, maybe it did what it's supposed to, and that didn't fit my standards.” Unlike most of the people I spoke with Tara did not think that the medication was helping her. However, her uncertainty about the nature of herself demonstrates the way in which antidepressants and biomedical theories can split the self into components and behaviors which are “me” and “not me.” Is Tara the anxious person who she has always known herself to be? Or is Tara the passive disengaged self that the antidepressants have revealed? The antidepressants can reveal to Tara these different ways of feeling, but alone they are unable to answer these questions.

Making distinctions

The biological theory of depression entails more than a simple redescription of the origins and causes of depression. It also invites a new relationship to depression or

anxiety as primarily a physiological problem. While the “psychological” conception of depression or anxiety certainly does not disappear from these narratives, it is clearly overshadowed and reframed as an experience that is felt in the body. Rather than appearing as a unitary sadness, depression is parsed into bodily capacities and physiological states such as lethargy, restlessness, or irritability. Antidepressants, then, are said to treat a physiological problem, but in the process they also give rise to a wide range of unanticipated bodily experiences. Part of the problem of figuring out what an antidepressant is doing is also distinguishing among these new sensations and getting a feel for their particular rhythms.

Angela poses the problem like this: “So you’re given a medication and you start feeling something you’ve never felt before in your life.” How is one to distinguish between the depression/anxiety, the effects of the antidepressants, and the, so called, real self? Katrina gets right to the point when she says that she misses “plain old” depression. She says that the medications don’t wholly alter her mood, or her self. As others told me, it’s not as if you take the medication, wait the expected three or four weeks,¹⁰ and then experience a transformation in mood from that day forward. Despite the message conveyed in the advertisements the antidepressants don’t give rise to a simple before and after narrative. In Katrina’s words, the medication introduces a “blend and mix” of experiences that are a challenge in themselves. It introduces a growing set of new experiences, modes of feeling, and techniques to manage moods and feeling. Describing this new “depression-antidepressant” mix Katrina says:

I’m not even sure what it is when it’s not medicated. I wasn’t even sure that I needed antidepressants, and I was taking suggestions from professionals with a

major grain of salt and now this mixture. There are more options on the menu, and I'm not as clear what causes the changes, and I also don't have as much, haven't had as much time and experience to test into the assortment of options on the menu....I'm pleased that at least I'm getting by, but [I'm also] distressed by that because it's another thing to be distressed, melancholy, and sad, and very negative, and to feel tortured by it. I don't dwell on it. (Katrina, acupuncturist, age 47).

The depth of depression may be altered on some days, but it may come back on other days. And at other times, it's unclear whether what she is feeling is a normal response to a stressful life, the product of a chemical imbalance called depression, or unwanted side-effects of the medication. Indeed, there is good reason for Katrina to be depressed – she is in the midst of a court battle for custody of her son. Yet, caught up in the use of antidepressants, Katrina starts to lose sense of whether her depression is a normal reaction to her difficult life situation, whether her reaction is made worse because of the medications, or whether she would be in a total state of collapse if she were not on the medications. While Katrina had some understanding of how to deal with the “plain old” depression, she appears lost and overwhelmed by the unpredictability of the feelings and moods introduced by the antidepressants. In other words, the antidepressants provide relief from the chaos and disorientation introduced by depression, but these are replaced by a new kind of chaos.¹¹ The medications introduce new problems and new risks for the self and Katrina has not yet learned the combination of medications and routines that would allow her to settle into a stable relationship with her depression.

Consider the further difficulty in distinguishing side-effects of the medication from normal effects.¹² In some cases these are easy to notice. For example, Teresa and Barbara both experienced severe lethargy. Teresa slept for 20 out of the 24 hours of the day after she first took Celexa. She felt a little bit less depressed when she wasn't sleeping, but concluded that she shouldn't be taking this drug. It was clear to her that the drug was putting her to sleep. After several weeks, Teresa's psychiatrist finally relented, and switched her to another medication. But for Zareen, these distinctions are not so easy:

I'm gonna take it in the morning and then be like "huh" like be really cognizant of "Is that a side effect? Is that a side effect?" You know. And I got a horrible headache that day, and I was like "I hope it's not the Prozac," and I couldn't decide if it was the Prozac, or if it was the stress of school, because I have a lot going on at school too, it's toward the end of the semester. (Zareen, student, age 33)

Once on the medication, Zareen pays greater attention to her body, and reads it for signs of the medicine's effectiveness. She tries to distinguish how she should feel because of normal stress, from what the medicine might be doing to her. Her body is no longer a familiar "habitus" whose aches and pains are explained through a taken-for-granted foreknowledge. Rather, the fact of having taken Prozac concentrates Zareen's attention, and draws-out particular feelings and experiences for further interpretation. "Is this a feeling that I already know and understand?" or "Is this something introduced by the Prozac?" The interpretation of the body is further articulated with the problematics of risk: "If it is the Prozac, should it be making me feel this way?" "Is this a tolerable side-effect?" or "Is it an effect that represents a larger danger?"¹³ The resolution of these

questions will require further experimentation, or at least a period in which Zareen becomes familiar with the particular feelings introduced by Prozac. She will need to re-learn certain aspects of her habitual way of being-in-the-world.

Jennifer, a serious athlete, also has a problem of distinguishing side-effects from normal physiological reactions. Her hands started shaking after several months on Prozac. At first, she didn't think this was unusual because she says "Sometimes when I play sports, my hands shake afterwards." The shaking became more persistent and, not trusting her own senses, she turned to a friend to figure out whether this was normal or abnormal:

I'd be just sitting in class, and one day I was like "Hey." I'd rest my hands, and I asked my friend "Does it look like my hands shake a lot?" and she was like "it's weird." (Jennifer, student, age 20)

Jennifer did not automatically know that this shaking was caused by the medicine. She wasn't even sure whether she could properly judge the actions of her own body. Indeed, the medications place many people in a position where they need to relearn the way their body feels so that they can distinguish how the medication feels, how the newly transformed depression feels, and how the self, managing and witnessing all this feeling, feels. This didn't effect Jennifer's faith in the medication, but rather taught her that taking medications is a "trial and error" process. "You gotta take medicine, and not take medicine." Despite their ambiguities and uncertainties antidepressants provide a stability and constancy that she is willing to learn.

Jennifer and Zareen struggle to distinguish side-effects from the normal effects of the medication. Alternately some of the people I spoke with go on and off medications to

confirm the truth of the biological hypothesis. Here they learn to distinguish between parts of the self that are caused by biological imbalance and parts of the self that are a “normal” reaction to the stresses of everyday life. For example, nearly every person that I spoke with provided an example of a time when they forgot, or intentionally decided to stop taking the medication. Sometimes, as Michael and Louise say, this is a “subconscious resistance” to the medication. In other cases, it is an attempt to test the truth of the biomedical hypothesis. Some people are not entirely convinced that they have a chemical imbalance called depression or anxiety. Out of curiosity, and the hope that maybe they are not dependent upon medication (or, at least, that their depression has gone away), some of the people I spoke with stopped their treatment. In this, they exercised a form of agency. By going off the medication people prove that, ultimately, they are still in control of themselves. Ironically, these stories served as proof that the disruption was beyond their control, that it was indeed a product of biological imbalance. One part of their self is capable of exercising the *freedom to forget*. The other part of their self is chained to the biological imbalance.

Given financial concerns, Jesse wondered whether he would be able to function without his medications. Shortly after our first interview, he decided to stop taking Prozac and Wellbutrin.

So I stopped, and it was, it was not good. I went along fine. I didn't feel any differently for a few days, and it just started to, I didn't even notice it. I didn't even really notice it, and by the last week, I would say, the end of last Wednesday everything came down on me within a few days. (Jesse, student, age 30)

The broken record of self doubt and suicidal ideation returned. Furthermore, Jesse had set up the psychological conditions to test whether the relapse was something that could be avoided. He wanted to know whether it really was the medication making a difference, or whether he was somehow tricking himself into the depression:

...and I approached it not in a way that I was trying to look for failure. I really wasn't. I thought "I'll keep it, and if things go ok I'll" you know, "If I need it again, I'll go back on it." And I can honestly say, and I think it's important, I didn't think about it as setting myself up for failure. It was not, it was definitely not, conscious. (Jesse, student, age 33)

Within days after returning to the medication Jesse felt better, and in control. For Jesse this *almost* serves as evidence that the depression really is biological, and out of his control. Even though Jesse is someone who says "it is definitely a biological predisposition" he still has doubts. His return to medication coincided with the end of an unhappy romantic relationship. He wondered whether he felt better because he was free from the relationship. Or, just before he started to take the medication, he dropped a university class that was causing him grief. Perhaps, he suggested, the freedom from that class gave him some breathing room and allowed him to overcome his worries. In any case, within the context of Jesse's emerging self understanding, he is increasingly convinced that suicidal ideation and the broken record of thoughts are products of a biological condition.

Furthermore, the biological understanding also begins to account for less distressing aspects of Jesse's behavior. In other words, the diagnostic bracket creep described by Zita (1998) and Shorter (1997) , also appears as an active force in Jesse's

life. The biological imbalance is not merely limited to Jesse's depressive condition, but it also makes sense of wider-ranging aspects of his personality. Jesse says that he was always *oversensitive*. Sensitivity in itself is not a problem. This is something he values about himself. However, the extreme character of his sensitivity – in his words, a product of biological imbalance – gets in the way of his life, and disables him with social anxiety and worry. In addition, given his understanding of the biological basis of his sensitivity, Jesse, who is studying to be a lawyer, accepts that he is not the kind of person who will be able to operate in a high pressure courtroom. The intractability of his emotional sensitivity, he suggests, will always get the better of him. He has learned that even on the antidepressants he is the kind of person, the kind of self, who cannot function in high stress work.

Finally, in settling on a distinction between the stability that he feels when on the medication, and the instability, oversensitivity and depression experienced when off the medication, Jesse begins to delimit the borders of his self. On the one hand, this means that Jesse learns what kinds of social situations he can handle, and what kinds of work he can do. On the other hand, there is a sense in which, using the medication Jesse is able to put up borders between his oversensitive self and the external world. Some of the people that I spoke with explicitly describe the medications as something that allows them to establish a kind of protective border around themselves. Louise says that the antidepressant “puts a skin between me and the world” and Katrina says that “it gives me a thicker skin.” Similarly, Mary says the medication “puts me on a different level where maybe the same things were still happening to me but I wouldn't, they wouldn't effect me, kind of like having a bubble or shield around me.” For Jesse, Louise, Katrina, and

Many these metaphors are used to communicate a positive effect of the antidepressants. They help them to step back from the world so that they are not overwhelmed and overtaken by external circumstances. This is a survival strategy that provides people with the basic ontological security to handle the anxieties and worries of everyday life, and the threat posed by the biological imbalance which they are only now learning to understand and manage.

The antidepressants, then, don't erase, cure, or finally eliminate the capacity for depression, anxiety or oversensitivity. Instead they put up walls, and push these feelings to the side. I will explore the significance of this in the final section of this chapter. For the moment I want to describe one more possible use of these antidepressants. Lupton and Tulloch (2002) have examined the "positive" uses of risk in their analysis of the pleasures that come with risk-taking. The risk society, they argue, constructs limitless forms of dangers to be protected against, but at the same time provides people with new boundaries to cross, and new fears to confront. Here risk can be used in rituals of self-improvement (e.g. stepping outside of one's comfortable boundaries), but also, in offering encounters with danger and death, risk can be used to heighten emotion and test the limits of the self.

I want to suggest that in experimenting with antidepressant medications and delimiting the borders of self, people are also given the power to actively engage and "play" with the risks that their biology poses to their well-being. A choice to stop taking the medication (intentional or otherwise) is also a slide back toward depression. No doubt, people are frightened by the return of depression and the chaos and danger that it threatens. Yet, in some cases there is a sense in which the medications also allow for a

new kind of engagement with that risk. The appeal of maintaining a proximity to risk was suggested to me when Jesse described the pleasure that he takes in his depressive fantasies about suicide and death.

The suicide fantasy...it's almost like a comforting kind of feeling of annihilation. To dwell on thoughts of suicide is as good an escape for the suicidal or for the depressed, as the erotic fantasy is for somebody. Some people, they daydream about "I wish I was fishing out on the boat in the Caribbean," and others might "fantasize about women" or "fantasize about men." I think that the depressive really lives their fantasy life in the idea that they will die. (Jesse, student, age 33)

Jesse is psychoanalytic in his self-description, and recognizes the way in which fantasies about death can become eroticized. For Jesse, the antidepressants put those fantasies on hold. But Jesse also knows that if he stops taking the medications these fantasies will once again overcome him. He is ambivalent about the fantasies. He wants to get rid of them because they threaten his existence, and they get in the way of his everyday life. Yet, he also takes a kind of pleasure in the fantasies.¹⁴ In taking the antidepressants, Jesse puts himself in a position where he can play with those fantasies and regulate his proximity to them. It is no doubt a serious form of play, but in this, Jesse acquires a new power over his self. With the help of the medications, he draws boundaries around his self. These keep the external world, and the biological imbalance, at bay, but insofar as the medications never rid Jesse of the illness (at least for now) he can drop those boundaries and immerse himself in that chaotic world once again. Indeed, the antidepressant narrative is not simply a before and after progress story, but it is a story in

which people are able to move back and forth from illness to health, from depression to selfhood, if they so choose.

Approximating normalcy

As the previous examples suggest one of the tasks that accompanies antidepressant use is the attempt to discern feelings of normalcy. The concept of normalcy, and the social process of normalization, is central to the Foucauldian tradition of thought. Though the techniques of normalization are widespread in neo-liberal societies, in the case of psychological health and well-being, these have been most thoroughly developed in what Nikolas Rose (1996) calls the psy-disciplines. Intelligence, aptitude and personality testing technologies, diagnostic systems such as the American Psychiatric Association's *Diagnostic and Statistical Manual* (DSM), and psychotherapeutic techniques more generally, provide classification systems and standards of normal behavior and functioning. These are not neutral measures of normal human functioning, but they implicitly assert moral standards that enable the management and regulation of large populations. Most importantly, in contrast to older forms of "sovereign" discipline that worked through direct forms of surveillance and punishment, these "disciplinary" technologies encourage voluntary compliance (Foucault, 1978). In this sense, normalcy is not something imposed from above, but it is actively desired by members of contemporary cultures. Several techniques of normalization were noted in the analysis of the advertisements. Everyday anxiety, worry and sadness were defined as abnormal conditions, and the ideal of a worry-free happy life was established as a realizable ideal. Furthermore the possibility of a complete and whole self was opposed to the self overcome by biological imbalance.

Perhaps more than anything, the people I spoke with believed that in comparison to other people they knew or saw at work their emotional sensitivity or predisposition to depression and anxiety was abnormal. Zareen, Louise and Samantha, for example, struggled with what they felt to be an excessive tendency to procrastinate. They attributed this procrastination to an underlying biological condition. Or when Jesse started taking antidepressants he had the sudden revelation that he had been at a disadvantage all of his life. “If this is how everybody has been going through life, then I’ve been going through it with a handicap.” This said, despite the range of images of normalcy offered by the psy-disciplines, for many the people I spoke with, normalcy was an elusive ideal, approximated by the vague and general concept of well-being, rather than more specific assertions about what a good or normal self should be. Here the realization of a normal selfhood was never a certain achievement, and even after people had experienced some relief with the antidepressants they remained caught up in an effort to better approximate this feeling of normalcy. In this context, experimenting with different types or doses of medication provided an opportunity to feel even more normal.¹⁵

Many people start taking the medications with the foreknowledge – usually learned from acquaintances – that going on antidepressants requires a commitment to a series of experiments. This is an attempt to find the medication that does not merely provide relief, but offers minimal side-effects, and approximates the elusive feeling of normalcy. Teresa’s commitment is most striking. First, she becomes an agent in her own self experimentation:

I felt like I was experimenting on myself, like I was taking suggestions from other people saying “Try this it will make you feel better” and I’m like “Ok, we’ll see.”

And then I didn't know what I was basically taking, and I didn't know what it was doing. (Teresa, unemployed, age 26)

Teresa eventually settled on Prozac. Even though it was not clear to Teresa that Prozac was really improving her mood, she stuck with it in the hopes that eventually enough would "build-up" in her system to finally make a discernible difference:

I was hoping not to feel depressed and low all the time, I was really hoping that if I build enough in my system and if we, after a while, increased the dose some more then it would bring me up to that seven or eight on a scale that I wanted to be at, instead of the two or three that I had always been at.

Prozac never brought Teresa these results. However, it brought her a kind of comfort in knowing that she was doing something to help herself. In the end, Teresa stopped taking the medication not because she gave up hope, but because she left school and no longer had insurance to pay for the medication. This was also a frightening moment for Teresa. First, because she feared withdrawal effects. Second, because she feared the return of her depression. Third, because, in the future, she did not want to have to go through the process of finding a medication, and learning it's particular rhythms, all over again.

In some cases, even when going off a medication makes no seeming difference, this does not reduce the commitment to a search for a feeling of normalcy. Rather, it provides an opportunity for further experimentation and testing. Louise, for example, in addition to taking medication for attention deficit disorder, and the antidepressants Wellbutrin and Lexapro, has been taking Neurontin to manage angry outbursts. She was especially concerned that she was inappropriately taking her anger out on her children. She wanted some balance and control over her self. Sometimes Louise forgets to take her

medications, and in fact, for several weeks before we spoke, she had stopped taking Neurontin:

I: Did you feel any different because of it, the being off of it?

P: No I can't say that I did.

I: So why go back on it?

P: Well, I'll see if there is maybe a difference. (Louise, student, age 45)

Louise is going back on the Neurontin because she thinks that it might make a difference. This new round of Neurontin just might take the edge off the anger, and give Louise a little more balance. At present even though the other medications allow her some relief from depression there are still some aspects of her behavior that she cannot control. The problem of finding a better cocktail of medications, then, involves Louise in a process where she distinguishes between different parts of her self – the part that causes depression, the part that causes ADD, and the part that causes angry outbursts – and then seeks medications that can address each of these problems.

This is part of a process in which people search for the right kind of medicine or the right dose of medication. Not too much, not too little. The one that feels right, and provides the appropriate level of balance. This tuning process depends upon a sensitivity to changes in mood and an anticipation of what normalcy would feel like. In the first few months that Jennifer was on Prozac, she and her psychiatrist increased the dose from 20 mg, to 40 mg, to 60 mg, and finally to 80 mg:

... and then we upped it I kept coming back, and like "Eeeh, not really." I couldn't tell whether it was doing something or anything. He said it takes a couple weeks so I waited a couple of weeks. (Jennifer, student, age 20)

Each instance was an attempt to figure out if the Prozac was making a difference. How can such a decision be made? What is it like to feel normal?

In one sense, to many of the people I spoke with, the answer is obvious. It's relief from the most pressing and distressing attacks on the self. In another sense, it's a relentless task with no clear reference point in the popular culture, or even in the consulting rooms of psychiatrists and physicians. Contemporary psychiatrists – increasingly psychopharmacologists – help people to choose and monitor progress on medications. They inform patients about side-effects and the potential dangers of psychiatric medicines. In order to assess the effectiveness of medication they rely upon people's own assessments of how they are feeling, and objective measures sometimes provided by counselors and psychiatrists, other times invented by people taking antidepressants. In the earlier quotation, Teresa describes the "scale" that she used to measure the effectiveness of the medication. Rebecca invents a similar scale. She started taking Prozac to combat high levels of anxiety and problems with obsessive-compulsive behaviors. Her psychiatrist, she said, was not able to tell her how much Prozac she should take because, in the end, Rebecca is the only person who can feel the difference made by the drugs. Rebecca explained her efforts to discern the proper level of Prozac:

Let's say I have OCD like 90% of the time, and then I started taking 20 [milligrams], and I had it like 60 % of the time. Let's say there's some sort of relationship like that, like I felt like if I took 20 more milligrams a day I would have it even less of the time. I mean basically I felt like it was starting to solve the problem, but that I needed more to really solve the problem. (Rebecca, student, age 20)

Here OCD has become a discrete entity, and Rebecca has assumed a perspective of disengaged observer (she has become the “punctual self” depicted in the advertisements). Its presence in Rebecca’s life is numerically measured, and this allows her to project the amount of medication that she might need to further reduce the presence of this illness in her life. Nevertheless, in the end, there is no straightforward equation that will allow Rebecca to determine the amount of medication that could bring the OCD to an ideal zero percent. Rather, Rebecca must experiment with the medication and then assess whether she feels that its presence is reduced.

From these examples we learn two important things about the relationships between antidepressants and normalcy. First, normalcy (or as it is sometimes described in the popular culture, “well-being”) is an endpoint with no clear substance. In his book on the *Triumph of the Therapeutic* Phillip Rieff (1966) described the emergence of a culture in which “well-being” becomes an end rather than a means. He recognizes this as a fundamental shift in the character of 20th century western societies:

That a sense of well-being has become the end, rather than a by-product of striving after some superior communal end, announces a fundamental change of focus in the entire cast of our culture – toward a human condition about which there will be nothing further to say in terms of the old style of despair and hope.
(p. 261)

The old style of despair and hope is one in which suffering and sadness is embedded within stories which make sense of the meaning of one’s sadness. This resonates with the dilemma described by Katrina when she said that she misses the “plain old” depression. For Katrina the sense and meaning of her previous sadness is overshadowed by the

complex pursuit of well-being enabled by the antidepressants. The antidepressants, and the surrounding discourses, do not provide Katrina with an understanding of why she is sad and why she can't be normal. They do not make sense of her sadness by locating it in relationship to valued endpoints. Instead, the antidepressant discourse asserts only the primacy of feeling normal and achieving well-being. It elaborates means through which a person can achieve well-being, but it hesitates to describe the purpose and the meaning of achieving normalcy, except to say that feeling well is better than feeling unwell.

This brings me to the second point. Without substantive narrative endpoints, well-being and normalcy become states that are not described or spoken, but rather *felt*. Here, the problem of being normal is generated from within the lifeworld of antidepressant use. It is a process in which the rhythms of everyday life are reconfigured to accommodate the new feelings and sensations introduced by medication. It is guided by an effort to find a bodily equilibrium in which the effects of the medicine are balanced against the distress caused by the illness. Objective measurement techniques, of the sort described above, are used to help people approximate this feeling of normalcy. These scales establish standards against which the relative stability of body and feeling can be measured. In this process, well-being is moved from the realm of shared story-telling to a realm of individual experimentation and practical involvement with the medications. Indeed, here, as Teresa pointed out, simply taking the effort to use antidepressants, and engaging the various forms of self-monitoring and surveillance constituted in their use, can provide a modicum of comfort and stability for the self. The promise of antidepressant treatment, then, is that by acquiring expertise in the various feelings that they enable, a feeling of normalcy may one day be achieved.

The Splitting Narrative

In this first section of this chapter I described how depression and anxiety enter into people's lives as disruption. Depression can overtake the self and threaten people's ability to function in everyday life. In some cases this is described as a total loss of self to a foreign and unfamiliar entity, and in other cases it is a perplexing disorientation that leaves people without the ability to achieve goals that they posit for their selves. In the second section I described how people use antidepressants not only to relieve otherwise intractable suffering, but also to make sense of the experience of taking antidepressant medications. In the process people attempt to distinguish between behaviors and feelings caused by the depression/anxiety, effects of the medications, and normal reactions to everyday life. I focused on these practices in order to demonstrate that the biological thesis is not simply an imposition from above, as it were, but it gains a certain credibility and texture as people experiment with the different ways that the medications can modify their feelings and their bodies. In many cases this leads to a search for a feeling of normalcy – a state of equilibrium in which people balance out the various side effects of the medications thereby gaining some freedom for their selves. In other cases, such as Tara's, the process results in a conclusion that antidepressants change the way the self feels, but that these changes come into conflict with ongoing experiences of selfhood.

The practice of using antidepressants also gives rise to a new narrative structure that has implications both for the way that people talk about and experience their selves and their suffering. This narrative explains the source and meaning of previous and anticipated disruptions, as a biological illness called depression, or anxiety, or some variation of mental illness. What was once inexplicable disruption assumes the form of

“this was the time,” or “this is the time during which my biology gets a hold of my self.” In this respect, the antidepressant narrative retrospectively constructs a person’s life, and the disruptions in that life, as the products of a biological dysfunction that has only now been discovered. This narrative also introduces a re-organization of the self in which certain parts are “split off” as attributable to biological dysfunction, and other parts are retained as the “real me.” I already hinted at this when I described the distinctions that emerge in the process of taking antidepressants. Some behaviors and feelings are attributed to biological dysfunction, and, using antidepressants, people are able to build borders around themselves to either protect against the threat posed by internal pathologies, or to protect against external threats. Even with people such as Tara, who decided to stop using antidepressants, the medications are able to show people aspects of themselves that they did not recognize before taking the medications. When the antidepressants made her feel passive and withdrawn, Tara was confronted with the possibility that her “natural” selfhood might be different from the anxious state of being she had come to take for granted.

In this section, I introduce the concept of a “splitting narrative” in order to further explore the impact that the use of antidepressants has on the structure of the self. The concept of splitting is borrowed from psychoanalytic theory, though it also resonates with scholarship on the social construction and experience of risk. According to psychoanalyst James Grotstein (1981), splitting is a fundamental mental mechanism that develops in the first months of life.¹⁶ It is a mechanism “by which the ego discerns differences within the self and its objects or between the self and its objects” (Grotstein, 1981: 3). Splitting provides a grounds for perceptual and cognitive development – as infants learn to

distinguish themselves from the surrounding environment they gain the ability to distinguish figure from ground, discriminate among objects in the environment, and eventually engage in mature analytic thought. The mechanism of splitting transforms an inchoate environment overwhelmed by indigestible feelings and sensations, into a field “of more utilizable components” (p. 5). Quoting Hannah Segal, Grotstein argues that when this basic capacity for splitting fails, people can lose their capacity to “pay attention” and “suspend emotion in order to form an intellectual judgment” (p. 15). The capacity for splitting also bears upon the formation of narrative understanding. In dividing up the world of experience into useful components, splitting enables the “ordering of sequences of activities, even to the extent of postponing the future” (p. 17). In other words, the ability to place oneself in time, and conceive of life as a story of progress, regression, or stability, rests upon psychic foundations that are achieved, rather than innately given.

Splitting also serves a defensive function, meaning that it protects the self against intrusive and threatening forces. Grotstein traces the concept of splitting through the work of Freud (especially emphasizing Freud’s later work on narcissism and ego development, Freud, [1923]1984), however the most influential conceptualization of splitting comes from the work of object-relations theorist Melanie Klein.¹⁷ Impressed with Freud’s discussion of the life and death instincts, Klein argued that the central problem in early psychic development is the management of the conflict between these two instincts. In their first months, infants exist in a state of confusion, unable to distinguish themselves from their environment, and unable to distinguish sources of pleasure and pain. Infants are fragmented and pummeled by aggressive energies that

threaten to tear them apart. Yet, at the same time, they are beset with the problem of coming to terms with a *primal* split from their mother, and the ensuing of task individuation. Establishing integrity and stability for the individual ego depends upon the capacity to “split-off” the persecutory and fragmenting impulses generated by the death instinct. Here the psychic mechanism of projection (a close ally to splitting), enables infants to defend against unwanted and threatening feelings. Infants “disperse” the threats posed by destructive impulses by projecting these onto external objects. They use the external environment as a kind of holding area for unwanted feelings, thus establishing both a basic relationship with an external world, and establishing divisions that will form the basis of inner life.

Most famously, Klein was interested in the split between good and bad objects (also described as the “good breast” and the “bad breast,” indicating the importance of the infant’s ambivalent relationship with its mother – one who both gives and withholds). By attributing extreme and idealized qualities of goodness and badness to external objects, infants are able to maintain, within their emerging psychic structures, clear-cut distinctions between aggressive and loving feelings. Full ego-integration, and the development of “normal” internal and external object relations, depends upon ensuing processes that bring feelings of aggression and love into closer alignment. Objects become “whole” once children are able to recognize that they can at one and the same time possess aggressive and loving traits (e.g. the mother is acknowledged as a person who can both frustrate and realize the child’s wishes). This process of “reparation” depends upon the security and safety provided by the initial split between aggression and love, as well as the environment that supports the cultivation of ego-integration.

Vamik Volkan (1998) has further elaborated this object-relations theory of splitting by pointing to the role that cultural images play in the management of psychic life. Volkan chooses the example of ethnic conflict to argue that cultural images can become containers or “shared targets” for the unwanted aggressive feelings that threaten children in early life. He writes:

I developed the theory that children of a given group have *shared targets* for projection, and suggested that these targets, mostly inanimate cultural amplifiers, represent the *beginnings* of a shared “other” (enemies) and a shared “we-ness”.

This leads to the concept of ethnicity, clan, or other large-group labels or markers. (1988: 48)

These shared markers include “dirty” and “bad” objects such as pigs in the Moslem culture (p. 48), or cultural enemies more generally. These targets can also be “good” objects such as foods, songs, and colors. The important point for Volkan is that cultural images become a means of separating-out and “holding” feelings and desires that would otherwise interfere with the capacity for self-development.

Volkan’s work, and psychoanalytic theories of splitting more generally, resonates with arguments made by risk theorists, and thus begin to dovetail with the larger concerns of this dissertation. Drawing on the work of anthropologist Mary Douglas, Deborah Lupton (1999a, 1999c) shows how cultures, selves, and bodies are organized through distinctions between the “sacred” and “profane.” The sacred are those people, objects, and elements of the self which are seen to have a fundamentally higher value – they are prized and good. The profane are dirty, abject entities that pose a risk to the integrity of self and community. They are to be avoided at all costs. Here the world of everyday life

is ritualized through splits between those things that are to be avoided, and kept at a distance, and those things which are to be pursued and nurtured. Indeed, Erving Goffman (1959, 1967) has suggested that in contemporary western cultures, the idea of selfhood has become a sacred entity, the integrity of which is sustained through everyday presentations of self, and deeply seeded “face-saving” techniques intended to preserve the performance of self at all costs.

My interest in psychoanalytic theories of splitting is not as a theory of pathological development and mental illness. Certainly, as psychoanalysts argue, the inability to develop a capacity for “normal” splitting in infancy can lead to both neurotic and psychotic ailments in later life. However, I am concerned with the role that antidepressants play in resolving the narrative disruptions described in earlier sections, and in turn the role that they play in re-organizing the structure of self. I emphasize the similarity between the ego-function of splitting described by psychoanalysts, and the way in which antidepressants are used to create and maintain distinctions within the self, most notably a distinction between aspects which are attributed to a dysfunctional (or bad) biology, and those aspects which are attributed to a real (good and desirable) selfhood. Antidepressants supplement or take-over a function once secured either through “normal” psychological development, or when this development fails, in psychotherapeutic settings. In this respect, the antidepressants are “ego-prosthetics.” They do not merely provide a baseline stability out of which further psychotherapeutic work can be accomplished. That is, their utility is not necessarily bound to larger narratives of psychotherapeutic progress (though clearly many psychotherapists will use antidepressants as tools to aid the psychotherapeutic process). Rather, insofar as

antidepressants become aids to everyday life, oftentimes used by individuals independently of psychotherapeutic work, they are increasingly integrated into the structure and organization of everyday psychic life.¹⁸ These are technologies that allow people to put aside parts of themselves, so that intractable emotion and feeling does not interfere with everyday activity and the progress of their unfolding life stories.

In addition, in the same way that Volkan argues that cultural images can serve as containers for unwanted parts of the self, I argue that biomedical narratives (such as those developed in antidepressant ads), also serve as containers or shared targets for unwanted aspects of the self. I put aside the question of whether the science behind antidepressants and the biological theory of mental illness is correct and true,¹⁹ and ask after the role that these biomedical narratives play in helping people to organize and understand their suffering. As I have suggested in my analysis of the use of antidepressants, people integrate the idea of biological dysfunction into the story of their personal experiences of psychological distress. They make distinctions between elements of the self which are “me” and “not me” and use antidepressants to manage and engage this split. When working effectively, antidepressants put aside the pathological components of the self, and thereby give persons the freedom to be themselves.

I further discuss the concept of a splitting narrative in two sections. First, the *Me and the not me* describes how antidepressants are used to erect distinctions between selfhood and biological pathology. This provides people with the chance to become empowered agents in a battle with depression. Second, even when depression can be said to be contained or under control – that is, not disrupting the everyday activity of the self – it nevertheless remains present as a distant phantom force. I argue that, in the splitting

narrative, biology becomes an *independent actor*. This describes the “life” and power that depression and anxiety are given once constituted as biological pathology. Even as antidepressants offer a relief from suffering, depression and anxiety, now reified as things-in-themselves, remains a constant threat to the well-being of the self.

Me and not me

The significance of the splitting narrative is best understood in contrast to previous kinds of self narration. I have argued in favor of a view in which narrative acts not merely as a means for communicating information about a self that exists in advance of social relationship, but rather as a form of social practice that, ideally, is able to affirm the situated relationship of self to other and, in this, provide a basic stability, structure and orientation for selves. This prioritizes the integrity of self, not merely as a social and ethical ideal, but also as a much needed resource in a “postmodern” risk society that threatens to fragment and split the self into pieces. Psychoanalytic theory has been introduced not only as a way of understanding splits within the self, but also as a form of narrative engagement that seeks to repair broken and disrupted selves by integrating cast-off or disavowed elements. For example, in the introduction to this dissertation, as well as in this chapter’s discussion of Julia Kristeva’s writing on depression, I provided examples of how psychoanalytic theory tries to integrate distressing aspects of the self within overarching narrative structures. In Freud and Breuer’s work on hysteria inexplicable and intractable hysterical symptoms – such as a numbness in the arm (Freud & Breuer, [1893]1991: 142.) or an uncontrollable disgust of drinking water (Freud & Breuer, [1893]1991: 142) -- are given meaning once they are interpreted as evidence of repressed memories. By recovering the emotional conflicts that provoked the hysterical symptom,

the physical experience of numbness or disgust is converted into symbolic form and thereby re-integrated into the ongoing narrative of self. In this respect, psychoanalysis is an example of an approach to narrative that allows for a movement between the past and the present, the self and the other, and the psychological and the corporeal. It breaks down modernist dualisms and opens up the possibility for a view of narrative which is both embodied and symbolic.

Splitting narratives work in the opposite direction, and maintain a firm distinction between those parts of the self that are attributable to biology (or body) and those parts of the self that remain in the realm of language and everyday self understanding. Rather than seeking integration of the inexplicable and intractable into a larger narrative of the self, the biological model distinguishes between the elements of the self which are “me” and those which are “not me.” For years Samantha held onto the view that she was a moody and depressed person. However, with the help of her counselor, she was able to see that the depression was not a part of herself:

I think, in the past, that I definitely could not separate it. It was Samantha.

Samantha is like, Samantha equals depression. It was something that just, it was, it was the same thing. I think lately I’ve been able to, I don’t know, I think in the past year or two I’ve been able to really separate it a lot more, and I see it as something that is a part of me, but not necessarily something that has to be part of me all of time. (Samantha, student, age 20)

In other words, the experience of taking antidepressants gives rise to two parallel stories. One of these is the story of the “real” self, unhindered and free from the constraints imposed by biological dysfunction. The other is the story of biology itself – a realm

composed of neurotransmitters and synaptic gaps over which the individual has no control.

Twenty-two of the 23 people I spoke with believed that their newly defined depression or anxiety was caused by a chemical imbalance in the brain.²⁰ For some, this biological knowledge was accompanied by a more elaborate story about the inner workings of their brain. Teresa talked about brain scan images that she had seen in magazines. She wondered what her brain would look like when all of the neurotransmitters were balanced. If, some day, the antidepressants worked to create a healthy brain, Teresa imagined that brain scans would show a brain in which there “would be no black, and it would all kind of be like a mixed rainbow thing.” In other words, Teresa fantasized about this other part of her self, as well as its significance for her health and well-being. Similarly, Tara reflecting on classes she has taken at university, imagined her inner life as a realm composed of neurotransmitters and synaptic gaps. The antidepressants could create “cascade effects,” setting off unanticipated biological consequences, for better or for worse.

While some people, such as Teresa and Tara, imagined the make-up of their inner brain life, for the most part the people I spoke with had little to say about this inner life. They trusted the expertise of psychiatrists and were content only to know that the antidepressants worked because they increased the level of serotonin in their brain. Here the idea that “my depression is caused by a chemical imbalance” was an opportunity to put aside further discussion or reflection on the character and origins of suffering. Where in previous models, intractable depression or anxiety was an opportunity for the incorporation of distress into ongoing narratives of the self (e.g. the discovery of

repressed memories and disavowed aspects of self) here the concept of biological dysfunction serves as a *container* or *holding area*, and recognition that there are elements of experience that can only be understood through expert biological knowledges. In this respect, depression or anxiety becomes something that is put outside of everyday, ongoing narrative. Here Barbara describes her understanding of how the medications put aside certain parts of herself:

I mean I guess, in a sense, it's things aren't coming to the surface, things are buried down, but it gets so much unhappiness buried down that it makes life easier to function. (Barbara, real estate agent, age 34)

And Jesse:

I compartmentalized it, and I've moved on from it. I think that that's the difference between the medication and not having it. (Jesse, student, age 33)

As dysfunctional biology is sorted-out a vision of unrealized identity and possibility emerges. No longer possessed by the idea that these are “really parts of me,” or that “I have an obligation to own up to these parts of myself,” people are given some *narrative freedom*. This is the self *I would be* if I didn't have a chemical imbalance, and it is the self that *I can be* if the medicine is working perfectly. What is especially striking, and I think contrary to popular belief,²¹ is that antidepressants don't necessarily make people into the kinds of selves that they want to be, or wish to be (though this is never far off). This is not a solution in which unflattering characteristics are relocated to a domain over which people have no control, and therefore no responsibility. In fact, in distinguishing biological aspects of their suffering from their normal personality, some conclude that “my self is a pessimist” (Samantha) or “I have a lot of anger inside of me” (Jesse). More

to the point, antidepressants place people in a position where they can realize their own selfhood, independent of the foreign influence of depression. Deeply resonant with modern ideals of freedom and authenticity, the self, as agentic actor, is preserved by jettisoning elements that get in the way of their freedom to be themselves.

Biology as an independent actor

Insofar as splitting narratives distinguish between parts that are “me” and “not me” they also help to overcome the *biological determinism* usually implied by biological accounts of self. In their study of “genetic risk” Novas and Rose (2000) reach a similar conclusion. The entry of biological knowledge into greater areas of everyday understanding does not necessarily submit people to forces and outcomes over which they have no personal control. Rather, Novas and Rose show that in their interaction with genetic testing technologies people develop new forms of responsibility tied to the challenges presented by inherent biological make-up. Similarly, people who use antidepressants do not think that all of their self is governed by depression, or that they have no control over who they are, and how they feel. Indeed, people interpret narrative disruption as a period in which biology overtook their selves, and determined their moods and behaviors. In this context, antidepressants are *tools* that help to push back the cloud, tone down emotion, and open up some space for the self. Antidepressants don’t change or take-over the self. They free-up the self to take responsibility for depression. By emphasizing the strict practices and responsibility required for managing depression and anxiety, the people I spoke with *stuck-up for them selves*. They challenged the popular belief that people who take antidepressants are merely doping themselves up, or avoiding responsibility for everyday problems and normal kinds of sadness. Living with a

biological mental illness, in fact, designated them as special types of people with unique forms of responsibility.

However, even as the antidepressants provide people with a new kind of freedom and an escape from biological determinism, they generate a new set of experiences, problems and dilemmas. This is what is meant when people say that antidepressants don't cure depression or anxiety, they just make it more manageable. For one, even when the antidepressants seem to be working well and allowing people to function in everyday life, many remain *haunted* by the feeling that the depression is still somewhere inside of them. This can be experienced as something akin to the "phantom limb" syndrome described by amputees. It is also similar to the experience of splitting described by psychoanalysts.

Grotstein writes:

Defensive splitting is an act of the imagination which bequeaths to the split-off portions of the personality a life-support system with the will to live, which then re-personifies this creation in a way that it might as well be thought of as someone else—were it not that some unconscious, mysterious connection, much like *déjà vu*, persists to cause the splitter the agony of being haunted by a split which he can neither remember nor forget! (1981: 11)

As splitting mechanisms, antidepressants provide people with control over the most intractable and inexplicable elements of themselves. However, in the course of constructing depression and anxiety as risky disease states, the biomedical narrative invests these with a life of their own, and a tremendous staying power. Even when an individual is not wracked by sadness and worry depression and anxiety continue to linger in the background, threatening to intrude upon the life of the self.

Mary for example, suffered from mild anxiety and depression. She took Lexapro and was happy with it, but she also added that the depression was still there even when on the medication:

It's kind of like, imagine, it's like a safety net so you're on the net you can look further down as to where you could be but you're relieved that you're stopped there. (Mary, teacher, age 37)

For Mary, the depression is just beyond the safety net offered by Lexapro. This didn't cause Mary any great worry. She was confident that the medication would keep her from falling further down. Mary then is an example of someone for whom the antidepressants worked well, even though they did not in any simple sense eliminate depression from her life.

In contrast, Katrina is not so comfortable with this split. When I spoke with Katrina she was taking Lexapro. Some days it seemed to work better than others, but for the most part it created painful divisions between her inner self, and the self that she projected to the world. On the one hand, the Lexapro allowed her to put on a smile and perform a happy selfhood for other people. In Erving Goffman's (1967) sense, she was able to "save face" for others. However, inside she remained depressed and miserable. As a result she sees her experience with antidepressants as an ongoing battle with her brain and the antidepressants. Katrina says:

Now it's hard to always be *battling this brain* that can't even remember to allow enough time to check in at work and do that stuff up there and allow time for traffic to get back to see my son when I said I'd see him. (Katrina, acupuncturist, age 47)

And closer to the point, she says that she feels like the antidepressants split her brain in two. “It felt like one part of my brain couldn’t even connect with another part.” Ideally, Katrina would like to experiment with holistic therapies. However, as I will discuss in chapter six, she is currently in the midst of a custody battle, and must continue to take the medication so that she can appear to be taking responsibility for her mental health.

Still others are haunted by the fear that the medications may stop working and that the depression will return. Jennifer had been on Prozac for four months and then switched to Lexapro for another four months. Like the others I spoke with, she had gained the ability to read her body and recognize the signs of a coming depression. Sometime in November she started to feel a little bit depressed and was terrified that the Lexapro had stopped working. She immediately went to the psychiatrist who told her that antidepressants sometimes stop working. She offered to supplement Jennifer’s Lexapro with a prescription for Wellbutrin and Jennifer agreed. Even though Jennifer was still on the Wellbutrin-Lexapro mix when I spoke with her three months later she wondered whether she let her fear of the depression overwhelm her judgment.

Well I think I actually jumped the gun too fast. I had like a month where I had maybe two or three days that resembled what it was like to be depressed. It wasn’t as bad. It wasn’t severe. It was just a feeling of wanting to be alone again, and that whole just wanting to crawl up and be unsocial. It wasn’t at all severe it wasn’t well.. but the fact that it was there scared me. (Jennifer, student, age 20)

Jennifer remembered the deepest moments of her depression. She feared that because she had a biological imbalance these could come back at any time, and more than anything she wanted to avoid falling into that hole. And even though she imagines a day when she

will go off the medication, and manage the depression with cognitive-behavioral techniques, she is frightened by the idea that depression is a thing that has, in the past, and can, in the future, overtake and overwhelm her.

Insofar as Jennifer conceives of depression as a thing-in-itself she treats it as an *independent actor* that operates according to its own biological rules, acquires its own history, and has a feel of its own. Even when the antidepressants are helping to contain the depression or anxiety this can lead to the feeling of constantly being on the look-out and embattled. In these instances, depression is something with which a person lives. In many cases (10 out of 23 people), the people I spoke with look back over their lives and say that they now realize that they had always been depressed. This can mean that they genetically inherited depression, and were thus “biologically predisposed,” always waiting for depression to enter their life full force. It can also indicate a point at which depression entered a person’s life and changed it forever. When Emma was a young girl her parents divorced and she began to experience severe anxiety and depression. This event “triggered” a lifetime of depression and obsessive worry to which she now believes, she was biologically predisposed. After years of experimentation with various medications, Emma concluded that depression is something biological. It comes in “cycles,” and it can be recognized from a distance. Emma knows that the depression is coming when the world starts to look darker. In her mind, this is a physiological symptom that signals the onset of depression. Furthermore, given the deepening of her depression over time, Emma accepted her doctor’s word that if she keeps going on and off medications, the illness will be exacerbated. She was terrified that depression would return and could even turn into a more severe bipolar illness, populated by psychotic

episodes and an even deeper split within her self. As a result she is committed to remaining on antidepressants for the rest of her life.

Conclusion

The feeling of being split in two, that depression or anxiety is still there even when the antidepressants are working, or the fear that depression may return, are consequences of the splitting narrative enabled by biological theory. The question of the efficacy of antidepressants aside, this narrative constructs illness as something unknown and unfamiliar to the self of everyday life. In doing so it gives biology a power over the self, and renders people beholden to the laws and rules of biological dysfunction. While this offers people some freedom from the more intractable aspects of psychological distress, it is by no means a cure or final resolution. Rather, in introducing the language of biology, medical psychiatry transforms psychological distress into a new set of problems. Here the individual comes to see their self as something at risk, and in need of ongoing surveillance and control.

In this respect, many of the people I spoke with saw the biological solution as an imperfect solution. Even as the medications allowed her to function in everyday life, Barbara felt that she was putting things off that might be better dealt with through talk therapy. However, she neither has the time nor the energy to pursue these alternative forms of self-understanding. Michael, who has been on numerous antidepressants throughout his life, prefers the psychodynamic explanations that he explores in individual and group therapy. Though he has not been able to adequately account for the depth of his depression, he resists the biological view of self and treats antidepressants as a pragmatic solution to a problem that he is still trying to understand in psychosocial terms.

He approaches antidepressants, then, with a feeling of resignation and failure, rather than an ideal answer to his depression. And even though Prozac allowed Zareen to get on with her life, she wasn't certain that she believed the biological account of her illness, or that she had dysthymia. Instead, she says that she needed to believe that she had a biological illness in order to make sense of what the medications were doing for her. In this respect, the antidepressants offered Zareen a "compromise" solution. They didn't help her to get the bottom of her suffering but they allowed her to get on with life.

This ambivalence about the biological solution is common, especially among people who suffer from "everyday" problems such as mild depression and anxiety. Despite the space I've dedicated to showing the ways in which people struggle to make sense of their use of antidepressants, in the end the narratives are marked more by uncertainty than outright commitment to a biological view. Indeed, despite the growth of new means and technologies to manage and control the risks newly invented in a biomedical culture, Lupton argues that

people often feel...that knowledges about risk including their own, are so precarious and contingent that they simply do not know what course of action to take. As a result, they may move between different risk positions at different times, sometimes attempting to control risk, at other times preferring a fatalistic approach that simply accepts the possibility of risk without attempting to avoid it." (p. 120)

At some points in their stories people accept the biological view, at other points they are not entirely content with this perspective and admit that they don't really know why they are depressed or anxious. Indeed, there are reasons to consider otherwise. Many of the

people I spoke with were in the midst of a major life transition, such as moving out of the family home to attend and live at the university or starting a graduate degree in a new city (Joanna, Jeremy, Zareen, Duyen, Teresa), beginning or ending a marriage (Mary, Natalia, Angela), or in the midst of a job transfer that took them to another area of the country, or world (Tara, Peter, Jesse, Mary, Catharine). These people were away from family, friends and, for the most part, alone in a new setting. In addition, most of the people I spoke with had stories about other distressing and depressing events from the past: six of the women I spoke with had suffered sexual or physical abuse; others described difficult early experiences with divorce and alcoholism, others remembered childhood disappointments and betrayals by friends.

Yet, even as these psychosocial accounts remain part of narrative they have also lost the explanatory power to account for depression or anxiety on their own. I am pointing to a change in the cultural discourse of suffering. Psychosocial accounts that emphasize the primary relationship between self, other, and society, no longer carry the weight necessary to explain the intractability of depression or anxiety. At the same time they are replaced with a biological theory of mental illness that leaves people without accounts of their suffering that make sense in terms of the languages of everyday life. Antidepressants bring at least some relief when nothing else seems to work, and this first hand evidence goes a long way in sustaining a biological theory of depression, even if it is an ambivalent commitment. Why would antidepressants work unless they corrected imbalances in the brain?

In this chapter, I have tried to show otherwise. No doubt antidepressants modify chemicals in the body and induce changes in the body and feeling. However, this need

not lead to the conclusion that the medication targets specific chemicals or brain structures that cause people to be depressed or anxious. This view, circulated in advertisements and endorsed by medical professionals more generally, covers over the fact that even this form of psychological treatment depends upon social and interpretive practices developed in the midst of everyday life. To this end, I was most struck by the fact that the use of antidepressants was often perceived as an individual responsibility. Many people I spoke with were shocked by the degree of responsibility they were expected to take in managing their newly diagnosed condition. In fact, many wanted a psychiatrist who would tell them what to take and how it should feel.²² Antidepressant use, no doubt, depends upon a set of social practices, but more than anything these develop in an atmosphere that closes off relationships to others, and turns the individual upon himself or herself as a resource for self-understanding and self-knowledge.

The perspective taken in this dissertation is that this process of individualization and medicalization ultimately misunderstands the social character of self and suffering, and asks individuals to take on too much responsibility for problems that are interpersonal and communal. This returns me to consideration of different forms of narrative understanding. In chapter two I argued that narrative has structural, expressive, and embodied dimensions. In particular, interpersonal narratives, which see the self as always situated in relationship to others, and cultural knowledges more generally, has the capacity to transform chaotic and incomprehensible feeling into shared understanding. These may not always relieve the depth of suffering that some of the people I spoke with encountered. However, it is a view that attempts to give selfhood a meaning that is larger than allowed in the individualistic and atomistic theories sustained through naturalist

approaches and the biological conception of mental health in particular. In this chapter, I have also shown how the dimensions of structure, expression and embodiment are realized in the individualized narratives that accompany the use of antidepressants. For one, these transfer the control and management of emotion and feeling to the level of the individual. Aided by antidepressants people are able to get a hold of the parts of their lives that threaten to get out of control. While the exposure to these medications and instruction in their use may originate in a psychotherapeutic or psychiatric setting, I learned that a great deal of the effort that comes in learning how to use antidepressants is achieved by individuals as they come to terms with the new feelings and experiences introduced by medications. Moreover, in the attempt to gain a basic stability and equilibrium (“normalcy”) while taking medications, people frequently take their bodies as objects to be studied and surveyed. In this, the capacities of an expressive and communicative body are overshadowed by the more pressing need to get the body and self under control (Frank, 1995).

Structurally, I have argued that one of the consequences of the process of taking antidepressants is the formation of a split within the self, and more broadly, the development of a splitting narrative which gives form and meaning to the use of antidepressants. The idea that there are parts of the self that are not really part of the self is implied in antidepressant advertisements and the biomedical view more generally. However, for my purposes I was interested in the ways that these knowledges are integrated into everyday practices of antidepressant use and storytelling. Here antidepressants provide a technique for splitting the self into manageable components. I described how people learn to use antidepressants to make distinctions between the “me”

and “not me.” Antidepressants also help people to draw borders around their selves. By creating a “skin” between the self and the world, antidepressants allowed people to step back from overwhelming emotion, as well as external forces (such as taxing relationships which generate overwhelming emotion), to provide some space and freedom for selves. Here selves are further individualized, in the sense that they contract into what Giddens (1991) calls a protective cocoon. Indeed, in contrast to the view of narrative in which the self exists in a large interpersonal space of shared narratives and moral goods (Taylor, 1989), here selves are overwhelmed and suffocated when immersed in those larger spheres. This is a risk management strategy that allows people self-control despite the risks the proliferate both within the self and the surrounding world.

I also indicated that antidepressants could be viewed as a kind of ego-prosthetic. Writing in the 1970s and 1980s, psychoanalytically inspired cultural analysts such as Christopher Lasch (1978, 1984) argued that with the loss of shared narrative traditions (such as would be found in the ideas of family, nation and community) people protected their selves by falling back on psychological defense mechanisms. In this context, people became narcissistic selves. I have suggested a further development. While Lasch argued that people defend their selves by falling back upon an almost innate mental mechanism, I have suggested that in the stories I heard, antidepressants either supplement or take over from those other ego-mechanisms. The reasons for this shift are manifold, and I can only suggest a combination of psychological and socio-cultural factors. I risk generalizing from the 23 interviews conducted in the course of this study, but it is a generalization that resonates with the arguments developed in the analysis of antidepressant advertisements, and trends in contemporary social theory. For one, the proliferation of a risk mentality in

everyday life and the further erosion of community and shared narratives (Putnam, 2000) leaves persons more embattled than ever before. In a culture that both elaborates the potential risks encountered in everyday life, and shifts increasing responsibility for the management of those risks to individuals, people struggle to find resources to aid them in the management of these risks, especially when those risks are thought to emerge from within the self. Antidepressants enter as one more means of controlling and containing risk. Second, as Foucauldians argue, the antidepressants emerge as part of a set of discursive practices that constitute mental “illness” in relationship to antidepressants. So viewed, antidepressants become a necessary means of combating an entire range of severe psychological problems, but also the more mundane forms of sadness and worry that threaten to destabilize and disrupt selfhood. These views of self and suffering are increasingly bound to the political economy of BigPharma, which only benefits from the view that antidepressants can offer relief from a growing number of psychiatric conditions and more general psychological problems (Angell, 2004; Metzl and Angel, 2004).

Finally, the 20th century image of “psychological man” (Rieff, 1966) as both a moral good, and a resource for self-understanding, has suffered serious criticisms and defeats both in academia and in the popular culture. Images of people who gather together their psychological resources in order to overcome personal setbacks and defeats, are replaced by images of people who negotiate social life and its accompanying problems through an expertise and knowledge of cutting-edge technologies. Here antidepressant know-how becomes one more realm of expertise possessed not only by doctors and psychiatrists, but shared by lay-people through popular memoirs

(Blackbridge, 1997; Falk, 1995; Slater, 1999; Wurtzel, 1997), Internet chat rooms, and conversations with friends and family. Indeed, as Knorr-Cetina (2001) has argued, persons are increasingly selves not in relationship to others, but in relationship to machines and technologies. Relationship becomes a means through which people share information about the use of these technologies, rather than a medium, in itself, that can sustain and support selfhood. Donna Haraway's (1991a) concept of the "cyborg" has resonated widely not only because it announces the irreducible presence of non-human actors in everyday life, but also because it promotes the integration and pursuit cyborg existence as a positive and liberating ideal. While the people I spoke with did not pursue antidepressants in order to realize new forms of being (rather, as I will argue in the next chapter, the antidepressant narrative remains situated within modern frameworks of authenticity and self-control), they are certainly members of a culture where non-human technologies are increasingly admitted as necessary supplements and extensions of human agency. In this, the people I spoke with became experts in the use of antidepressants. They learned their particular rhythms and, in many cases, learned how to use antidepressants to control and manage unwanted aspects of their selves.

In this respect, antidepressants and the biological theories that accompany their use serve two purposes. First, they legitimize the view that depression and anxiety is a problem in the individual, and for the individual. Second, as a tool that can control unruly emotions, antidepressants provide individuals with the ability to handle risks that are otherwise too much for any single person to handle on their own. In the next chapter, I continue to examine this process of individualization as it enables to development of "positive" views of the self. That is I ask the question: If antidepressants allow people at

least some kind of freedom from depression and anxiety what do they do with this freedom? How does it influence the stories that people tell about their selves and the kind of selves that they would like to be?

Chapter 4 Notes

¹ David Karp's (1993, 1996) research on depression is particularly significant in the context of this dissertation. Karp, a symbolic interactionist sociologist, conducted interviews with depressed persons. A component of his research was a study of the encounter with antidepressants in which he described the transformation of identity that occurs as people begin to take antidepressant medication. In particular, Karp argues that successful treatment with antidepressant medication leads to an acceptance of the view that depression is a biological problem rather than a psycho-social problem. He details four phases in this "conversion" process. *Resistance* involves an initial reluctance to take antidepressant medications due to the stigma attached to their use. *Trial commitment* involves a compromise between doctor and patient in which the patient agrees to try antidepressants for a delimited period of time. *Conversion* is the phase in which, if the medications are successful, people accept the view that their depression is a biological problem. *Disenchantment* is a phase in which people temper their initial enthusiasm for the medication and recognize the limits and sometimes failures of antidepressant medications. The interviews conducted in this research suggest a similar pattern of identity transformation. There are nevertheless several important differences. First, Karp's study is primarily concerned with the conversion to the view that depression is a biological problem. This is also a concern in this chapter, but it is situated within the larger question of transformation in the structure of narrative and selfhood. Second, while Karp's analysis focuses on the transformation of identity from phase one through to phase four of his schema, the present analysis is concerned with the techniques and practices that situate antidepressant use. Unlike Karp who assumes a more or less stable self at the core of antidepressant use, I argue that the character of selfhood (especially in its narrative dimensions) is transformed in the use of antidepressants. In other words, for Karp the self remains a linguistic being while I argue that the techniques of self-interpretation are transformed in the use of antidepressant medications. Finally, though this research was not intended as an assessment of the adequacy of Karp's four phase schema it is not clear that his analysis holds for all the people that I interviewed. Given the widespread circulation (in advertising and in the media) of antidepressants, and the biological view of mental illness, the people that I spoke with did not as thoroughly resist the decision to take antidepressants as suggested by Karp. Though many appreciate the stigma associated with antidepressant medications most already accept the view that depression is a biological problem. If there is a conversion of belief it is to the view that people are in fact depressed in the first place. As I describe at a later point in the chapter, most of the people I spoke with did not know they were depressed or anxious or bipolar until they were told so by their psychiatrists or family physicians.

² There are also other kinds of metaphors: the role that antidepressants play in larger narratives of self (which will be discussed in the next chapter, e.g. "they helped me to become myself again"), and the role that the antidepressants play in relationship to other people (which will be discussed in chapter 6, e.g. "they allowed me to be there for others")

³ For example, the Homeric and field theory narratives described by Simon (1978, see chapter 2), the narratives of family and tradition described by Rieff (1966) and Lasch (1979, 1984), the community narratives described by Putnam (2000), and psychoanalytic narratives that privilege the analysis of childhood family dramas and the therapeutic relationship. The point is not whether the narrative takes the "individual" as the center of analysis but rather the character of the space in which self-narrative unfolds. Even though the prize of psychoanalysis is a stable, self-aware individual, the character of this knowledge is assumed to emerge out of childhood relationships and it is given expression in the psychotherapeutic relationships. In contrast, the naturalist view takes internal biological states as a primary source of self and pathology. Dilemmas of selfhood are worked out through the manipulation and transformation of these individual biological states.

⁴ Further, Kathy Charmaz (1983) argues that the experience of chronic illness can lead to a loss of self.

⁵ Further, the distinction between types of people or severity of suffering is not so clear cut. I hesitate to draw too fine a line between, for example, those who primarily complain of anxiety and those who primarily complain of depression. Though I spoke with both types of people, the metaphors used to describe disruption are frequently mixed. Furthermore, some people who diagnosed themselves (with the aid of a family physician or counselor) as depressed or dysthymic talked extensively about social anxiety and perpetual worry, than about depression, and the anxious described moments of weepiness and

punishing self-hatred. This is not helped by the fact that SSRIs are prescribed for both depression, anxiety, and more general everyday complaints.

⁶ To be clear, I describe Kristeva not in order to provide a full-fledged account of the origins of depression, but in order to contrast Kristeva's "narrative" and "semiotic" solution, to the solution offered through biomedicine. Indeed, it is unclear whether all of the people I spoke with suffer from the kind of melancholia and depression described in Kristeva's book. Some characterize themselves as clinically depressed, some as bi-polar, others as mildly dysthymic, and others as anxious and obsessive. Furthermore, these diagnoses are rarely offered by psychiatrists (and never psychoanalysts), more often by physicians and counselors, and sometimes they appear as self-diagnoses based on characterizations of depression and anxiety weaned from the culture more generally (e.g. from the antidepressant advertisements). For this reason, the relationship between specific kinds of psychological suffering and the disruption of narrative is not the focus of this chapter. Rather, the interest is in a general difference between approaches that seek to restore narrative disruption, disorientation and the loss of self-control through expressive activity, such as self-narration, and those which see narrative and expression as peripheral to the task of overcoming suffering.

⁷ In Kristeva's (1989) view object loss is a universal feature of psychological life, that has become particularly problematic for the depressed person. This object loss is first experienced in the separation between child and mother. The mourning for the loss of this primordial relationship is an *impossible* mourning because the wholeness and integrity attributed to the mother's body is an unrealizable ideal, though the influence of this ideal is powerful in both individual psychological life, and cultural expressions.

⁸ For Kristeva, following on Freud ([1917]1984) and Klein ([1957]2002), depression is a mourning for an object to which one feels both love and hate. The challenge of narrating depression is recognizing this ambivalence for the lost object and at the same time freeing the self from the hold that the lost object exercises over the self.

⁹ This is similar to Howard Becker's (1953) claim about people who arrive at the decision to try marijuana. Until the time that they first try the drug, the marijuana user only knows that other people use it to "get high." Similarly with most of the people that I spoke with there is only a general knowledge that people use antidepressants to overcome depression. Becker adds that a new understanding of marijuana emerges through concrete practices. Becker writes "He knows that others use it to 'get high,' but he does not know what this means in concrete terms. He is curious about the experience, ignorant of what it may turn out to be, and afraid that it may be more than he bargained for" (1953: 236).

¹⁰ The idea that antidepressants take three to four weeks to work was common knowledge for all for all of the people with whom I spoke. Nevertheless, while for some people the antidepressants took three to four weeks to work, for others significant changes were experienced within 3 or 4 hours, or sometimes within days.

¹¹ Why then does Katrina stay on the medications? It is not necessarily because she could not live with unmedicated depression. Rather, as will be discussed further in chapters 5 and 6 Katrina continues to take medications because they seem to positively affect her son's behavior, and because they allow her to "save face" before the courts which are overseeing her divorce and custody proceedings.

¹² While the extremities and side-effects varied from person to person, everyone I spoke with described some side-effects. These might have been a minor inconvenience, as when Zareen described her head-ache the first day she started taking the medication. In this case, the side-effects did not cause any major problem or call for a long-lasting attention to her transformed body. In other cases, such as Katrina, the side-effect of the medications leads to an ongoing effort to find stability and a basic feeling of normalcy.

¹³ Medical sociologists have described a similar period of adjustment when people first start to experience the onset of chronic illness (Bury, 1982). The difference here of course is that the people I spoke with are adjusting to the effects of medication, and more generally, the feeling of being a "normal" self. What is striking is that insofar as antidepressants are said to restore normal selfhood, this normalcy is something that has been learned from the body up

¹⁴ For others, there may be a relief in the idea that if they stop taking the medications, they can finally give up the battle (with the depression, with the worries of everyday life, with the medications themselves), and tempt annihilation.

¹⁵ This should be distinguished from the idea developed by people like Peter Kramer (1993) and philosopher Carl Elliot (2003) that antidepressants allow people to feel "better than well." Indeed, Barbara

takes offense at the idea that medicines make people better than well. Rather, as she puts it, by bringing serotonin levels up to normal they allow people to feel the way that they should feel.

¹⁶ This review of splitting is based on James Grotstein's (1981) book *Splitting and Projective Identification*.

¹⁷ According to Grotstein (1981) other important contributors to the psychoanalytic theory of splitting include W. R. D. Fairburn, W. D. Winnicott, H. Rosenfeld, W. Bion, H. Kohut, and M. Mahler. These theorists either contributed to Klein's formulation of splitting (e.g. Klein modified her theory of schizoid processes in order to accommodate Fairburn's conceptualization of the paranoid-schizoid phase of development) or developed the object relations tradition through further analysis and theoretical work on the concept of splitting. A full review and comparative analysis is provided by Grotstein.

¹⁸ This is an important claim that must be further qualified. With the exception of three people that I spoke with, everyone had participated in some kind of psychotherapy. Without a more intimate knowledge of what happened in those psychotherapeutic settings I cannot make strong claims about the relationship between psychotherapy and antidepressants. However, I did ask the people that I spoke with to name or describe the kind of psychotherapy that they had undertaken. Consistent with larger professional trends, most people described "cognitive-behavioral" therapies that emphasized work on developing coping strategies and the elimination of harmful, untrue, or unrealistic thoughts. Michael was the only person to indicate that he had participated in and found value in a form of psychodynamic therapy. Furthermore, psychotherapy was oftentimes viewed as a short-term process that helped people to get themselves back on their feet, rather than the more extensive self-examination employed in psychoanalytic therapy. Jesse likened psychotherapy to a "tune-up" – something that he does only when he begins to feel particularly out of joint and disoriented. Indeed, the effectiveness of antidepressants allowed people to live without therapy. Many, such as Joanna, Zareen and Jennifer stopped counseling once the antidepressants started to help them feel better. Finally, where for many people, psychotherapy was seen to be something that is an important part of treatment, it was not as fundamental as the use of antidepressants. Antidepressants were something that provided people with a fundamental stability – a means of living in the world – and psychotherapy was something that taught people how to better organize and run their lives. This included learning what antidepressants were and why they worked as they did. Thus, for example, Samantha indicated that one of the most important accomplishments of psychiatric counseling was coming to an understanding that depression was not a part of her self, but rather that it was something caused by a biological imbalance.

¹⁹ Though as I have suggested earlier numerous critics are wary of the science behind antidepressants.

²⁰ The one person, Natalia, who did not draw this conclusion had taken Prozac for four years and had stopped within the last year. Only recently, she had been told by a friend that depression is caused by a chemical imbalance in the brain and that antidepressants restore that imbalance. Natalia was surprised and mistrustful of this explanation. She did not give much thought to why the antidepressants worked, and was the only person who believed that depression was a product of personal weakness rather than a blameless biological condition. Unlike other participants, Natalia thought of depression as a part of her self which reflects badly on her capacity to live a good life.

²¹ And the criticism that people who take antidepressants are using an easy or quick solution to problems that they should handle on their own.

²² Though a few, such as Barbara, who had learned how to use antidepressants many years before I spoke with her, were skeptical about the ability of psychiatrists to help her and tell her what was wrong with her. Instead, she took the pragmatic decision to treat antidepressants as something that she controlled, and about which she could make personal decisions. The visit to the psychiatrist was viewed only as an opportunity to get her prescription filled.

Chapter 5: The Transformation of Authenticity

What we ought to be doing is fighting over the meaning of authenticity, and from the standpoint developed here, we ought to be trying to persuade people that self-fulfillment, so far from excluding unconditional relationships and moral demands beyond the self actually requires these in some form. The struggle ought not to be over authenticity, for or against, but about it, defining its proper meaning. We ought to be trying to lift the culture back up, closer to its motivating ideal. (Taylor, 1991, p. 73)

Well for me it was like, I was ok, and then for a long time I was someone else, but now I'm back....but even better. (Jennifer, illustration of "return-to-self" narrative)

I guess it's different for me because I was diagnosed when I was real young, so I only know, I don't really have anything to, I guess this is also a part of it, that I don't really have anything to relate back to. I can't really say "Well this is me when I'm not on medication," because the last time I really wasn't on medication was when I was 12, 13 years old. (Samantha, illustration of "always-been-ill" narrative)

One of the most intriguing claims made in the advertisements is that antidepressants make people feel like their selves again.¹ What does it mean to be like oneself again? What does it feel like to be oneself again? In chapter three I showed how this was an idealized construction of the self built on impossible fantasies of wholeness and plenitude lacking in narrative depth. In chapter four, I showed that the recovery of self, if it is something that happens, is never a clear-cut before-and-after narrative, but

frequently involves commitment to a new set of practices and an understanding of intractable depression or anxiety as something that is “not me.” In addition, though my intent was to emphasize the splitting mechanism, I also hinted at the normative elements in self-recovery. For example, people begin to experiment with medications in order to get a feel for their normal, chemically balanced self, and they come to conclusions about the make-up of their self as it exists in that healthy state. The encounter with antidepressants, then, is never simply a search for relief, but it is also driven by ideals and narratives of what it means to be a good self, a happy self, or a self that can be in the world with others. In this chapter my aim is to more carefully examine the narratives of self which embed antidepressant narratives.

The first of the three quotations above frames the relationship between narrative and selfhood that I pursue in this chapter. In particular I am interested in the ways that the concept of authenticity informs and is transformed within antidepressant narratives. Taylor argues that contemporary conceptions of selfhood inherit modern concerns with authenticity and the problem of being a “real” self. Authenticity is, in Taylor’s terms, a moral source of crucial significance for understanding contemporary selfhood. It describes the sense in which, for many, to be true and full human beings we need to be in touch with our inner selves (1991, p. 26). The concept of authenticity acquires its unique character through 18th century Romanticism. Romanticism was a cultural and intellectual movement that responded to the abstract instrumentality advocated in Enlightenment thought.² In addition to informing many popular conceptions of selfhood, Romanticism also shapes the hermeneutic and narrative conception of self that informs this dissertation. In contrast to the emphasis on disengagement, utility and self-control

represented in the writings of philosophers such as John Locke, Romanticism pursued an organic and holistic conception of selfhood. Charles Guignon (2004) argues that there are three important components of the romantic conception of authenticity. First, it sought to recover a sense of oneness and wholeness. Where scientific reason opposed human beings to the natural world, Romanticism sought to re-embed human beings in a universe of deep natural sources. Second, romanticism developed the idea that truth is discovered through an immersion in feeling. Here romanticism valorized not only the importance of “being in touch with oneself” but also the expression of these feelings in creative and imaginative activity -- especially through art. Indeed, according to Taylor (1989), this immersion in feeling gains its power and its urgency from the idea that human activity expresses deep, natural currents. To turn inward, in this sense, is to find the power of nature within oneself. This requirement was further articulated with themes of originality and individuality. Taylor argues that the notion of authenticity was grounded in the view that people were only being true to themselves when they were able to put themselves in touch with those elements which were most unique to the individual. The immersion in feeling gives rise to a kind of dialectic in which expression mediates and makes available the hidden forces of nature. This view provides the basis for a pursuit of self-understanding; a theory of self-knowledge in which the story of one’s life becomes an ongoing attempt to better articulate these most crucial elements of human nature. Taylor distinguishes this from earlier traditions in which selfhood was located in a religious cosmology:

To see what is new in this, we have to see the analogy to earlier moral views, where being in touch with some source – God, say, or the Idea of the Good – was

considered essential to full being. Only now the source we have to connect with is deep in us. This is part of the massive subjective turn of modern culture, a new form of inwardness, in which we come to think of ourselves as beings with inner depths. (1991: 26)

Finally, the romantic notion of authenticity was tied to the idea that the *self* is the highest and most encompassing of all that is found in reality (Guignon, 2004). In these romantic origins, self understanding was not to be achieved through scientific investigation and study, but through expressive activities that, at one and the same time, put people in touch with the deepest sources of their being, and made these aspects of themselves available to others. True selfhood is found deep inside and it can only be accessed through creative expression. This Romantic view of selfhood is opposed to views that would locate selfhood in external sources, such as religious hierarchy, and it is opposed to utilitarian and scientific views that see selfhood as a byproduct of efforts to maximize pleasure and reduce pain. The self becomes a good in itself; a higher metaphysical ideal and valued endpoint. Indeed, as valued endpoint the ideas of self-realization and self-fulfillment come to inform narrative self-understanding, wherein the story of one's life increasingly comes to be seen as the pursuit of authentic self-realization.

This particular source of self-understanding has of course come under criticism from postmodern and poststructuralist scholars. Postmodernists, such as Kenneth Gergen (1991), argue that, in the postmodern information society, the self is saturated, fragmented and dissolved into the relationships and possible identities made available through, for example, exposure to television and film. This structural transformation undermines the possibility that people could discover the integrity and wholeness

prioritized by Romanticism. For Gergen (1991) authenticity is an outdated ideal, the hopeless pursuit of which causes a form of existential grief that he calls “multiphrenia” (p. 73). Indeed, for Gergen, given the growth of information and travel technologies the ideal of authenticity has little time to live. He suggests that western selves are becoming postmodern selves, characterized more by their ability to change identities from moment to moment and situation to situation, rather than to cultivate a prized inner core. Something similar is indicated in the proliferation of postmodern and poststructuralist theories that see contemporary selves as cyborgs (Haraway, 1991a), machinic assemblages (Deleuze & Guattari, 1988), postsocial beings (Knorr-Cetina, 2001), somatic individuals (Rose, 2004) or biosocial beings (Rabinow, 1992). For many of these theorists, the language of authenticity no longer resonates with the structural and cultural conditions of the time in which we live.

Why, then, talk about authenticity? The opening quotation from Taylor guides me here. Even as social and cultural theorists deconstruct the concept of authentic selfhood, the idea remains a powerful force and aspiration within contemporary cultures (especially western cultures). It is an ideal that informs self-understanding and shapes conduct in everyday life. This is evident in the self-help culture (Guignon, 2004) where figures such as Oprah Winfrey (“Oprah”) and Phillip C. McGraw (“Dr. Phil”) encourage people to find the “*you* that can be found at your absolute core” (McGraw quoted in Guignon, 2004, p. 2). Another instance is found in the antidepressant advertisements which promise that Prozac, Paxil or Zoloft could help people to *become their selves again*. Indeed, in this latter instance the notion of authenticity is integrated into biological theories of the self. This is captured in neuroscientist Joseph LeDoux’s (2003) claim that

the essence of the self is within the brain. Here the development of biomedical technologies and knowledges (and antidepressants in particular) do not necessarily undermine the aspiration toward authentic selfhood. Rather as they move from the laboratory, or mental hospital, into everyday life, the meaning and uses of antidepressants are transformed in order to meet the needs of selves as they go about their everyday activities. Indeed, Arthur Frank (1995) argues that in illness narratives, the concept of authenticity becomes an important resource for combating the objectifying and colonizing languages of western medicine. He writes that “speaking in a voice recognizable as one’s own becomes increasingly difficult, so speech proliferates in search of that voice. Self-stories proliferate” (p. 71). Of course, the ubiquity of the language of authenticity is not necessarily a point disputed by postmodern and poststructuralist scholars. The problem for them, rather, is the way that this ideal constitutes and disciplines neo-liberal subjects, and enforces dominant ideals such as integrity, stability and self-responsibility (Rose, 1996).

This is where I see the important difference between Taylor’s approach and the approach developed in postmodern and poststructuralist thought. Taylor, of course, is also critical of many contemporary manifestations of authenticity discourse. Most troubling for him is the manner in which these dislocate the language of authenticity from its cultural, historical and interpersonal moorings. Contemporary accounts oftentimes cover-over the situated, narrative and dialogical character of contemporary selfhood and treat selfhood as if it were a natural fact rather than an historical, cultural and interpersonal achievement. Furthermore, the idealization of authenticity hides the problems that come with the concept. In particular, as it has manifested in popular

discourse, authenticity gives rise to a “soft relativism” in which people are unable to challenge one another’s view through appeal to reason or shared values (Taylor, 1991: 21). Each person is seen to have their own means of knowing what is good for them and what feels right for them. This, as I have tried to show in the previous chapters, is a kind of individualization which grants tremendous authority and responsibility to individual selves, but also closes narrative down around the self. In the contemporary culture the authentic self is frequently a lonesome self unable to realize the transformative potential of interpersonal narration and dialogue.

However, even though the language of authenticity and selfhood has taken this atomizing turn, it need not be sloughed off as a useless ideal. Indeed, Taylor argues that the very fact that these concerns have become central to many people in contemporary western cultures means that we cannot simply deconstruct or abandon them. They are indispensable and, for many, the best languages available for making sense of their lives. This is why Taylor is equally critical of both the naturalism and the poststructuralism described in chapter two: He writes:

Once we have established our best possible account of the questions we have to take seriously in order to actually live our lives, once we have clarified, in other words, what the ontological assumptions are that we can’t help making in practice as we go about the business of living, where in heaven or earth could the epistemological arguments come from that should convince us that we are wrong? (1988: 56)

In other words, despite the critical deconstruction of concepts such as authenticity and selfhood, social theory must also be able to account for the ways in which people make

sense of their lives as they go about their everyday activities.³ In the previous chapter, I demonstrated some of the ways in which people use antidepressants to find relief from suffering, and to achieve a modicum of stability and normalcy. I introduced the concept of *ego-prosthetic* in order to describe how antidepressants can become extensions of what, at one time, would have been seen as psychological capacities. No doubt, this characterization approximates what the poststructuralists and postmodernists refer to as postsociality, cyborgian selfhood, or somatic selfhood. However, beyond this, the people that I spoke with embedded their use of antidepressants within languages of authenticity and self-control. The antidepressants, as Jennifer says in one of the quotations that opens this chapter, helped her to come back to herself. This remains an important aspiration for Jennifer, as well as a framework that makes sense of her recovery from an inexplicable depression.

Given the continuing relevance of these kinds of values and aspirations, the critical project is not one of replacing these languages, but rather of deepening their meaning by placing them within the cultural and dialogical processes that give them birth. For people like Taylor, the project of deepening the meaning of contemporary languages of selfhood involves an historical recovery of the *sources of the self*. He shows that many of the contemporary features of selfhood gain their importance, significance and enduring weight through an historical process whereby these become part of the taken-for-granted background of everyday life.⁴ Thus, even though the relationship between contemporary uses of authenticity and their cultural origins have been “thinned out,” the hermeneutic project involves resituating selfhood within these moral sources. In part, for Taylor this offers a way out of the groundlessness and malaise experienced by

contemporary persons. In this chapter I attempt to deepen the meaning of authenticity by locating it in the kinds of traditions described by Taylor, but also by describing the ways in which these languages are used within contemporary contexts – in particular – the practice and use of antidepressants.

The narratives of the people I spoke with retain a sense of the importance of being a real self – of finding a “core” that can ground one’s position in the world, and organize the unfolding narrative of self. I divide the depiction of this search for selfhood into two narrative types: *return-to-self* narratives and *always-been-ill* narratives.⁵ The opening quotation from Jennifer represents the general structure of the narratives of about eight of the people that I interviewed.⁶ In this return-to-self narrative, people experience their mental illness as a sudden and inexplicable interruption in their life. The antidepressants allow them to return to a state of well-being that they remember from before the loss of self. In some cases, the remembered self is only a few months distant. In other cases, as with Jesse, the former self is many years in the past. Now thirty, Jesse locates his lost selfhood at around age twelve or thirteen. This was the time when something inexplicably changed in his personality. He went from being interested in arts and literature, to a person with poor school grades and a “rebellious” attitude. This soon led to an involvement with illicit drugs, and many years as an alcoholic. Jesse says that for those years his life stalled, and it is only now, with the help of the antidepressants, and some important life choices, that he can get back to the interests and passions that animated him when he was so much younger.

Samantha tell an always-been-ill narrative. She has a lot to say about her self and her hopes and her aspirations, but these do not benefit from a memory of a former self.

She says that because she has been on medications since the age of thirteen she has no clear memory of a time when she felt like herself. Her narrative is representative of about ten of the people that I interviewed (see footnote 6). They have either been ill or on medication for such a long time that they either have no prior reference for their self, or at least have forgotten what their self feels like. In some cases, these people strive for some kind of “authentic” or “natural” selfhood. This speaks to the continuing power of the idea that people have some kind of inner, real self – a personal identity that is uniquely one’s own. Even though the lives of people who tell always-been-ill narratives remain closely bound to their illness, they continue to strive after a glimpse or experience of their real selfhood. Whether or not people seek a return to self or seek some previously unrealized encounter with self, the narratives vary in terms of the extent to which antidepressants allow people to realize selfhood. In some cases, the antidepressants return people to their selves, or allow them to develop a new sense of self. In other cases, medications provide relief, but they also confound the effort to be one’s real self. Sometimes, as we learned with Katrina in the previous chapter, antidepressants can introduce a blend and mix of challenges which further confound the quest for selfhood – in these cases, whether remembered or anticipated, selfhood remains an unrealizable ideal.⁷

It should be clear from this brief discussion that the distinction between return-to-self and always-been-ill narratives also makes sense of the role that memory plays in constituting the story of self. In return-to-self narratives, people possess memories of an idealized past – oftentimes including a depiction of a happy childhood, and life, up to the first encounter with depression or anxiety. In the always-been-ill narratives, childhood memories anticipate the later development of a full-fledged psychological condition.

Hence the story of the self is one in which a person was *always already* predisposed to illness, even if it was not recognized at the time. Indeed, these childhood indicators are frequently seen as indicators only once the biomedical definition of self has been discovered. In the end, the question is whether antidepressants help people to return to a lost state of selfhood, or whether they help people to overcome a longstanding aberration in the self, and therefore give them the opportunity to be themselves for the first time ever. This characterization, of course, is not a neutral characterization but reflects the interests of this chapter. I wanted to know whether the concept of authenticity, so central to modern and popular contemporary definitions of selfhood, played a role in the way that people spoke about their selves and their encounter with antidepressants.

I divide the remainder of this chapter into two sections. In this first I discuss the return to self narrative and show how it embodies the notion of authentic selfhood. I further describe how in comparison to romantic and hermeneutic conceptions, the idea of authenticity and the way in which it is realized, is transformed through the use of antidepressants. Even though being true to oneself and being a “real” self is important to many of the people I spoke with, precisely how that authenticity is achieved and what it means for people takes on a new character in the antidepressant era. Building on some claims introduced in chapter four I argue that, more than anything, authenticity is described as the *feeling* of being oneself. This demonstrates a lineage with the romantic view that authenticity requires an immersion in feeling, but it also uncouples the relationship between feeling and expression that was also important to romanticism.

In the second section, I discuss the always-been-ill narrative. In some instances, when the medications fail to work, the always-been-ill narratives are characterized by a

strong split between the self that has always-been-ill, and the natural self that people hope, or imagine, lies beneath the illness and medication. In cases where the medication is described as working, since the person who has always-been-ill has no prior reference for selfhood, they take pride in the control and discipline that they demonstrate in learning to contain their illness. Here authenticity is further articulated with themes of utility and self control; more pragmatic than the return-to-self narrative, the people who have always-been-ill define their selfhood through their encounter with illness.

The Return to Self

Joanna tells a tight, linear story that depicts the return-to-self narrative, and in particular, highlights the theme of authenticity -- the desire to find fulfillment in one's own unique self. Joanna is 20 years old and a student at the university. She had a perfectly happy childhood. Her family provided a supportive environment where she felt no "pressure." She was successful in sports, and as Joanna remembers it, her teachers thought of her as a conscientious student. Nevertheless, when she came to university, Joanna lost herself. She wanted to be, what she called, a "real person": someone who reads literature, cooks organic food, talks about music, and passionately discusses ideas. Yet she was troubled by her inability to find like-minded people at the university. Her roommates ate at McDonald's and wanted to party more than they wanted to discuss what they were learning in class.⁸ In light of this, Joanna found greater joy in the relationship with her parents than with people at the university. Even if on the telephone, her parents were excited to talk with her about art, music, philosophy, and religion. Even though Joanna had tried to become herself at the university, she kept coming home to find the real selfhood that she had imagined awaited her in the outside world.

In many ways, then, this first part of Joanna's story is typical of many middle class young people. She values independence, self-expression, and wants to be the kind of bohemian authentic self cultivated at universities.⁹ But when she moves into this adult-world she feels cut-off from others and misses the comfort, care and even authenticity that she realizes, in retrospect, her parents provided. She wavers back and forth between her parents, and the challenge of being an independent individual in the world. This is also when Joanna was overcome by her first depression:

I fell into this little bout of depression. I couldn't eat for like a month and I got really depressed and I remember um I took myself to the mental health center because I was like "what is wrong with me" – I couldn't sleep um I didn't sleep for like two weeks and I was like "Oh my God, what is going on" nothing like this had ever happened to me before. (Joanna, student, age 21)

The psychologist told her that she had signs of clinical depression and an eating disorder. Surprised by this news – she had never thought of herself as someone who could have either of these things -- Joanna immediately "snapped" out of the depression, and did not return to the psychologist's office. She began a romance with a friend from her past, and through this, she says, realized some authentic selfhood. In this relationship she was really able to be "herself":

Just having fun and not even realizing that you're having fun, and just saying whatever you want to say and being whatever you want to be, and having someone who's sitting next to you, or sitting across from you, like love the person you are, just because...you're you.

This is a theme that Joanna returns to throughout our conversations. The self, in this view, does not reside in its achievements, relationships or qualities. It is free from the determining qualities or constraints imposed by image or outward appearance. It is something like an essence possessed by individuals. It is worthy of appreciation and expression just because it is one's self, and it desperately wants to be loved for simply being that self. Real, authentic selfhood – the kind of selfhood worthy of love -- is paradoxically, a disembodied, contentless selfhood.¹⁰

Though this kind of selfhood is imagined by many of the people I spoke with, it is particularly relevant for Joanna, who soon developed a full blown eating disorder. Despite the fact that in her mind she should have been happy, Joanna was overcome by an obsession with “skinniness.” In the context of the current discussion, her interpretation of the onset is insightful. She figured that even though she had found happiness in her authentic romantic relationship, she was also fearful that her real and independent self would be absorbed into the relationship. She was feeling crowded in, as if she might stop being her real self. At least in its initial stages, Joanna thinks, her eating disorder was an attempt to distinguish herself as a truly unique person – someone who would catch everyone's attention. “I was unique from others, and I had wanted to be unique because that was honest. But I was like going way too far, and it was like I was unique because I was bones.”

But the eating disorder also took Joanna's self. It turned her into a person who she does not recognize or understand to this day.¹¹ For Joanna, then, this period in her life is lost time – a time during which she lost herself to inconceivable forces. Where in the past she had loved to eat, now it was an overwhelming burden to her. She lost close contact

with her parents, left her boyfriend, and developed no meaningful relationships at the university. The climactic point comes when one very tough night she looked in the mirror and said “Oh my God, I have anorexia.” This is a sudden and dizzying transformation in identity. She recognizes herself as someone who is not “normal” but has an “illness.” She seeks psychotherapy but also begins a process of mourning brought on by the loss of her anorexic identity. Joanna was overcome by a depression unlike anything she had felt before: she experienced a deep emptiness, she was hopeless, she was always crying, and despite her choice to get well, she was unable to “get work done” in psychotherapy. With the help of her psychologist and psychiatrist, she learned to recognize this intractable sadness as biological depression, and was prescribed Lexapro.¹²

Within this story Lexapro becomes meaningful as the medication that helped Joanna to become herself again. Even though Joanna had taken the first step to get the help for her eating disorder, she said that Lexapro was the only thing that could remind her what it feels like to be herself. In the months after she had admitted her anorexic identity, Joanna walked around in a depressive and anxious daze unable to look people in the eye. Once the Lexapro started working:

I could now *remember* what it felt like, and like just to *remind* me of these little things, and to actually notice things and to notice other people, not just get lo.. be lost in my head (emphasis added).

In the midst of anorexia and depression, Joanna now sees that she had misinterpreted what it meant to be authentic. She had confused authenticity with outward appearance. The medicine brought her to a place where she could remember the self who could “love the person you are, just because...you’re you.” Catharine, another person I spoke with,

expressed a similar sentiment. She lost herself to a serious depression which led to a suicide attempt. She hoped that the antidepressants would make her into the self that she was in high school. Finally, after experimenting with two other antidepressants, Zoloft brought her to the point where she could experience some kind of comfortable selfhood:

It was one of the first nice days that we had, and I was like: "It's so cool being me," and it stopped me dead in my tracks. I called my psychologist and said: "Do you know that it's cool to be me," and he's like "It is," and I was like "Yes it's just finally." And that was about two months after I was on the Zoloft that I felt that. (Catharine, active duty navy, age 21)

Like Joanna, Catharine has passed through her depression in order to return to the point where she could simply appreciate herself for being herself.

In allowing a return to self, Lexapro participates in the narrative magic described in chapter three. The "real" Joanna had become stuck in time, and her narrative had taken a course determined by her biological make-up. Some, like Catharine, believe that this biological make-up is inherited. They can list all the people in their families who have suffered from some kind of psychological illness, and believe that events in their lives drew out an inevitable encounter with depression. Joanna, however, says that she can't be certain. She thinks that her biological imbalance might have something to do with a genetic heritage, but she has no evidence of this. It is more likely that the depression was caused by events in the social world. These could have "triggered" biological imbalance so that her biology took over from her self at a certain point in her life. In contrast to the inherited imbalance which inevitably builds up over time, Joanna's imbalance emerges in the course of everyday events. Lexapro resets the chemical levels, and allows Joanna to

start over again from before the point where she lost control of her life. By reminding Joanna of what it feels like to be herself, the Lexapro allows her to jump back over the year of suffering and misery to the selfhood that she knew before she got caught up in her illness.

However, the return-to-self narrative also works another kind of magic. Even as antidepressants help people to become themselves again, they consistently allow people to become better selves. In this respect, return-to-self is not just a jump back. It is also a movement forward, and an experience that provides the hope of better days ahead. This is what Jennifer means when she says “I’m back...but even better.” It is also what Jesse is doing when he returns to the age of 12 or 13. He becomes the self he was at that time in his life, but he is also able to reject parts of that self which he now knows are destructive. Though at age 12 he aspired to be an artist, he now realizes that the creative romanticism and rebellion that came with being an artist was detrimental to his personal development. So instead he retains the enthusiasm, excitement, and essential motivation that drove him at that age, rather than its particular expression in art work.

Joanna, it will be recalled, never resolved her struggle to be an authentic self. She sought selfhood at the university, then in conversations with her parents, then with a boyfriend who reminded her of the past, and then, according to her interpretation, she sought some kind of authenticity in thinness. Before the anorexia took over, she lived in an emotionally charged ambivalent state, unable to decide who she was. Thus, when Joanna says that the medication returns her to herself, she does not mean the self that was caught up in all this psychological turmoil. Instead, through a combination of antidepressants and psychotherapy she is able to recover the *essence of the feeling of*

being a self that, in retrospect, she associates with the aspirations and ideals of that entire period of her life. Individuals who successfully return to self, not only “start up again where they left off,” but they, in a sense, re-inhabit what it was like *to want to be* that self, in that time and in that place. In chapter four I introduced the idea that the antidepressants enabled people to approximate *feeling states* that they described as normalcy. This also becomes an important idea in the return-to-self narrative. More than anything, authenticity is described as the *feeling* of being oneself. This indicates a connection to the romantic view that authenticity requires an immersion in feeling. However, the relationship between feeling and selfhood has also undergone a significant transformation. In romantic views coming in touch with feeling was coupled with expressive activities. The immersion in feeling was part of an activity of self-expression and hence self-discovery. As such, being in touch with one’s inner feeling was also a means of restoring a connection with nature as well as with other people.

Feeling is something different here. It is an end in itself – feeling like oneself is akin to settling into a familiar and safe space – the feeling of being oneself. And consistent with what has been said about the dangers presented in a risk society and the need for selves to cocoon and draw borders around themselves, here being a real self is interpreted as finding a solid ground out of which one can safely engage the surrounding world. Authentic selfhood is not merely a metaphysical ideal – a pursuit worthy in itself – but it is also a palliative – an idealized way of feeling that gives the embattled individual a place out of which to live. In this respect, the comfort of authentic selfhood brings an end to the conflict that animated Joanna’s previous struggle for authenticity. It imposes a closure upon the narrative tension of that earlier time, through the valorization of an

indefinite but comforting feeling. Here memory provides Joanna with an ideal or lost selfhood that she can now rely upon to make sense of the changes wrought by the antidepressants. In these kinds of narratives, memory offers up *states of feeling* that sustain people in their attempts to overcome suffering, and move their own lives forward.

Let me develop this idea through another example that emphasizes the idea of recovering the feeling of being oneself. Katrina is a forty-seven year old acupuncturist-in-training. She is also the mother of a young boy, and, when I interviewed her, she was in the midst of a very troubling divorce and court-battle for custody of her son. The narrative that she told begins in high school, when her class was visited by a famous American author. He encouraged the students to live an adventurous life in search of new experiences. Katrina enthusiastically followed this advice and moved to New York, where for years she pursued a high energy, ambitious lifestyle. In fact, even though she now thinks she should have lived with greater “balance,” Katrina sees an important part of herself in this energetic lifestyle.

Katrina’s ability to be herself depends upon getting a certain feeling back. This feeling is interpreted through changing frameworks of self-understanding. At two different times in her life, Katrina describes two different effects of the antidepressants. Here, I suggest, the feeling given by the antidepressants is not so much a product of the particular nuances of the medication (the medical argument) so much as it is grounded in the aspirations of self at the time (the hermeneutic argument). When she first tried Prozac, in the late 1980s, Katrina was struggling to retain the energy of her New York lifestyle. The medication gave her a boost so that she was able to carry on for a short time longer:

P: I felt, um, sort of like a can-do spirit. My guess is I just got burnt out, and it started with a psychical thing, on one hand, and emotional, and people, and life, and interaction, and experiences on the other. And the two kind of ran down and burned down their selves and each other until they needed an infusion of something, and that infusion, it was almost like the Michelangelo Sistine Chapel thing. That infusion. That spark.

I: Are you talking about the Prozac when you talk about the infusion?

P: Yeah. The stuff, it's just a re-igniting, um, little sparks. It was stoking my ability to rev up my own life source. The Chinese have a word for it: Chi.

(Katrina, acupuncturist, age 47)

Understood through the Taoist philosophical framework that Katrina now cites, the medications helped her to recover the life source that she had lost. She gets back into that high-energy mode of life. This allowed her to continue the adventurous lifestyle, pursue her dream job, and dump a boyfriend who was threatening her autonomy.

More recently, Katrina is a mother, seeking balance, and trying to make the best life possible for her son, despite the court-battle and her struggle with depression. In this context, when it is working, Lexapro allows her to experience momentary pleasures in the midst of a necessarily hectic and overwhelming lifeworld. Here she simulates a moment shared with her son. She says to him:

“Hey we’ve got some fresh laundry. Don’t you love the way the jeans feel when they’re fresh out of the dryer,” you know, to “let’s make pancakes.”

And in our second conversation, describing the effects of antidepressants, she identifies this moment again and says:

Just pleasure in little things, and just being able to acknowledge these wonderful things and wonderful tidbits. Just life.

Here, Katrina is not overcome by worry, sadness, or the grueling court-battle. She is able to live in the moment, and “link” with her son.¹³ Katrina does not necessarily think that she finds her real or authentic self in these moments. There are other parts of her self as well: a dedicated advocate for children’s rights, an acupuncturist, and a person curious and knowledgeable about science and medicine. However, what I am trying to emphasize is that when these medications work, they bring Katrina a certain *transparency of feeling*, an ability to just *be-in-the-world* without doubt or internal conflict. In these moments, her desire to enjoy her son and simply be there for him matches her feeling state. Indeed, this is a tremendous accomplishment for Katrina. Even though she had some success with Prozac in the late 1980s, and early 1990s, at present she is having trouble finding a medication that works properly. As will be recalled from last chapter’s discussion, Katrina says that the medications create splits within herself. She tries to realize a transparency of feeling and action, but is often left with the feeling that she is just “faking it.” From the outside it looks like she’s living in the moment, happy and connected with others, while on the inside she is sad and depressed. From this perspective, antidepressants are medicines that help people to pretend to feel like authentic selves, and the return to self is more like an accomplishment for others than it is the self-discovery that modern culture (and antidepressant ads) wish it to be.

Return-to-self narratives are an accomplishment that depend upon a combination of discursive practices and modes of feeling. In particular, I want to emphasize the idea of feeling, because it captures something important about the selfhood enabled through

antidepressant medication and the form that authenticity increasingly takes in a biomedical culture. In chapter four, I detailed the way in which the use of antidepressant medications draw attention toward the body, and the different ways that the body can feel: off medication, on medication, on different medications, on medications combined with various kinds of exercise and diet, and many other combinations. This gives people a feel for depression and anxiety. It also gives them a feel for their selves. Clearly, it would be too strong to claim that people no longer come to know themselves through conversation, self-reflection, and the active construction of life through narrative – *a hermeneutics of the word*. Many of the people I spoke with tell rich stories and work through their selves in conversation and reflection. Furthermore, they often tell me how they learned about themselves and their particular behavior patterns through psychotherapy. However, my point is that antidepressant medications are the kind of technology that place the language of self second to the feeling of self. People come to know themselves through a process wherein selfhood is increasingly known and discovered through the approximation of feeling – *a hermeneutics of the body*. It is not as important to tell the story of one's life as it is to recover a memory of self through feeling. This provides a grounding for action in the present and a hope for personal development in the future.

This has several other implications which speak to way in which the ideal of authenticity is realized in the use of antidepressants. In addition to emphasizing the importance of expressive activity for self-realization, some variants of romantic thought privileged the encounter with dark forces within the self (Guignon, 2004). Even though nature was conceived as the well-spring for expressive activity, nature was also viewed as

a force that can be unpredictable and dangerous. For many romantics, the quest for self involved a journey into the darkest centers of the self. Here romantic expressivism also impacted theories of art and in particular the relationship between art and madness. The madman – even the depressive melancholic – was viewed as a creative hero because he came in touch with parts of himself that others did not dare to approach. In the work of writers such as de Sade, Rimbaud, Bataille and Artaud we find the idea that being authentic is a matter of “expressing all that is brutal and ugly” and of the “flouting of social norms in name of madness and violence” (Guignon, 2004: 105). Similarly, antipsychiatrist R. D Laing rebelled against the medical psychiatry of the 1950s and 1960s precisely because it’s instrumentality threatened to silence the authentic voice of madness. This view – that madness can be a source of creative and authentic selfhood -- makes its way into some of the narratives that I heard. Duyen, for example, suffers from a bipolar disorder and believes that in taking medications she cuts herself off from a creative spirit generated in the manic phases of her illness. So too, Jesse prized the rebellious artist that he remembers from his childhood, but fears the melancholia that accompanies that form of self-expression.¹⁴

More generally, though, the biomedical narrative leaves no room for a connection between authentic creativity and madness. In his recent *Against Depression*, Peter Kramer (2005) vehemently argues against the idea that depression can be a source of creativity and inspiration – a necessary component of artistic work. This is a view shared by most of the people who I interviewed. It speaks to the larger sense in which contemporary conceptions of authenticity are rarely located in a deep expressive interior. Indeed, where, according to Taylor, romantic expressivism depended upon a notion of the

self's deep interior (a place in which nature's energies swarmed), the biomedical view fills up that space with the material of neurons and neurotransmitters. In chapter four I argued that antidepressants are individualizing technologies that, in many cases, help people to erect protective barriers between themselves and the world around them. Here I am suggesting something further. Antidepressants are part of a larger discourse that hollows out the inner self, cutting that space off as a resource for self-understanding. In the biomedical society, unpredictable and dangerous, the unfathomable interior depths of human beings become risky interiors. Indeed, I would suggest that the deep interior of the self becomes risky because of the paucity of shared narratives that could help people to mediate their relationship with these kinds of spaces. In biomedical narratives, authenticity is a valued aspiration for the self, but it assumes a much more defensive stance. It allows people to recover the parts of themselves that they remember to have provided them with comfort and stability. In this, authenticity is something experienced and felt on the "surface" of the body, rather than accessed through an encounter with deep inner forces.

Second, where the romantic conception of authenticity emerged as a response to the instrumental and disengaged reason of Enlightenment science, in these narratives, science and technology serve the interests of authentic selfhood. Antidepressant technologies have the capacity to put people in touch with the feeling of being one's self. No doubt, the older view, in which authenticity was opposed to science and technology, is present in the interviews that I conducted. For example, as David Karp (1996) has also noted, the decision to begin taking antidepressants oftentimes requires that people overcome the worry that they are taking an easy route out, or that by taking

antidepressants they are not being true to themselves. However, with the exception of Tara (who came to see anxiety as an important part of her authentic self) and Natalia (who believed that she could not be her real self while taking antidepressants because they were an artificial solution), everyone I spoke with overcame these initial fears and, as I argued in chapter four, came to see depression or anxiety as a illness that was not a part of themselves, but rather an illness that posed a danger to their selves – a risk to be managed. Constituted as such, antidepressants become the kind of technology that does not, by definition, occlude the self. Rather, antidepressants are the kind of technology that can clear the way to authentic selfhood. As such, when antidepressants fail to restore the feeling of being oneself, it is not because antidepressants are opposed to selfhood, but rather that the individual has not yet discovered the right combination of medications that would enable the freedom to feel like oneself. In this respect, the promise that antidepressants can restore selfhood encourages the formation of a quest narrative, wherein the pursuit of selfhood is bound to a search for the right medication, psychotherapy, and other lifestyle considerations (e.g. diet and exercise).

In these examples, I've highlighted the idea that feeling, experienced in the present, is made meaningful when it is interpreted as a return to a former, better place in one's life. In this context, the central dynamic in the return-to-self narrative is this attempt to settle into a remembered "habitus" of the body. In its freedom from suffering, and relative lack of psychological conflict, the habitus of a remembered self comes to feel like the real self. For a few of the people I talked with, this return of selfhood was a quick and easy accomplishment; a seemingly natural recovery of something lost to biological imbalance. However, in the vast number of cases, such recovery was tentative,

momentary and oftentimes only imagined. The efficacy of antidepressants was not convincing, nor was the widespread claim that antidepressants “make you into yourself again.” Indeed, as the memory of the feeling of one’s real self recedes under the weight of illness and/or medication, the return-to-self narrative loses contact with the present and is replaced by an always-been-ill narrative.

Always Been Ill

While the return-to-self narrative emphasizes an immersion in the feeling of selfhood, the always-been-ill narrative is characterized by the elusiveness of this feeling. Even though these people talk about real and authentic selves, they have never, or at least rarely, experience, what others call, the feeling of selfhood. In some cases this is because they have always suffered from psychological illness, and therefore do not have experience with the kinds of happiness, peacefulness and authenticity that they take to be the social norm. In other cases, this is because they have been on medication for so long that they have forgotten what it feels like to be their real selves – the self they imagine existed before collapse. Barbara, for example, has suffered since her childhood. After her depressed father committed suicide, she knew that she was “tainted” – different from other people. She started taking antidepressants later in life, though for her there was always a sense that medication was inevitable for her. Fearful of the stigma that comes with antidepressant medication, she held out until she could no longer deny that she was constitutionally depressed and that it wasn’t just going to go away. Prozac was a success for her. It helped with chronic low-level depression and allowed her to get by in everyday life. She was no longer sad and weepy all of the time, and was able to get out of bed, go to work, and take care of her daughter on a consistent basis.

Though she continues to struggle with depression, Barbara says of the medication: “I think this is who I naturally would be.” The wording is important. On the one hand, “naturally” draws together biological and authenticity themes. Since Barbara has no point of comparison from within her own life, she infers that her real self is the self that emerges when Prozac balances her brain chemistry. On the other hand, Barbara describes herself in the future perfect tense – the self I *would be*. This is not the self that she is by default, or that she knows from memory. Instead, it is the self that emerges when the medications are working well. It is a selfhood that is never certain, and that is forever bound to her chronic depression and the medication. In contrast to the self assumed in the return-to-self narrative, this strikes me as an especially unstable selfhood. It does not have the support and comfort provided by the memory of a better time. There is no existing narrative structure that could “coddle” the self. Instead, the self depends upon the whim of psychiatric medications and, more than anything, is constituted through activities in the present – just getting by, gaining control over emotions, and finding spaces of relief. Barbara says: “you know happiness is a great idea, but right now I’m just shooting for security.” Indeed, in general, I found that the always-been-ill narratives had an edge and cynicism which was lacking in the more optimistic return-to-self narratives.

I’ll draw out further features of the always-been-ill narrative with Angela’s story. Angela, 59, is one of the most troubled people with whom I spoke. She was also one of the most passionate, articulate, and deeply concerned about the fate of her self. She has been diagnosed with mixed bipolar disorder, and says she has been on hundreds of different medications over the past 25 years, including all of the SSRIs, except Lexapro. Currently she is taking a tri-cyclic antidepressant as well as numerous anti-psychotics and

anti-seizure medications. Where in the past, someone like Angela likely would have been hospitalized, the medications have allowed her to maintain a functional everyday existence, and she has never spent any time in hospital. Though she is now on disability insurance, she was trained with a Master's degree in social work, and up until several years ago held a full-time job. While Angela's story, and the kind of medications she is taking, are certainly not the norm among the people with whom I spoke,¹⁵ I think that Angela's self-understanding draws-out features of the biomedical self that function less discretely in other narratives. In its extremities, Angela's narrative clarifies the always-been-ill narrative.

Though Angela's troubles did not fully emerge until she was in her twenties, she traces her bipolar disorder to genetics: "Well statistics are that one in three children of a person who has manic-depressive disorder has it, and I got it. My mother has three kids. I got it." In both of our conversations she referred to a childhood episode which, in her mind, is clear evidence that she was bipolar even back then:

I'm very sensitive to people who are in pain, and I want to help. This goes right into what I've done [with work]. When I was a child, I will always remember, I was found, maybe in fifth grade, I got up in the middle of the night to go to the bathroom and off of our bathroom ... was a part of the attic. It was freezing cold and in there were all our old dolls and they, you know, for some reason I remember they had no clothes on. So I covered them up. (Angela, 59, unemployed)

Throughout our conversations, Angela distinguished between behaviors that were caused by the bipolar illness, and those that were products of her real self. This "oversensitivity"

is an early example of something caused by the illness.¹⁶ In contrast to the return-to-self narrative, the always-been-ill narrative evokes memories in order to demonstrate the longstanding, inevitable character of illness. Indeed, if these memories help Angela to re-inhabit a feeling state, it is a feeling of coldness, vulnerability and coming illness. As she grows older, the illness becomes more intense and her sensitivity wreaks increasing havoc in her life. Now, Angela says, she acts impulsively and responds excessively both to things that excite her, and to things that cause her misery. She has no control over these behaviors and outbursts. Indeed, throughout our first conversation, Angela “performed” and demonstrated the mood swings that characterized her everyday life. One moment, as she described the misery of depression she was weeping. In the next, she was talking excitedly about her illness. In another moment she was complaining loudly about the pharmaceutical companies and their simplified, cynical misrepresentation of depression.¹⁷

My purpose in this project is not to determine what causes particular kinds of psychological distress, but rather to describe the ways that people understand and talk about their selves and suffering. This said, it is important to add that even though Angela believes her bipolar illness is caused by a worsening biological condition, her “social” story is extremely distressing. She was married to an abusive husband, with whom she had two children. She eventually left this man and, for a while, cared for her two children on a slim budget. Despite these efforts, she lost her children to him in an aggressive and humiliating court battle. At least in the story I heard, the emergence of Angela’s illness coincides with these marital and legal abuses. This ex-husband continues to occupy an important position in her life story. Angela told me that several months ago, when her

psychiatrist changed her medication, she had terrible dreams in which she was haunted by this man.¹⁸ The distress brought-on by these events also caused isolation and trouble at the workplace. She lost her job because of her angry outbursts and unpredictable behavior. After that, her illness further deepened. In another interpretive framework, these social and interpersonal abuses, rather than an appeal to biology, might have been enough to account for Angela's suffering and near total loss of self. Whether or not Angela's condition is best described as biological, it is certain that the biological account of psychological distress covers over and denigrates the social roots of Angela's suffering.

The always-been-ill narrative reconstructs a life so that all events point to the inevitability of illness. This inevitability is tied to the biological theory of self. In contrast to the return-to-self narrative in which the medications free people up to feel like themselves, here the self is *fated* to a lifelong struggle with illness. This demonstrates the different ways in which return-to-self and always been-ill narratives manage time. In the return-to-self narrative, the antidepressants allow people to seize control of their destiny, and guide the course of their lives, even if it is through a return to an earlier state of selfhood. In the always-been-ill narratives, the self may acquire some freedom and breathing room, but the course of its life depends upon the course taken by an illness.

The always-been-ill narrative provides for a complicated relationship with authentic selfhood. Indeed, even though the real self is a distant and evanescent feeling, it retains a position in the always-been-ill narrative. It does not necessarily drive the story – people are not in search of their real selves – but it is recognized as an important

component of their being. Right from the start of our first interview, Angela told me that she has three “Mes”:

Ok. I’ll tell you this. I have three mes, and they’re all intertwined...so it’s very difficult some times, a lot of times to figure out which one is me. I have the effect of the medicine. I have myself...and I have the depression.

The bipolar illness/depression is the most miserable aspect of her life. When it is at its worst she just wants to be “wiped out.” There is no doubt for Angela that she needs the medication. When she stops taking it, she loses control of herself and is overtaken by her illness. She becomes a danger to herself and to others.

At the same time, the medication does not cure illness or bring her closer to herself. Instead, it creates a compromise state in which she is neither wracked by illness, nor in-touch with her self. The medication is like “an overlay onto the depression.” It covers depression up, but it doesn’t take it away. “It’s like paint over paint, and when you remove the paint, there it is.” At the same time, the medication makes her self into a different person.

It’s like it creates a different person. They try -- the doctors and the medicines they choose -- they try to create a person, or character, or personality, or a state of mind that is able to exist as well as possible, as effective[ly]...in today’s world. And, um, in doing that it changes some of you.

For one, she says, the medicine destroys the “continuity” of self. Angela offers a description of the typical progress narrative:

You know your self is a continuum. Along that line you learn from experiences, and you grow psychically and psychologically.

However, the medications make the self “stale.” In Angela’s case, by controlling emotion the medicine puts her out of touch with emotion. As a result, the narrative of her self is frozen in time. In this frozen state, Angela *knows* that she has a self which she values. She lists interests and passions: studying art, collecting coal miner’s scrip, helping other people, her sense of humor, and her surprising optimism. However, she is rarely able to take pleasure in those aspects of self. In contrast to those who tell return-to-self narratives, Angela cannot return to a moment of “pure” selfhood in which she is free from the forces of depression, or the effects of medication.¹⁹

Teresa, who thinks of herself as someone who has always suffered from low-level depression, is in a similar, though more hopeful position. I say hopeful because, unlike Angela, Teresa does not feel that her life is under threat when she is not taking the medications. She can live without antidepressants and, in fact, has done so for the last six months, because she lost insurance coverage for her medications. Teresa knows herself as someone who is kind and sensitive and caring. However, this selfhood has always been accompanied by a perpetual sadness that makes her feel empty. She has always known herself through this sadness. She stayed on Prozac for three years in the hope of defeating the dysthymia. However, the medication didn’t work very well and it changed her personality. She became short-tempered and impatient. The self that she thought of herself as – kind, caring, helpful -- was lost to the medication. Nevertheless, even if the medication really worked, she told me that it would not return her to a former selfhood. This was impossible because she had never known a self independent of depression. Instead, “it would be like the next level in my life. Like I went from this low level, then I stepped up to something else.” Teresa cannot say exactly what this self would be like or

feel like, only that she knows that the depression would be gone, and she would still have the capacity for kindness and caring.

Both Angela and Teresa have an idea of who they are and what they would like to be, but the feeling of being this kind of self is elusive. It is present as a memory or ideal, but it is not inhabited as a feeling. This *distanced self knowledge* is an important feature of the always-been-ill narrative. Selfhood – as the authentic real me – is something long-gone or buried beneath a cloud of depression and medication. Yet it remains accessible as a source of self-knowledge -- “I know this is who I *would be*” – through inferences and *secondary* “data” sources. Parents or friends might remind someone of a time when they were different than they are now. Or, at least, they might tell the person stories about the self they had expected them to become. Distanced self knowledge can also be derived from one’s own actions. Though a person might lose “feelingful” contact with their self, they nevertheless infer from their own actions that they must still have a self, somewhere inside. In this part of the interview, we were talking about Angela’s optimism:

P: Yeah an idealistic kind of thing, and that makes me a fighter. You know it never occurs to me not to keep doing, not to keep, although you know I want to just give up but I don’t.

I: Where is this coming from?

P: Angela, I think.

I: This is Angela?

P: There’s some personality elements that come through and

I: And that’s what keeps you going?

P: And that’s a battle.

I: And you have a lot of faith in that Angela.

P: No. I don't have any. Well no. The sense of loss of yourself is so great that it's almost subconscious. It's not a conscious fight at all. Although I know I do it. You know, never, it never, it never occurs to me to not try another medication even though...

Angela's refusal of my comment, "and you have a lot of faith in that Angela" reveals the unfamiliarity and desperation of Angela's experience. This "fighting personality" is not a self that grounds Angela's everyday life. It is not a source of sustenance in which she can immerse herself when times get tough. Though on the surface it may appear to be a heroic progress narrative – Angela continuing to fight the monster of her depressive illness against all odds – in her experience the narrative lacks that kind of self-fulfilling meaning. Even though the structure of the narrative resembles other narratives, it is not invested with the same self-sustaining meaning. She only knows that she's fighting her depression because she's still alive, and still trying new combinations of medications. She's not in touch with the force behind that fighting energy. For her, the self which undertakes this fighting is buried somewhere under the medication and the depression. It's "subconscious," and she only knows it through its surface signs.

Katrina, though I described her as telling a return-to-self narrative, shares this sentiment. Sometimes, she is in touch with her self, but more often than not she is split-apart and feels like she's faking her social performances. Katrina doesn't understand how she can be a depressed person -- which in her mind, by definition, is someone with no hope – and yet continue to seek new kinds of solutions, new kinds of medication. She infers that throughout all of her trials there must be a part of herself that is optimistic.

This contradiction perplexes her, and, even though she hopes for it, she finds no resolution in the medication. Distanced self knowledge doesn't necessarily offer hope, so much as it is a fact of life: "I keep fighting, therefore there must be something within me which does the fighting."

There is another aspect of the always-been-ill-narratives that I have not yet talked about. Thus far, I have emphasized the idea that in the always-been-ill narrative the feeling of being a self is elusive and at a distance. However, there are some always-been-ill stories in which people do acquire a feel for self. This selfhood is learned through the technologies and practices used to control depression, bipolar illness, severe anxiety, etc. For some people, especially those who tell return-to-self narratives, these technologies bring control over emotion and mood so that the greater end of renewed selfhood can be realized. However, especially for those who have no memory of a better or more authentic selfhood, the technologies provide an opportunity for defining one's self and one's purpose for the first time ever. In Taylor's sense, these are technologies that allow people to realize the valued modern theme of self-control. In the earlier part of this chapter, I emphasized the important role that the ideal of authenticity plays in constituting modern selves. It grows out of romanticism, and in return-to-self narratives, it is expressed as the feeling of being oneself again. In the always-been-ill narratives, the self-control enabled by antidepressants resonates with the values developed through a utilitarian tradition, which emphasizes the virtues of instrumental reason. This form of rationality is bound to modern conceptions of self-determining freedom, but it also gains it credibility in its relationship to another moral ideal which Taylor calls the "affirmation of ordinary life." He writes:

Another moral strain has entered the picture. What I call the affirmation of ordinary life, the sense that the life of production and reproduction, of work and the family, is what is important for us, has also made a crucial contribution, for it has made us give unprecedented importance to the production of the conditions of life in ever-wider scale. (1991: 194)

In contrast to return-to-self narratives that gain their sustenance from some kind of idealized former self, in many of these always-been-ill narratives sustenance comes from the virtue attached to the hard work that is realized in overcoming one's suffering, and the accompanying ability to go about one's life work. When the antidepressants are said to "work," these narratives are primarily forward looking. They leave behind a past filled with turmoil and confusion and open up to a future where illness has finally been put to the side. Indeed, this gets close to the description of late-modern selves advanced by Anthony Giddens. People, immersed in a risk society, become selves as they learn to "colonize the future" against anticipated risks (Giddens, 1991: 111). The people who have always-been-ill come to recognize the risk within themselves, and from this engagement, project a future with some freedom for the self.

Emma for example, has lived with depression and anxiety since her parents divorced. She has spent the last 20 or so years learning about the cycles of depression and the techniques – both chemical and cognitive-behavioral -- that she can use to control and avoid her illness. Recently, after a particularly bad relapse, Emma accepted her psychiatrist's word that she will always be depressed, and that, unless she stays on medication, the depression will worsen. Emma of course has all kinds of aspirations and personal values that define herself, but she continually returns to the theme of

functionality. The medication provides her with a relief from sadness and the “what if” thinking that defines her anxiety: what if I am gay? what if I have a brain tumor? what if I hurt somebody? In contrast to the lifetime of illness and the threat of its perpetual return, on medication, Emma is able to achieve a feeling of *normalcy*:

Feeling like I do when I feel normal. When *I* feel normal. I wanted to be like when I felt normal. So for me my normal is being able to function, not having these “what ifs” continually running through my head not feeling like I wanna bang my head against a wall to make them go away. That kind of stuff. I mean I just wanted to feel balanced I just wanted to feel normal. (Emma, university administrator, age 26)

Emma is careful to distinguish between normalcy as a shared convention – something to which everyone should aspire – and individual normalcy – a state of being, unique to each person. In this, of course, Emma also seeks the ideals of authenticity central to the contemporary culture. Each person has their own way of being a self, and of feeling normal. Using Emma’s logic, in the case of the return-to-self narrative, normalcy might mean returning to the kind of self that a person was in high school or in childhood, or at some other self-defining moment in the past. In Emma’s case, normalcy is defined in relationship to her struggle with illness. She is normal – and being herself – when she has control over her life and depression. For Emma, self-awareness comes through understanding her unique behavioral patterns, and how different kinds of medication, forms of exercise, and diet impact her ability to function efficiently and in control.

The ability to have this control brings with it a sense of accomplishment and self worth. Peter, who has just recently found the combination of medications that allows him

to exercise control over bipolar illness takes pride in the fact that he is diligent in his self-awareness. He knows how to monitor the relationship between his medication and his moods, so that when he starts losing control he can adjust the medications. He contextualizes this kind of self-knowledge by describing a visit to the psychiatrist to increase the dose of his medications:

I'll say I need some more, and they'll say "Well, why do you feel you need some more," and I'll start explaining some symptoms, and things like that, and I'll say that for the last couple of days I've taken the liberty of increasing it myself, and I've noticed a difference a positive difference, and they'll begin to think about it, and they'll process it, and consider it, and then they'll say "Ok we agree with you." I just present myself to them as somebody who's uh somebody who's remarkably in tune with my own sense of stability, or in tune with my lack of stability at times, and when they see this presentation, how I present myself this way, they have a tendency to respect that. I've had psychiatrists make the remark of "Peter you impress me as somebody who's who is really in-tune with how he feels." (Peter, student, age 33)

In this passage Peter depicts himself as an agent in control of his medication and hence his self. In this control he also finds "liberty" and freedom. Of course, it is not necessary for people to have struggled with illness all of their life – or for a very long time -- to take pride in their ability to watch over their moods. However, in the always-been-ill narratives this self-control assumes a uniquely important position. Since illness is understood as something that never disappears, self-control becomes a personal task and a necessary responsibility.

Finally, many of the people I spoke with believed that their hard-earned self-knowledge is something that can be of benefit to others. Peter wants to be a research psychologist so that he can further examine the science behind psychological disorder. In addition, one day he wants to write a personal memoir about his battle with bipolar disorder that can be an example for others. Emma says that she has learned something about suffering from her illness, and as a result is better able to understand and care for others who suffer like her. Though in certain instances, the self-control sought by Emma turns wholly inward upon the self (she believes that she must care for herself before she can care for others), it is also bound to an ethic of “practical benevolence” and a larger sense of social justice (Taylor, 1991: 106). Self-control is not simply a form of instrumental reason that colonizes the life-world of feeling and authentic selfhood, but it is also suffused with the hope of helping others through one’s own example. Emma wants to help others by living her everyday life with an attention to the disabilities and disadvantages of those around her, and she also wants to show others, like her, how to control and manage depression. This is a theme that recurs throughout the interviews. Many of the people I spoke with wanted to help overcome the stigma associated with antidepressant medications so that others need not suffer: a) the illness in the way that they have, and b) the fear of being labeled “crazy” or unusual.

In this context, always-been-ill narratives are intimately tied-up with the struggle to gain control over one’s self. This can result in a happy ending in which people finally gain the ability to control their moods and live in the world. It can also be a terribly unhappy story, like Angela’s, who uses the medications to get her moods under control, but gains no sense of accomplishment or pride from that control. Because she is so split

off from her self, she never gets the *feeling* that she is the force that is controlling her health. For Angela, control is not self-defining. It is just hanging-on. In the cases where self-control is an accomplishment, the stories become progress and stability narratives (Gergen, 1994c). Emma learns the truth of her condition and accepts her responsibilities as a person who is mentally ill. This is an expanded version of the splitting narrative described in the previous chapter. In some cases the splitting narrative occupies a small period within the larger story of a person's life. It fills-in what happened in the first few months of antidepressant treatment, before a person got a feel for themselves again, and got their life back on track. In Emma's and Peter's cases the micro-drama has been expanded, and it becomes the drama of their entire lives. In its first articulation, the value attached to this narrative comes from the idea that "I am being myself and acting with responsibility when I am taking care of myself and controlling my illness." Moreover, though on many accounts the antidepressants can be seen as technologies that colonize self and feeling within regimes of self-control, it is also clear that they are bound to ideals embedded in a powerful tradition of thought which sees technology as a means to improve the life of individuals, and social life more generally.

Conclusion

In this chapter I have introduced two kinds of narratives of self that accompany use of antidepressant medications: the return-to-self narrative and the always-been-ill narrative. I have focused on these two because they have provided an opportunity to discuss the relationship between antidepressants, selfhood and cultural ideals such as authenticity and self-control. The fact that I have discussed these as two more or less discrete kinds of narratives does not mean that they are mutually exclusive or that people

do not adopt different kinds of narratives at different times in their lives. It is possible I think that if people stay on antidepressants for a long enough time the feeling that they are really becoming themselves again might be lost to the sense that they have been on medications for a very long time and therefore have no sense of who they really are. At the same time, I suspect it is possible that people who have been on medications for many years could, one day discover a medication or a form of therapy or perhaps even a relationship that suddenly brings back a feeling of being a long-lost self. Indeed, in many cases the always-been-ill narrative is not defined by the absence of some kind of image or ideal of self, but rather by the inability to recover the feeling and ease and the transparency that they believe came with that sense of selfhood.

There are also other kinds of narratives that I have not discussed at length here because they do not capture as broad a swath of themes as the two chosen for elucidation. I'll say a few words about two especially interesting narratives. Jeremy, for example, told what I can only call a "suspension" narrative.²⁰ Despite two interviews, and numerous questions through which I attempted to get a sense of who he is or what events he thought defined his life and his self, Jeremy had no concrete vision of his past or his future. He is currently taking Zoloft for depression and he, of course, wants to continue to feel as good as he does on the medication. Of all the people I spoke with Jeremy is one of the few who was willing to call the antidepressants "happy-pills." They brought him a feeling of ecstasy. However, there is no sense that the medication returns him to a state of selfhood that he lost to illness, or that he gains any sense of satisfaction or self worth from his battle with illness. It is more like Jeremy is using the medications to freeze his life, and to put a hold on time so that he does not need to remember a past, or dream of a future. He

is happy to exist in a kind of suspended state of selfhood. This strategy, of course resonates with what I have been saying about selfhood from the start of the chapter. More than anything the antidepressants exist in a universe where selfhood is accomplished through feeling rather than explicit narrative construction. In Jeremy's case, this feeling is not contextualized through a personal narrative, it is simply an abstract feeling of relief, and joy at the fact that he has been able to buy himself some time before he has to start moving again.²¹

Natalia tells a different kind of narrative which holds onto the view that technologies, such as antidepressants, by definition occlude the self and render it inauthentic. Unlike every other person I spoke with, Natalia feels that she is to blame for her depression. For her, depression is something that comes from a personal inability to deal with a difficult situation. The flaw is in her personality rather than her brain. In this context, even though the antidepressants helped Natalia to get through a difficult period in her life, they do not help her to become her self again. She says that she might feel better, and she might feel like herself, but she knows that when she is feeling good and taking the antidepressants, this is not her real self. Her real self would be the self that feels good, and is able to handle life's problems, without antidepressants. Natalia, then, has been unable to construct a narrative in which she can be an authentic self and still take antidepressants. Indeed, Natalia's narrative is especially instructive because she is the only person I spoke with who hadn't heard that depression is a "real illness with real causes."²² She did not know that depression was caused by a drop in levels of brain serotonin. This is important because Natalia thought of antidepressants as supplements or add-ons – an additional boost to her otherwise normal (but depressed) self. In contrast,

those who think of depression as a change in brain chemistry are more likely to conclude that antidepressants aren't adding anything new to one's self, they are simply restoring what should already be there. For some, this also means that they are restoring a selfhood to which they are *naturally* entitled.

There are, no doubt, many other narrative types that are the product of various combinations of life experience, cultural background and effectiveness of medications. My point however has not been to make final claims about the number and types of narratives that people use to understand their encounter with antidepressants. Rather, I have been trying to show how the meaning of antidepressants is shaped by cultural frameworks and shared moral traditions. In this I have emphasized that people interpret their encounters with antidepressants through cultural frameworks that emphasize authenticity, but also self control. In the return-to-self narratives, antidepressants allow people to recover a selfhood overwhelmed by biological imbalance. The always-been-ill narratives also posit a real self, however in these stories that self is a distant memory or something that people have never really known. Here people take pride in the more pragmatic fact that they have been able to overcome and control an unruly aspect of their lives. This pride in self-control, of course, also makes appearances in the return-to-self narrative but it does not become the basis for a new kind of identity.

As noted at the outset of this chapter, rather than abandoning ideals such as authenticity and self control, Taylor suggests that the role of the social theorist is to situate these forms of self-understanding within larger cultural frameworks. The problem in other words, is to open up the use of antidepressants to dialogical and narrative understanding. This means two things. First, it means that we should see all human

activity as interpersonally and culturally situated. Second, it means that as situated activity we should also see the various forms of human activity and expression as forms of life worth arguing about – defending, criticizing, seeking a middle ground. This move is powerfully resisted in a culture that views depression and anxiety as biological problems located within the individual. In a large swath of human and social science research, as well as the popular representations of selfhood, people are believed to naturally possess selfhood. As I have argued throughout this dissertation this is a view in which relationship, conversation, and narrative understanding are all seen as ineffectual forms of self-care because they do not directly intervene at the biological core. Or, at a minimum, psychosocial solutions are seen to be inefficient because they modify biochemistry in a round-about fashion. Moreover, in the context of the present argument, this is a move that puts questions about selfhood out of bounds: What kinds of selves should we try to be? Should we even try to be selves? How should we be in the world for others? What should we do with deep sadness and worry? Selfhood (or at least the most important traits of oneself) is determined in advance – by one’s biological make-up. Or, more generously, in contemporary accounts, selfhood is something that emerges in the interaction between biological predispositions and the social and cultural variables that impact the development of genetic potential and brain structures. In either case, selfhood is not something argued about in itself, but rather an outcome of variables that work their magic on the brain. So too one’s predisposition to pathology is understood biologically, as are the solutions to psychological suffering and despair.

One response to this kind of biomedicalization is a full-hearted critique of biomedicine and antidepressant medications. This kind of critique falls back upon older

notions of authenticity – including versions inspired by romanticism – and necessarily sees technology as a form of instrumental reason that colonizes the self, and the capacity for authentic human relationships. Numerous social critics, and popular magazine authors, rally against the widespread use of these kinds of medications because they threaten visions of self that they argue have been fundamental to western cultures.²³ For example, Leon Kass (2003), head of the President’s Commission on Bioethics, worries that antidepressants provide an easy way out of everyday worries. In so doing, they rob people of encounters with “normal” experiences of sadness and worry that would, in earlier times, have led to the development and formation of strong “character.” Insofar as antidepressants smooth-over the life course, they are also said to diminish the importance and meaning of suffering in human life. In this, human beings increasingly become inauthentic beings – artificial creations propped up by mind and mood altering substances. Natalia was the one person that I spoke with who expressed this sentiment. She worried that as long as she was taking antidepressants she could never be her real self (even if she felt good) because, by default, the act of taking antidepressants contaminates selfhood. There is of course something to be said for this critique, especially the worry that in becoming immune to personal suffering people also become unable to recognize the vulnerability and pain in others.

Nevertheless, I think that this critique goes too far. For one, none of the people that I spoke with could be said to be free from, or immune to, suffering. In fact, as I pointed out in chapter four, the antidepressants oftentimes create new challenges and new forms of suffering. And further, in defining themselves as ill many that I spoke with came to view themselves as vulnerable persons, despite their newfound strength. Emma was

only one of many who told me that her experience with antidepressants led to a greater sensitivity for the suffering of others. Rather than eliminating their capacity for care, sympathy and ethical engagement with the world, the encounter with antidepressants opened up new forms of interpersonal care. Second, this kind of criticism fails to recognize that the choice to take antidepressants is one in which there are few other available solutions in the contemporary culture. The narrative and interpersonal structures, as well as the spaces in which people could restore their selves unaided by medication, have all but disappeared. As a result, for many, the opportunity to work through their problems in talk psychotherapy, find sustenance in community organizations, or simply live through their suffering in order to develop a stronger character (if this is valued) are either unavailable, unaffordable or too time consuming.

More importantly, I think, this kind of critique does not pay attention to the way in which people who take antidepressants are actually drawing on the moral traditions and aspirations that the critics uphold. Most people who spoke with me were worried about the stigma attached to the use of medications, and in particular the view that in taking these medications they were taking an easy way out, or acting inauthentically. They prized the virtue of authenticity, and sought to describe how they realized it, or at least sought to realize it, through the use of antidepressants. This is not to say that these kinds of authenticity discourses are without their problems. The return-to-self narratives show that authenticity is articulated with individualizing and defensive strategies. Where in earlier visions, the search for authenticity was something that made selves available to others, in the current view it leans heavily toward a self-enclosed subjectivism where the wants and needs of the self are prioritized (out of necessity I think) over the position of

the self within larger frameworks. In becoming themselves again, people retreat into a nostalgic longing for a lost past or alternately, in the always been ill narratives, they strive for an idealized selfhood which they have never known, but seek to possess.

However, in closing this chapter what I want to emphasize is that despite this contraction of narrative around the self, the use of antidepressants also speaks to a longing for forms of relationship and sociality denied in other areas of the culture. “We should be arguing about the meaning of authenticity,” as Taylor says, not as a state easily achieved, but as a deep-seeded aspiration that unfolds dialogically, culturally, and within changing contexts. In this respect, the stories that people told to me were also arguments in defense of certain visions of self. Here narrative is not merely a recounting of the story of one’s life, but it is also an attempt to convince another (and the willingness of the other – me- to be convinced) about the worthiness of one’s life. Antidepressant narratives close in around the self and render selfhood a feeling state, rather than a deeply articulated resource for self and others, but this is not all. These narratives also express a deep care, and joy, for being a self, being true to that self, developing that self, and further, of being that self for others. Here being oneself – even if it is attenuated by the effects of antidepressants and the individualizing narratives that surround their use - is also recognized as a form of self-engagement that allows people to be in the world for others. In this respect, the experience of taking antidepressants is sometimes articulated with an ethic of benevolence and care. The *quest* for the right antidepressant becomes a story that can be shared with others. By citing *my* example – by testifying and bearing witness to the way that I have learned to overcome suffering through antidepressants -- I can also lead the way for others, and thereby make their suffering less painful and more bearable.

Emma now has a greater sympathy and empathy for those who suffer depression and anxiety. She wants to do everything that she can to destigmatize the practice of taking antidepressants, and to give people the opportunity to feel as strong and in control of their lives as possible. Jennifer has joined a campus group that educates people about depression and antidepressants. She does not want others to face the misery of depression alone. Peter wants to become a research psychologist so that he can better understand bipolar disorder and help other people who suffer from it. He also wants to write a memoir – give narrative expression to his experience – so that he can be a comfort to others. Angela sees herself as a part of a community of sufferers, and she tells me that she cares deeply for those others who suffer like her.

Here the work of social theory is not to describe these as postures rendered inauthentic by antidepressant medication, or to abandon the languages of authenticity that sustain these aspirations and hopes. Rather it is to emphasize and demonstrate the manner in which these are dialogical accomplishments, never given by a pill, but achieved through practical interpretative activities. These stories describe people's effort to be someone, despite a culture and society that seems to trip them up at every step.

Chapter 5 Notes

¹ This claim is not exclusive to antidepressant medications. It is an aspiration embodied in many products and advertisements. Indeed, it is an aspiration of the modern self. However, the claim seems especially important with antidepressant medications which, at least in theory, are said to act directly on elements of the self: mood and emotion. In this respect, antidepressant medications acquire a higher status as products that don't merely promise selfhood, but can give selfhood by altering the chemistry of the brain (see chapter 3).

² Romanticism is certainly not reducible to any single description. As a response to Enlightenment science and Industrial Revolution, romanticism was a movement that arose across western Europe (in Germany, France and England) and was also influential in America. I only describe some general features of Romanticism in order to ground the notion of authenticity and its relationship to contemporary selfhood. This summary relies primarily on Taylor (1989, 1991) and Guignon (2004).

³ In *Sources of the Self*, Taylor refers to this as the Best Account (BA) principle. It is the basis of his epistemological approach and distinguishes his work from both naturalism and poststructuralism (see chapter 2). He writes: "What we need to *explain* is people living their lives; the terms in which they cannot avoid living them cannot be removed from the explanandum, unless we can propose other terms in which they could live them more clairvoyantly. We cannot just leap outside of these terms altogether on the grounds that their logic doesn't fit some model of 'science' and that we know a priori that human beings must be explicable in this 'science.' This begs the question. How can we ever know that humans can be explained by any scientific theory *until* we actually explain how they live their lives in its terms?... This establishes what it means to 'make sense' of our lives, in the meaning of my statement above. The terms we select have to make sense across the whole range of both explanatory and life uses. The terms indispensable for the latter are part of the story that makes best sense to us, unless and until we can replace them with more clairvoyant substitutes. The result of this search for clairvoyance yields the best account we can give at any one time, and no epistemological or metaphysical considerations of a more general kind about science or nature can justify setting this aside. The best account in the above sense is trumps. Let me call this the BA principle" (1989: 58).

⁴ This no doubt depends upon the assumption that there are indeed forestructures – cultural, historical and embodied – that inform, make possible and serve as a backdrop to everyday life. Furthermore, the hermeneutic position assumes that it is possible to give expression – to give narrative form – to these forestructures – so that the background meaning of people's lives can become more clear. A deconstructionist such as Jacques Derrida would take aim at this very assumption and, indeed, in *Of Grammatology*, has shown that this kind of romanticism (in part developed out of the work of Jean Jacques Rousseau whose writing Derrida deconstructs throughout *Of Grammatology*) depends upon a western conceit that assumes a dichotomous distinction between an organic, holistic, natural, background of life and a rational, orderly, meaning carrying form of symbolic expression. Derrida is certainly correct in this assessment. However, as Taylor points out, this kind of critique does not mean that we need to wholeheartedly abandon the ideals that these kinds of distinctions embody. Rather, in recognizing their contingency it is also possible to compare and contrast the relative worth of such views.

⁵ The concept of a return-to-self narrative is described in French anthropologist Marc Augé's (2005) recent reflection on memory entitled *Oblivion*. He describes three "figures of oblivion" (by describing these as figures rather than mechanisms or processes, Augé emphasizes the ritual character of memory and forgetting). The ambition of the first figure, "return," is "to find a lost past again by forgetting the present" (p. 56). This, in part, influences my conceptualization of antidepressant medications as providing a return to self. Augé also describes two other figures of oblivion. The ambition of "suspense" is "to find the present by provisionally cutting itself off from the past and the future" (p. 56). My discussion of Jeremy's "suspension of self" captures this element of oblivion. The third figure of oblivion is the "rebeginning" which "aspires to find the future again by forgetting the past, to create the conditions for a new birth that, by definition, opens up into every possible future without having a single one" (p. 57). In some respect, the always-been-ill narrative provide for such a rebeginning, but the analogy is imperfect since in these stories the people I spoke with remain bound to the presence of illness through the ritual act of taking medication.

⁶ Early on in the narrative analysis it became clear that the ability to return to selfhood was a determining factor in how people understood the relationship between authentic selfhood and the antidepressants. These

distinctions are never clear-cut and hence operate as ideal-types intended to elucidate the interaction between antidepressants and the notion of authentic selfhood. In terms of data analysis, this distinction depended upon specific claims made by people about the relationship between antidepressants and selfhood. For those people who told return-to-self narratives, at some point in our conversations, they made a claim that the antidepressants helped them to feel like themselves again, allowed them to pick up where they left off, or put them back into the place where they were before they had experienced the narrative disruption discussed in the previous chapter. In addition to these kinds of claims it was also important that the people who told return-to-self narratives idealized this former state of selfhood, and recognized it as embodying their true potential as persons. Eight people, Joanna, Zareen, Jesse, Jennifer, Katrina, Catherine, Duyen, and Mary, told stories like this.

In the always-been-ill narratives, antidepressant efficacy cannot be measured by a return to a former state of selfhood because, as they understand their lives, these people have never had a real self to which they could return. They have “always-been-ill” (to varying degrees) and the presence of this illness – by definition at odds with selfhood – negates the possibility of a return to self. Ten people, Michael, Samantha, Peter, Barbara, Teresa, Emma, Rebecca, Angela, Wanda, and Louise, told these kinds of stories. This is not to say that these people who have always-been-ill cannot discover their “real” selves. However, this discovery depends upon the ability of the medication to bring some aspect of themselves forward which they have never known or felt. The narratives of the remaining five people are discussed in footnote 7, and at the end of this chapter.

⁷ Given that these distinctions are ideal-types no one person perfectly fits into either category. However there were those people whose stories were further a-field, and represented a different kind of relationship to self. Tara told a story that, in some ways, could be characterized as an always-been-ill narrative (she was anxious since she was a young child and she considers the possibility that this is due to a chemical imbalance). However, Tara believes that the medications do not help her at all, and she reaches the conclusion that they cannot help her. Her definition of self is tied to her anxiety (see chapter 2). It is not seen as an aberrant aspect of her personality, but defines what is authentic about her. Natalia, on the other hand, believes that she has a long lost authentic self, but that the medications, by definition, cannot help her to return to this selfhood. Certainly, the medications help Natalia. They help her to overcome her anxiety and depression. However, unlike every other person I spoke with, Natalia believes that, by definition, the use of antidepressants renders her inauthentic. Even if the medications help her to feel like she did before she suffered depression, the antidepressants make this an artificial and inauthentic achievement. She would only be her real self if she felt like herself again without the help of the antidepressants. Both Tara and Natalia tell stories in which the antidepressants make them into inauthentic selves. Jeremy is in a different category altogether. His encounter with antidepressants is neither informed by memories or by anticipations of the future. The antidepressants allow him to live in a state of suspension – they make him feel good, in the moment – and he wants to retain that feeling for as long as he can. There is a sense of a life calling to Jeremy that he doesn’t entirely want to engage.

Finally, I found it difficult to characterize the narratives of two of the people with whom I spoke. Most of the narratives possess a basic linearity. Even Jeremy, who suspends his relationship to past and future, nevertheless locates his self in a story moving from past to future. However, it is difficult for me to say whether Greta and Harvey understand themselves in some kind of linearity, or in relationship to the idea of selfhood. Certainly, both of these interviews were populated by discussion of previous events, and aspirations for their selves. However these events seemed to bear no clear relationship to one another. Their stories are not held together by a “narrative thread.” Greta’s story was complicated, because, in addition to suffering a severe depression, she also told me that she suffers from dissociative personality disorder. In addition to curtailing some of her depression, antidepressants helped Greta to integrate some of her diverse identities. Harvey’s discussion of antidepressants resonated with the analysis in the previous chapter, however, when it came to talking about the story of his life, Harvey seemed more interested in discussing sport’s scores and pool. These interests no doubt shaped Harvey’s sense of self and grounded his everyday pursuits, but he gave me no indication that “selfhood,” as a pursuit in itself, was of any interest to him. One thing this indicates is that the pursuit of self, indicated by the other twenty-one people with whom I spoke, should not be taken-for-granted. Not every narrative is informed by the idea that there is a self or at least can be a self, even though, as Taylor and others argue, it is an important source of knowledge in contemporary life. In short, in terms of self understanding, I am unable to say whether Harvey and Greta envision any relationship between antidepressants and selfhood. In this respect, these two individuals

expose either the theoretical limits of this dissertation, or my limitations as a researcher, unable to more fully imagine the lifeworlds of Harvey and Greta.

⁸ Here Joanna follows Ritzer (2000) in suggesting that there is something disenchanting about eating at fast food restaurants like McDonald's. According to Ritzer, McDonald's is a contemporary manifestation of the principles of "rationalization" described by Max Weber at the turn of the 20th century.

⁹ This kind of bohemian authentic selfhood is elaborately depicted in Elizabeth Wurtzel's famous memoir *Prozac Nation*. She writes: "It wasn't supposed to be this way. I was supposed to be an exotic little American princess, a beautiful and brilliant bespectacled literature student reading Foucault and Faulkner at my rolltop desk in my garret room with hardwood floors, full of whimsical plants and chimes hanging from the ceiling and posters of movie stars from the forties and bands from the sixties on the slightly paint-chipped ivory walls. There were going to be lots of herb tea and a beautiful Mediterranean hookah and paisley cushions and Oriental rugs on the floor so that I could run my own bohemian salon from my guileless little love pad. I wanted a futon with a thick crimson-colored bedspread where I could make love endless nights through sleepy mornings with my boyfriend, a guy who had grown up in Connecticut and played lacrosse and the guitar and me, and who loved me with naughty desire, respect and abandon" (95).

¹⁰ Joanna's description of her authentic self also seems to share in what Alford (2005) has called an "Orphic" freedom. Alford interviewed young people for their thoughts about freedom and found that, for the most part, freedom was equated with the desire to simply be free and take pleasure in the moment.

¹¹ A problem in itself. Despite psychotherapy and a commitment to self-understanding, Joanna cannot recognize this troubled, ill person as her self. She knows that it happened to her. She has learned about the causes of anorexia and can apply these to her experience. She also knows how to manage anorexia and depression. Nevertheless, this part of her life remains split-off from the rest of her life. It is a period during which she was "not me." Though Joanna one day hopes to have a deeper understanding of what happened to her, she is not sure if she'll even know.

¹² Though antidepressants are also prescribed for eating disorders, Joanna told me that she was given Lexapro for depression. In contrast to her description of depression as a biological imbalance, I was struck by Joanna's description of anorexia's psycho-social and cultural origins. Where she uses the language of biology to account for the origins of depression, she talks about the "culture of thinness" and its impact on girls' self image to explain the origin of anorexia. Though I do not have the data to support any broad claims, I am struck by the possibility that Joanna understands anorexia as a cultural problem and depression as a biological problem because they have been represented as such in the media.

¹³ This idea of being-in-the-moment is connected with the eastern philosophies described by Katrina. It has also been taken-up and popularized in contemporary popular American Humanistic psychologies. For example, the psychologist and researcher Mihayli Csikszentmihayli (1990) popularized the idea of "flow" in his self-help classic *Flow: The Psychology of Optimal Experience*. Flow occurs when a person gets caught-up in the moment, and time stands still. It allows people to be their unhindered selves, and gives rise to optimal creativity.

¹⁴ There are also mental health movement groups that try to balance the biomedical model of mental illness with these expressivist conceptions of authenticity. For example, the Icarus project (www.icarusproject.com) is an Internet community and support group for sufferers of bipolar disorder. Even though they advocate the use of psychiatric medications for the management of bipolar disorder, they also conceive of bipolar illness as more than an illness. Drawing on the mythological figure of Icarus – who flew too close to the sun – they imagine themselves as people endowed with a unique capacity for creativity. They have access to natural sources that others do not. In particular, members of the Icarus project wonder whether they would do much better in a society where their unpredictable behaviors and creative energies were valorized rather than feared and stigmatized.

¹⁵ Though I don't want to make too strong a claim here. Even people who were suffering from "milder" conditions had been prescribed some of the strong medications Angela was taking, e.g. "Neurontin" and "Lamictal"

¹⁶ Almost everyone I spoke with who suffered a mood disorder said that one of their problems was they were too sensitive. In their minds this is a valuable and noble personality trait, but in the contemporary world it is also a liability that leads to suffering. Antidepressants tone the sensitivity down both psychologically and physiologically.

¹⁷ I use the term "performance" carefully here. For one, it is a reference to the symbolic interactionist idea that selfhood is a performance for others (see especially Goffman's (1959) "dramaturgical" model).

Angela, who is speaking to me about her abnormal and uncontrollable self is also performing this uncontrol-ability for me. I return the favor by taking note of her performance, and for example, offering her a tissue when she begins to weep. The performative nature of our conversation is also emphasized when Angela continually points out her performance. She weeps and then tells me that this is evidence of her bipolar condition. She has trouble remembering a fact and tells me that this is evidence of the memory loss caused by her medications. According to Goffman, Angela's efforts to point out her performance would ruin the performance. However, in this case, Angela pulls off the performance because her demonstrations are attempts to show me how much she suffers.

¹⁸ Though not certain, Angela suggested that the change in medications made her more susceptible to these bad memories. In this kind of explanation she combines a psychoanalytic theory of the repressed unconscious with a biological theory of mental illness. Indeed, even though Angela holds to a biological theory of causation she relies upon psychoanalytic language throughout our conversations. At one point she said to me that even though it caused her distress, she was proud of the fact that her bipolar illness gave her greater access to her unconscious mind.

¹⁹ From a biological perspective, the "staleness" might be interpreted as a product of the combined effect of all the medications Angela is taking. In contrast, the SSRIs are promoted as medications that are more targeted and less complicated than Angela's cocktail. In theory, the SSRIs make people feel more like themselves because they don't "numb people out." However, I spoke with a number of people who were taking single SSRIs, but who shared Angela's experience – they felt disconnected and distant from their selves (see Chapter 4). The medication cut-off the tops-and-bottoms of emotions and it put the feeling of being a self at a distance from everyday life.

²⁰ As indicated in note five, this notion of "suspension," in part, benefits from Augé's (2005) discussion in *Oblivion*.

²¹ Jeremy also described this "resistance" to self-narration when he told me about his efforts in psychotherapy. Jeremy was frustrated with his therapist because the therapist always waited for Jeremy to talk. He would not tell Jeremy what to say. Jeremy thought that this was bad form because therapists should tell people about themselves and in that way help them to solve their problems. When we met for a second interview Jeremy told me that his previous therapy session had gone well because he had finally said something that got his therapists attention.

²² That is, her physician hadn't told her the serotonin story. She also hadn't taken note of any of the advertisements. She only recently learned from an acquaintance that depression may be caused by a chemical imbalance. Her question for me time and again was: Do they really have proof? Do the scientists really know this? When I asked her whether it would make a difference to her whether or not this was a biological condition she told me that it probably would because then she would not be to blame and she would not feel guilty. Nevertheless, she was going to hold onto her view until she had certain scientific proof.

²³ This kind of argument, it should be clear, is separate from the critique that antidepressants harm people, lead them to commit suicide, or bind them to the pharmaceutical industry. Peter Breggin (1995) is an example of a vocal critical – a kind of modern day antipsychiatrists – who critiques antidepressants on the grounds that they are "toxic" medicines. The criticism I am depicting here does not necessarily address the physical dangers of antidepressant use so much as the perceived moral and cultural dangers.

Chapter 6: Recognition, Self and Risk

Until this point, I have described the antidepressant narrative as an individual project and accomplishment. In chapters three and four I argued that even though the biomedical culture promises restored selfhood through antidepressant medications it generally leaves the person alone to discern this selfhood. Modern psychiatry builds a relationship between individuals and medications rather than between self and other, or self and community. In chapter five I argued that in using antidepressants people are able to realize modern ideals of authenticity. By putting aside otherwise intractable depression or anxiety people are freed-up to be the kinds of selves that they want to be. This is especially the case with the return-to-self narratives, though as I also showed, people who have always-been-ill are able to formulate identities around their struggles to control and contain illness.

In this chapter I want to examine the social aspects of antidepressant use and their relationship to the self. Even though antidepressants address the individual self, this formulation of selfhood unfolds in the context of larger social processes. I have assumed this from the start of the dissertation, and have shown how antidepressant narratives continually rely upon and integrate images and values available in the popular culture. For example, the ideas of authenticity and control are not “natural” aspirations of the self, but rather they emerge out of valued modern conceptualizations of the self. At least for some people, it is meaningful to be authentic because this idea has the weight and support of a tradition behind it. Furthermore, the idea of authenticity is deeply integrated into cultural expressions and social institutions. Television celebrities such as Oprah Winfrey and Dr. Phil McGraw claim that in order to be happy and successful, people must first

learn how to be true to themselves (Guigon, 2004). These visions of self are morality plays rehearsed and circulated in the media and in everyday interactions (Illouz, 2003).

In earlier chapters I have also relied upon the symbolic interactionist idea that people only become selves through symbolic exchange. According to this view, the self is always a social self and the idea of self-contained individuality is an illusion and futile aspiration. Early sociologists and pragmatist philosophers such as George Herbert Mead, Charles Horton Cooley and William James argued that selfhood only emerges when people are able to imagine themselves through the eyes of others. Cooley ([1902]1962) said that the self is always a “looking glass self.” And Mead ([1934]1962) described a developmental process in which children are first able to see themselves as their parents or caretakers see them (the “individual other”) and later as an entire imagined community sees them (the “generalized other”). In its most basic sense, this is what Taylor has in mind when he says that persons become selves when they orient and take up positions in relationship to the people with whom they share a culture and set of ideals. For Taylor, as well as the symbolic interactionists, selfhood is dialogical. It never exists within a single person but unfolds in a back and forth movement between persons.

The self-knowledge that comes with antidepressant medications is also dialogical. In much the same way that young children depend upon others to learn how their bodies should feel, and how they should stand in relationship to others, people who are taking antidepressants rely upon others to help sort out the relationship between the feelings aroused by antidepressants and their sense of self. Recall, for example Jennifer who, as I described in chapter four, asked her friend to help her decide whether the trembling in her hands was normal or abnormal. Jennifer did not know whether this was something that

the medications were doing or whether it was a part of her normal reaction to exercise. It only became clear that this was an effect of the medication when she asked her friend to observe her behavior. Or consider Michael. When he started taking antidepressants he told a few friends and family members to watch over him. Michael says:

There have been times in the past where I have told people so that they could kind of keep on eye out to see, to make sure that I wasn't freaking out. (Michael, computer programmer, age 43)

He was afraid that the medications would cause him to behave in ways that he could not recognize, and so he relied upon others to tell him whether he was behaving strangely. In this respect, Michael's efforts to come to terms with the use of antidepressants is analogous to what Howard Becker (1953, 1967) describes in his research on learning to use marijuana and LSD. In particular, in his study on marijuana users, Becker (1953) argued that three factors had to be met in order for a person to gain pleasure from smoking marijuana. First, a person needed to learn to smoke the drug in a way that would produce real effects. In chapter four I detailed the various experiments that people used in order to find a dose and a medication that provide a modicum of stability and normalcy. Second, a person needed to recognize the effects of marijuana and connect them with drug use. Similarly, in chapter four I showed how people learn to distinguish between side-effects of the medication and real effects of the medication. These were further distinguished from "normal" stress reactions to everyday life and effects of the medication. Third, marijuana users must learn to enjoy the sensations that they learn to perceive when taking marijuana. Especially in this latter respect, the co-operation of experienced marijuana users is essential in learning to take pleasure in the experience.

They help the marijuana initiate to interpret frightening and chaotic experiences in a positive light, so that what was once unfamiliar and frightening can become a source of pleasure. There are, of course, differences between learning to use marijuana and learning to use antidepressants. For one, antidepressants are not used as part of a recreational group activity – according to Becker, a central feature of marijuana use. In fact this is an important distinguishing feature. While the experience of using marijuana is interpreted by fellow-users in the moment of use, as it were, many of the feelings and sensations introduced by antidepressants are sorted out by the individual in his or her own daily activities. Other people enter into the story after-the-fact of taking antidepressants. In Michael's case these other people are safeguards – not necessarily people who will tell Michael what the experience of taking antidepressants should feel like, but rather people who can tell Michael when he is getting out of control, or when his personality seems to have shifted. In contrast to the worry and fear that comes with first time marijuana users, the fear of antidepressants is in large part the fear that “I will become someone different and not even recognize it.” In co-ordination with the experimental activities described in chapter four, this checking-in with others provides a means of distinguishing between the effects of medications and normal behavior. It also provides the emerging biomedical self a stability and certainty that cannot be derived from the individual self alone.

Other people told me that they rely upon close friends and family to determine whether the medication is changing their personality. A number of the people I spoke with did not know that the medications were working until a friend or family member told them that something was different about them. Teresa, for example, didn't know that

the Prozac was making a difference until about three months into treatment a friend said to her:

“Teresa you’re really irritable lately, what’s going on?” and I was like “What do you mean, what are you talking about?” (Teresa, unemployed, age 26)

This, of course, was not the result that Teresa had hoped for. Nevertheless she only realized that Prozac was making any kind of difference when a friend pointed this out to her. Teresa concluded that the antidepressant must have caused this change in her personality. Katrina also relied upon close friends to gauge changes in her personality:

After I was on Prozac my then boyfriend said “Oh it’s like a night and day difference. You were getting like you could hardly get out of bed in the morning and now you’re, now you get out of bed and you even dress differently” (Katrina, acupuncturist, age 42).

And she relied upon a girlfriend for this account of the medication

I’m not for sure about them, so I asked one really articulate friend, and she said “It’s almost as if your keel is stronger in the water, it’s like you have a deeper keel.”

These accounts of the way in which self-knowledge is ascertained through others are particularly interesting in the context of the emerging biomedical narratives. It underlines the sociological fact that antidepressants do not automatically work through biology, but depend upon co-operative social relations in which people help others to figure out who they are and what they are feeling. While in some cases acquaintances provide metaphors, such as “even keel,” to help understand the suspected changes, these symbolic interactions do not need to be elaborate discussions of the self. Indeed, they can be simple

prods and comments: “you seem different today” or “how come you’re so happy lately?” or “do you think that your medication is working?” These comments can turn a person’s attention upon themselves and call for an account: “I must be feeling different because of the medications” or “I guess antidepressants do make people happier” or “I’m not sure that they’re working. I feel a little better but not great.”

The idea that making sense of the medications depends upon interaction with others provides the backdrop for this chapter. Further examples will follow. However, I also want to place this basic process within the context of larger sociological themes. First, in addition to concepts such as authenticity and self-control Taylor (1994) argues that *recognition* is central to contemporary selfhood and identity formation. While dependence upon others has always been an issue for people, it is only in recent times that people have become dependent upon others for feelings of self-worth. This points to a larger shift in western cultures away from forms of self-fulfillment that depended upon situating oneself in relationship to God, to modes of fulfillment that depend upon relationships forged within the realm of everyday, or ordinary, life (Baumeister, 1987; Taylor 1989). Here both Taylor (1989) and Baumeister (1987) note that in the late 19th and early 20th century, interpersonal fulfillment is realized in the bourgeois family, and the accompanying institutions of romantic love and friendship. Further, Giddens (1991, 1992) argues that the late-modern period (i.e. the late 20th and early 21st century) witnesses the development of forms of “pure relationship” in which the intimate sphere of interpersonal relationship is pursued as a form of life for its own sake. The pure relationship emerges in tandem with the need for individual recognition. It is a form of relationship “sought only for what the relationship can bring to the partners involved”

(Giddens, 1991: 90). It demands emotional openness and the capacity of partners to recognize and satisfy one another's individual emotional needs. And consistent with what Giddens' describes as the late-modern turn toward reflexivity, pure relationships are organized in an open fashion. They are self-correcting and depend upon a continuing process of self-examination and checking-in with one another to ensure that the relationship is satisfying the needs of both partners.

Though clearly these forms of pure relationship demonstrate the dialogical character of self-formation, they also draw attention to utilitarian and instrumental elements in contemporary forms of intimacy. The other person is used in order to satisfy personal, narcissistic needs, and when the relationship fails to achieve those ends it can collapse. Here theorists like Giddens tend to overemphasize the positive achievement of intimacy and trust in relationship, rather than the contests of power and control which also insinuate supposedly "pure" forms of relationship. In addition to emphasizing the fundamentally dialogical character of selfhood I also want to argue that the search for recognition unfolds in a contested terrain between self and other (Benjamin, 1988; Laing, 1969, 1961). To develop this argument I depend upon the work of psychoanalytic theorists such as Jessica Benjamin and R. D. Laing, but in particular the work of Jessica Benjamin.

The perspective developed here assumes that individual selfhood is an unstable accomplishment, rather than a natural possession. Despite contemporary ideologies of the free and transparent selfhood, persons often struggle within a space *between* self and other. The boundaries are never settled and constantly remapped. As something that is between persons, the self is never entirely free of others, but in a tenuous and contested

position between self and other. As such, person's are never in full control of themselves, but must always reckon with forces that seem to come from outside of the self -- tradition, culture, other persons. At first, this view benefits from Taylor's narrative, embodied theory of the self. People can never extricate themselves from the cultural narratives through which they are formed. People are never outside of language, and they often experience the encounter with cultural narratives and ideals, as things that they cannot resist or cannot deny. They can, in other words, never get behind or on top of the world through which they are constituted. In this respect, there is a level of self-narration that is never simply chosen – as a preference – but that deeply situates the self in networks, relations, and undeniable “truths.” Furthermore insofar as the modern self requires recognition from the other, the self is always bound to the other (Taylor, 1994). It cannot cut itself free and loose, but must constantly return to the other for self-affirmation and feelings of worth. In all, despite widespread ideologies which valorize independence and individual freedom, persons are always caught up in institutions and feelings that overwhelm and possess them.

Taylor, I think, is right about the central role of recognition in modern life and in the life of the self. However he does not provide enough insight into the nitty-gritty, and frequent futility and disappointment, entailed in the modern quest for recognition. Though Benjamin also sees equal and mutual recognition as an ideal for selfhood and interpersonal relations she demonstrates how difficult it is to achieve this mutuality of recognition. The effort to separate from others and to become an individual self is entangled in relations of domination and control. As a starting point, Benjamin refers to Georg Hegel's concept of the master-slave dialectic. As Hegel conceived it, human

subjects desire recognition of their selves by others.¹ This is the means by which consciousness of self is formed and affirmed. However, this quest for recognition is fraught with paradoxes. In particular individuals want to be recognized as omnipotent beings, but “as each subject attempts to establish his reality, he must take account of the other who is trying to do the same” (Benjamin, 1988: 32). The possibility of mutual recognition is undermined by the desire for omnipotence. Here the search for recognition devolves into an attempt to exert power over the other – the power to be recognized without having to recognize the other. Benjamin further locates these forms in interpersonal domination in modern western cultures that valorize instrumental reason and technical knowledge. In this, she follows critiques developed by Max Weber, and members of the Frankfurt critical school. Instrumental reason is disenchanting. It promotes an ethic in which the domination of nature, self and other is promoted. And, in so doing, it alienates people from their selves, from one another, and from their common labors.

However, even as Benjamin (1978) shares in this basic critique, she also challenges the assumptions that ground the Frankfurt theory of the self. In short, Benjamin argues that critical theory is nostalgic for a kind of internalization of authority common to the bourgeois family under the influence of an authoritarian father. Critical theory laments the loss of the father to the growing conformism of fascist societies. In the absence of a strong father, children are unable to internalize a conscience that allows them to critically withstand mass mentalities and state led agendas. Benjamin argues that in its valorization of the independent, strong-willed bourgeois ego, critical theory misses the active inter-subjective processes that underpin the activity of this ego:

Critical theory misses the active intersubjective process which creates this culture, although it identified so clearly the loss of agency and authorship which prevail in and through it. For the critical theorists the subject was largely constituted by recourse to the idea of critical reflection, rather than by the idea of intersubjectivity....Nor does their conception of psychic nature include the ingredient which supports the nurturant activity whose decline they lament—the need for recognition of self in other and other in self. (1978: 55)

Here Benjamin also moves beyond classical psychoanalytic theories that privileged the resolution of the Oedipal complex as the most important moment in psychosexual development. In attempting to find a way out of these relationships of domination and subordination (especially as they impact the position of women in contemporary societies) Benjamin offers a theory of self that places fundamental importance on pre-Oedipal relationship of dependence and interpersonal care. She offers a relational view in which the self is seen as always intertwined with others in deep relationships of love and hate, even as it seeks individuation and independent selfhood. This, I think, also complements Taylor's emphasis on the importance of understanding the dialogical character of selfhood and recognition. Though Taylor recognizes authenticity and individuality as important modern ideals that should not be abandoned, he also insists that these must always be understood as shared achievements, open to the flux and flow of relationship.

This said, my argument in this chapter is that the development of a biomedical theory of the self and psychological distress operates out an ideal of recognition, but at the same time makes "authentic" recognition an impossibility. That is, even though

antidepressants allow people to be themselves for others, this is also an attenuated selfhood. It puts to the side the powerful and sometimes overwhelming feelings that someone like Benjamin argues are central to the formation of selfhood and the quest for recognition. Antidepressants mediate the relationship between self and other. At the surface, they make the self available for others. Tied up with the malaise, anxiety and self-loathing that burdened the people I spoke with is the loss of relationship. Stories about depression and anxiety are also stories about alienation and the loss of other people. Thus, when antidepressants work, they allow the self to be with others again. This comes up time and again. Describing the effects of Prozac, Wanda says:

I remember just feeling like independent and I also remember feeling like I've joined the human race because what I had found previous to that is that all kinds of things that like other people found soothing and helpful would make me completely miserable and more upset (Wanda, research psychologist, age 38).

However, this return to an idealized state of authentic selfhood and relationship is mediated by instrumental technologies – antidepressant medications. In themselves, antidepressants do not necessarily lead to forms of domination and control. However, insofar as they are paired with logics of the isolated atomistic self, they cover over the more important dialogical and relational aspects of self formation and the need for recognition. In the end, the antidepressant ethic demands that people enter into relations with others already in control of themselves. Unruly and unpredictable emotions are, as we learned in chapter four, split-off from the self and contained by antidepressant medications. In this respect, the antidepressants enable forms of relationship in which people are expected to put aside the parts of themselves that threaten the stability and

predictability of relationship. In this way we can also see how antidepressants can come to the rescue of the “pure” relationships that Giddens argues are increasingly important in late-modern societies. The medications ensure an equality and stability of communication and emotional bonding so that I can “be there for my partner,” even if at some other level I might be overpowered by emotions and feelings that would threaten the homeostasis of the relational system.

I develop this argument in three sections. In the first, I argue that antidepressants provide people with a means of achieving recognition where otherwise ordinary, everyday suffering would go unrecognized. It provides entry into a language and set of practices which translates personal suffering into the language of biology. As many of the people I spoke with told me, depression and anxiety are “real illnesses with real causes” that should be thought of as conditions like diabetes or in some cases cancer. People who use antidepressants not only show others that there really is something wrong with them, but also that they are taking responsibility for the unruly and diseased aspects of their selves. In the second section, I show how social institutions such as the legal system and the family sometimes require that people take antidepressants medications and accept biological definitions of their suffering. By defining persons on its terms, the institution makes people recognizable, but also covers over the social origins of psychological distress and interpersonal conflict. In this respect, the antidepressants serve the purpose of social control and interpersonal organization.

In the final section of the chapter, I consider the ways in which antidepressants “theorize” the connection between self and relationship. Though, as sociologists argue, the self is always a social phenomenon – a product of symbolic exchange and cultural

framing – antidepressants work within a logic that increasingly individualizes the self (Bauman, 2001; Beck & Beck-Gernsheim, 2002; Giddens, 1991). This process of individualization, of course, is not new. As sociologists have argued, it is a central theme of modernity and what Giddens call late-modernity. However, antidepressants add an extra twist to this development. In particular, people are required to take personal responsibility for the risks that their unruly and unpredictable emotions bring to relationship. In this respect, there is a painful tension at the heart of antidepressant use. Even though relationships necessarily give rise to powerful desires, frustrations, and anger, antidepressants allow people to take unruly emotion out of relationships. They are asked to get themselves under control so that relationship can proceed as an idealized scenario of rational and reasonable communication, inflected only with normal and appropriate sentiments and feelings. In the end I claim that this misconceives the deep and oftentimes confusing and uncertain emotional relationships that make selfhood possible in the first place.

Recognition and the Self

Ever since she was a young child Rebecca has suffered from high anxiety and obsessive-compulsive behaviors. This is related to an unusual kind of eating disorder which she says causes her to dislike particular kinds of foods. For example, she has never been able to eat citrus foods. To her, citrus seems like non-foods, something equivalent to eating dirt. The eating disorder and the anxiety did not cause Rebecca many problems through her childhood, though when she reached high school her picky habits became a social impediment. She didn't like to sit near people who were eating certain foods and she was limited in what she could eat when she visited the homes of friends. High school

was also a time when Rebecca experienced increased anxiety about grades and college prep work. She was locked into obsessive routines over which she had no control. For example, she would study late into the night sacrificing sleep for school assignments that she knew would not make much of a difference to her overall grade. Rebecca showed remarkable initiative in seeking treatment for her anxiety and convincing her parents that she has a biological problem in need of antidepressant treatment. She distinguished between emotional eating disorders and her eating disorder. According to Rebecca, her problem is just a matter of fact – she doesn't like certain kinds of foods and concludes that this has something to do with her biological make-up. This language of biomedicine provides her with an explanation of her troubles and offers her a unique identity of which she is proud. She sees herself as a “quirky” person and recognizes her choice to take antidepressants as yet another example of this quirkiness.

However, achieving this identity was also a part of a process in which Rebecca uses the idea of biological dysfunction to distinguish herself from other members of her family (including five brothers and sisters). Rebecca began our conversations with several examples in which she suggests that her problems are somehow connected to her relationship with her mother. For example, Rebecca's mother is allergic to fish, and when she was a young child her parents were worried that Rebecca might also be allergic to fish. She tells a story about an incident from her childhood:

Once I was at a friend's house and her mom made fish sticks and we had them and nothing happened to me and I was totally fine but like my mom picked me up and asked what we ate for dinner and I saw like my mom's reaction to fish sticks, and apparently like I would realize I wasn't supposed to have eaten it or something,

and then I started crying and my parents just told me I like I was really like like I was really traumatized by the experience that I ate something that I shouldn't have...I was yelling "get it out of me" and I was very scared from it because my parents always said "don't eat it," and I'd eaten it. I guess I was scared something would happen to me. (Rebecca, student, age 20)

This formative moment in Rebecca's narrative demonstrates Rebecca's entanglement with her mother. It is as if Rebecca's parent's fear of allergy is transmitted to Rebecca in the moment that she begins to yell "get it out of me." Though Rebecca does not make the connection between her fear of fish her mother's allergies Rebecca suspects that her mother passed her anxiety onto her:

My mom is also a very anxious very worried very concerned so it wouldn't surprise me if she like transmitted that onto me. I should say I don't eat fish.

Rebecca provides a sense of the way in which her anxiety overlaps with her mother's anxiety. Her mother's fears and worries become Rebecca's fears and worries, and this connection to her mother this connection insinuates itself into Rebecca's developing self. Picking up the story at a later point Rebecca talks further about her identification with her mother. She emulates her mother when she "obsessively" engages in exercise:

My mom's really big into like exercising, and eating healthy, and all this stuff, and I felt compelled to like exercise every day, and my mom thought this was great she's like "Rebecca's going on the treadmill." You know everyday I would run four miles on the tread mill, and even if I was I have so much homework I'm so tired I was like "I have to do it." It wasn't like I could just say I'll skip tonight

because I'm very routined and it was like if I skip it one night then I'll be more inclined to skip it the next night.

This pursuit of exercise gets a strong hold on Rebecca. It is a force that she cannot control and that she cannot understand. Rebecca also starts to give us a sense of how overwhelming connections to other people can get represented as biological dysfunction. As we've seen in earlier chapters, the uncontrollability and inexplicability of Rebecca's obsessions – which spreads from food and exercise to becoming an entire personality trait – anxious-obsessive -- is interpreted as biological disorder. Rebecca takes antidepressant medications in order to get the anxiety under control.

Here, however, the antidepressant medications and the calming effect that they provide, act as more than relief. They are also a point of positive identification and a means by which Rebecca distinguishes herself from her parents and seeks recognition. Indeed, in Rebecca's story she takes charge of her eating disorder and anxiety. In high school, she is the person, not her parents, who decides that something is wrong. She is also the person who tells her parents that she needs to see a psychiatrist. Though her parents are wary, they respect Rebecca as a mature and independent woman and support her in her decision to start a course of antidepressant medications. She rejects her first therapist's attempt to get her to talk about her eating disorder. Again Rebecca asserts, her problem is not emotional – it does not require a talking cure. Instead she opts for antidepressant medication. One way to understand Rebecca's aggressive pursuit of antidepressants is to suggest that it is a means to distinguish herself from her mother. For Rebecca, her problem is not related to her identification with her mother or the anxiety that her mother has passed onto her. Rather, for Rebecca this is an internal biological

problem. She affirms her individuality and asks that her parents recognize and support her choice to take antidepressants. The biological account of her illness then does two things. First, it explains the origins of Rebecca's compulsive behavior, and second it underlines her independence and uniqueness. She is seeking her own solutions to her own problems.

In Rebecca's case, as with many of the people I spoke to, the antidepressant narrative involves an assertion of a biological identity which becomes a means of seeking recognition. For some people this identification provides an opportunity for the recognition of suffering that could not otherwise be recognized. Joanna tells a very moving story of how she was able to convert her mother and family to a recognition of the necessity of taking antidepressant medications and by implication to biological source of her suffering.

Like Rebecca's parents, Joanna's parents were skeptical and frightened by the prospect of their daughter taking antidepressant medications. Joanna was also afraid. She thought that in taking the medications she would be losing her independence and seeking an easy solution to her dilemma. Yet during a weekend at home with the family the following scene unfolds. She says to her mother:

"I'll tell you something, if more time goes on like this where I feel like this, I'm gonna kill myself" and I was like "Oh my god I can't believe I just said that," and I said it to my mother, who's my best friend, who would do anything for me. I would do anything for her, and it was just she, her and I in the kitchen, her and me in the kitchen. And we were just standing around talking and I can't believe to this day that those words came out of my mouth. I just sat there with my mouth

open and she just looked at me, and she was like “Please don’t ever say that again” and she just started crying and she’s like “ You just need to go on this medicine, Joanna.” She’s like “You know it’s true.” She’s like “I think that you know you really need to at least try. It kills me my own daughter just said she wants to kill herself but you are feeling terrible.” (Joanna, student, age 20)

At the moment, both Joanna and her mother are transformed, and the antidepressant mediates this transformation. They realize that Joanna is dealing with something that is beyond her control, and that the only means of combating this illness is through medication. This recognition echoed through Joanna’s family. Her father and her brothers collectively decided that Joanna would take the medication. Indeed Joanna’s mother sat down at the kitchen table and helped Joanna to cut the pills into smaller doses so that she could start treatment.

Joanna is the only person I spoke with whose family so fully and suddenly recognized her problem as a problem in need of antidepressant medication. Others sought recognition from family members, but failed to achieve it. Teresa for example struggled with depression all her life and never received recognition for her suffering. Her sister, while supportive could not understand depression. Teresa’s parents were wary of her complaints and, from Teresa’s perspective, could not appreciate the depth of Teresa’s suffering. For example, Teresa’s mother thought that Teresa’s problems were caused by poor sleep habits. In comparison to Teresa’s understanding that her depression is the result of an unshakeable biological imbalance, the “sleep habit” explanation seemed weak and dismissive. Now that Teresa recognizes herself as someone who is biologically depressed, she wants her parents to recognize her depression and to treat her

accordingly. She wants her family to tolerate her mood swings and to recognize that it's not Teresa, but the depression, causing her to withdraw into her room. She wants her parents to support her efforts to get well and to encourage her in therapy and in her search for a better medication.

I would like my family to recognize that I am depressed and I do need to get help and I would like them to be supportive of that, because it would just make it so much easier for me to feel better about everything that I'm doing if I know that my family is behind me and the last couple of times I've tried it's been really wishy-washy, so like "Are you proud of me for trying to help myself or are you resentful? -- Help me out here." (Teresa, unemployed, age 26)

Where at one point Teresa might have needed recognition for her suffering in itself, now she simply seeks recognition for her efforts to get well. She doesn't need to tell her sister or her family about the pain caused by her sadness. Indeed, these have become thoroughly medicalized and individualized. Insofar as they have been cast-out of narrative they are also outside of language and communication. Depression, as a biological phenomenon stays within the individual, and as such there is no real sense in speaking it aloud for others.² Instead, Teresa seeks recognition for her efforts to get well. Within the context of biomedical knowledge, these are the elements of the self which are visible and representable to others. She wants her family to be proud of the fact that she has recognized that her problem is biological, and that she is now seeking therapy and medication to overcome this problem.

Similarly, when Mary began taking antidepressants her family responded with shock and fear. Her mother gave her information about suicide risks associated with

antidepressant medications, and suggested that Mary try to fix her problems through a change in diet and exercise.

When I did come forward with the depression their whole response was, I don't even know if they recognized that I was depressed. It was just: "If anything is causing you problems you need to exercise." So um clearly nobody needs to take any sort of medication....Their whole thing was you just need to exercise, and you could take some herbal remedies. I'm not against exercising and herbal remedies, you know, I think that has it's place as well. I just happen to think that I need something more than that

I: What would you like that response to be?

P: Just acknowledging that maybe, just talking to me more about how I'm feeling and acknowledging that I've made a decision that I feel is right for me instead of getting in there and saying "No, no, that's not what you need. That's not the right decision." Just acknowledging it for being what it is. (Mary, teacher, age 37)

Like Teresa, Mary doesn't ask her family to recognize her sadness. She now asks for recognition of her decision to get well. In addition, Mary's discovery of her own biological dysfunction translates into a desire not only for others to recognize this dysfunction in her, but also to recognize it in themselves. Mary has a brother who she thinks is depressed. Yet, her brother refuses to take antidepressants, and like Natalia, who I introduced in chapter five, he thinks of antidepressants as an inauthentic form of self care. Mary's brother prefers to live with his depression and work through it on his own terms. This frustrates Mary because she believes that her brother's depression leads to a cynicism that taints relationships within the family. Similarly, Samantha and Jennifer

have friends who are depressed and their depression makes life difficult for those around them. Yet these friends also hold onto the view that their sadness, their unpredictability and even the pain that they cause others is a central component of their identity.

Samantha and Jennifer are frustrated, then, by friends and family who do not recognize in themselves a biological dysfunction that, in their view, could be easily cured.

In his analysis of antidepressant use, David Karp (1996) argues that the decision to take antidepressants requires a personal “conversion” to the view that “I have a mental disorder in need of biochemical treatment.” This requires abandoning the view that I am normal, or my suffering is normal, and accepting a new identity as someone who is ill. In these examples, Mary, Samantha, and Jennifer demonstrate another element in this process. Their self-recognition also requires that others recognize this biomedical identity. But this goes even further yet. In seeking to legitimize this self-understanding they also want others who suffer like them (Mary’s brother or Samantha and Jennifer’s friends) to recognize that they too might have a biochemical imbalance. To merely accept depression as the “way that I am” is an affront to the identity that Mary, Samantha, and Jennifer have so painstakingly cultivated. To them it seems wrongheaded and irresponsible to continue to suffer depression when depression and mental illness pose a risk to both self and other.

Overall, what I have attempted to describe in this section is the transformation of the need for recognition through the language of biomedicine. Assuming a biomedical identity becomes a means by which many of the people I spoke with not only made sense of their psychological distress, but also tried to make sense of it for others. I’ll summarize with three concluding points. First, the language of biomedicine helps people to

individuate themselves – in distinguishing themselves as people who possess a biological illness, the people I spoke with also claim an identity that recognizes their unique way of being in the world. For some, such as Rebecca, this is also a means of extricating themselves from the conflict and suffering that emerges in relationship with others. Indeed, many of the college students that I spoke with were leaving home for the first time.³ They were negotiating the life transition from family to adult life. In this context, antidepressants can also be seen as technologies that help people to handle the “separation anxiety” that people experience as they struggle to become their adult selves. The medications help to tease the individual out of long-established relationships and provide them with their own feet to stand on. What is striking is that the new identity is also an illness identity in which individuals learn to be themselves by learning to manage their mental health on their own terms.

Second, this individual illness identity is not enough on its own. The formation of the new identity also requires that other people recognize this identity and the struggles that individuals have gone through to achieve this kind of self-knowledge. This recognition does not take suffering as something to be recognized in itself. Rather, the point of pride is the responsibility that individuals have taken in learning to manage the risk that their newly defined illness poses to their selves and to others. Here Lupton (1999) suggests that in the risk society, forms of risk-avoidant self-care become a moral imperative. In the eyes of those who have learned to manage risk – both for the benefit of themselves and others -- the failure to take advantage of all risk management strategies indicates either a lack of skillfulness or moral failure. Even in this individualization of psychological distress, the pressing need for recognition is still in evidence. On the one

hand, antidepressants make people available for others by getting the most disruptive elements of their selves under control. On the other hand, the biomedical identity, in itself, becomes a means of making oneself available for others. As a new part of the self, the antidepressant identity becomes a basis for the formation of new kinds of relationships and interpersonal acknowledgement. Joanna most fully realizes this when her family gathers around her to help her negotiate her use of antidepressants. In contrast, Mary hopes for a re-organization of family dynamics, but, in the end, is frustrated by her family's unwillingness to see itself on her terms. Mary sees the changes that the medications have brought in herself and she imagines that if others in her family (e.g. her brother) also take care of themselves some communicative and relational ideals can be realized. She desires what she calls a "Hallmark" family – one in which people recognize one another's needs, and provide necessary emotional support (i.e. a version of Giddens' "pure relationship"). It thus further frustrates and saddens Mary when her family refuses to recognize her use of antidepressants, and in so doing refuse to realize the communicative and relational ideals that her new self-understanding seem to promise.

Finally, this search for recognition through the language of biomedicine can also fall flat. In Goffman's (1963) sense, the redefinition of oneself as mentally ill – a person with a biological condition in need of antidepressant treatment – can become a *spoiled identity*. Some fear that the use of antidepressants stigmatizes them as mad, crazy, or dangerous people. In the case of what Goffman calls *discreditable* identities, people must manage information about themselves so that the potentially discrediting stigma will not be discovered by others. Angela told me that, for her, this was a "life and death" matter. More precisely it is a life and death matter for her social self. She said that when others

find out that she is bipolar she is socially isolated and feared. Peter doesn't even tell people that he has a bipolar disorder because he fears the repercussions. Both Angela and Peter need others to recognize that they are biologically ill and that they should not be feared, yet neither of them feel safe telling others that they have a bipolar disorder, even though, out of anger Angela no longer holds back – she let's everyone know who she is.

However, most of the people that I spoke with were not worried that others will think that they are crazy or dangerous. Instead, they face a stigma that comes with the widespread use and promotion of antidepressant medications. At the end of chapter five I described some of the widely-circulating cultural criticism about the use of antidepressants. Some, who hold onto a purist notion of authenticity, critique the use of antidepressants as an easy way out – in short, the choice to take antidepressant is a failure of people to live up the “normal” challenges of human existence. Most of the people that I spoke with understood these kind of criticisms as a challenge faced by antidepressants users. Twenty of the 23 people that I spoke with told me that they want to help undo the stigma attached to the use of antidepressant medications. Thus in our interviews they sought to demonstrate that their choice to take antidepressants was not a moral failure, but a decision taken out of the need to control and manage risks that their biology posed to themselves and others. Here the search for recognition is not merely an effort to be “seen” by friends and family on one's own terms, but it also a desire to be recognized by what George Herbert Mead (1934/1963) calls the “generalized other.”

The Family Drama

In the previous section I focused on individual efforts to seek recognition from others. If successful their biological view of depression is confirmed and they enter into a

new form of relationship with others. Sometimes this is successful, as in the case of Rebecca and Joanna. Other times this effort is met with frustration and further alienation – as with Mary and Teresa. In this section, I reverse the direction of influence and show how social institutions impose biomedical identity upon individuals from above, as it were. In these examples, social institutions demand that people accept a biomedical understanding of their selves and their suffering.

The most striking example comes from Katrina's narrative. As indicated in the previous chapter, when I spoke with her, Katrina was in the midst of divorce proceedings. She was also seeking custody of her six year old son. Several years ago, in order to resolve her problems with depression Katrina underwent a full psychological assessment. Where in the past she had suspected that something was wrong, here she was diagnosed with clinical depression. Now on "official" record, her husband's "aggressive" lawyer used this diagnosis of depression against Katrina. She was stigmatized as an unfit and unreliable mother. Here she quotes the lawyer:

Now here's this woman. She thinks she should have custody of this kid. She's so depressed she can't even take care of him, and she's not even willingly taking antidepressants. (Katrina, acupuncturist, age 47)

Indeed, Katrina is not willingly taking antidepressants. She has tried Prozac, Celexa, Wellbutrin, Zoloft and now Lexapro, but none of these have provided her with effective relief from her depression. Most have produced unbearable side-effects. The side-effects interfered with her physiological well-being, but they also impacted her ability to be with others in relationship. For example, one antidepressant alienated her from her husband and child: "I felt that I was being strange around my husband. I didn't even wanna come

home and be around my husband and child because I was afraid they'd see how strange I was."⁴

Given this psychological and social failure of the medications, Katrina would prefer to experiment with homeopathic techniques. Though she cannot say that these will relieve her depression, she believes that they will result in fewer side-effects. The homeopathic technique also seems to better match the "eastern" vision of self, suffering, and illness that Katrina describes throughout our interview. In this sense, homeopathy is a form of self-care that would bring Katrina closer to her worldview. Perhaps she would not feel so fragmented if her engagement with the depression was informed by her sense of what a self is and how it should be treated – holistic and complex. Yet, Katrina must remain on the antidepressants in order to prove to the courts that she is taking responsibility for her mental health. She is in a double-bind. On the one hand, as the lawyer puts it, she's already suspect because, officially, she suffers from a chemical imbalance. On the other hand, Katrina must continue to take ineffective medicines and forgo alternative treatments. This allows her to maintain the credibility of someone who has taken responsibility for an inherent imbalance. She is seen as someone who has made the choice to get well.

Since I have this diagnosis on record I made sure by golly if they're gonna make this a problem in a custody case by golly I'm gonna nip the problem in the bud.

I'm gonna take whatever I need to take even though it's a nightmare to try to find one that doesn't have side effects...

However, there's a further twist to Katrina's story. The previous passage continues

...I was determined [to find one that didn't have side effects], but then I started finding that they were working, and it did have seemingly a good effect on my son.

Here the word *working* does not mean that Katrina finds an ideal solution to her depression. She remains, as we saw in the last chapter, split into fragments. However, in her understanding, she is now able to contain the sadness so that it doesn't affect her son. She can pretend for her son and for others that she is a happy and responsible person. Though Katrina's measure of success is her ability to bring balance to her son's life, the medication will also allow Katrina to put her depression aside for the sake of the courts. She will be able to perform the act of responsible selfhood for the lawyers, though it is by no means clear whether this will be enough to overcome the stigma that continues to haunt her case.

Katrina's encounter with the courts is dramatic, though I suspect not uncommon. Some people take antidepressants in order to assume a role that bestows social and legal legitimacy. They do something that they don't necessarily want to do, or that isn't necessarily working for them, in order to engage demanding social systems. The individual, in other words, makes a sacrifice of parts of their self in order to sustain relationship. In the previous example Katrina is required to present a certain face to the courts. Louise and Mary make a similar move when they take responsibility for controlling rage and anger. After discussion with her husband, Louise decides that she should use medication to control her anger so that she does not take this anger out on their children. Mary decides that in order to survive the first year of marriage she had better get her own anger under control. Her husband, she adds, also has a problem with

anger, but Mary sees it as her task to control her mood. Even though Mary believes that her depression and anger have roots in biology, she doesn't think her husband's anger management issues are biological.⁵ These two examples involve struggles to balance independent selfhood and the demands of relationship. Both Louise and Mary want to be in the world with others, but they also want to be independent and in control – to have an untouched space for their selves. Though certainly not incompatible, these two goals also frustrate one another and Louise and Mary take it upon themselves to manage their emotions so that the conflict between self and other is smoothed over. They make a choice to contain a part of themselves rather than to “let loose.” As seen in chapter four this buys them a kind of freedom; neither is quite as overwhelmed by the presence of others, and as Louise says: the medication “puts a skin between me and the world.” In this respect, Louise is able to buy herself some space. She is able to satisfy the demands of family and marriage and retain some personal calm, by dampening her sensitivity to others.

There are also more subtle examples of how institutions demand that people fulfill or step into a particular identity. In his *Politics of the Family* psychiatrist R. D. Laing (1969) develops the concept of a family drama. Laing describes the family as dramatic scenario or space in which individuals are *induced* to take up particular roles in order to sustain a shared fantasy of wholeness and completion. According to Laing, and in contrast to the ideology of individual in-born selfhood, persons are not born to be who they are. The self, and even its particular pathologies, are not written into one's genetic code. Rather the idea of genetic codes and biological dysfunctions is an account derived after the fact to entrench an identity that actually has its roots in social scenarios. This can

be both alienating – as persons are induced to take up roles determined by the family – and comforting – as persons are invited into an existing structure and provided an identity that has meaning for, and is recognized by other members of the family.

At age 13 Samantha started having trouble at school. Up until that point she had felt mildly depressed but now she was feeling “helpless” and “completely worthless.” She started to cry all the time, had no friends, and had suicidal thoughts. Her parents were concerned and took her to see a family friend – the wife of a neurologist that her father knew.

I went to her and basically they said.. “Yeah this girl is depressed.” I just started crying in the middle and I was really embarrassed and I was crying. (Samantha, student, age 20)

She was prescribed Zoloft and has been taking medications since that time. Though in retrospect, Samantha is thankful that her parents sought help, she also recounts this event as a kind of “alienative coalition.” Goffman (1961: 138) uses this phrase to depict the moment when a family sides with a psychiatrist to commit an unruly individual to a mental institution. For Goffman, this is the beginning of the “moral career” of the mental patient – a set of institutional procedures by which a merely strange or unusual individual is transformed into a mental patient. In the case of antidepressants the career choice is more subtle, as Samantha will not be sent to a hospital. She is placed on medications, kept within the family, and will see psychiatrists and counselors as an outpatient. Nevertheless, she is told that she is not who she thought she was – she is a depressed person who needs medications. Furthermore, she experiences this not merely as a decision made by the family friend – the expert psychiatrist -- but by the group: “*They*

said... this girl is depressed.” Samantha’s antidepressant narrative, then, begins with this moment when the family, in a sense, closes ranks and puts her on medication.

In the months that follow, Samantha’s mother gave her the medication every morning. She was involved and watched over Samantha’s health. Both mother and father checked in with her asking whether the medications were working. Even in this atmosphere of care and concern however, Samantha didn’t want to be on the medications. She said that she didn’t want to be like others, and she thought that the medications made her like other people. In contrast to Rebecca, who viewed the medications as indicators of her unique personality, at least at first, Samantha saw the antidepressants as technologies that robbed her of her unique – though depressive – traits:

I wasn’t so happy taking medications in the beginning. I never really wanted to fall in with everyone else. I really just wanted to be myself. If that meant doing or liking what other people wanted that was ok, but, in general, I didn’t want to fall in line. I wasn’t a very rebellious teenager, but .. I basically just did what I wanted and my parents were pretty good about leaving me alone. I wasn’t a bad kid.

Even though Samantha now thinks her parents did the best thing for her, in this passage there is a lingering sense that Samantha was just trying to be herself.⁶ Continuing the last quotation she says “but when I started learning a little more about depression and how it worked...” she realized that depression was a biological condition that required medical treatment. This begins a process through which Samantha develops an always-been-ill narrative. Within the context of this new narrative she is no longer worried that the medications rob her of her individuality and make her like everyone else. The medications have become necessary solutions to an otherwise intractable dilemma which

her parents were able to help her to resolve. Under this redefinition of self, Samantha accepts that she needs the medications. Her only concerns about the medication include an uncertainty about what she will do when she wants to have children, or whether she will need to be on the medication all of her life.

Samantha is not the only person in her family who is taking antidepressants. Her mother suffers depression and has been taking antidepressants since Samantha was a young girl. In fact, her mother's depression is a concern and an issue for the entire family.

I mean she doesn't talk about it.. we don't, it's not like "Oh I'm depressed, let's talk about it.." It's more she she yells and screams a lot and she gets mad .. the smallest little things and when she's .. even if she misses it she really has to be consistent because she'll run out [of the medication] without telling anyone and then she'll just start going off on everything.

The family can tell when mother has forgotten to take the medication, but father is usually "the first one to realize it." He also makes sure "she always has it so that we don't really run into that problem." The family doesn't talk about the depression, but there is an implicit organization and set of positions that people take up in relationship to one another. The family knows how to respond when mother goes a little mad. Samantha and her father know that you shouldn't get into an argument with mother. You should just "step back" or "leave the house" or whatever is necessary. Samantha's younger sister though not depressed is, like mother, stubborn. She is only now learning that there are times when you should just step back from an argument with mother.

In Samantha's case, the family is drawn together in a network that watches out for unruly emotions and destabilizing behaviors. In a sense, since these behaviors are mediated by antidepressant medication, family members enter into relationship not with mother or Samantha but with the depression – a chemical imbalance; a real illness with real causes. In the logic of the biomedical society, the family's intervention into Samantha's sadness is an attack not on Samantha but on the dysfunctional biology. And when father watches over mother's behavior he's actually watching for the depression rather than mother herself. This network of relationships ensures that the mental illness can be contained, that individuals can be "themselves", and that the family can function normally – as it was intended to function. Though few people talked about what this normal family would look like I think that Mary was getting at it when she described her fantasy "Hallmark" family. They talk and listen and provide support. Zareen also points toward this when she talks about a very special evening when she was able to use her counseling skills to talk with her mother. She felt that her mother was listening to her and affirming her problems. This was the kind of "pure" relationship that she wanted with her mother (Giddens, 1991: 90).

By describing Samantha's initial resistance to the medication I suggested that there is coercion involved in these kinds of family processes. Samantha's "rebellious" behavior and risky suicidal ideation is converted into an illness that can be managed and controlled within the existing family system. These parts of her self become a risk both to herself and to the life of the family. Samantha, at first resistant to the use of medication, learns to accept her biological condition and her responsibilities both as an individual with a biological imbalance, and as a member of a family who suffers depression and

mental illness. However, in emphasizing this coercive aspect I have not yet talked about how this biological condition also serves as a means of positive identification. This an important aspect. As the language of biomedicine and the use of antidepressants regulate interaction they also define and open up new forms of relationship and family involvement. In general terms, Paul Rabinow (1992) describes this as the emergence of a “biosocial” subjectivity. He describes the emergence of new kinds of communities and interest groups that cohere around a shared illness identity. Here I am interested in the way that the language and technologies of biomedicine transform and sustain existing institutions such as the family. In the case of Samantha’s family, the recognition of depression as a family trait links members and holds them together in a common cause (even though this might bring its own kinds of miseries and challenges). For example, in assuming a biomedical identity Samantha is now like her mother. She shares an understanding that neither her sister or father can share.

I mean now I kind of I kind of talk to her about it.. I can ask her anything .. like I know that if I have any questions or if I want to know anything I can ask. If she doesn’t want to tell me, she won’t, but she’s pretty good about it if I have any questions.

There are conditions on this relationship – “if she doesn’t want to tell me” -- but now Samantha has something that makes her like her mother. She can sympathize with her mother’s condition and also appreciate her mother’s strength in her battle with depression.

The family drama is not merely an effort to impose order and organization within the space of the immediate family. It also immerses members within an intergenerational

drama (Laing, 1969). The drama of past generations is *projected* into the present and members are induced to take up practiced roles. Laing offers the example of Mrs. Clark whose son David stays out late and won't speak with her.

Who does David take after? According to Mrs. Clark and her mother, he is just like what Mrs. Clark was when she was his age. And who did she take after when she was a teenager? According to Mrs. Clark and her mother she took after her father: as her mother goes on to say, he used to stay out to all hours (1969:17).

Laing is describing how new family members are drawn into the family drama. The family makes sense out of its members by referring back to previous generations. The troubling behaviors in the present are written into an already familiar story around which the family has been organized for generations. This acquires an even thicker meaning in the biomedical era where members are said to inherit genetic traits. People like Samantha are compared first to mother, but then to mother's sister and also to grandfather.

Samantha then is like all those other people who went before. Samantha says:

She [mother] told me about my aunt. She said that she had been really bad and that she'd had a lot of trouble finding stuff to be on. And then she told me about my grandfather. And I said to myself. "*Wow maybe this isn't me* maybe this isn't." Oh that's also a big thing. There's something wrong with me. Why am I like this? Maybe it's not. Maybe this is something I was born with, that I can't necessarily get rid of so quickly. So that made a big difference. I still think of it that way. Maybe because it makes me feel better. It definitely makes me feel better. To know that there. I honestly believe that there's something biological about it.

People in the present not only resemble members of past generations, but insofar as depression is, in Jeremy's words "genetically inherited," they learn that they have always been destined to be like those other family members. I want to underline the fact that in these family dramas the idea of genetic inheritance is an inference rather than a scientific fact. Previous generations were not tested for a genetic marker of depression. Instead, the consistent recurrence of a particular kind of suffering – in Laing's terminology, a recurring character in the family drama – is interpreted as evidence of genetic predisposition. It is something that "I was always destined to become" because, for example, "I have my aunt's biology." This knowledge brings Samantha relief because she learns that the depression is not her fault or her responsibility – it is biological. I am also suggesting that it brings Samantha comfort because it ties her into a kind of family tradition. Her burden is lessened because, as clinical depression, her suffering is part of something larger than herself. She has assumed a position within a drama known to the family, and in this respect the family absorbs Samantha's lonely burden. This does not necessarily make her feel "better" but it gives her personal story some perspective and some meaning.

This reference to previous generations is common in the narratives I heard. These stand as proof of the biological basis of illness, but they also provide opportunity for the development of webs and networks of relationship, both imagined and enacted. They make sense of the otherwise inexplicable suffering, and they link people together both in the immediate present and across time and space. In creating these links people also tell narratives about their position in relationship to an ongoing family story. Right from the start of our first interview Catharine places herself in a lineage of mental illness: "I know

a cousin or something is schizophrenic, somebody else hung themselves, so there's been a lot of recurring depression in my family." She does this to show me that her illness really is biological, but also to say that there is something special about her family and herself: *they* have always been part of *her* present struggle. Louise sees her oversensitive nature and her "dramatic" emotional behaviors in her grandparents. She also projects this dramatic personality trait into her children, thereby drawing the family drama from past to present and into the future. Jesse describes an uncle who was in and out of mental institutions, and a grandfather who was an alcoholic. Jesse, also an alcoholic and depressed, imagines that he shares his grandfather's disposition but also knows that he has improved his grandfather's lot. In contrast to men of "that" generation who took the burden on themselves, Jesse has learned that he can treat his condition with medication and psychotherapy. His story is thus one in which he shares the burdens of previous generations, but progresses beyond their engagement with those burdens. Zareen, self-diagnosed with dysthymia, becomes a means by which her mother can better understand her own depressed brother. That is, Zareen's mother gets a sense of what's going on with her own brother by listening to what Zareen has to say about her biological mental illness. Zareen becomes a kind of bridge between her mother and her uncle, who until present remained strange and incomprehensible.

Finally, about a year before Jeremy started taking Zoloft his older brother started taking Zoloft. As a result Jeremy feels a connection to brother when he is diagnosed with depression and starts taking Zoloft. He trusts his brother when he tells him that Zoloft is a safe drug and a good drug. Jeremy is also comforted to know that the depression runs in the family:

They tell me it runs in the family, you know, “Your brother has it, your uncle, your grandmothers so um it’s probably nothing you can control,” and you know they’ve been they’ve helped me um they helped me find a doctor and I guess they paid for all the insurance it’s under their name so that’s nice. (Jeremy, student, age 20)

The diagnosis with depression and his use of antidepressants involves Jeremy in a thick web of relationships. He can relate to his brother in a new way. He possesses a genetic marker that ties him to previous generations. And he deepens his dependence upon his father, who both helps him to find a doctor and pays for his medication. Indeed, Jeremy’s life on antidepressants is closely tied into his relationship with his father. He continually checks up on Jeremy’s well being, and has even called Jeremy’s psychiatrist to see how things are going. Jeremy was a little bit angry about this but also believes that his father was acting in his best interests.

The point that I am trying to make is that even as antidepressant advertisements promise to free people up to be individual and authentic selves, the antidepressants also tie people into networks and institutions of *care* and *control*. This resonates with what neo-Foucauldians have said about contemporary forms of psy-discipline. The exercise of power over others does not always appear as a brutal and obvious form of subjugation, but it also, frequently, appears in the guise of benevolent actions and efforts to help people get better and feel more like themselves. This care and control also indicates the ambivalence that, psychoanalysts argue, often accompanies even the most intimate and caring forms of relationship. Care can also be a desire to control, possess and, in Benjamin’s (1988, 1978) sense obtain recognition of one’s self from the other. This is a

also a web of relationships in which the definitions and borders of the self are at stake. As I argued in the first section of this chapter, individuals who have learned that they have a biological imbalance and require antidepressants seek recognition of this new identity. They fight for recognition of this new biological identity and in so doing draw a line in the sand “This is the self that you will recognize – that I need you to recognize.” In this section, I have argued that the process works in the other direction as well. Institutions such as the courts and the family make people recognizable by inducing them to take up roles and positions that are sanctioned by psychiatric science. In this way, the selves and identities imagined by the state or the family get inside of people. In this process Katrina is fragmented – she becomes a happy self for others but remains depressed within herself. She sacrifices her own sense of coherence and well-being for the sake of her son, and for legitimacy in the eyes of the courts. In other cases people are wholly reinvented. Samantha, though at first she resisted and sought to sustain her own idea of individuality, learned that depression is a biological illness with real causes best treated using antidepressants. This drew her into a new pattern of relationships, within her immediate family, and across generations. Indeed, like so many others she starts to see herself as part of a tradition of biological imbalance. Like her mother and her aunt and her grandfather she is ill and in need of medication.

Of course, these two processes are not mutually exclusive. Individuals seek recognition for their illness even as they are required by larger institutions to assume a certain biomedical identity. The larger point is that the development of a biomedical identity depends upon the recognition that one receives from others and the presence of narratives that help to make sense of the new identity. Further, the discovery of biological

imbalance is not a discovery of a natural fact, but unfolds within webs of relationship in which individuals struggle to become individual selves, yet even in this individuality to retain a connection to others. These webs also include doctors, counselors and psychiatrists. However, in comparison to the family, these relationships seem peripheral to the everyday struggles of individuals to seek recognition and acquire self-definition. The psychiatrist or counselor introduces people to antidepressants and biological theories of psychological distress, and thereby helps to initiate a re-definition of self in biomedical terms. This can serve the interests of someone like Rebecca, who needs professional support in proving to herself, and others, that she really has a biological problem. From the other side, the psychiatrist can serve social institutions such as the family or the legal system. For example, Samantha's and Jeremy's parents sought the help of psychiatrist friends when their children began to behave strangely and unpredictably. In these cases, psychiatrists intervene in family life to help maintain the order and organization of the family drama. They say to parents and children: "she is just like you and needs to be treated with medications."⁷

In this respect, selfhood is an unsettled space constantly remapped. It sits somewhere in between self and other and is mediated by both social institutions and technologies such as antidepressants. In this context antidepressant medications play two roles. First, they introduce a biological knowledge which allows people to explain their suffering to others in a language that draws upon the authority of psychiatric science. Second, the medications are used by people to manage their mood in a particular manner. The drugs help people to bring unruly emotion under control so that they can enter into relationship with others. Samantha's mother is unbearable when she runs out of

medication. When overtaken by her biology, Rebecca is obsessed with the need to exercise and do her homework. She cannot simply go out and enjoy the company of friends. When Jesse is off the medications he demands things that his father can't give him. When he starts the medications he realizes that he doesn't need to have certain kinds of conversations with his father. He puts those desires and needs aside. And so on. The self, I suggest, is not an individual entity that reaches out rationally and reasonably toward others. It is always entangled and overpowered by emotions that draw it toward others. This tendency "to want from others more than they can give" is fought back by the antidepressants. It is this problem that I want to explore in the final section of this chapter.

Self and Other in the Risk Society

Though I relied upon the notion of a family drama to illustrate the way in which biomedical identity can be imposed upon the individual, this was not intended as an analysis of the family for the family's sake. I am pointing to some more general social processes which are part of the biomedical age. People are invited to share in larger stories about their biological heritage. As suggested by Rabinow (1992), this kind of biosociality is certainly not limited to families, but can become the basis of new kinds of communities. In these, people identify themselves through their biological predispositions and seek knowledge and techniques of self-care through the examples set by others in those communities.⁸

However, especially in the case of psychological distress, these relationships are highly conditional and require that individuals take responsibility for the management of their health and wellness. This, once again, draws attention to the themes of risk and

individualization. As Ulrich Beck (1992) argues, in contemporary societies, across the world, everyday life is characterized by a presence of risk: the dangers of terrorism, the threat of economic collapse, and the fear of environmental toxins. As Lupton (1999a, 1999b) further argues, risk is experienced as the impending threat of disease and genetic disorder. Especially as medical science develops new categories and technologies for diagnosing and managing illness, individuals are left with a responsibility to minimize the risk that disease and illness pose to their own health. In chapter four I described how the use of antidepressants both introduces the language of risk into everyday life – people are seen as being at risk of biological dysfunction – and at the same time provide tools and techniques to manage this risk. Risk is increasingly seen as a potential threat to the happiness and well-being of the self, and individuals accept the moral responsibility of managing the risk that their dysfunctional biology poses to themselves, but also the risk that this dysfunctional biology poses to others. This gives rise to the possibility of becoming authentic selves – people who are able to be themselves, despite the threat that depression and anxiety pose to the achievement of selfhood. At least in theory, the use of antidepressants also allows people to achieve idealized forms of relationship. In this concluding section, I want to further describe the way that people understand the risk that their biological dysfunction poses to relationship. In tracing these examples I also describe the idealized forms of relationship potentially enabled by antidepressants. In contrast to the view that selves are always emotionally intertwined with one another – both in relationships of love and hate (Benjamin, 1988, 1978) – this ideal presumes that individuals come to relationship fully intact. Overwhelming emotion is put to the side so that “pure” relationships characterized by equality, mutuality and open communication

can be pursued. Despite the appeal of such ideals, the antidepressant solution nevertheless disavows the inherently dialogical and embattled elements of relationship, thereby closing down the possibility of understanding human relationship and selfhood in fuller depth.

The demand to manage one's risk to self and others is best illustrated by returning to the websites and promotional materials that I discussed in chapter three. These do not only provide information about medications and their uses, but they also offer instructions on how to watch out for biological dysfunction in others. For example, promotional websites teach people how to watch out for depression in friends and family so that they can advise them to start taking medication. Under the heading "recognizing depression and anxiety in others" Pfizer's Zoloft website provides a symptom checklist that can be used to assess friends and family members. They then advise:

First you need to help the person get proper diagnosis and treatment. This could mean getting your loved one to see a doctor in the first place. You might even need to make an appointment and go to the doctor with him or her.⁹

And then the forgone conclusion

Once on treatment, you should encourage the person to follow it as advised and stay on treatment, even after getting better.¹⁰

This benefits both the individual with illness and the quality of their relationship with the "care-giver." Because the depressed person might not see or have control over their illness, it is necessary to help them to help themselves get better.

Some of the people I spoke with took this advice to heart and depended upon others to help them manage the risk posed by their illness. Catherine, for example, describes how others watch out for her at the workplace:

The other day I was just “nyaanyaa,” and one of the girls I work with she was just like “Listen I’m really not trying to offend you: Did you take your Zoloft last night?” and I was like “No” and she’s like “You’re being a jerk today” and I was like “Sorry.” And they noticed it, people notice it. (Catherine, active duty navy, age 21)

Catherine does not worry whether other people know that she is biologically depressed. She relies upon others to tell her when she is being a “jerk.” In this respect others watch over Catherine and help her to monitor her use of the medications. Catherine is happy to do this. She sees it as her responsibility to take the medication on time, and in the right dose, so that she can be social and so that people at work can depend upon her.

There is a contradiction at the heart of this effort to get people to take individual responsibility for their psychological distress. On the one hand, the self is always in relationship. It is a dialogical creature that comes into being in symbolic exchange with others and with cultural images and values. On the other hand, the biological model of psychological distress and antidepressant technologies conceive of certain parts of the self as something outside of, or off limits, not only to everyday relationship, but also to professional therapeutic relationships. Where the psychoanalytic perspective placed central emphasis on the healing powers of the transference relationship between analysand and analyst, the biological perspective places central emphasis on the relationship between an individual and a medication. Insofar as intractable depression and

anxiety is a product of internal chemistry it is ultimately viewed as a problem that in some fundamental way requires an intervention at the biological level. When left unattended it becomes a risk to self and others.

Many of the people I spoke with believe that their illness – mild depression, severe depression, bipolar illness – makes them a risk to other people. They experience parts of themselves as a danger to others. Duyen for example describes an episode in which she overreacted to a romantic slight. She was at a party and came across a man she had previously dated. He was making advances on another woman. At first she wanted to “break her neck and then do something horrible to him” but she didn’t attack either of them. Instead, she went out to her car where she screamed and could not stop screaming. She felt unbearable pain that she could not stop feeling. She wanted to drive to the man’s house and destroy his property or crash her car into a pole. In retrospect, Duyen sees this as a disproportionate reaction to a minor event. She was betrayed but she would like to be able to respond in a way that doesn’t cause her so much pain and doesn’t pose a risk to herself or to others. Though her pain and her reaction is a response to a betrayal, she locates the risk within herself. She was vulnerable because she had recently stopped taking Paxil. The Paxil, though not perfect, had allowed Duyen to maintain control over disproportionate and painful responses.

Duyen fears that her illness might take over and cause her to hurt herself or others. Others I spoke with identify a less aggressive danger. In their depression they are a burden to others. In some cases they imagine depression as a kind of *toxic* thing that can spread from self to others. For example, Katrina describes the effect that she feels she has on others:

... someone who's just such bad news it's even risky to be around, like toxic, you know, so gloomy that it's even risky for other people to be around me, because the gloom is gonna spread to them, even if they have good insulation. It can still be risky to them, and I don't wanna generally don't wanna be that. Even when I am that, I'd rather keep it to my self so that it won't be a downer for others. (Katrina, acupuncturist, age 47)

Once conceived as a reified entity – a biological thing-in-itself - Katrina's depression becomes a force that can move between people. Even with all of their defenses up – their “insulation” – people could be overwhelmed and damaged by her sadness. As a result she needs to manage the amount of time that she is around others:

It's a fair risk, a fair amount of the time. These people have to watch how much time they're around me.

On the other hand, Samantha sees how difficult it was to live with her mother's depression. It took a lot out of her mother and the people who lived around her. As a result, she thinks of it as her responsibility to

keep it to myself. I don't want it to rub off. I don't wanna rub it off on...not that I'll make people depressed, but I don't wanna hurt other people. (Samantha, student, age 20)

Instead of viewing depression as a form of relationship or a product of relationship, Samantha thinks of it as something inside of herself that has properties of transferability. It can “rub off” on others and it can hurt others.

Emma uses another metaphor to describe the risk that she poses to others. She thinks of her depression and anxiety as something that drains the energy from her mother:

I think she was feeling emotionally drained by me, constantly wanting to process this, finding some way to figure it out, or whatever it was that I was doing at the time. (Emma, university administrator, age 25)

This is also how Emma understands her mother's decision to send her to counseling and to put her on medications. Emma's mother did not have the expertise or knowledge to handle Emma's depression and anxiety. Therefore, Emma thinks of her mother's decision as something that she had to do to protect herself. In this process, Emma was put in a position where she could learn to manage for herself all of the anxieties and fears that erupted when her parents were divorced. The relational risk that came out of the divorce—the powerful feelings and emotions that were unleashed – were moved from the midst of relationship into Emma's biological make-up.

Emma, Katrina, Duyen and others I spoke with, believe that divorces and betrayals and other relational ruptures are a source of pain. However, they also believe that their responses to this pain are disproportionate, abnormal and in this abnormality a danger to both self and others. Their biological condition gets in the way of productive and meaningful relationship. In this, they also feel a responsibility to an idealized kind of relationship. I asked the people I spoke with what kind of person they thought they needed to be in the contemporary world. The answers revealed a vision of self and other in which unruly emotions are kept out of relationship so that relationships could proceed in a rational and respectful manner. These were relationships in which the need for individual independence and self-control was balanced against the dependence upon others. When depressed Zareen was unable to rationally engage people at the workplace. She was too sensitive to the demands of her supervisor and took these as painful personal

insults. However, when her dysthymia was under control she was better able to “absorb” the pain and hurt she feels. She can keep going and not let sadness and weepiness take over. In this respect, antidepressants are a kind of prophylactic. They protect relationship from disruption and allow a smooth co-ordination of activities. Tara was upset because she thought she was taking her emotional baggage out on her fiancée. She did not treat her patients at work in this way, and she thought it was unfair that her fiancée should have to bear the brunt of her anger and irritability. And once on the medication, Wanda felt that she was freed from her emotional need to be nice to other people. In the past, she had relied upon others to control and manage her mood. When the antidepressants were working she gained independence and was pleased because “I didn’t need other people as much.” She didn’t need others, and in this respect she could treat relationship as a something from which she could come and go as she pleased.

This is a view of relationship which elevates rationality and coolheadedness over emotional entanglement. It resonates with what Giddens has described as the pure relationship of late-modernity. Relationship should be a place for the equal and respectful exchange of ideas, thoughts and feelings – a means of coordinating behavior and seeking satisfaction of individual needs. Similarly, in discussing the relationship between individualization and relationships, Beck and Beck-Gernsheim posit an “ideal intimacy situation” – a variation on Jurgen Habermas’s “ideal speech situation”:

To adapt Habermas’s concept of ‘ideal speech situation,’ we might speak here of an ‘ideal intimacy situation.’ If the former refers to general norms, the latter establishes specific rules for the intimate interactions involved in relationships, marriage, parenthood, friendship and the family – a normative horizon of

expectations of reciprocal individuation, which, having emerged under conditions of cultural democratization, must be counterfactually assumed and sustained.

(2002, p. xxii)

Here the relationship also possesses the valued qualities of democracy and equality. It is a sphere in which neo-liberal ideals of recognition, authenticity, and independent selfhood can be realized and nurtured. It is a “co-operative individualism, which presupposed that each has a right to life of his or her own and that the terms of living together have to be renegotiated in each case” (Beck & Beck-Gernsheim, 2002, p, xxiii). In other words the ideal intimacy situation is a place wherein individuals come together in mutual support and understanding, but also a place in which the limits of relationship are recognized – in these relationships there should be enough room for individuals to be with others, and at the same time be themselves.

The use of antidepressants, and the incorporation of the language of biomedicine into the sphere of everyday life both illustrates these ideal forms of late-modern relationship, and exposes the limits of these ideals. Antidepressants put aside unruly emotion in order that open communication and negotiation of relationship and identity can proceed. They, in a sense, democratize relationship, so that even those who are “biologically” incapable of reasonable and rational interpersonal engagement are given the opportunity to participate in these forms of life. However, as I argued in introducing the work of Jessica Benjamin and R. D. Laing, and to a lesser extent Taylor’s dialogical view of selfhood, these kinds of relational ideals are difficult to achieve. Moreover, their realization depends upon leaving unruly and overwhelming elements of the self out of relationship – putting these to the side so that the greater goals of negotiation and co-

ordination can proceed. In these examples, it is clear that there are certain parts of the self that cannot be negotiated. The claims that they make on selves and others are too much for relationship to handle. In these cases, emotional control becomes the responsibility of the individual. This does not mean that relationships are devoid of feeling and emotion. Rather, distinctions are made between emotions that are appropriate for relationship, and emotions that should be left out of relationship. Emotions that create dependency and that threaten to overwhelm and control others are inappropriate, and when they threaten to get out of control these are to be handled with antidepressants.

If relational ideals that assume mutuality and equal self-recognition are to be realized – and I do think that they are ideals worth pursuing – people must also be able to understand the powerful and unruly interpersonal forces that continually challenge these ideals. The individualizing and atomizing view developed within the biological model and further reinforced in the practical use of antidepressants, does not get us very far here. It depends upon an assumption that by their very nature human beings are atomistic creatures. Personality and emotional make-up is shaped in advance by genetic heritage and biological predispositions. These emerge from inside the self, as it were. Here unpredictable and unruly emotion is thought of as a product of internal processes. Even in cases where people recognize and describe environmental sources of distress – such as break ups in the family or childhood trauma – their inability to understand and overcome these problems is attributed to a biological dysfunction that makes them too sensitive to a world that other people have managed to live in quite happily.

I make the reverse assumption. In the first instance people are relational beings deeply entangled with others. This benefits from the work of sociologically minded

theories of the self, but is thickened up through the work of psychoanalytic theorists such as Jessica Benjamin (1988). In the beginning of this story there is no clear distinction between self and other. Psychoanalysts usually envision this as the bond between a mother and child. To become a self requires that an individual distinguish herself from the other, and in turn gain recognition from the other as an individual self. This individuation, supported and required by modern social institutions, is always emotionally charged and continues to be emotionally charged throughout life. Here emotional attachment is the “matter” that makes selfhood possible. In contrast to the empty airy space that individualists assume to exist between persons, this perspective sees the space between self and other as a terrain rich in meaning and always in dispute. Deep sadness, mild persistent sadness, overpowering anxiety, obsessive compulsive behaviors, grow out of this space. Insofar as emotion and self are always in relationship, they are by definition larger than any single self, and its control and understanding exceeds any single self.

When the biological model pushes responsibility for interpersonal risk and unruly emotion into an individual’s internal chemistry it does two kinds of damage. First, it asks that individuals accept a burden that, in my view, is properly a relational burden. Indeed, by pushing these relational elements further back upon the individual self, the biological perspective puts too much stuff into a small cramped space – the brain is not very big after all. When antidepressants “cut off the tops and bottoms” of emotions, or “put a skin between self and other” they make unruly emotion manageable and livable, but they also give rise to burdensome and frightening splits within the self. Individuals, as I argued in

chapter four, are able to enter into relationship, but only after accepting that they carry within themselves risks and dysfunctions.

Second, insofar as the biological model of mental health becomes the most talked about and widely circulated understanding of psychological distress, it pushes to the side narrative and dialogical articulations of selfhood and suffering. Here the narrative theory is not merely the view that people have stories to tell about themselves. Indeed, the biomedical society is replete with stories about people's encounter with life-saving technologies. These are told in memoirs, presented in advertisements, collected on promotional websites, and further distributed through face-to-face conversation. In many of these cases though, stories about the self serve only to further entrench the view that psychological suffering is an internal and individual problem – a product of biochemical imbalance best treated with antidepressants. These are often heroic stories of individual accomplishment, but in the end this heroism is not enough to sustain the self. People also need others.

In contrast, to speak of a narrative alternative is to assume that shared, interpersonal storytelling has a power to constitute selves in health and illness. Here, as Claudio Neri (1998) argues, narrative can become a medium that can “hold” and “digest” overwhelming and incomprehensible feelings and emotions. For this we need a rich view of narrative – narrative as embodied, narrative as something that can shape and hold time and space, narrative as something that can give people places in which to live with and for others. Emotions need room to breath, to strike out, and to devour. How is it possible to retain and maintain some relational space for the emotional self without destroying one another in the process? Are there narratives that could handle and give meaning to these

emotional entanglements? Is it possible to maintain a commitment to valued modern ideals of authenticity and independence, and yet maintain people in deep connection to others? The answers to these questions exceed the scope of this dissertation. As such, I will leave them as hopeful possibilities to be taken up at another time.

Chapter 6 Notes

¹ Hegel's dialectic is situated in a much larger philosophy of Being, in which the human subject becomes a kind of historical vessel through which Reason (God) comes to realize its freedom as consciousness. In both the development of historical understanding and the development of self-understanding, the self begins in a state of minimal consciousness and through its engagements with the material world and other person develops a self-consciousness. Hegel's story of the master-slave relationship, demonstrates the way in which the achievement self-consciousness is also fraught with contests of power and domination. Both the master (the lord) and the slave (the bondsman) depend upon one another for recognition. Hegel depicts a struggle in which individuals vie for control over one another. The master is the one who is willing to risk his life in order to secure a certain recognition from the subordinate other. This nevertheless is an unsatisfying recognition because it is not willingly given. It is rather a form of domination which seeks recognition but is perpetually frustrated in this desire.

² This is also captured in sociologist David Karp's (1996) *Speaking of Sadness*, where he argues that the depressed person suffers because he or she has an experience that is incommunicable. The sadness and emptiness of depression cannot be shared with people who have not experienced depression. While many of the people I spoke with share this attitude, I'm making a different point. Karp is saying something about the ontological status of depression. It is a unique experience because it is outside of language. This gives depression its unique relationship to the self. Karp however does not conclude therefore that we should have nothing further to say about depression. My concern is that the biological model a) argues that depression is an incommunicable experience and b) concludes that we cannot and should not try to say anything about the experience of depression – it is mere biological dysfunction.

³ This includes Joanna, who as I argued in chapter five, struggled to find her authentic self at the university, but in this process kept returning to the comfort provided by her family. Jennifer and Jeremy were two other college students whose course of antidepressant treatment coincided with their departure from the family.

⁴ The new antidepressant was either Zoloft or Celexa. Katrina couldn't exactly recall. She went off the medication soon thereafter.

⁵ This points to what Irene Broverman et al. (1970) refer to as the "double standard" in mental health. In this, cultural stereotypes of male and female traits shape the judgment of what is considered abnormal and normal gender behavior. In particular, in comparison to males, females are seen to be naturally less aggressive and less prone to anger. Therefore, when these behaviors emerge in women they are more likely to be interpreted as indications of mental disorder rather than normal and expected behaviors.

⁶ One time, in protest, Samantha stopped taking the medication. She started to feel sick. She didn't realize that these were withdrawal effects. But she learned her lesson and was willing to stay on the medication rather than suffer the side effects. Could we say that the medication colludes with the family decision to put Samantha on medication? Do the medications themselves ensure that Samantha stays on the medications even when her parents cannot watch over her all of the time? Samantha seems to experience it like this, and rather than face the side effects, and the prospect of further depression, she accepts that the medications are there to help her.

⁷ Laing (1969) is particularly critical of the interweaving of family and professional psychiatry. He sees psychiatry as a defender of oppressive family systems and dramas. For Laing, the psychiatrist steps-in when the family – in particular the father – can no longer maintain order in the household.

⁸ One very popular means of gaining understanding of antidepressant medications is through Internet chat sites. I didn't speak with anyone who had participated in such chats but examples can be found at <http://hastypastry.net/forums> and <http://theicarusproject.net/>.

⁹ http://www.zoloft.com/zoloft/zoloft.portal?_nfpb=true&_pageLabel+recog_how_to_tell; retrieved November 23, 2005

¹⁰ *ibid.*

Chapter 7: Conclusion

“Without a bent for melancholia there is no psyche, only a transition to action or play”

(Julia Kristeva, *Black Sun*, 1989: 4)

In this dissertation I have relied upon narrative and hermeneutic theory in order to examine the impact that the languages and technologies of biomedicine have on self-understanding. I have described a number of ways in which self-understanding is transformed in the encounter with antidepressants. For one, the idea of biology is introduced both as a content of narratives and as a means through which the self is re-structured. As content, the biological theory introduces new “characters” into the story of selfhood. For example, depression, as internal biological dysfunction, becomes a risky and dangerous enemy to be fought off with antidepressants. The biological theory also participates in a more general social trend wherein “well-being” becomes a valued endpoint in the story of selfhood. In contrast to older narrative forms in which well-being was an ends to a greater means, in these narratives well-being is experienced as a bodily equilibrium, a feeling state which provides comfort and support for individuals who are overcome by otherwise inexplicable and intractable forms of psychological distress. The introduction of the biological view of mental illness also provides the grounds for a re-structuring of selfhood. In chapter four, I showed how the idea of biology can become a container for split-off or disavowed elements in the self. Distinctions are made between behaviors and feelings that are “not me” and behaviors and feelings that are the “real me.” In connection with this splitting of self, I also argued that certain functions of psychic life are increasingly taken-over by antidepressants. People who are practiced in

the use of antidepressants are able to use these to manage and control unruly elements of psychic life. Here I introduced the concept of the “ego-prosthetic.”

The idea of ego-prosthetic has implications for our understanding of the role that narrative plays in contemporary life. In chapter two I proposed a theory that granted narrative a tremendous amount of power. Narrative was seen not merely as the act of telling stories, but it was also described as an embodied medium that has the capacity to structure action, and convert chaotic feelings and experiences into meaningful forms of understanding. In this view, narrative is also able to hold selves together, and even if it cannot always “cure” psychological illness, it can make that suffering available for shared understanding and thereby provide it with an important grounding and intelligibility. In a society in which the problems of the self are increasingly individualized and psychiatric theories valorize the notion of atomistic, self-contained selfhood, this view of narrative suffers, and as I suggested some of its key functions are taken over by antidepressants. They “teach” people about themselves and their biology, they help to manage emotion, and they become ego-prosthetics that allow people to split-off risky and threatening elements of their selves. Here, the relationship between individuals and medicines assumes priority over the inter-subjective relationships that, for example, were prioritized in psychoanalytic narratives. Antidepressants become a means of preparing individuals, in advance, for relationships with others. In Goffman’s sense, the hard work of becoming a self and maintaining the presentability of self for others is worked out in the backstage of social life. Selfhood is a shared ideal, but it is an ideal that each and every person is expected to come to on their own.

Most striking, though, is that the biomedical view of self, and the use of antidepressants, does not lead people to wholly rethink themselves in biological terms. Indeed, one reason for discussing the splitting mechanism was to show how antidepressants are used to realize older, modernist, aspirations of selfhood – authenticity, self-control, and the hope for mutuality and equality in relationship (“pure” relationship). Even though the use of antidepressants often involves people in deeply involving efforts to control side-effects, search for better medications, and achieve a feeling of normalcy, the medications also provide people with the freedom to be themselves. Some postmodern and poststructural theorists argue that these vestiges of the modern self should be abandoned. They are seen as components of neo-liberal ideologies and disciplinary regimes. In contrast, I follow the lead of Charles Taylor and argue that these remain powerful sources of the self. When reconceived in narrative and dialogical terms, the “self” can be situated as a strong foundation not only for helping people to realize personal wants and desires, but it can also serve as a basis for larger social and political endeavors. Many of the ideals associated with modern selfhood are also ideals that underwrite contemporary neo-liberal democratic institutions. Especially in global and multicultural societies the entitlement to individual and human rights, as well as the right to one’s own cultural practices depends upon the capacity to recognize the “authenticity” that resides in these diverse forms of life. Authenticity and other modern ideals are only a problem when they result in an atomistic individualism and the fragmentation of social life; when they give rise to what Taylor (1991) calls a “soft relativism” that allows people to retreat into individual preferences rather than negotiate the larger social ideals that ground all acts of self-understanding. In this respect a theory of the self must be able to 1)

allow people to realize ideals of self-fulfillment and yet 2) retain a focus on the fundamentally dialogical character of selfhood, subjectivity and identity. Here to be a self is to be in the world with others and to recognize a commitment to common ideals.

However, there are also powerful social forces working against this ideal. For one, the evaporation of shared narrative forms, and collective social institutions pushes selves into a defensive stance. Instead of seeking selfhood through others, or through shared commitments, contemporary persons, as Anthony Giddens (1991) offers, cocoon themselves within individual narratives. Antidepressants, come to the aid of this cocooning of self, enabling people to put up skins between themselves and the world so that they can find some room to pursue individual aspirations and goals. These narratives reflect the modern aspirations toward authenticity, self control, and pure relationship but they also engage these cautiously, from behind a protective skin.

Moreover, this individualization and cocooning of self is further encouraged by the proliferation of a risk mentality. Here, as Beck (1992) argues, individualization and risk management go hand-in-hand. The general fear of environmental destruction, financial collapse, transnational terrorism, the threat of crime, and the spread of disease are encountered at the level of everyday existence as a perpetual risk to the well-being of self. In addition to the fear of these external risks, contemporary medical and psychiatric science contribute to the growing fear of risks internal to the self. I argued that the encounter with antidepressants not only introduces people to the possibility that their biology poses a risk to their well-being, but also offer technologies, in the form of antidepressant medication, that can be used to manage and combat these risks.

Furthermore, the act of taking antidepressants and understanding depression and anxiety in biological terms brings new risks into the life of the self – the widely discussed fear that taking antidepressants can lead to suicide, the introduction of unfamiliar and confusing feelings and side-effects into everyday life, the worry that the antidepressants can change one’s personality, the concern that antidepressant might stop working and depression would return full-force, and the fear that depression – now a reified biological entity – can destroy the self and others. In the very act of offering a treatment for intractable depression and anxiety, the discourse and technology of antidepressants constitute these as risks to be feared and treated, rather than elements of self to be understood. The proliferation of such risks, both externally and internally, leads to a further sequestration of self – the attempt to preserve a safe, defensive space for the individual.

Finally, the mainstream social and natural sciences don’t help us very much in overcoming the propensity for individualization and the fear of risk. Indeed, these sciences frequently serve to legitimate the view that the self is an atomistic creature. Here, as Taylor (1991) argues, contemporary natural and social science frequently mistake the social ideals of individualism and authenticity for theories of human agency. Rather than recognizing these as dialogical accomplishments grounded in historical and cultural arguments, they are taken to be matter-of-fact qualities of human beings. Cognitive psychologists assume, from the start, that cognition and feeling are capacities that reside within the minds or brains of individuals, and that their elucidation depends upon further study of the structure and organization of the mind (Danziger, 1990). Rational choice theorists posit a basic individual rationality. Human beings engage the

world and social life through a process of rational and instrumental calculation – oftentimes viewed as innate capacity – that seeks to maximize pleasure and minimize pain. The possibility that rational calculation is a social and moral achievement is frequently bracketed and considered of secondary importance to the task of understanding how rationality works. These forms of methodological individualism are further legitimated by neuroscientific research that seeks to ground human cognition and feeling, as well as psychopathology, in brain structures and genetic predispositions. On these views, the hope for authentic and satisfying selfhood is to be found through further research on the individual factors that predispose people to sadness, worry, anxiety and other forms of malaise, and the development of techniques that allow people to develop their capacity for both the management of their lives, and the risks that are seen to naturally threaten full and complete selfhood.

Even more vexing, the biomedical view of self and the discourses that surround the use of antidepressants put people at odds with the ideals that these medications would seem to help realize. Again drawing on Taylor, this is a part of a more general cultural inarticulacy over the dialogical character of selfhood. It should be clear, of course, that one of the ideals associated with antidepressants is the relief of pain and suffering. Here the basic ability of antidepressants to bring stability to the chaos and confusion of intractable depression and anxiety cannot be understated. Yet, even on this point, antidepressants offer a compromise solution rather than complete engagement with the sources of such malaise. For one, consider some of the problems, risk, and forms of suffering that the medications introduce: distressing side-effects, engagements with a psychiatric system that promises relief (especially in the advertisements) but often leaves

people on their own to figure out which medications are working and how well they are working, the construction of depression and anxiety as risks to be feared rather than parts of the self to be understood, the pain and sense of fragmentation that, for some, comes with splitting-off parts of the self, and finally, the stigmatization that, as many of the people I spoke with told me, continues to haunt the use of antidepressants. Ironically, in making the choice to get well, people are also asked to accept the possibility that in some fundamental way they are not well, and may never be well. In a society that prioritizes individual solutions to systemic contradictions, these new forms of suffering become an added burden for the antidepressant user.

In addition, antidepressants promise to restore selfhood. In correcting chemical imbalances they help people to become the selves that: 1) they had lost to chemical imbalance or 2) had never known because of the interference caused by depression and anxiety. In this, the medications help people to realize the modern, and even today prevalent, desire to be authentic selves; that is, to seek self-fulfillment and share their achievements with others. There is, as Taylor argues, already a contradiction at the heart of contemporary authenticity discourse. Insofar as it is articulated with ideologies of individualism and subjectivism, authenticity becomes a matter of “soft relativism” – selfhood is that *thing* that people are seen to naturally possess. In this, as I argued in chapter three, the ideal of authenticity is also reified – it becomes a thing that can be bought and sold on the free market. At least as the ads tell us, self-fulfillment can be achieved through the purchase of a medication that restores the imbalances that render a person inauthentic. Moreover, as I argued in chapters four and five, in this atmosphere, the quest for authenticity becomes a defensive retrenchment into comfortable feeling

states. There is, no doubt, pride in this accomplishment, and it brings a feeling of self worth that can also be shared with others. In this respect, people use antidepressants to make themselves available for others: containing and controlling anger so that children can be protected against unruly outbursts, taking up a position in family drama in order to maintain the coherence and integrity of that life form, and protecting idealized visions of “pure” relationships from the elements of self that pose risks to those ideals.

However, without a dialogical base out of which to understand these strivings, the self is threatened with isolation and lonesomeness even as it pursues relationships with others. To promote this dialogical theory of the self means situating the taken-for-granted (i.e. naturalized) languages and aspirations of the self within the historical and social sources that continue to inform their meaning. This is not only a matter of telling a history of the self, but it is also a matter of reconstructing shared narratives – the stories about selfhood, its aspirations, its dangers, and its disappointments that people hold in common. Samantha, one of the people that I interviewed, saw her struggle to overcome depression as a pursuit that she shared with others. She knew that millions of Americans were involved in the same quest for well-being as she. Yet, for her, this knowledge was an abstract knowledge. Quite poetically, I think, she said: “Now I know that there are millions of people who are diagnosed as depressed, and all these people feel alone, but really they’re all feeling alone together.” Samantha recognizes a commonality in this lonesomeness, but hasn’t been able to bridge the gap between self and other. In this respect, as technologies that leave people to pursue selfhood and well-being on their own time, antidepressants are fragmenting. They fragment the self – leading people to split off unruly elements of their feeling – and they fragment larger collective bonds. These two

problems are related. The disappearance of narratives that could make sense of the self in relationship to others, also leaves the self alone to handle its severest losses and emotional crises. The antidepressants pick up the pieces, but insofar as they push the self further inward, they fail to restore the capacity for interpersonal narrative that I believe is so central to mediating the engagement with self, others, and the world more generally.

Here the idea of shared narration – of telling stories about the self that have some kind of common significance -- must also be practically realized. It is not enough, in other words, that the biomedical culture proliferates stories of individual well-being, and heroic victory over illness and disease. There is no paucity of such stories. Indeed, we are living in the age of narrative, where every person has a story to tell and is free to tell it. Every person's and every group's story can be seen on television programs, in movie theatres, in advertisements, and all over the Internet – on websites, but increasingly on personal “blogs.” The problem is not a lack of stories. Further, the problem is not that there are not enough places to tell stories. There are countless self-help groups and consumer mental health advocacy groups that bring people together under a common roof to share their stories about their particular form of suffering, and the treatments that helped them to overcome their illness. At a certain point, the proliferation of stories and places to tell stories begins to look like a problem itself -- symptomatic of the inability to tell any really good story. Or perhaps, this signals the inability of one's own story to bridge the gap between self and other.

Here, what is needed, I think, is a re-visioning of the way that selfhood – authentic or otherwise – is understood and engaged in everyday life. Even in its most individuated moments, selves must be seen as creatures that are always in relationship to

others. This can mean, as it frequently does for Taylor, understanding how people are caught up in moral and cultural traditions that make undeniable demands upon people. It can also mean, as it does for numerous psychoanalytic thinkers, that even the purest relationships – those which realize the aspirations of mutuality and equality – are also ruled by deep interpersonal emotional involvements and demands. Indeed, insofar as the loss of the other is a tragedy which shapes the life of the self, it is a loss that is rehearsed in relationship after relationship, perhaps never overcome – perhaps a story that can never be adequately told or lived.

In concluding, let me try this from one last angle. I want to consider whether the biomedical view of depression and anxiety cuts people off from valuable components of their selves. In particular, are depression, anxiety, frenetic worry, and deep sadness important modes of selfhood? Are they, perhaps, necessary forms of self-engagement that make self-fulfillment and meaningful relationship possible? This is obviously a tricky question to address. I don't want to put myself into the position that I critiqued in chapter five. There I introduced some contemporary arguments (Kass et al., 2003) which feel that the widespread use of antidepressants signals a threat to traditional moralities of self and society. One of the fears is that if people use antidepressants to treat everyday, normal worries they also rob themselves of certain character-forming experiences. A similar critique is the neo-romantic view that deep depression and madness is a necessary element to creativity.¹ By using antidepressants to smooth-over the rough spots in our souls, we cut ourselves off from the wellsprings of creativity, and thereby become less human. This is the image of antidepressants and depression that Peter Kramer (2005) has vehemently attacked in his recent follow-up to *Listening to Prozac, Against Depression*.

Kramer, rightfully I think, argues that it is irresponsible to stigmatize and challenge the use of antidepressants in the name of “heroic melancholy” (2004: 212).

Maybe a better way of putting the question is: are depression, anxiety, frenetic worry, and deep sadness important modes of selfhood *anymore*? This emphasizes my interest in the cultural impact of antidepressants, and what they indicate about the way the self is now understood and engaged. Here of course I risk making a generalization from the people that I spoke with to making claims about a more global change in the culture of selfhood. Indeed, the people that I spoke with were self-selected. They wanted to talk with me because they had a story to tell about the antidepressants – for good or for bad. They, for the most part, came from middle-class backgrounds. Other stories might include the way that antidepressants are used by people from different income brackets, or from different parts of the world. But I also feel comfortable in generalizing for a number of reasons. These medications have become part of the popular culture. They are no longer contained in asylums, but are increasingly a component of everyday life. And insofar as the stories about antidepressants circulate widely in the media and in face-to-face conversation they also constitute new languages of the self. The very fact that they are spoken of so widely and generate such debate suggests that these discourses resonate with and give expression to dilemmas encountered in contemporary life.

Once again: Are depression, anxiety, frenetic worry, and deep sadness important modes of selfhood anymore? Psychoanalyst Melanie Klein argued that, in the early years of life, children acquire the capacity to assume what she called the “depressive position.” The depressive position follows an earlier stage of development – the paranoid-schizoid position – in which the infant fears that its ego is under attack. It experiences the

separation from its mother as a threat of annihilation, and exists in a violent world where it both defends against, and attacks objects that it imagines to be a threat. In a further effort to preserve ego-integrity the infant splits itself, and objects in its environment, into good elements and bad elements. The depressive position emerges when the child begins to perceive the objects in its environment as whole objects:

The resolution of splitting of selves and objects in the depressive position occurs through what Klein calls reparation. The infant becomes, as development proceeds, inescapably aware of the separation from the object (the primal split) and simultaneously becomes aware of guilt toward the object in regard to phantasied damage done to it. Probably the infant's speculation about why mother split him of stimulates his awareness of this guilt. As the infant longs for the departing mother, he also is restoring her as an image of representation in his mind (Grotstein, 1981: 31).

The capacity, then, to assume the depressive position is also the capacity to integrate the various elements of one's psyche. It requires coming to terms not only with the threats posed by the world, but also through the development of a feeling of guilt, and through a desire for "reparation" of the imagined harm done to others, the development of the capacity for empathy and care. Here the word depression does not refer to disease, but it refers to an attitude that the self takes to itself and the world. This is an attitude central to bridging the gap between self and other. This attitude is necessarily mediated by narratives that consider relationship more than a telling of one's story, but also a means of mediating relationship. This is the story in which "depression" is not an internal disease, but rather an attitude or a position taken to the self, others and the world.² In this

respect passing through a depressive position would seem crucial not only as a means for engaging the world of others, but also for realizing the ideals of our contemporary culture – empathy, sympathy, benevolence, and wholeness of self. Here the psychoanalytic theory of self meets up with Taylor’s narrative hermeneutics – a desire for recovery and retrieval – a grounding of the self in rich stories that not only bridge self and other but ground this relationship in heavy and deep backgrounds.

The language of biomedicine colours the words “depression” and “anxiety” so that they cannot be viewed as forms of relationship, but rather become thing-like entities that reside somewhere inside of the self. In the quotation that opens this conclusion, Julia Kristeva describes melancholia as fundamental to the psyche. “Without a bent for melancholia there is no psyche, only a transition to action or play” (1989: 4). I understand her to mean that the self is held together only in its encounter with an unspeakable absence. Melancholia is the attitude of care that seeks the recovery of that which can never be recovered. It thus moves selfhood forward in a persistent quest that drives reflection both inward (toward self) and outward (toward other). Despite all that I have said about the antidepressants and the self, it remains unclear to me whether these medications remove this element from psychic life, or whether they merely return persons to a state where they can re-engage the problems of loss and relationship. Most of the people that I spoke with assured me that the antidepressants did not rob them of feeling or emotion, and despite the feelings of lonesomeness that sometimes accompanied their use, the medications opened them up to others in ways that they would not have been able to otherwise.

In either case, it seems clear that even if the antidepressants restore this basic capacity for selfhood, the surrounding biomedical culture fails to provide languages and stories that would allow this quest for selfhood to continue. For with the antidepressants, once well-being is recovered, the story comes to an end, and there are few other stories that could pick up the baton, and carry forward this act of self-narration. The story of well-being is the story of the times, and the pleasures of authenticity and self-control, even if desired, are regularly interpreted in its light. Indeed, in a globalizing culture that aims toward greater connectivity, faster speeds of movement, the unceasing flow of capital, the ongoing transformation of identities, and the mutability of all life forms, the desire for wholeness and the integrity of selfhood seems a liability rather than an ideal to be pursued. In this case, maybe only a basic stability and integrity – a holding together of the self through whatever means – is required. If this is the case, then we might well celebrate the story entailed in the discovery and dissemination of antidepressant medication, and the pursuit of well-being for its own sake.

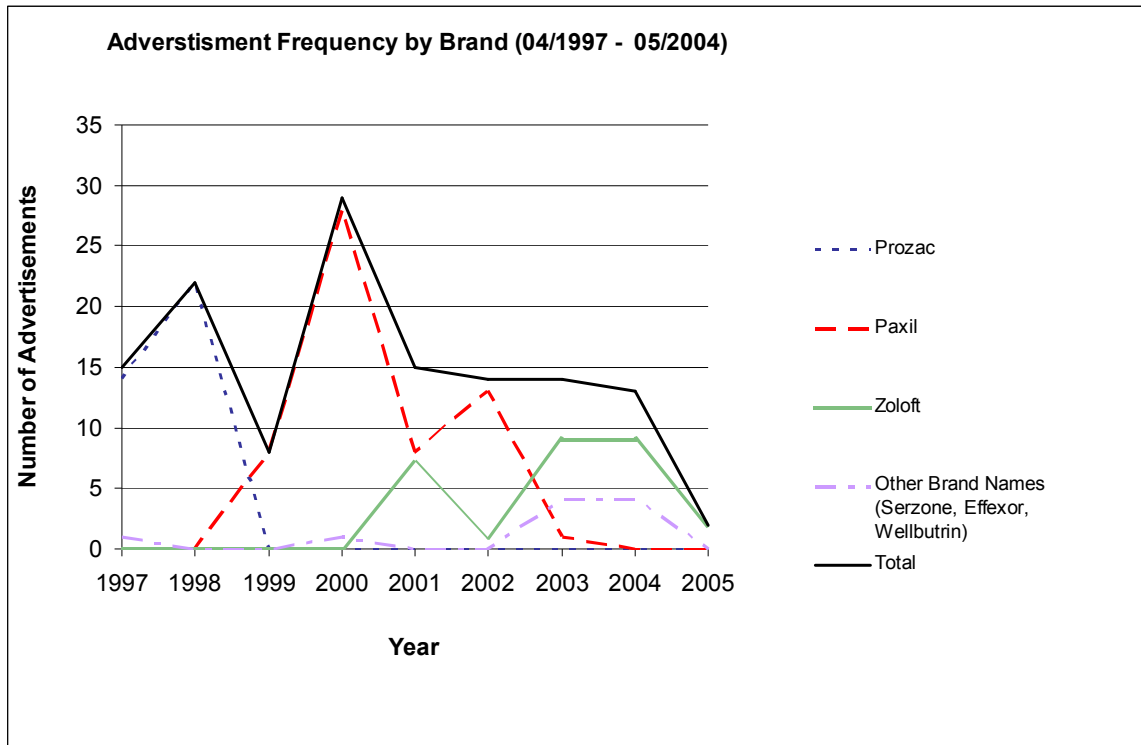
My view, however, is that the story of selfhood, both historical and lived, continues to serve as a rich and indispensable background for interpreting and engaging the complexity of human expression, both old and new.

Chapter 7 Notes

¹ This theme is thoroughly discussed by sociologist George Becker (1978) in his book *The Mad Genius Controversy*.

² Though, of course, the inability to resolve one's passage through the paranoid-schizoid or depressive position can result in later-life pathology.

Figure 1: Advertisement Frequency by Brand



Appendix 1: Methods and Analysis

The empirical components of this research were conducted between October 2004 and June 2005. Antidepressant advertisements and internet promotional materials were collected between October and December 2004, though subsequent materials were added through to June 2005 as new ads became available and websites were updated. Interviews with people who were taking or had taken antidepressants were conducted between January and June 2005. Interview questions and ongoing analysis were, in part, influenced by preliminary ad analysis and promotional materials, though the interviews were not driven by an effort to establish a direct link between advertisements and self understanding. Similarly, analysis of the advertisements were influenced by materials discussed during interviews. For example, early in the interviews it became apparent that some people hope that antidepressants will “make them into themselves again.” This drew my attention to the significance of advertising slogans such as “welcome back” (Eli-Lilly’s Prozac), “you’re not feeling like yourself” (Pfizer’s Zoloft), or “your life is waiting” (GlaxoSmithKline’s Paxil).

The Advertisements and Promotional Material

As is discussed in chapter three, I do not assume that advertisements cause people to think about themselves in a particular manner, or that these advertisements are the only means by which people learn about antidepressant medications. Other sources of such knowledge described by participants in this research include: scientific articles both in the popular press and on the Internet, university classes, encounters with medical professionals including family physicians and psychiatrists, and discussion with friends

and family members. In this respect, I studied advertisements in order to gain an introduction to the kinds of language available for discussing the self in a biomedical culture.

I gathered three kind of materials: 1) Magazine advertisements for antidepressants, 2) television advertisements for antidepressants and 3) Promotional materials for antidepressants including Internet websites and materials sent through the mail.

Magazine advertisements were photocopied from nine popular, widely distributed, magazines: *Time*, *Self*, *Glamour*, *Sports Illustrated*, *Men's Health*, *Essence*, *Esquire*, *Reader's Digest* and *Psychology Today*. I reviewed each issue of each magazine that was published between July 1997 and May 2005. I started with 1997 because that was the year Eli-Lilly began promoting Prozac through direct-to-consumer advertising. Nineteen ninety-seven was also the year that the American Food and Drug Administration (FDA) relaxed regulations to allow promotion of prescription medications direct-to-consumer through television (Angell, 2004). While prescription medications had been promoted in magazines before this date, this was not the case with the antidepressants, which until that time, had only appeared in professional pharmacy and medical journals.

The magazines were chosen for their visibility, large readership, and breadth of audience. Though this study does not investigate the relationship between magazine demographic, and advertising strategies, I chose magazines that target a number of different audiences and social groups in order to ensure a complete collection of ads. *Time*, for example, provides general news and current events, *Self* addresses women's

health and fitness, *Essence* is an African-American women's lifestyle magazine, and *Esquire* is for men's fashion and lifestyle.

Though I collected a wide range of ads for psychiatric medications, for this analysis I included only ads for antidepressant medications: SSRIs (which block the re-uptake of serotonin), SNRIs (which block the re-uptake of serotonin and norepinephrine:), and a DRI (dopamine and norepinephrine re-uptake inhibitor). Six different brand name medications were advertised: Prozac, Serzone, Paxil, Zoloft, Effexor, and Wellbutrin. This includes extended release (XR) and controlled release (CR) formulae of these medications.¹ There were 21 different ads, which appeared a total of 132 times across the years and magazines under review (see Figure 1). Of the nine magazines reviewed ads appeared most frequently in the *Glamour* (25%), *Self* (19%), *Time* (19%) and *Sports Illustrated* (16%) followed by *Esquire* (9%), *Reader's Digest* (8%) and *Essence* (5%). There were no advertisements for antidepressants in *Men's Health* or *Psychology Today*.

Television advertisements for Zoloft, Paxil, and Wellbutrin were viewed through the on-line commercial archive *Adland* (www.ad-rag.com). The archive included five ads for Zoloft (from 2003, 2004, and 2005), three ads for Wellbutrin (from 2003, 2004, 2005), and one ad for Paxil (from 2004). Finally, I examined two websites used in the promotion of the antidepressants Paxil (www.paxilcr.com) and Zoloft (www.zoloft.com). I also subscribed to GlaxoSmithKline's "CRBalance," an on-line guide, support system, and customized information source for people taking PaxilCR. This included access to on-line materials including a "condition tracker," "refill reminder," and weekly e-mail newsletters. I was also assigned a personalized, computer-generated guide. I received

similar materials about Zoloft from Pfizer, through their “Knowing More” mail campaign. In short, for the months of October, November and December 2004, I created around myself an environment populated by ads, promotional materials, and user guidelines.

Since the most comprehensive set of materials was the magazine advertisements, I used these as a starting point for analysis. I employed a form of discourse analysis that was aimed primarily at describing the narratives, images and depictions of self that appeared in the ads. The analysis unfolded in two stages. First, I reviewed all 21 ads to get a feel for the content and style of the ads. This search was guided by some general assumptions about the rhetoric and strategy of pharmaceutical advertising, especially as described by Metzler (2004) and Goldman and Montaigne (1986). I also relied upon Judith Williamson’s (1978) book *Decoding Advertising*. To my knowledge this is the most comprehensive and sociologically oriented demonstration of methodological techniques used in advertising analysis. Though I do not report all of these findings in this study, I considered and took notes on: strategies of normalization and medicalization (e.g. descriptions of depression or anxiety as disease); descriptions and pictorial depictions of the biological underpinnings of psychiatric illness; descriptions and pictorial depictions of the biological mechanism attributed to antidepressants; depictions of the self, both pictorial and textual; references to social aspects of selfhood, such as involvement with family and recreational activities; and narratives of self, such as stories of recovery. This first stage of the analysis provided me with an understanding of how these advertisements work, and how they depict selfhood.

The second stage of analysis was a formalization of my findings from the first stage. I described the story, or kinds of stories, told about the self, biology, and antidepressants. What kinds of narratives are these? Does the story come to, or promise, resolution? If so, what kind? What is the role of the antidepressant in this story? What kind of biological imagery, if any, is employed in the advertisements? Are there certain narrative structures shared by all of the ads? I also searched for contradictions or narrative dilemmas that arose from the stories told in the ads. For example, though antidepressants are said to restore happy selfhood, this restoration requires that the users of antidepressants imagine that they are in some fundamental way diseased or disordered. I was able to carry this apparent contradiction into my analysis of the interviews. Do people try to resolve this dilemma? If so, how is it done?

Furthermore, it is important to note that this analysis was not strictly concerned with the world of the text, but rather ways in which texts – or at least the imagery produced in these texts -- might be taken up by readers and integrated into their personal stories of self. As such this is a discursive analysis that keeps in mind the relationship between cultural texts and the lived, practical character of storytelling. As such, in addition to describing the narratives constituted within texts, I isolated slogans, images and characters that the advertisements *made available* to readers and popular culture more generally. In this respect, the ad analysis looks toward, and in part relies upon, material discovered in the interview portion of this research. For example, while biomedical science provides a complex and highly theoretical language for understanding depression as a biological concern, the advertisements place into the foreground certain simplified, straightforward narrative elements. One prominent example is Pfizer's

cartoon image of neurotransmitter action. This is a central in the Zoloft ads, and intended to establish to biological basis of SSRI action.

This analysis was checked, and supplemented, by comparing it to television ads, and the promotional internet websites. In particular, the internet materials provided a seemingly inexhaustible web of hyper-text connections to depression and anxiety resources, access to articles and scientific descriptions of antidepressants, but most importantly “hands-on” materials that could be used in the self-diagnosis and eventual management of one’s illness.

The Interviews

I interviewed 23 people who were taking, or had taken antidepressant, medications. Participants were recruited using posters placed in various locations on the campus of a large American public research university, and at libraries, coffee shops, grocery stores and community centers in a heavily populated, middle class, suburban community (See Appendix 2). The posters requested interviews with people who were taking or had taken SSRIs or SNRIs for any reason. Though the majority of the people I spoke with were taking antidepressants for depression (15/23), there were also people who were taking antidepressants for anxiety (2/23), some for a combination of depression and anxiety (3/23) and others for bipolar disorder (3/23). In addition to depression or anxiety, several people were suffering from other conditions. Two women had struggled with eating disorders, one person had been diagnosed with dissociative identity disorder, and one was taking medication for attention deficit disorder. In this study I reported the name of the condition provided to me by the participants, as understood by participants. Many of the people I spoke with, in concert with family physicians or psychotherapists,

diagnosed themselves. Others were officially diagnosed by psychiatrists according to DSM criteria (Diagnostic and Statistical Manual of Mental Disorders). Others had seen psychiatrists but did not think they had been diagnosed. They assumed they were depressed because they were taking antidepressants. Furthermore, participants understood depression in different ways. Though some people thought that they suffered from clinical depression, their concerns better approximated what others call chronic anxiety. Though some described their depression as severe, it was not clear from the narratives that this depression was any more severe than people who talked about normal or even low level depression. Given the narrative and hermeneutic approach to this research, the accuracy of these diagnoses are not in themselves important. What interests me is the way that this psychiatric terminology enters into, and transforms, personal narratives (for review of participant details see Appendix 4).

Participants were self-selecting, and included five men and eighteen women ranging in age from 20 to 59. The average age was 32 years (median = 32 years). Ten participants were students at the university (7 undergraduate, 3 graduate) and 13 were from the community. Three participants from the community were unemployed, and the other ten were employed in occupations including school teachers, a real estate agent, a person on active military duty, a university administrator, an acupuncturist, a health care consultant and a research psychologist. While the majority of participants were Caucasian (though in one case, originally from eastern Europe), three identified themselves as Asian American, one as Euro African, and one as one-quarter Hispanic and three-quarters Caucasian. Four of the people interviewed had used antidepressants in the past for a period of at least three months, but were no longer using them. The remainder were

currently taking antidepressants. Twelve of these people were presently taking one antidepressant, two were taking two antidepressants, and the last five were taking either one or two antidepressants in combination with some other psychiatric medication. The length of time on the antidepressants, of one kind or another, ranged from three months to 25 years. Five people had been on antidepressants for less than 6 months, eight for between 6 months and five years, nine for between 5 and 10 years, and one for over 10 years.

Interviews were conducted in one of two places: a seminar room at the university, or a study room in a public library (at her request, one participant was interviewed at home). Both rooms were private and quiet. With the permission of participants, interviews were tape recorded. I transcribed these interviews at a later time. Most participants were available for two semi-structured interviews.

The interviews were guided by a narrative method. In the first interview, I asked participants to tell me the story of why they started using antidepressants, and how this fit into their overall life story, and understanding of self. The interviews were also guided by a set of questions which I either used to prompt participants, or to deepen a particular aspect of a story. These questions touched on three thematic areas: a) the self and antidepressants, b) self and others and c) attitudes and opinions about the medication (see Appendix 3). When time permitted, I also showed participants some examples of the ads collected in the first part of this research, I was able to do this with eight people. In many cases, participants answered questions without my prompting. I nevertheless remained an attentive listener, jumping into the story from time to time to re-formulate, or clarify an aspect of the narrative. In this respect, as narrative researchers regularly point out, the

narratives were co-constructions – relational achievements influenced not only by the participants’ attempt to say something about their life and experience, but by my participation as an interested researcher. With the exception of one person, all participants seemed to have no trouble telling a story about themselves, and their experiences with antidepressants. Though the material discussed was sometimes difficult and emotionally challenging (other times it was light-hearted and funny), I thoroughly enjoyed listening to, and getting involved in, these stories.

Seventeen of the 23 participants returned for a second interview. I tried to space the interviews one week apart, but due to scheduling conflicts this varied from one week to one month. In between the two interviews I reviewed material from the first interview, and developed a second set of questions. These questions were intended to fill-in areas of the narrative not discussed in the first interview (e.g. childhood events that might be important to understanding present life circumstances). Some areas of the narrative were not discussed because the participant felt that they didn’t have anything to say about that time of their life. In other cases they were filled in with what Riessman (1990) has called a “habitual” narrative – a loose generalization about a period in time (e.g. “I had a happy childhood”). This said, my goal was not necessarily to have people tell an entire life story (even if such a thing were conceivable), but to provide the kind of story that best illuminated the relationship to antidepressants.

Interview Analysis

As numerous researchers point out, narrative analysis does not simply consist in summarizing the story that people tell about their lives. It is not, in other words, just another technique used to collect another kind of data. Instead, as I describe in chapter

two, narrative research involves assumptions about the narrative character of life (Frank, 1995; Bury, 2001; Kearney, 2002, Josselson, 2004; Ricouer, 1984; Robinson, 1990, Taylor, 1989). Even when people are not consciously telling the story of their lives, they are organizing their understanding of the world and relationship to self, and others, through narrative. Indeed, I sometimes learned more about the structure of an antidepressant narrative not from the narrative itself, but from narrative asides, opinions offered outside of the context of the narrative *per se*, or things that were left unsaid or unelaborated. For example, key to this dissertation is the fact that in many cases, after committing to antidepressant treatment, and the biological view of illness, people remain silent about the sources of their depression. The question, “Why do you think you are depressed?” is answered with “I don’t know, I guess it’s biological.” Oftentimes, the biomedical account of self gives rise to the kind of narrative in which certain parts of the self are put to the side, or left out of the story. The final story told in a project such as this, then, is more than a report on the stories developed in interviews. It involves reflections on the interviews and attempts to say as best as I can what kind of narratives people are telling: How are they structured? How are they organized? What kinds of selves do they constitute or assume? How do they compare to other kinds of narratives? Where do they seem to be in conflict, or silent? This interpretive activity encompasses a tension between what hermeneutician Paul Ricoeur (1970) has called the “hermeneutics of faith” and the “hermeneutics of suspicion.”

Narrative researcher Ruthellen Josselson (2004) has elaborated the significance of these two forms of interpretation. The hermeneutics of faith “is characterized by willingness to listen, to absorb as much as possible the message in its given form” (p.3).

It tries to re-tell the story like it has been told in the interview setting. It also relies on a kind of phenomenological method; that is, an attempt to inhabit the story being told, and see it through the eyes of the teller. In contrast, the hermeneutics of suspicion “is animated by suspicion, by a skepticism towards the given” (p. 3). Through techniques such as psychoanalysis, deconstruction or analyses of power, the interpreter attempts to describe: elements of the narrative that are not explicitly spoken, yet central to a narrative, spots which seem especially contradictory, or areas that seem “tender to the touch.” The hermeneutics of suspicion also punches holes in the idea that one can easily, phenomenologically, inhabit another’s lifeworld. This does not mean that such empathic resources should not be utilized, only that their limits, inconsistencies, and idealizations be recognized. Richard Ochberg (1995) puts this hermeneutics of suspicion in a slightly different light when he says that the narrative researcher’s responsibility is to re-tell a narrative so that it becomes more puzzling for researcher, research subjects, and readers.

The tension between the hermeneutics of faith and the hermeneutics of suspicion, as well as the effort to make puzzles out of these antidepressant narratives, animated my engagement with these narratives from beginning to end. I developed a faith in the hopes, aspirations and accounts of self given by the people as they try to relieve suffering, and bring some order to their lives. I tried to demystify the biomedical account of self, and demonstrate the contradictions and silenced aspects of self, regularly generated through antidepressant narratives. I have also tried to render suspicious, and make into a puzzle, my own interest in antidepressant medication, and the stories people told to me.

These reflections aside, my analysis of these narratives included two stages. The analysis began with the first interviews, where I loosely relied upon a “grounded theory”

method (Strauss & Corbin, 1998). After each interview I wrote short memos to describe prominent themes and possible narrative types: epic, heroic, progressive, regressive, tragic, habitual, comic, retrospective, among others (Frank, 1995; Gergen 1994c – see chapter 2). I returned to second interviews with these in mind. Memos also provided the opportunity to compare across participants for common themes. I continued to write memos and compare interviews as I transcribed interviews. Certain themes and narrative types started to solidify about two months into the interview process, some of which included: metaphors used to describe the medication (multivitamin, maintenance drug, something that cuts off extremes of emotions, something that makes me numb); the idea that people don't always know whether the medication is working or not; the idea that the medication allows a person greater control over their selves; and the idea that the biological account of depression splits the self into "Me" and "Not Me" dimensions, among others. While I continued to ask the same questions I had of previous participants, the interviews were increasingly directed toward deepening my understanding of those emerging themes. When I completed the last interview in June I prepared a list of recurring themes, and narrative forms.

In the second stage of analysis, I re-read transcripts and memos with two related goals in mind. First, I wrote a brief account, and sketched diagrams of each participant's narrative, focusing on structural elements, comparing to other narrative types, and asking questions like: What kind of narrative is this? What role does the antidepressant medication play in this narrative? What does it do for the self? What kind of self does it require, or allow, a person to become? How does it relate to other kinds of narratives about the self? At the same time, I continued to define common themes, and sought to

understand their significance within the narrative types that I was beginning to discern. I was very wary of reifying particular themes by extracting them from the context of narratives. Nevertheless, in order to gain some analytic traction I introduced a coding scheme to indicate sections of the interview transcripts that addressed seven themes: narrative structures; practices of using antidepressants; concepts and descriptions of self; experiences and feelings on the medication; attitudes toward and understanding of the medication; description of depression or mental illness more generally; social aspects of antidepressant use. I selected appropriate sections from each interview and collected them under thematic headings in separate Microsoft Word files. More than anything, these allowed me to quickly find places in specific interviews that addressed certain concerns.

In the end, I've presented the interview results in two basic ways. First, at various points in the analysis I describe common themes. Even though I introduce these as common themes that I encountered in analyzing the interviews, they should also be read as "ideal-types." Thus, for example, while in describing the "splitting narrative" I provide numerous examples of what I mean by this concept, this should be understood as an attempt to provide an understanding that best approximates what I heard across the interviews. Here, though I always try to place particular accounts in a narrative context (i.e. the context of a person's life and encounter with the medications) I sometimes do not tell whole stories. Rather, I group a number of participant's accounts together to elucidate the common theme. This is especially the case in my description of "depression and relief" (chapter 4), "approximating normalcy" (chapter 4), "making distinctions" (chapter 4) and the "splitting narrative" (chapter 4). I also provide these examples to show the kind of variation around a certain theme. When there is significant variation from a theme

I make note of it. When appropriate I also present the number of participants, out of 23, whose interview showed the presence of a particular theme. However, here it should be noted that this study was not designed as a survey of particular themes. For this reason, perfect comparison across all participants is not possible. Future research might derive survey questions from the themes explored here, though such a study would not capture the narrative focus intended here.

Second, in order to provide some richer context, I more closely tell the stories of some people that I interviewed than others. I have chosen to elaborate these particular stories: 1) to show the particularity of people's experiences with the antidepressants, but also 2) to show these particular experiences demonstrates a theme or narrative common to a larger number of participants. Thus, for example in chapter 5, I rely upon Joanna's story to demonstrate the return-to-self narrative, and Angela's story to demonstrate the always-been-ill narrative. Connections between these particular narratives and other person's stories are introduced as the analysis proceeds. There were two participants – who I have called Harvey and Greta – who I do not refer to very often in the analysis. In a basic sense, Harvey and Greta used the antidepressants in the same way as others with whom I spoke. They both described themselves as people who had chemical imbalances and it was also clear that the antidepressants made a difference to their lives and how they dealt with their psychological pain. However unlike the other people that I spoke with Harvey and Greta did not tell lengthy narratives or stories about themselves or the encounter with the medications. For a number of reasons that I discuss in Chapter 5, footnote 7, these interviews continue to perplex me. I am not sure whether this is because Greta and Harvey have little to say about their experience with antidepressants, or

whether I, as a researcher, have been unable to sufficiently imagine the lifeworlds of Harvey and Greta. In any case, I make note of their relative absence in the main analysis.

I would hope that the claims made here about the experience of taking antidepressants, and the narration of selfhood within that context, would not be taken as a final statement on the stories told to me, but rather as a series of characterizations of these stories, open to further elaboration and discussion. The test in other words, is whether the analysis and story told here makes sense of, and illuminates, previously unarticulated aspects of antidepressant use.

Appendix 1 Notes

¹ My sample excludes advertisements for anti-anxiety medications (most notably Buspar which ran a series of ads between 1997 and 2000), and medications for pre-menstrual dysphoric disorder (PMDD). In some ways this is an arbitrary decision, since antidepressants are also marketed for the treatment of anxiety, and PMDD medications are SSRIs (Prozac and Zoloft) marketed under different names for a differently constructed disorder. However, from the outset, this research has been concerned with the impact of the *idea* of antidepressant medications, specifically SSRIs and the new breed of antidepressants (SNRIs and DRIs). All of the ads chosen for analysis emphasize the mechanism of serotonin, norepinephrine, or dopamine re-uptake. The anti-anxiety medication Buspar does not fall under that umbrella and is more closely resembles the tranquilizers of an earlier era, whereas PMDD medication uses entirely different imagery and presumably addresses a different audience and problem (though of course depression is also a gendered disorder, long associated with women's "moodiness," see for example Metz, 2004). Deconstructing these categories and these relationships is a task for another study.

Appendix 2: Recruitment Poster

Are you taking **Antidepressants?**



If so, I would like to speak with you: Participants, 18 years and older, are requested for a sociological study on the relationship between antidepressant medications (**Prozac, Paxil, Zoloft, Wellbutrin, Effexor, Lexapro**, etc.) and self understanding.

If you are taking *or* have taken antidepressant medications, for any reason, I would like to hear about your experiences: Why did you begin taking these medications? What does it feel like to take these medications? Have they been helpful? Have they influenced the way that you think about yourself, and your relationships with other people?

Confidential interviews will take 1-2 hours, to be conducted at a time and place convenient for you.



If you are interested, please contact Jeff Stepnisky in the Department of Sociology at name@xxx.xxx.xxx or by phone XXX - XXX - XXXX.

This research has been approved by the University of Maryland Institutional Review Board, file # xx-xxxx. For confirmation contact xxx@xxx.xxx or call XXX-XXX-XXXX.

Appendix 3: Interview Questions

Category 1: The Self and Psychotropic Drugs

1. I'd like to start by getting a sense of who you are and how you think about yourself, and your life. Tell me about yourself. What defines you; your hopes, your aspirations? What is most important to you in life, to your sense of self and well being?
2. What drug(s) are you taking? How did you learn about it? Why did you start taking it? What did you expect from it?
3. Tell me about your experience with the drug.
4. Has the drug helped you? How?
5. Has the drug changed your sense of who you are? For good or for bad?
6. How do you think the drug works?
7. How does the drug make you feel?
8. When did you first notice the drug's affect on you? What did you notice?
9. What did you expect the drug to do for you?
10. A lot of the ads for these drugs claim that the can make you "feel like yourself again." Have you felt that way? What do those words mean to you?
11. What does it feel like to have a sense of well-being?"
12. What is mental health? What would it mean for you to be mentally healthy?
- 13: how did you know that the drug was working?

Category 2: Self and Others

1. Do you think that since you began taking the drug your relationships with others have changed?
2. Do you tell other people that you are taking this medication? Who? Why? What do they think about it?
3. Would you recommend that other people take these drugs?
4. Do you feel that you have a responsibility to yourself, and others, to take these drugs?

5. Have you heard other people talk about drugs like Prozac and Paxil? What do they say about the drug? What do you think about what they say?
6. What role does your physician/psychiatrist play in your life?
7. What kind of person do you think you need to be to get by in today's world? and then Has the drug helped you to be that kind of person? If so, how?

Category 3: The Drug

1. What do you think of the drug? Do you like it? Do you think you could live without it? Would you want to live without it?
2. How has the drug become a part of your everyday routine? When do you take it? Do you take it privately, or does it matter when and where you take it?
3. Have you had any problems with symptoms and side effects of the drug? How do these impact your feelings about the drug?
4. Have you seen television or magazine ads for these drugs? What do you think about how depression/anxiety is represented in those ads?
5. What has this drug taught you about yourself?

Appendix 4: Participant Details

#	Name*	Condition	Medication	Previous medications	Time on Medications	Occupation	Age	Gender	Race/ethnicity
1	Tara	Anxiety	None	Zoloft	2 – 3 months	Graduate student	22	female	Caucasian
2	Michael	Depression	Lexapro	Wellbutrin, Effexor, Zoloft, Paxil	10 years	Computer Programmer	43	male	Caucasian
3	Samantha	Depression	Lexapro (20 mg) Lamictal (100 mg)	Wellbutrin, Zoloft, Effexor	7 years	University Student	20	female	Caucasian
4	Peter	Bipolar Disorder, type 1, with psychotic features	Zoloft (150 mg); Depacote (1500 mg); Geodon (116 mg); atarax	Lithium. Paxil, Risperidol, Haldol	6 years	University student	33	male	¾ Caucasian ¼ Hispanic
5	Barbara	Chronic low level depression	Prozac (40 mg)	Wellbutrin, Zoloft, Lexapro	8 years	Real Estate Agent	34	female	Caucasian
6	Joanna	Anorexia with severe depression and anxiety	Lexapro	-	2 – 3 months	University Student	21	female	Caucasian/Jewish
7	Zareen	Dysthymia (low level depression)	Prozac (10 mg)	-	2 months	Graduate student	33	female	Asian-American
8	Jeremy	Depression	Zoloft (50 mg)	-	4 months	University Student	20	male	Caucasian
9	Teresa	Dysthymia	None	Prozac, Celexa	3 years	Unemployed	26	female	Caucasian/Italian
10	Jesse	Depression	Prozac (generic, 20 mg) Wellbutrin(150 mg2/day)	-	14 months	University Student	30	male	Caucasian
11	Jennifer	Major Depression	Lexapro (20 mg) Wellbutrin (150 mg)	Prozac	1 years	University Student	20	female	Filipino-American
12	Louise	Depression, Attention Deficit Disorder	Wellbutrin; Lexapro (10 mg); AdderallXR (20 mg); Neurontin	Aurorix	2 years	Graduate Student	45	female	Euro-African

* all names are pseudonyms

#	Name	Condition	Medication	Previous medications	Time on Medications	Occupation	Age	Gender	Race/ethnicity
13	Rebecca	Anxiety, Obsessive-Compulsive Disorder; Eating Disorder (NOS)	Prozac (40 mg)	-	3 years	University Student	20	female	Caucasian
14	Greta	Severe Depression and Dissociative Identity Disorder	Wellbutrin (300 mg)	Effexor, Prozac	10 years	Unemployed		female	Caucasian
15	Emma	Clinical Depression and anxiety	Lexapro (10 mg)	Prozac, Celexa, Wellbutrin	10 years	University Administrator	25	female	Caucasian
16	Katrina	Depression	Lexapro (10 mg)	Prozac, Celexa, Wellbutrin, Zoloft	10 years	Acupuncturist	47	female	Caucasian
17	Angela	Bipolar depression (mixed)	Parnate (35 mg); Trileptal (600 mg); Neurontin (1200 mg); Klonopin (4 mg); Lithium (300 mg); Lamictal (25 mg)	21 courses of ECT; Prozac, Paxil, Zoloft, Wellbutrin	25 years	Unemployed, on disability insurance; former career in counseling and social work	59	female	Caucasian
18	Catherine	Major depression	Zoloft (150 mg)	Wellbutrin, Paxil	18 months	Active duty Navy	21	female	Caucasian
19	Harvey	Depression	Prozac (30 mg)	-	on and off for 10 years	Administrative Aid (military)	48	male	Caucasian/Jewish
20	Natalia	Depression	none	Prozac (20 mg)	4 years	Pre-school teacher	32	female	Caucasian/Hungarian
21	Duyen	Bipolar disorder, type 2	Paxil (20 mg); WellbutrinXL (150 mg); Lithium (600 mg)	Celexa, Effexor, Centrax	3 years	Health Care Consultant	25	female	Asian-American
22	Mary	Depression and anger	Effexor (35 mg)	Lexapro	6 months	Teacher	37	female	Caucasian
23	Wanda	Moderate Depression and Attention Deficit Disorder	St. John's Wort	Wellbutrin, Prozac, Zoloft, Paxil	8 years	Research Psychologist	38	female	Caucasian

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