MORE THAN BLUE:
DISCOURSES OF/ON WOMEN AND DEPRESSION

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Abstract

More Than Blue: Discourses of/on Women and Depression

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This dissertation challenges the traditional linguistic and rhetorical approach of studying talk about health and illness via the doctor-patient dyad. Although studies of doctor-patient discourse have often postulated the influence of the patient's "lifeworld," they have rarely questioned how this lifeworld is rhetorically constructed from the discourses available to patients. Focusing on myriad discourses produced by and about women suffering from depression, this project introduces a model of conversational uptake that serves as the basis for analyzing talk critically and textually. Thus, this project extends Anne Freadman's articulation of generic uptake and cultural memory. Uptakes involve putting forward topics or genres and responding to the topics or genres of others. Uptakes can, in this interactional model, be successful, unsuccessful or even partial, depending on the future uptakes of one's interlocutors. But, uptakes are more than simple conversational moves; they are also instantiations of discursive power.

Three semi-structured group interviews conducted in June and July 2002 form the conversational corpus for this study. Two groups of women suffering moderate symptoms of depression and one group of mental health professionals were interviewed to provide samples of talk about depression. In analyzing the interviews, the dissertation also engages with selected corpora of pharmaceutical advertisements, popular media articles, self-help literature, and medical and government publications. As the analysis shows, current constructions of depression rely on chemical and mechanical imagery, which simplify the disorder by overlooking social and

environmental influences, and reinforce the idea that pharmaceutical solutions are appropriate and sufficient. Chapter one provides an overview of the texts studied and an analysis of the currently circulating discourses on depression; chapter two outlines the theory of conversational uptake; chapter three considers how uptakes use norms and cultural/discursive objects, like the "emotional woman"; chapter four addresses the directionality of uptake's memory; chapter five examines the intertextuality of uptake's memory, and explores how such references involve translations of appropriate subjectivities.

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To my family

CHAPTER ONE

THE CIRCULATION OF LANGUAGE ABOUT DEPRESSION

> *"To most of those who have experienced it, the horror of depression is so overwhelming as to be quite beyond expression. . . .But in science and art the search will doubtless go on for a clear representation of its meaning."*
>
> – William Styron, *Darkness Visible*

As William Styron predicts in his 1990 autobiographical account of his experiences with depression, the scientific, philosophical, and personal search for both a representation of and a meaning for depression continues today, over a decade later. And, as Styron suggests, the experience of depression continues to evade description by those who have first-hand knowledge of it. Not only does the disease rob daily activities and interactions of their pleasures, it tends to steal adequate rhetorical expression as well. A study of "normal people" describing depression, cited by Lewis Wolpert in his study *Malignant Sadness*, finds that "in spite of all the complaints about how unsatisfactory the word 'depression' is for describing the illness, the two terms most closely linked to depression were grief and sadness" (76). Such studies (setting aside the question of who might qualify as "normal" in the study design, and the ways that this distinction further removes the power of articulation from those apparently "abnormal" people who suffer from the illness itself) highlight a reliance on the common, universal experiences of grief and sadness to make sense of depression. Indeed, conceptualizing depression as an excess of these everyday emotions makes it comprehensible to those who have not suffered from it. While this identification process is undoubtedly necessary if depression is to be the focus of extended social, political, and research attention, it also has the potential to reinforce the social expectations for individual self-healing and stoicism. The alternative—that depression is categorically different from sadness and grief, that it is a distinct physical condition like heart disease or diabetes—does not provide a much clearer answer, being unable to account either for depression's similarities to identifiable emotional experiences, or for its continued stigmatization.

For Andrew Solomon, author of the 2001 bestseller *The Noonday Demon*, depression is both one extreme on the continuum of emotional experience and also a distinct category of illness. And, it is neither. No matter the route one takes to reach it—whether gradual path or sudden trigger—the experience of depression is located outside of common understanding. Depression, in Solomon's words, is "a place that is genuinely different" (17). Yet because this different place nevertheless resembles the sadness, grief, and anxiety that are part of the human condition, depression is a difficult disorder to describe. Beyond statements about the inability of language to capture the experience of depression, only a few common images emerge: darkness, heaviness, an abyss. Each description repels rhetorical and scientific precision. Because its diagnosis depends on such metaphors, depression represents an elusive and fascinating convergence of rhetorical and physical health. Our dependence on language to describe, diagnose, and treat depression is the subject of the project that follows. Yet, this project is concerned not only with the complexities of depression's rhetorical-physical manifestations, but also with the ways that these manifestations articulate and reconstruct gendered notions about health and behavior. Depression is commonly viewed as a women's disease; various studies suggest that it is found in two or three times as many women as men. This project draws attention to the ways that women are affected by and participate in the rhetorical construction of depression and women's emotionality. Ultimately, then, this project considers the language that is used by and about women who are depressed in the United States, asking how these language practices affect individuals' experiences of health and illness.

In order to address questions about such discursive circulation, this study has been designed to capture talk and texts about depression that are outside of the traditionally studied genres of doctor-patient interactions. Instead, three semi-structured interviews, conducted in June and July 2002, provide the main source of data for this study. Two interviews were conducted with groups of women experiencing moderate symptoms of depression, and one interview was conducted with a group of mental health professionals, who work with depressed clients. In the analysis of these conversations, I also draw on other textual sources including self-help books, news articles, pharmaceutical advertisements, and government health brochures. In the pages that follow, I provide an overview of the language practices currently surrounding depression and a rationale for studying them in their diverse locations, for studying them outside of the doctor-patient interview.

Lacking empirical measures for diagnosis, which are currently the only acceptable form of material evidence, depression inhabits a rhetorical world that for the moment at least, is perceived to be less real, less tangible, and less disabled than the world of, for example, multiple sclerosis or cancer. And, although Susan Sontag's *Illness as Metaphor* warns us of the possibilities of social interpretations superceding physical realities, it seems that mental illnesses have a long way to go before they will be considered alongside "physical" conditions.[1] This project has not been conceived as an indictment of current healthcare practices that maintain such mind/body separations. Nevertheless, the project does suggest that language practices themselves are not insubstantial factors in experiences of disorders like depression. Specifically, this project explores the ways that *what* we say (individually and culturally) about an illness affects *how* we inhabit both healthy and ill subjectivities. These questions are of particular relevance for women who suffer from depression because of the volume of discourse directed at them. In short, I am arguing that a critical, rhetorical, feminist analysis of the language circulating around depression provides an opportunity to explore the impositions of discursive power and individuals' responses to those impositions.

The idea that language structures both thought and physical experiences is not new. Indeed, language is implicated in the structures against and through which we perform and judge ourselves and others. This is essentially Pierre Bourdieu's concept of the "habitus," which he defines as a "generative and unifying principle which retranslates the intrinsic and relational characteristics of a position into a unitary lifestyle" (8). In other words, the habitus is the collection of dispositions and habits of life; it is that which organizes and gives coherence to everyday activities.[2] The habitus both structures and is in turn structured by individuals' daily practices; it is intimately linked to ongoing social interactions and therefore avoids the static, monolithic features of ideologies. Further, for Bourdieu, the habitus produces a system of distinctions between lifestyles (related specifically to class) that "constitute a veritable *language*" (8, his italics). Thus, the habitus generates a system of signs (behaviors and practices) that are available for analysis and critique. Our reactions to and even our experiences of depression are, in this analysis, conditioned by the precepts of our individual habitus, providing an explanation for the cultural variations sometimes described among various groups suffering from the disorder. While some sufferers seem to experience depression through more somatic symptoms, this is not, I would argue, because "poor, ill-educated patients lack the linguistic skills to express their emotional experiences" (Wolpert 37). Rather, it is a consequence of different relationships with the habitus, and such somatic symptoms should be read for the ways that they illuminate, in the words of Arthur Kleinnman and Byron Good, "depression as socially produced and culturally constructed through the interpenetration of personal distress and social realities in the context of local knowledge and local systems of power" (493-4). In this analysis, depression becomes a signifier of social relationships, and the language used to describe it is therefore an important site of inquiry into those relationships.

The concept of depression gains its coherence—as non-physical, as individual, as gendered—in western psychological and cultural thought via the dispositions of a predominant habitus. Further, individual rhetorical practices (including conversation, memoir writing, pharmaceutical advertising, and doctor-patient interviews) help rearticulate these prevalent perceptions: the language practices surrounding depression re-establish gender and health commonplaces. Beyond these moments of behavioral regulation, such language practices also function to transcribe beliefs onto the body. This can be seen in psychologist Peter Kramer's concept of "cosmetic psychopharmacology" (xvi), where social pressures to be outgoing and productive justify ingesting the antidepressant Prozac.[3] The transfer of language into physical realities can also be seen in the ambiguity of the term *prescription* to refer both to the written genre composed by a physician and to the contents of the container one receives from the pharmacist. The medication becomes the actualization (with material consequences both positive and negative) of the linguistic reality defined in the doctor's office. And, for Solomon, a sufferer of depression, the medications themselves are turned back into language: "Every morning and every night, I look at the pills in my hand: white, pink, red, turquoise. Sometimes they seem like writing in my hand, hieroglyphics saying that the future may be all right and that I owe it to myself to live on and see" (30). In each of these examples, the slippage between physical and rhetorical realities provides evidence for the discursive construction of health and illness. Further, the slippage offers moments for study when the predominant habitus is being enacted.

In addition to the multiple interpenetrations between language and physicality, the circulation of language *about* depression affects the habits and actions of individuals. Describing the prevalence of melancholy among Elizabethan aristocrats, Solomon cites the notes of a physician of the period, whose patients are reported to be "speaking not simply of waves of sadness but complaining quite specifically on the basis of the scientific knowledge and fashion of the time" (300). Comparing this phenomenon to the "early Prozac days, [when] everyone and his uncle Bob seemed to be getting depressed and battling depression and talking about battling depression" (300), Solomon makes clear that social circumstances are implicated in rhetorical practices. In other words, patients inhabit and articulate illness subjectivities in response to their current cultural context, leading to a self-perpetuating system of responses to illnesses like depression. Further, these examples suggest that the proliferation of discourses on depression is likely to induce changes in the linguistic practices of individuals. This dissertation explores the content of such changes and proposes a theory of how these changes can be studied.

In the following pages, this chapter provides an overview of the language that is currently circulating about depression. The research presented in this project is informed by critical discourse analysis[4] and feminist linguistics; the focus of the overview will be to demonstrate the ways that depression is a gendered phenomenon. The first section explores the two main discourses that construct our current understanding of depression. I call these two discourses the "biomedical" and the "psychotherapeutic," referring to their focus on brain chemistry and talk therapy, respectively. Following this overview, I turn to a feminist consideration of the phenomenon of depression. How, I ask, is this illness gendered? To answer this question, I examine three corpora of texts relating to depression. First, I consider the explosion of book publishing on depression. Next, I look at news articles published between 1998 and 2002. Finally, I examine pharmaceutical advertisements from the same period. All of these analyses provide the discursive background for the semi-structured interviews that form the core of this study. As I argue, these interviews provide the evidence for the (re)circulation of gendered beliefs about depression, and the chapter concludes by describing the methodology and analytical processes for the interviews.

Discourses on Depression: Biomedical and Psychotherapeutic

In the following section, I consider the two main discourses on depression that help construct and reinforce the predominant dispositions toward it. In the Foucaultian sense of discourse, I mean to suggest that these two formations are structuring statements about cultural life. These discourses participate in and enact the predominant habitus as described above. They operate in and through the texts that make up this study, and the women that I interviewed draw upon and recirculate them in their conversations. These discourses operate on the levels of topic and syntax, and they provide a framework within which statements are viewed as legitimate. The biomedical discourse is represented by the focus on chemistry and biological vulnerabilities to depression; the psychotherapeutic discourse relies heavily on therapeutic and self-help genres to suggest ways that individuals should "heal themselves."

Biomedical Discourse

The biomedical discourse is best represented by the current popularity of "brain chemistry" as source and possible cure for mental disorders. In this discourse, depression is a treatable "imbalance" of chemicals, essentially, a mechanical problem that requires (most often) a pharmaceutical intervention. Poet Chase Twichell, writing about her experiences with depression, relies heavily on the biomedical discourse of mechanics and brain chemistry. She writes:

> The biochemical chain reaction that results [in depression] is extremely complicated, much of it still hypothetical. What is known is that certain neurotransmitters (especially serotonin and norepinephrine) do not work properly, causing a disruption in the flow of information between nerve cells. It's like a game of telephone; the message gets lost as it

> travels, eventually affecting cellular metabolism, hormone balance, and the circadian system, the clock that determines cycles of rest and activity. (23)

In Twichell's description, qualities of the biomedical discourse include the use of chemical names, for example, "serotonin" and "norepinephrine," and the reliance on mechanical and systemic metaphors. Twichell uses the images of information flow, a game of telephone, and the notion that a clock regulates bodily activity to describe the mechanisms of depression. Importantly, she notes that what is wrong is that something "do[es] not work properly." This idea of *working* is key to the mechanical metaphor that sits at the root of the biomedical discourse; if something does not work, the solution is to fix or replace the faulty mechanism. Sara Rosenthal, author of *Women and Depression*, a 2000 self-help guide for women, brings this mechanical metaphor into the domestic realm. After describing the role of serotonin in the brain, Rosenthal writes:

> A simple analogy is to imagine that this system of brain chemistry exchange is like a washing machine. Serotonin is the 'water' that flows in at certain times and is flushed out. Normally, enough water flows in and out, and the machine functions properly. But depression is akin to low water pressure. It would be like setting your washing machine on high only to find that the water level doesn't go beyond low. (157)

Clearly, Rosenthal's choice, appearing in a book directed explicitly at women, is meant to bring the mechanics into a "familiar" world of domestic labor. The implicit effect of this metaphor, however, is to reinforce the problem of depression as one of incomplete domestic chores, an additional source of guilt and anxiety for many depressed women.[5]

Pharmaceutical companies are, obviously, very invested in this biomedical discourse on depression; they are uniquely positioned to offer solutions to these mechanical problems. Advertisements for both Prozac and Zoloft use the idea of levels of serotonin in their explanations of depression. In the words of one Prozac ad, "When you're clinically depressed, one thing that can happen is the level of serotonin (a chemical in your body) may drop." Similarly, for Zoloft, "[w]hile the cause is unknown, depression may be related to an imbalance of naturally occurring chemicals in the brain." In both cases, the pharmaceutical companies are very careful to use mitigating language like the modals *can* and *may.* Nevertheless, as the interviews conducted for this study demonstrate, these markers of uncertainty do not detract from the power of the biomedical discourse. Implicit in such biomedical talk of "levels" and "balances" is the assurance that there is an optimal level, a "fill line," for serotonin. New York writer and teacher Joshua Wolf Shenk describes this reliance on the mechanical models of depression as a means of lessening uncertainties and "provok[ing] the least fear of the unknown." He writes:

> Phrases like 'running out of gas,' 'neurotransmitter deficits,' 'biochemical malfunctions,' and 'biological brain disease' are terribly common, and are favored by well-intentioned activists who seek parity between emotional and somatic illnesses. Pharmaceutical companies also like machine imagery, since they manufacture the oils, coolants, and fuels that are supposed to make us run without knocks or stalls. This language not only reflects, but constructs our reality. (247)

The discourse that I have labeled biomedical clearly originates in the scientific realms of neurotransmitters and the biological sciences, yet it is not a strictly scientific pattern of language use. Indeed, the phrase "chemical imbalance" is, in fact, a translation of the scientific jargon into a simplified metaphor for public consumption. In this discourse, depression is essentially a mechanical problem—an imbalance of chemicals—and, as such, it is easily resolved with the correct commodified solution (i.e., pharmaceuticals). The function of this biomedical discourse, it seems to me, is to produce statements like Ronald Fieve's in his preface to his revised edition of *Moodswing*: "No longer are most depressions treated with long and expensive courses of psychotherapy. A wide array of safe and effective antidepressants is now available to treat chemical imbalance" (ix). Thus, in Fieve's terms, the quick fix of pharmaceuticals is an improvement on longer psychotherapeutic processes. The combination of a mechanical metaphor ("chemical imbalance" or "low water pressure") and a convenient commodified solution seems both "obvious" and "natural."[6] Nevertheless, a competing discourse on depression, the psychotherapeutic, offers a different and more rhetorical set of problems and solutions.

Psychotherapeutic Discourse

The psychotherapeutic discourse stems from and encompasses the various talk therapies for depression—from Freudian psychoanalysis to Aaron Beck's more recent cognitive therapy.[7] Current popularizer David Burns might best sum up this discourse in his *Feeling Good: The New Mood Therapy*:

> Your blue moods can be compared to the scratchy music coming from a radio that is not properly tuned to the station. The problem is *not* that the tubes or transistors are blown out or defective, or that the signal from the radio station is distorted as a result of bad weather. You just simply have to adjust the dials. When you learn to bring about this mental tuning, the music will come through clearly again and your depression will lift. (30-31)

Although Burns' explanation sounds suspiciously mechanical—echoing the power of this kind of metaphor for health/illness—his concern (and that of cognitive therapy) is for "tuning" one's cognitions, one's thoughts, and not one's chemistry. In other words, the psychotherapeutic discourse revolves around modulating affects, not around regulating the chemistry of physical systems, as in the biomedical discourse.

One important feature of the psychotherapeutic discourse is its emphasis on a different sort of work than the biomedical discourse deploys. In the biomedical, "work" is a mechanical term: neurotransmitters are not functioning properly and need to be repaired. In the psychotherapeutic, the "work" that must be done is to be completed by the conscious efforts of an individual to change her or his thinking. The Zoloft advertising slogan capitalizes on this kind of work by suggesting that "When you know more about what's wrong, you can help make it right." This slogan places an emphasis on *knowing*, suggesting the cognitive responsibilities of sufferers. Nevertheless, in the context of the Zoloft ad, the knowledge encouraged is of the mechanical processes and not necessarily the self-knowledge promoted by the psychotherapeutic discourse. Closely paralleling self-help and coaching registers, the psychotherapeutic discourse is characterized by a friendly stance, often containing statements like: "Part of being human means getting upset from time to time, so I can guarantee that you will not achieve a state of never-ending bliss! This means you will have to reapply the techniques that help you if you want to continue to master your moods." (Burns 17). Despite such interpersonal gestures, however, the key component of this discourse is its emphasis on individual, cognitive work. In her collection, *The Deepest Blue*, Lauren Dockett gives the following advice: "It's helpful to remember that you will begin to get better before you start to feel better. Wellness is *work*. It requires some *slogging through* without rewards in the early stages, and the negative thinking is often the last thing to change. But have faith, it won't take long before *the work* will make sense" (150, emphasis added). As Dockett's description suggests, the key to the psychotherapeutic discourse is an emphasis on work done by the individual on her or his thinking and attitudes.

The distinction between "chemical" (i.e., pharmaceutical) and "non-chemical" (i.e., talk therapy) solutions to depression is becoming increasingly blurry. In today's technological environment, the appeal of precise, chemical answers seems to be the preferred solution.

Acknowledging this preference, researchers and clinicians committed to talk therapies (and to the psychotherapeutic discourse) have begun to produce evidence for the physical/chemical effects of their own forms of treatment. The preface to the revised edition of Burns' book describes studies that compare brain scans for patients who successfully complete cognitive therapy with scans for patients taking antidepressants. These scans are very similar, according to researchers.[8] Burns seems to acknowledge the power of the biomedical model in his introduction and seeks to put his own preferred model, talk therapy, into the same category. This move admits the causal role of brain chemistry in depression, but argues for cognitive as well as biological influences on such chemical realities. Burns writes: "Although we are taught that depression may result from an imbalance in brain chemistry, recent studies indicate that cognitive behavioral therapy may actually change brain chemistry" (xxi). Here, Burns draws on the explanatory simplicity of "brain chemistry" to promote his brand of work: cognitive therapy. Indeed, the Zoloft advertisement deploys both discourses, the "balance" of serotonin and the "work" of knowing what is wrong, and it seems clear that the discourses are converging. Both of these discourses are prevalent in the texts collected for this study; they both contribute to the predominant habitus that informs current reactions to and experiences of depression.

For women experiencing symptoms of depression, the biomedical model may offer to legitimize depression as any other physical problem, but it also draws on a history of labeling women "unbalanced" and in need of various forms of regulation. Similarly, the psychotherapeutic discourse offers a sense of control over depression, but it also isolates and places responsibility on the individual. Both discourses avoid making social roles and class obligations an issue in depression; both avoid characterizing depression as a political or cultural problem. Given these discourses on depression, the central question for this dissertation is: What are the effects of these discourses on individuals confronting symptoms of depression? In the end, I am concerned with the ways that an individual's linguistic production responds to, participates in, and, potentially, challenges the rhetorical power of the discourses that surround her.

The Gender(ing) of Depression

One of the most consistent pieces of knowledge reported about depression is the finding that women are approximately twice as likely to be depressed as men.[9] According to the National Institute of Mental Health (NIMH), each year 12% of US women and 6.6% of US men are affected by a depressive disorder ("Women Hold"). According to the World Health Organization, "depression is women's leading cause of disease burden" when measured in disability-adjusted life years ("Global Burden"). In her 1990 study, *Sex Differences in Depression,* Susan Nolen-Hoeksema finds that "no matter how you define depression, after puberty women show more depression than men" (6). The consistency of this finding across a variety of age ranges and cultures has become so much a part of our understanding of the disorder that simply being female puts one at risk for depression. For example, *Diagnosis According to the DSM-IV* is an instructional film documenting ten patient interviews each followed by a discussion among a panel of psychiatrists, psychologists, and other mental health professionals. In the film, Barbara (a middle-aged, white woman) represents the diagnosis of Major Depressive Disorder (MDD).[10] Clearly, the choice of a female patient with this disorder is meant to reflect the greater numbers of women who apparently suffer from clinical depression. However, the choice of Barbara also helps to reinforce assumptions about who is susceptible to the disorder. In the discussion that follows Barbara's interview, the sense of depression as a "woman's disease" is introduced by Steven Moldin, a clinical psychologist. Near the beginning of the discussion, he points out that "Barbara is very typical as a sufferer of major depression given the fact that she is a woman." Moldin follows this remark with a listing of statistics proving the gender gap in depression; he does not elaborate on any other way that Barbara might be considered "very typical" of MDD patients (and neither do any of the other panelists). In fact, the conversation turns immediately to Barbara's atypical ability to express her symptoms. This discussion, staged to help clinicians use the diagnostic criteria of the DSM-IV, does not question or even qualify the equation "depressed patient = woman." The specter of gender is raised but never directly addressed or problematized.

Early feminist criticism of mental health categories (e.g., Phyllis Chesler's 1972 book, *Women and Madness*) suggest that women's "madness" is more appropriately explained as a healthy response to social and physical oppression. More recently, Ellen McGrath, a prominent clinical psychologist and member of the APA's National Taskforce on Women and Depression, has published *When Feeling Bad Is Good*. This "innovative self-help program" distinguishes between two distinct depressions: "Healthy Depression" provides the impetus for change and self-evaluation, while "Unhealthy Depression" is a debilitating illness. Appearing at the beginning of a decade of increased pharmaceutical intervention into our moods, McGrath's text works to delineate the boundaries of an illness, but it also echoes Cheshler's sentiment that there are good reasons why women may be depressed.[11] The danger of this critique, and indeed of any critique that suggests illness is a social construction, is that it will go so far as to negate the actual physical realities of patients. Nevertheless, these antecedent feminist critiques have set the stage for the analysis I am undertaking below.

Suggesting that the project of language scholars is "a raising of consciousness about the ways that we as readers are acted upon by texts," Sara Mills comments on the audible silence with respect to gender within the fields of critical linguistics and stylistics (3). For Mills, the heightened consciousness implied in stylisticians' projects must involve "making strange" the ways that gender is represented in our culture (2). Mills and other feminist language scholars, then, would suggest that the unquestioned equation set up by the medical professionals in *Diagnosis According to the DSM-IV* would be a place to begin an investigation. We should ask ourselves *why* and *how* this equation exists within our discursive world, in what ways this formula encodes underlying assumptions about the world and the place of (gendered) bodies within it. Other feminist scholars, like those whose work appears in Sue Wilkinson and Celia Kitzinger's collection, *Feminism and Discourse: Psychological Perspectives*, view language as an interactive site that both constructs subjectivities and offers space for resistance. These scholars point to language as a complex, productive location for analysis and change. Taking such scholarship as my guide, the following analyses explore three corpora of texts relating to depression. In each section, then, I address the gendering of depression and suggest moments when these gendered assumptions are naturalized.

Corpus One: Books on Depression

According to Bowker's *Books in Print* database, the number of books, audio, and visual materials published on depression has been growing steadily in the last half-century. As seen in Figure 1.1, the number of items published on this topic grows rapidly after about 1980. In the five-year period from 1978 through 1982, Bowker's lists eleven items in print. The following period, from 1983 through 1987, more than five times as many items (52) are published. The numbers continue to double (or nearly so as in the case of 1998-2002) in each successive five-year period. By 1998 through 2002, the number reaches 546 items available in print. This exponential growth in the eighties and nineties is very likely a reflection of the growing interest in depression, fueled by the manufacturing of antidepressant medications perceived to be safer and to cause fewer side-effects. Books addressing depression have ranged from clinical treatises like

Aaron Beck's *Depression: Causes and Treatment*, published in 1972, to popular memoirs like Martha Manning's *Undercurrents*, published in 1998. Such books represent a range of rhetorical responses to depression. Although a comprehensive description of the books, pamphlets, and other informational media on depression is not possible here, it is important to recognize the range and quantity of materials currently available.

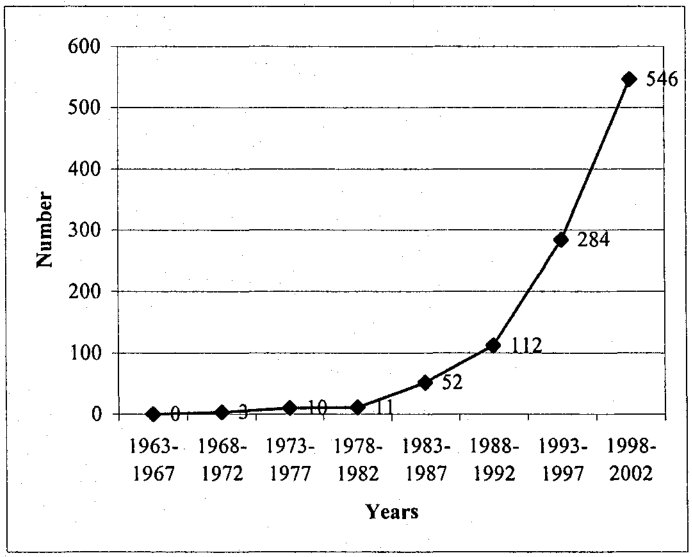


Figure 1.1: Depression Books in Print[12]

Another popular source of publication information is the online database maintained by Amazon.com. Listing the number of books currently for sale, under the Amazon category "Health, Mind, & Body," Table 1.1 testifies to the current popularity of depression as a topic.[13] As Table 1.1 shows, while many health topics have a hundred or more titles currently for sale on Amazon.com, only depression and breast cancer have over a thousand titles. That breast cancer is also a very popular topic suggests something of the audience "Health, Mind, & Body" books might be imagining. Women are far more likely than men to be consumers of literature on breast cancer, and the large numbers of books directed at this topic indicates a sizeable market among women for literature specifically addressing their own health and illness. The parallel boom in texts addressing depression might therefore be read as a gendered phenomenon. Indeed, 160 of the titles on depression are additionally categorized by the subject header "women"; only 21 of the titles are additionally categorized by "men." The remaining nine hundred titles are presumably gender neutral, but the evidence certainly points to women's greater consumption of these texts, and as the following analysis will demonstrate, "gender neutral" texts are often directed at women implicitly. Though I cannot here provide a full catalogue of the myriad texts on depression, three general categories suggest themselves. I will briefly address each type in an effort to set the rhetorical stage for the future analyses presented here and in subsequent chapters. In general, popular books on depression fall into three groups: self-help manuals, memoirs and (sometimes) fictional accounts of sufferers, and sourcebooks. Self-help manuals present programs and exercises for the reader to follow; memoirs narrativize the illness; sourcebooks often blur these genres, including moments of autobiographical narrative, but seek to catalogue and explain the phenomenon of depression.

Table 1.1: Amazon.com "Health, Mind, & Body" Book Titles

SEARCH TERM	TITLES
Depression	1,104
Breast Cancer	1,057
Heart Disease	600
Lung Cancer	175
Headache	98
Leukemia	116

Self-Help Books

As George Dillon has pointed out in *Rhetoric as Social Imagination*, advice literature provides an excellent source for investigating the interpersonal relationships created through texts. In the end, as Dillon argues, these relationships rely more on a social imagination than they do on their references to concrete readers and writers. The social imagination required of individual writers and readers enables the creation of relationships even when exact rules for interaction cannot be secured. Among the slippery problems of a theory of social interaction is the ability of language to be both sincere (as in Speech Acts) and gestural (where sincerity must be doubted) (Dillon 115). Thus, advice texts and their readers must operate under the assumption that the content and its applicability is genuine in order to leave questions of sincerity aside. Yet, as Dillon points out, "the reading of advice becomes itself the security blanket: not only does it allow the reader to indulge fantasies of power and success, but it manages to banish fears and anxieties" (114). Thus, such texts contain the opposition of "action/inaction" which "seems to arise from the very process of representation itself: to give name and shape to anxieties and uncertainties is already to counter the fear that they cannot be mastered" (115). Advice texts on depression operate within this important opposition—by naming the beast, depression, they promise to contain (even banish) it within their pages. In addition to this process, these texts also contribute to the gendered notions of depression, focusing explicitly or implicitly on the largest consumers of advice literature.[14]

Among the common features of recent self-help books on depression, the imperative list that often appears on the front or back cover gives a good indication of the fears that are being called and dispelled rhetorically. These lists come in a variety of forms, including selection criteria for readers. The back cover of Marie-Annette Brown and Jo Robinson's *When Your Body Gets the Blues* provides a set of questions to help readers identify when they have the "Body Blues." The questions—for example, Do you eat too much? Have you gained weight? Do you have difficulty concentrating?—evoke their ideal audience (she who nods frequently in response) and act as a guide for readers. Whether or not they experience these symptoms, readers should proceed as if they did. Such questions highlight one of the problems with codifications of social interactions via writing: the reader may not be positioned as the text envisions, but that does not make her less sincere as a reader. Whether or not the reader actually inhabits the social position dictated by the text, she is encouraged to imagine that she does as she reads. Beyond this positioning accomplished through the questions, it is important to note that *When Your Body Gets the Blues* is directed specifically at women, and not only at women but women whose "most common and vexing symptoms of this syndrome are overeating and weight gain" (4). For all readers of this text, whether they physically experience the syndrome or not, the position inhabited when reading sincerely is that of a woman concerned about her weight.[15] Thus, the publishing "hook" for this text is a concern for body image, not necessarily for depression itself. This link between depression and body image is one of the ways that the phenomenon is gendered and that women are deemed likely to be depressed. Brown and Robinson are careful to note that they are not addressing women with clinical depression and that the women in their study are experiencing symptoms of depression, without the constantly depressed mood or severely debilitating manifestations of major depression. Nevertheless, the text contributes to current knowledge about depression, a term that itself covers a broad range of experiences from mild grief to devastating illness. The first Library of Congress subject heading for *When Your Body Gets the Blues* is "Depression in women—Popular works." Thus, this text is deemed both popular and gendered, and it contributes to our cultural understanding of *depression* not the *body blues.*

In another version of the promises and demands of self-help texts, Gabriel Cousen's *Depression-Free for Life* promises and commands: "Experience dramatic results without prescription drugs; Customize the program to work for you; Enjoy long-term health and well-being" (front cover). These promises evoke and allay current concerns with prescription medications, one-size-fits-all programs, and long-term successes. *Depression-Free for Life* also contains a list of promises to organize its own expert role. On the back cover, we learn that the book "Helps you customize your approach through easy self-assessment exercises; Outlines a five-step program for harnessing your own body chemistry; Includes a seven-day meal plan; Features thirty savory but simple recipes." As these promises indicate, the book transforms biochemical reactions into nutritional mandates. Capitalizing on a notion of medications as standardized and therefore impersonal, Cousen's book requires "more of a sense of self-responsibility than is involved in merely taking a drug" (xiii). Here, the reader/sufferer is both flattered and admonished to take control of her/his own recovery. Yet, the fact that this control takes the form of "savory recipes" indicates that the intended audience is likely female. Not only are women more likely to suffer from depression, they are far more likely to be the caretakers of depressed individuals, including themselves. Therefore, recipes for avoiding depression target women in both their patient and their caretaker roles.

Implicit in each of these self-help texts is a definition of strategies for combating depression that are gestural rather than sincere, because these strategies remain on the pages of the books unless they are translated by the reader into actions. Though the texts promise answers and cures, they alone cannot effect them—this is the rhetorical paradox of self-help books (written by experts to help others, who cannot be counted on to receive the help as intended). What the texts can do, however, is define depression in such a way as to locate responsibility for the illness in the individual. In this way, readers become culpable in any failures of the system. One particularly effective mechanism of such reader positioning is the practice of defining depression as a series of maladaptive behaviors. Based on Aaron Beck's cognitive therapy, *Feeling Good* by David Burns displays the contradictions between *self*-help and *expert* solution. The back cover proclaims: "The good news is that *you* can rid *yourself* of anxiety, guilt…and other 'black notes' of depression" (emphasis added). Here, the reader is clearly the agent of her or his own transformation. But, the jacket copy continues by saying that "in FEELING GOOD,...Burns...outlines the remarkable, scientifically tested techniques that can lift your spirits and help you develop a positive outlook on life." In this second sentence, the techniques become the agent of cure, burying the realities of who will do the work of applying them. Further, the credit for these treatments goes to the designer of the techniques, Burns himself, and not to the individual. If successful, the "scientifically tested techniques" cured you; if not, you must not have applied them appropriately. The choice of *techniques* as the signifier of a range of recommended practices and behaviors is important because it lends coherence to the system while implying that the necessary skills must be developed, therefore providing a ready excuse should they fail to produce the promised outcomes.

The back cover of *Feeling Good* also contains a curious list, which is not clearly attributed to either the act of reading or the act of following Burns' program. The list itself presents a definition of depression that targets stereotypically feminine behaviors. While this bulleted list follows a paragraph of promises that the book makes, it is not linked to these promises with the expected punctuation (i.e., a colon). Instead, these points read as both commands and promises. The implied future promise, contingent on a reader's successful application of the text, is that she will learn to "recognize what causes [her] mood swings." Nevertheless, the list on the back cover formats these promises as imperatives: "Recognize what causes your mood swings; Nip negative feelings in the bud; Deal with guilt; Handle hostility and criticism; Overcome addiction to love and approval; Build self-esteem; Beat 'do-nothingism'; Avoid the painful downward spiral of depression." The imperative mood of these promises, and the fact that they precede the exhortation to "Begin now" the work of recovery, suggests that the book imagines a reader who may not be *following* Burns' advice, but may simply be *reading* the book. In other words, the imperative mood seeks to compel a particular reading subjectivity, but at the same time, it acknowledges the potential for uncooperative readers. Thus, the genre of self-help is ambiguous about its audience, hoping to capitalize on readers who are sincere and those who are simply interested in the gesture of self-help. In *Feeling Good*, the characterization of the reader as addicted to "love and approval" seems particularly directed at women, as does the leveling of the criticism of "do-nothingism." In these generic criteria, depression becomes an illness of those who are female, or at least feminine in their need for connection, their difficulty in handling guilt and criticism, and their lack of self-esteem. Given these criteria, the attempt to ensure compliant readers through imperatives participates in a long history of managing women's behaviors.

In addition to these examples, there are a variety of self-help books directed specifically at women. *When Your Body Gets the Blues* is one example, but others provide additional help for female sufferers of depression. Among books aimed directly at women, there is a trend toward including more female voices in the texts. In the Foreword to Lauren Dockett's *The Deepest Blue*, Matthew McKay writes that the book "is a chance to meet women who have made this journey before you. Their voices have the resonance of authenticity because they know depression from the inside. Theirs isn't clinical or shrink knowledge—though shrinks would be wise to listen to it—but awareness grown from the daily struggle to understand and overcome their own depression" (ix). McKay's introduction highlights the feminist goals of the book: to use women's lived experiences to help other women negotiate their own. Interestingly, McKay emphasizes the authenticity of the women's, as opposed to institutional, knowledge of depression. Nevertheless, McKay's Foreword is a necessary legitimatization of the women's lived experiences; his authority is highlighted on the cover of the book, eclipsing the individuals whose knowledge he praises.[16] The text itself continues the construction of a female community, using first-person plural pronouns and first-names throughout. For example, Dockett writes: "Whatever the reason for our feelings, we live in an era that assumes they're easily gotten over. We all know that depression is treatable. 'Hurry up,' we can almost hear others saying, 'and get treated.'" (95). Here, the construction of a female community, besieged by a faceless public urging faster treatment, helps articulate a readership that is disempowered by social conventions. Other examples of advice manuals targeted at women include Valerie Davis Raskin's *When Words Are Not Enough* and Ellen McGrath's *When Feeling Bad is Good*. Raskin's book attempts to give women real answers about depression and various pharmaceutical treatments for it; McGrath's encourages women to learn from the various kinds of depression (labeled "Healthy" and "Unhealthy") and improve their lives. In each of these books for women, struggles for the right to speak and know about depression are clearly evidenced. Although wanting to privilege the authentic voices of female suffers, Dockett's book nevertheless relies on the Foreword by McKay. Both Raskin and McGrath attempt to speak with their readers, rather than to direct them. However, both rely on their expert status, and, in the end, both prescribe rather than negotiate solutions.

In addition to indicating some of the ways that a female audience is imagined through the self-help texts examined here, I want to pause briefly on the ways that expertise is exhibited in these texts. Explicitly, these self-help texts mark their authors as experts by listing their academic and professional degrees. Thus, *Feeling Good* is authored by David D. Burns, M.D. and *When Feeling Bad is Good* by Ellen McGrath, Ph.D. Lauren Dockett's book is prefaced by Matthew McKay, Ph.D., and Ronald R. Fieve, M.D.'s *Moodswing,* is given the distinction (above the title) of being "DR. FIEVE ON DEPRESSION." This marking of expertise seems part of the interaction that must be imagined between writer and reader—readers of self-help literature are prompted to trust the author's sincerity and knowledge because of his or her academic accomplishments. This expert status becomes important because in depression, what is at stake is often figured as the patient's *self.* Raskin writes: "I see medications perform a miracle: They make women feel like *themselves* again" (xvii, emphasis added). Dockett says of depression that "[t]hose of us who have experienced depression know how painful the *absence of ourselves* during the depressive episode can be" (3, emphasis added). I will return to questions of expertise in chapter five, but this emphasis on selfhood is important because it reinforces a perception that depression is an *individual* problem.

Memoirs

A second category of books on depression includes memoirs, biographical, and autobiographical accounts, often written by celebrities or popular figures.[17] These texts offer personal narratives (sometimes ostensibly fictional as in Sylvia Plath's *The Bell Jar*) of struggle with the illness. Such texts are important for their cyclical progressions: Martha Manning's *Undercurrents* (1995) describes "a yearlong descent into, and eventually out of, the unbearable hell of depression" (front cover); Tracy Thompson's *The Beast* (1996) is subtitled "A Journey Through Depression." In these and others, the memoir functions to contain depression within the narrative frame that provides a beginning, middle, and end. These memoirs function as testimonials for others suffering from depression—most include (sometimes most explicitly in reader quotes on front and back covers) statements about how the author overcame depression, and by the transference of reading, how the reader might likewise triumph. These stories of hope are important and telling, and they also contain statements of popular beliefs about the illness. Such commonplaces participate in the biomedical and psychotherapeutic discourses on depression.

In an essay entitled "One Cheer for Melancholy," Susanna Kaysen describes an encounter with a woman who claimed to be "clinically depressed" over the death of her dog. For the woman, Kaysen writes, "the important word was 'clinical'" (42). This leads to Kaysen's analysis of the two most prevalent responses to depressed people, responses that play into the psychotherapeutic and biomedical models of the disorder. Kaysen writes: "The Failure of Will theory is equally popular with people who are not depressed. Get out and take your mind off yourself, they say. You're too self-absorbed. This is just about the stupidest thing you can say to a depressed person, and it is said every day to depressed people all over this country. And if it isn't that, it's, Shut up and take your Prozac" (42). For Kaysen, both of these discourses are used as a means of understanding depression, and yet both place responsibility on the depressed individual to take immediate action (and therefore be accountable for its success/failure). In her 1994 memoir, *Girl, Interrupted*, Kaysen complicates the biomedical discourse by suggesting that it is an easy explanation for some mental disorders like depression, but that it also excludes other categories of mental illness like her own diagnosis of "borderline personality disorder." She accuses the reader, saying "If my diagnosis had been bipolar illness, for instance, the reaction to me and to this story would be slightly different. That's a chemical problem, you'd say to yourself, manic-depression, Lithium, all that. I would be blameless, somehow" (151). Thus, for Kaysen, the biomedical discourse not only explains depression, it also excuses the sufferer from some of her responsibility for her illness. Yet, as her frustration with the "Shut up and take your Prozac" argument demonstrates, this discourse is not without its negative consequences for individuals either. In these excerpts, Kaysen demonstrates the power of and the desire for coherent explanations of depression and other mental disorders. Nevertheless, explanations that perpetuate the biomedical and psychotherapeutic discourses also perpetuate gender stereotypes and expectations that sufferers will heal themselves quickly and quietly.

Books like Elizabeth Wurtzel's *Prozac Nation* (1994) offer social critique along with narratives of illness. Following her successful journey through depression (though, as she admits, she is not personally free of the illness, her narrative has, however, reached a successful containment of the illness), Wurtzel describes depression as a "social problem," arguing that "an entire culture of depression has developed" (308). Nevertheless, such moments of social critiques are external to the progression of the illness narrative, and are therefore not characteristic of this genre. Memoirs offer less explicit instruction than self-help tests; instead, they offer a chance to see one's experiences reflected in the stories of others, and they ultimately function toward containment rather than action. Further, many of the best-selling memoirs are authored by women: Martha Manning, Elizabeth Wurtzel, Lauren Slater, Susann Kaysen, Tracy Thompson. Thus, women seem to be producing and consuming more of these narratives, which helps reinforce assumptions about their greater proneness to the disorder.

Sourcebooks

Sourcebooks can be seen as an outgrowth of memoirs, as many modern examples include sections of autobiographical reflection alongside more detailed historical, social, and scientific knowledge. It is important to note, however, that men author more of these texts than women. The genre itself can be traced to Robert Burton's *The Anatomy of Melancholy*, the first edition of which appeared in 1621. Recently, Solomon's *Noonday Demon* remained on the best-seller list for months. Jeffery Smith's *Where the Roots Reach for Water* offers a "Personal & Natural History of Melancholia," and Lewis Wolpert's *Malignant Sadness* addresses a variety of theories, treatments, and explanations of depression. These books often include personal anecdote as an authenticating mark—the authors have been there too—but they are more than narratives. Solomon's book is subtitled "An Atlas of Depression," and it includes twelve chapters, headed by their topics, including "Treatments," "Populations," "Suicide," and "Politics." In addition to these topical sections, Solomon's book participates in the self-help gesture of naming and containment, much as the self-help and memoir genres do. In a chapter on poverty, Solomon writes "What can be named and described can be contained….To be given the idea of depression is to master a socially powerful linguistic tool that segregates and empowers the better self to which suffering people aspire." (343). The atlas does, however, articulate some of the predominant habitus' gendered definitions of depression. In a discussion of depression in children, Solomon implicates mothers in their children's illnesses. He writes:

> To improve the mental health of children, it is sometimes more important to treat the mother than to treat the children directly….Children of depressed mothers have more difficulties in the world than do children of schizophrenic mothers: depression has a singularly immediate effect on the basic mechanisms of parenting. Children of depressed mothers may suffer not only depression but also attention deficit disorder, separation anxiety, and conduct disorder. (181-2)

Here, Solomon gestures toward the gender neutral term *parenting*, but given the clauses that precede and follow this reference, it is clear that he is speaking of *mothering* exclusively. In moments like these, the attempted objectivity (implied by the title and ambitious aims of the volume) of the sourcebook can be questioned.

Texts like Solomon's present themselves as comprehensive and knowledgeable resources. Unlike the self-help texts, however, they do not display their academic or medical credentials prominently on their covers. In fact, these books often avoid naming the sources of their knowledge, relying on generalized research and crediting "studies" or "research" instead of specific reports. The example cited at the beginning of this chapter—used by Wolpert to identify common descriptions of depression—makes this move. And, although Solomon's book is extensively footnoted, the main text relies more on Solomon's own summaries of knowledge and on quotations from individual therapists and researchers. In this way, the sourcebook seems to personalize knowledge, relating it to individuals and using colloquial language and phrasing. For example, Solomon describes eye movement desensitization therapy, an alternative treatment for depression, as "a bit kitschy" (140). These moves—personalizing information and backgrounding academic and research credentials—place the sourcebook's authority in the middle-ground between personal and research understandings of depression. As such, sourcebooks target an audience seeking more than self-help and memoir, an audience composed of "empowered consumers" of healthcare information.

Together, these three categories of popular texts on depression—self-help guides, memoirs, and sourcebooks—contribute to the predominant habitus surrounding depression. These texts articulate and therefore (re)enact beliefs about depression: that it is gendered female, that it is an individual's personal struggle, and that talk about depression (breaking the silence) is the necessary first step toward treatment. As has been suggested in the above analysis (and will be reiterated throughout this project) the first two tenets of this habitus are particularly problematic for women. The gendering of depression does not, as one might hope, focus more attention on the specific needs of women. Instead, the ways that depression is gendered female tend to reiterate stereotypical views of women as irritable, complaining, and passive. Additionally, the isolation of the disease is compounded by the ways that the texts articulate depression as a solitary journey. Memoirs, often seen as a way of bringing attention and humanity to illness, also conform to the typical narrative pattern that requires a concluding resolution that belies depression's recurrent nature. Further, these texts often draw attention to the importance of the caretaker role, a role most often assumed by women. In the discourses on depression, even depressed women are expected to fulfill their caretaking responsibilities both for themselves and for their families.

The third assertion reinforced by current discourses on depression suggests that talking about the disorder is a necessary and, to some extent, sufficient political response. The explosion of self-help and memoir texts in recent years points to a growing conversation about depression. Certainly celebrity spokespeople like Mike Wallace and Tipper Gore draw public attention to the disorder. Nevertheless, these celebrities have not been able to change substantially the social, economic, or environmental realities that affect depression. Today, it is easier to talk about depression than it was even a decade ago, but talk has not always resulted in circumstantial benefits. Solomon points to this difficulty when he quotes US Representative Lyn Rivers (Democrat, Michigan) as saying "Depressed people don't nag enough" (362). Drawing public and, more importantly, political attention to depression is difficult when, as Solomon points out, "depressed people tend to find everyday life overwhelming, and they are therefore incompetent lobbyists" (362). In a strange way, the proliferation of texts surrounding depression does not draw political attention to the issues that depression ought to raise: how to ensure appropriate accommodations for people suffering from depression under the Americans With Disabilities Act; how to alter social structures to address some of the pressures that seem to lead to depression; how to provide adequate health care for physical *and* mental illnesses. Because of these unanswered questions, this dissertation considers how the *discourses* on depression become the predominant *responses* to depression. In other words, this project draws attention to the daily discursive practices of individuals in order to identify where and how the predominant habitus is enacted and embodied in their understandings of their experiences. It attempts to redirect critical analyses toward the roles of individuals in their own discursive construction.

The paradox of textual analyses like those I am attempting here is that texts are necessarily altered in their moment of reading. Drawing critical attention to a particular moment in a memoir recontextualizes that moment within the analytical apparatus that I have constructed. Nevertheless, such moments do provide key information not only about my context of reading but also about their context of production. This is what Dorothy Smith calls the "indexical" nature of texts. Smith argues that "[a]ll texts are indexical, in the sense that their meaning is not fully contained in them but completed in the setting of their reading" (197). In the moment of reading, labor is employed for "the production in local historical settings of simulacra of the textually imagined ideal" (198). In other words, the material effects of texts can only be studied in situated practices of reading and interacting with them. Nevertheless, as Smith's work articulates, current modes of social organization depend upon "the textual capacity to crystallize and preserve a definite form of words detached from their local historicity" (210). Thus, texts do contain traces of the habitus that enables them; they often idealize a particular set of dispositions. For this reason, I am arguing, attention is well spent on the myriad texts currently circulating about depression. These texts provide insight both into the cultural contexts of their production and also into the cultural expectations of their consumption. In the following sections, I explore two more corpora of textual representations in order to broaden and deepen my claims about the predominant habitus as it affects perceptions of depression.

Corpus Two: Media Texts

Newspapers and weekly news magazines provide venues for much of the public knowledge about health and illness. Stories featured in these sources represent generalized versions of scientific reports and other similarly constructed information. In his study of news discourse, Teun van Dijk asserts that "the media are not a neutral, common-sensed, or rational mediator of social events, but essentially, help reproduce preformulated ideologies" (*News* 11). Seeing news discourse as a reproduction of ideologies, van Dijk outlines a variety of structural and discursive analyses that seek to highlight and challenge these ideologies. Following his analysis, I view news discourse as both a reproduction and an enactment of social dispositions. Thus, turning to news stories about depression enables me to highlight some of the current beliefs about gender, emotion, and responsibility for health. In the US, three weekly news magazines rank in the top forty magazines based on average circulation for 2002.[18] *Time* is the most popular, with a readership of over four million. *Newsweek* and *US News and World Report* both reach over two million readers each week, with *Newsweek* ranking nineteenth and *US News* thirty-seventh among US popular magazines. All three magazines have made depression a cover story in recent years, signaling the growing public awareness of the disorder. For this study, I examined full-text articles in *Newsweek* and *US News*, both of which are available from the Lexis-Nexis online database. These magazines represent mainstream sources of news discourse, and they provide a reasonable sample of moments when depression has been considered newsworthy.

In order to collect an adequate corpus of news stories, I used the search capabilities of the Lexis-Nexis database. Searching for the terms "depression" and "mood," I located thirty-eight articles. Of these, I eliminated brief articles (under five hundred words), book reviews, and celebrity profiles. Among the articles thus removed were several significant stories that indicate the growing acceptability of discussing depression publicly. Nevertheless, these articles did not primarily represent discourse on depression; they were more concerned with the status and history of the public individuals. For example, in 1997, Katharine Graham's autobiography is excerpted in *Newsweek* (Feb. 3, 1997). Graham's husband's struggles with manic-depression are discussed in the beginning of the excerpt. Similarly, in 1999, an article on campaign visits by the

Vice President's wife, Tipper Gore, highlights her struggles with depression (*Newsweek* May 24, 1999). Both of these articles, along with other celebrity mentions, indicate a growing acceptance among US news sources to discuss depression. However, I excluded them from the corpus in order to limit the sample to texts that addressed the topic of depression more generally.

The remaining nineteen articles in my corpus provide a sampling of the extended coverage of depression throughout the time period (see Appendix A for a list of the articles included in this corpus). The articles include one per year from 1988 through 1995, except in 1990, when three articles appeared. That year, Prozac was featured on the cover of *Newsweek*. No articles met the selection criteria in 1996, 1998 or 2002, but for the years 1997, 1999, 2000, and 2001, a total of nine articles were included. The corpus thus contains nineteen articles, encompassing over 29,000 words. Although this is a rich and complex body of text, the focus of my analysis here is limited to the portrayal of depression sufferers within these articles. One of the striking features of these extended news articles on depression is their use of such individuals as examples, either as a framing mechanism (e.g., telling a personal story to open and close the article), or as corroborating evidence throughout the article.

I examined fifty-two mentions of individuals as examples in 15 of the 19 articles selected. In four of the articles (21%), no individuals were used as examples. From this list, I excluded references to celebrities (e.g., William Styron) because such references were often made in passing and did not contain much of a description of the individual. For example, a July 2001 *Newsweek* article entitled "The Baby Blues and Beyond," declares: "Like [Andrea] Yates, virtually all new mothers who harm their children are suffering from postpartum psychosis—not plain old PPD." In this example, the mention of Andrea Yates, in the news at the time for killing her children, clearly invokes a frightening female archetype, but does not provide a personal portrait of the Yates.[19] Additionally, I excluded examples where an expert is quoted using an individual as evidence. These instances, for example Dr. Peter Kramer describing a patient who calls herself "Ms. Prozac" (*Newsweek* Mar. 26, 1990), are examples of the discourse of expert witnesses and not particularly of individuals suffering from depression. Finally, I excluded examples of children who suffered from depression because the examples were told through the eyes of the children's mothers. This dual focus of the examples made them difficult to classify, and so these examples were removed. It is significant, however, that none of these examples of children suffering from depression were told through a father's eyes. One child sufferer does tell his own story and is therefore included in the examples for analysis.

By applying these exclusion criteria, I collected a set of examples that included thirty-five discrete instances in fifteen articles. As Table 1.2 shows, the overwhelming majority of the examples (nearly 75%) used in these articles are of women. This gender imbalance exceeds the statistical finding that women are twice as likely to be depressed as men. Thus, it exaggerates and reinforces the gender gap in depression. The examples used in these articles typically include either direct quotation from the individual or attribution of thoughts and feelings to her. For example, in a 2001 *Newsweek* article: "After Leslie Wolter gave birth to her second child, Aidan, last year, she felt she was losing control. 'I couldn't relax, I couldn't calm down, I was worried all the time,' says the 31-year-old English teacher from O'Fallon, Ill." This example is important not only because it fronts the name of the individual (a means of personalizing the example), but also because it prefaces the direct quotation with an assessment, that Wolter "felt she was losing control." In many of the examples in this corpus, the women are portrayed in this way: as losing

Table 1.2: Examples by Gender

Example Gender	# of Examples	Examples Percent	# of Words	Words Percent	Words/ Example
Female	26	74.29%	2,613	61.47%	100.5
Male	9	25.71%	1.638	38.53%	182.0
Totals:	**35**		**4,251**		**121.5**

control, as being worried, nervous, or upset. Another important feature of Wolter's example is the fact that it contains information both about her age and her physical location: "says the 31-year-old English teacher from O'Fallon, Ill." As Table 1.3 shows, in nearly half of the examples of women, age was listed; similarly, in over half of the examples of women, a place of residence was listed. For the examples of men, however, the statistics are quite different. Only about a third of the time are men identified explicitly by age, and only one example listed a man's residence. In addition, in two of the nine examples of men, significant women in their lives were included in the discussion. In both cases, the women were portrayed as "concerned" or "nervous." In the examples of women, husbands and other family members are sometimes included, but usually within the direct quotation of the woman herself. Thus, the women themselves instigate social relationships in their own examples, a role assumed by the news discourse when the example is of a man. In two instances of men as examples, the articles attribute concern to their female supporting cast members. In one extended piece, it was "[John] Novotny's worried daughter [who] insisted that he speak with his doctor" (*US News*, May 18, 1988). The description of his daughter as *worried* reinforces gendered notions about women's greater emotionality, and her action (insisting that he visit his doctor) reiterates the caretaking role assigned to women. Similarly, in the case of Andrew Crittendon, who suffered from depression as a child, it is his mother who is portrayed as worried, whereas Andrew is more matter-of-fact about his experiences. In this 1997 *Newsweek* article, "Andrew's mother, Beverly, started to worry when a trip to Six Flags Great Adventure didn't lift his spirits, and her concern

Table 1.3: Age and Residence Specified

Example Gender	Total Examples	Listed Age	Age Percent	Listed Residence	Residence Percent
Female	26	12	43.15%	14	53.85%
Male	9	3	33.33%	1	11.11%
Totals:	**35**	**15**	**42.86%**	**15**	**12.86%**

turned to terror when the child started talking about suicide." Here, his mother's "worry" eventually becomes "terror." Certainly, these are justifiable emotions in the face of a loved one's depression. What is significant, however, is that women are the only ones who are characterized as having these extremes of emotion and as being the emotional caretakers of their families. Thus, the women used as examples in these articles display their worry more freely and in the service of maintaining their family's health.

The use of "real people" as examples in these news articles represents an interesting phenomenon. While the people provide a human touch to the stories, they are also used as a means of expressing non-scientific information like worry and anxiety. The fact that women are more often used to convey this kind of information seems significant not only for the ways that depression becomes the emotional burden of women (whether or not they are the one afflicted with the disease), but also for the ways that stereotypical versions of women are maintained through these characterizations. In addition, these examples seem to be taking on some of the modality that scientific reports contain grammatically.[20] In some cases, the cautionary note common in scientific articles is inscribed onto a single woman. For example, in one article, fears about over-prescribing of antidepressants are written on the person of Robin Berkley. "On her third visit [to her internist]," the article reports, "she exited with a Prozac prescription although she had merely asked a few questions about premenstrual syndrome. Within four days, she was sweating, jittery and having trouble sleeping" (*US News* Nov. 8, 1993). Here, the possible adverse reactions to Prozac are exemplified through Berkley's individual physical experiences. The impact of such examples is significantly different from the impact of a cautionary statement like those contained in pharmaceutical advertisements: "Prozac is a prescription medicine, and it isn't right for everyone. Only your doctor can decide if Prozac is right for you—or for someone you love" (Prozac ad, *Reader's Digest* Jun. 1998). In this statement, the advertisement clearly evokes the caretaker role for its readers, and it avoids explaining why Prozac might not be right for everyone (side effects and contraindications are contained in very small print on the reverse side of the ad). In news articles, examples serve as a means of transferring information about side effects and alternative narratives onto the bodies of individual women. These (often adverse) reactions can therefore be minimized as the idiosyncrasies of identifiable individuals. While these embodiments attempt to make scientific claims about side effects less abstract, they also reduce the potential generalization of the information. That Berkley had an adverse reaction does not necessarily warn readers that a specified percentage of *all* users experience these and other side effects.

Overall, the women used as examples in the articles are happy with their medications—their moods are safely regulated and they, in the words of Karin Taylor, "feel restored" (*Newsweek* May 5, 1997). Notably, in one *Newsweek* article (Feb. 7, 1994) examples of a woman and a man are used to explore the treatment options, namely staying on the medication or going without. Jackie McMann is used as the example of someone who dislikes the side effects of the medication, but "stayed on the drug while regaining her emotional balance." She follows her doctor's orders, acquiescing to his expert status. In the same paragraph, we learn of the male patient of a Boston psychiatrist who "went drug-free and has never regretted it." These two examples, so closely following each other, reiterate the stereotypes of the strong, self-sufficient male and the weak, unbalanced female. The use of individuals as examples in news articles is not a neutral choice, and these examples contribute to the rhetorical construction of depressed patients' subjectivities. The greater number of women used as examples, as well as the amount of personal detail included in women's examples, contributes to the current perceptions of depression as primarily a female concern. Further, social attitudes towards and expectations of women—that they are emotionally vulnerable, that they assume caretaking roles—are rehearsed and recirculated. Although this analysis has been brief, it begins to demonstrate the complexity of our current rhetorical situation: reporting news about depression both disseminates information and reinforces gender expectations.

Corpus Three: Pharmaceutical Advertisements

IMS Health researchers report that in a 2001 Internet survey[21] of 343 people, consumer attitudes about Direct-to-Consumer (DTC) advertising are generally neutral to positive (Blankenhorn, Duckwitz, and Sherr). "Empowered consumers," the researchers write, "expect that when making purchase decisions, they will have access to complete and objective information about the choices available. They are eager to be educated" (2). According to the data collected, nearly half of the respondents (47%) "indicated that DTC advertising led to improvement in their care" (3). Further, "patients are persuasive, and doctors are listening" the report concludes. "One-quarter of the IMS HEALTH survey respondents requested a prescription from their doctors. And, two-thirds reported that their doctor prescribed the exact brand medication that was discussed" (3). In a recent survey conducted by the Office of Medical Policy, a division of the US Food and Drug Administration (FDA), 80% of respondents said they would be somewhat or very likely to talk to their doctor about a specific drug for a condition that was bothering them if they had seen an advertisement for that drug. The National Institute for Health Care Management reports that "[p]harmaceutical companies spent $1.8 billion on mass media…advertising in 1999, up 38.5 percent from the $1.3 billion spent in 1998" (Findlay 1). Taken together, these statistics indicate that DTC advertising is good business for pharmaceutical companies looking to increase their profits. And, although it is clear that the advertisements do provoke conversations between doctors and patients, little attention is given to the complex rhetorical situation that is constructed via the ads.

Doctors and patients now find their interactions mediated through a variety of textual representations. In a survey of ten US periodicals in 1998-1999, Steven Woloshin et al. found that DTC advertisements "rarely quantify a medication's expected benefit, and instead make an emotional appeal" (1146). This finding leads Woloshin et al. to conclude that readers are likely to overestimate the benefits of advertised products and to expect that everyone using the products will enjoy all of the benefits. In addition, women are often the targets of more of this kind of advertising. Michael Wilkes, Robert Bell, and Richard Kravitz surveyed "eighteen diverse lay magazines from 1989 through 1998" for pharmaceutical advertisements, and found 320 distinct ads. They conclude that "women were more likely to be targeted than men" (115). Additionally, Wilkes, Bell, and Kravitz used a telephone survey of Sacramento residents to determine attitudes toward DTC advertising. Among their results, it is important that approximately half of the respondents believed that DTC advertisements received prior approval from the FDA or other government agency (which they do not). This finding clearly suggests that the trust that consumers place in DTC advertisements might be based on faulty assumptions. In 1992, L. R. Krupka and A. M. Vener summarized research on DTC ads for over-the-counter medications, for alcohol, and for tobacco. Though they cited a number of studies that were inconclusive about gender targeting of advertisements, they did find that more consumers are consulting sources beyond their physicians for information about drugs.[22] Much of the literature in health and medical journals addressing DTC advertising focuses on the numbers and content of a wide range of advertisements. To gather a rough idea of how depression medications were being portrayed to a general audience, I conducted two systematic journal searches: the first a search of three recent (year 2000) magazines with varied readerships; the second a search of general audience news and information magazines over the time period of 1998-2002. The following sections provide an overview of the data collected.

Gender & Advertising

Given the range of results concerning the targeting of gender in pharmaceutical advertising, my first journal search targeted three popular magazines with different readerships. Following the model described by Woloshin et al., I chose magazines with high circulation figures and different audiences (see Table 1.4).[23] Sampling the first issue of every other month in 2000, I surveyed six issues of each magazine. Advertisements counted in this survey included over-the-counter (non-prescription) medications, prescription medications, and informational advertisements (e.g., an advertisement by Pfizer for depression that did not list any proprietary drug, but listed web and a toll-free phone number for more information). As Table 1.5 shows, the vast majority of advertisements are located in *Good Housekeeping*, with an average of nearly twelve per issue. In contrast, *Sports Illustrated*, which is read primarily by men, contained very few advertisements for pharmaceuticals of any kind. It should be noted that dietary supplements (e.g., Gatorade or PowerBars) were not considered drugs for the purposes of this study. In this survey of issues, a total of nine (10.71% of the ads collected) advertisements for drugs relating to mental health were located. These were found primarily in *Good Housekeeping*, though one advertisement for Paxil appeared in *Sports Illustrated*. This ad pictures a woman leaning against a wall, suffering (the copy tells us) from social anxiety disorder. In *Good Housekeeping*, three advertisements for the anti-anxiety drug Buspar appeared, each depicting a cartoon figure of a woman bombarded by words describing symptoms of anxiety. In two of these ads, the words are literally falling on the woman's head; the headline reads: "Is anxiety overwhelming you?" In the

Table 1.4: Magazine Circulation and Readership

Magazine	2002 Circulation	Readership
Good Housekeeping	4,699,736	Women
Sports Illustrated	3,249,418	Men
Newsweek	3,183,008	General

third Buspar ad, the woman is drawn sitting on top of the pile of symptom-words. These ads depict the current rhetorical situation for depression: an avalanche of words bombards a largely female audience. The majority of ads in this survey appeared in *Good Housekeeping* magazine, and thus, women appear to be targeted with the majority of drug advertising. In this search, no advertisements for mental health drugs were located in the general readership magazine, *Newsweek.* However, as the next section demonstrates, such magazines do carry advertisements for a range of antidepressants.

Table 1.5: Drug Ads in Consumer Magazines

	Good Housekeeping		**Sports Illustrated**		**Newsweek**	
Over-the-Counter						
Mental	1	1.41%	0	0.00%	0	0.00%
Other	27	38.03%	0	0.00%	0	0.00%
Subtotal:	28	39.44%	0	0.00%	0	0.00%
Informational						
Mental	4	5.63%	0	0.00%	0	0.00%
Other	3	4.23%	0	0.00%	2	22.22%
Subtotal:	7	9.86%	0	0.00%	2	22.22%
Prescription Drugs						
Mental	3	4.23%	1	25.00%	0	0.00%
Allergy	4	5.63%	0	0.00%	3	33.33%
Arthritis	8	11.27%	0	0.00%	1	11.11%
Appearance	4	5.63%	2	50.00%	0	0.00%
Sexual Dysfunction	3	4.23%	0	0.00%	0	0.00%
Other	14	19.72%	1	25.00%	3	33.33%
Subtotal:	36	50.70%	4	100.00%	7	77.78%
Totals:	**71**	**84.52%**	**4**	**4.76%**	**9**	**10.71%**
Average Ads/Issue:	11.83		0.67		1.5	

Antidepressant Advertising

The second advertisement survey included in this study involved locating specific DTC advertisements for antidepressant medications. For this survey, three general readership magazines, *Time, Newsweek,* and *Reader's Digest*, and also the Sunday newspaper insert, *The New York Times Magazine*, were examined. Table 1.6 lists the circulation figures for each of the sources under consideration; each was chosen for its high circulation and visibility.[24] These magazines were surveyed for the months of February, June, and October for each year, 1998-2002. For the weekly magazines (*Time, Newsweek,* and *The New York Times Magazine*), four issues were surveyed for each month, thus excluding the fifth issue in months where a fifth issue was printed. *Reader's Digest*, a monthly periodical, yielded three issues per year. Altogether, 195 magazine issues were searched for antidepressant advertisements. Medications advertised in this corpus included: Prozac, Paxil, Zoloft, Celexa, Remeron, and an herbal supplement Kira (see Appendix B for a list of advertisements included in this study). In addition to these, eight advertisements for anti-anxiety drugs were also located. These are worth noting because antianxiety drugs are often also used to treat depression. In fact, Paxil was first approved as an antidepressant, and later as an antianxiety medication. Two advertisements for Paxil as a cure for social anxiety disorder appeared in 1999; four advertisements for Paxil as a cure for generalized anxiety disorder appeared in 2001 (all in the month of October, following the events of September 11, 2001); two advertisements for BuSpar (another anti-anxiety drug) appeared in

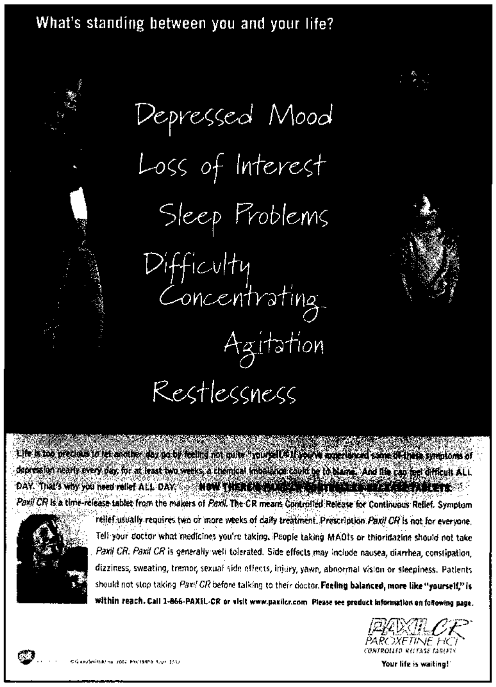
Table 1.6: General Interest Magazines Circulation

Magazine	Circulation 2002	National Rank
Reader's Digest	12,078,469	3
Time	4,111,927	10
Newsweek	3,183,008	19
New York Times Magazine	1,682,208	n/a

1998 and 2000 respectively. Table 1.7 lists the total number of antidepressant advertisements located, not including these additional anti-anxiety medications. In this corpus of eleven antidepressant ads, six picture women, one pictures only the pill itself, and four use cartoon representations of non-humans. None of the advertisements visualize the depressed individual as male; a single PaxilCR ad (Figure 1.2) depicts a family, but the father grasps his son's shoulders protectively while they both look accusingly across the page at their wife/mother who has her

Table 1.7: Antidepressant Advertisements

	1998	1999	2000	2001	2002
Reader's Digest	3	0	0	0	0
Time	1	2	0	1	1
Newsweek	0	0	0	1	0
NY Times Magazine	0	0	0	2	0
Total:	4	2	0	4	1
				Grand Total:	**11**


What's standing between you and your life?
Depressed Mood
Loss of Interest
Sleep Problems
Difficulty Concentrating
Agitation
Restlessness
PAXIL CR
PAROXETINE HCl
CONTROLLED RELEASE TABLETS

Life is too precious to let another day go by feeling not quite "yourself." If you've experienced some of these symptoms of depression nearly every day, for at least two weeks, a chemical imbalance could be to blame. And life can feel difficult ALL DAY. That's why you need relief ALL DAY. **NOW THERE'S [illegible]**

Paxil CR is a time-release tablet from the makers of *Paxil*. The CR means Controlled Release for Continuous Relief. Symptom relief usually requires two or more weeks of daily treatment. Prescription *Paxil CR* is not for everyone. Tell your doctor what medicines you're taking. People taking MAOIs or thioridazine should not take *Paxil CR*. *Paxil CR* is generally well tolerated. Side effects may include nausea, diarrhea, constipation, dizziness, sweating, tremor, sexual side effects, injury, yawn, abnormal vision or sleepiness. Patients should not stop taking *Paxil CR* before talking to their doctor. **Feeling balanced, more like "yourself," is within reach. Call 1-866-PAXIL-CR or visit www.paxilcr.com Please see product information on following page.**

Your life is waiting!

Figure 1.2: PaxilCR Advertisement (*Time* Oct. 21, 20002)
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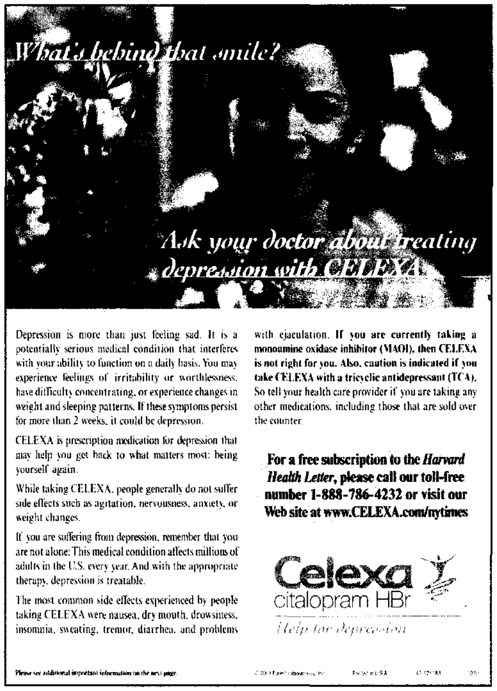
arms crossed over her chest and does not meet their gaze. In an inset picture, the woman smiles, with her son's head on her shoulder—a depiction of the benefits to be had from PaxilCR, the "controlled-release" formula of the antidepressant. Two elderly women are pictured in the Remeron advertisement, enjoying a cup of tea, and the message is directed at doctors: "Prescribe an antidepressant they can feel good about" (*New York Times Magazine,* Oct. 29, 1999). Thus, an elderly population is not directly addressed in the advertisements. Instead, the physicians are engaged in collaboration with the ads. In the Celexa advertisement (Figure 1.3), a woman is pictured from the shoulders up, standing behind a floral display. The focus is soft and her smile is questioned by the headline: "What's behind that smile? Ask your doctor about treating depression with CELEXA." In a non-branded advertisement from Pfizer, a woman leans her forehead against her hands and stares into the camera; she is quoted as saying "At first I didn't want to get up for work. Then I didn't want to get up at all. My doctor said I was


What's behind that smile?
Ask your doctor about treating depression with CELEXA.
Celexa
citalopram HBr
Help for depression

Depression is more than just feeling sad. It is a potentially serious medical condition that interferes with your ability to function on a daily basis. You may experience feelings of irritability or worthlessness, have difficulty concentrating, or experience changes in weight and sleeping patterns. If these symptoms persist for more than 2 weeks, it could be depression.

CELEXA is prescription medication for depression that may help you get back to what matters most: being yourself again.

While taking CELEXA, people generally do not suffer side effects such as agitation, nervousness, anxiety, or weight changes.

If you are suffering from depression, remember that you are not alone: This medical condition affects millions of adults in the U.S. every year. And with the appropriate therapy, depression is treatable.

The most common side effects experienced by people taking CELEXA were nausea, dry mouth, drowsiness, insomnia, sweating, tremor, diarrhea, and problems with ejaculation. **If you are currently taking a monoamine oxidase inhibitor (MAOI), then CELEXA is not right for you. Also, caution is indicated if you take CELEXA with a tricyclic antidepressant (TCA).** So tell your health care provider if you are taking any other medications, including those that are sold over the counter.

For a free subscription to the *Harvard Health Letter*, please call our toll-free number 1-888-786-4232 or visit our Web site at www.CELEXA.com/nytimes

Please see additional important information on the next page.

Figure 1.3: Celexa Advertisement (*New York Times Magazine* Oct. 28, 2001)
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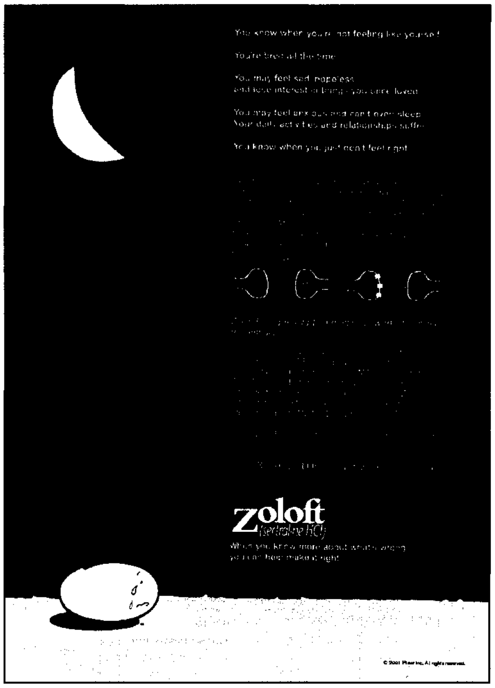
depressed…Then I learned that treatment can help" (*New York Times Magazine,* Oct. 24, 1999). In this case, the woman is not necessarily the agent of her own treatment, but she is at least the subject of the advertisement's utterance. Finally, in two ads for the herbal supplement Kira (containing hypericum, an extract made from St. John's Wort), women are pictured surrounded by troubles-text: "The typical problems and worries of the average 'super mom' can be enough to put you over the edge" (*Reader's Digest*, Feb.1998); "When I turned 55, suddenly everything seemed to be happening all at once" (*Reader's Digest*, Feb. 1998). In each of these advertisements, women are the patients in need of medical attention.

In addition to these advertisements that explicitly picture women, four (two for Zoloft and two for Prozac) use cartoon images of non-humans. In the Zoloft advertisements, a rounded egg- or rock-like figure cries against a stark, black background (Figure 1.4). In one version of the advertisement, the figure sits under the overhang of a cliff; in another, it weeps under a sliver of



You know when you're not feeling like yourself.

You're tired all the time.

You may feel sad, hopeless
and lose interest in things you once loved.

You may feel anxious and can't even sleep.
Your daily activities and relationships suffer.

You know when you just don't feel right.

When you know more about what's wrong,
you can help make it right.

© 2001 Pfizer Inc. All rights reserved.

Figure 1.4: Zoloft Advertisement (*Time* Jun. 4, 2001)
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the moon. This creature might be read as feminine, because of the image of the moon and the egg-like shape of the creature itself. Further, when this advertisement appears on television, the viewer is sometimes encouraged to see additional information in *Redbook*, a women's periodical. In the two Prozac advertisements, facing pages form a contrast: between a black background and gray, rain clouds, and a light blue background with a bright sun ("Chances are someone you know is feeling sunny again because of [Prozac]"); and between a dark blue background with a leafless tree and an orange background with a tree in full foliage, reproduced in Figure 1.5, ("Chances are someone you know is blossoming again because of [Prozac]"). Though both ads are very careful to use gender neutral terms (using second person address and generic experiences like "losing a job or having a chronic illness"), rarely are men described as either "sunny" or "blossoming." These cartoon images cannot, however, be classified as targeting only women.[25] Nevertheless, when combined with other rhetorical forms like news media and books on depression, these ads are very likely to be part of women's current rhetorical scenes.

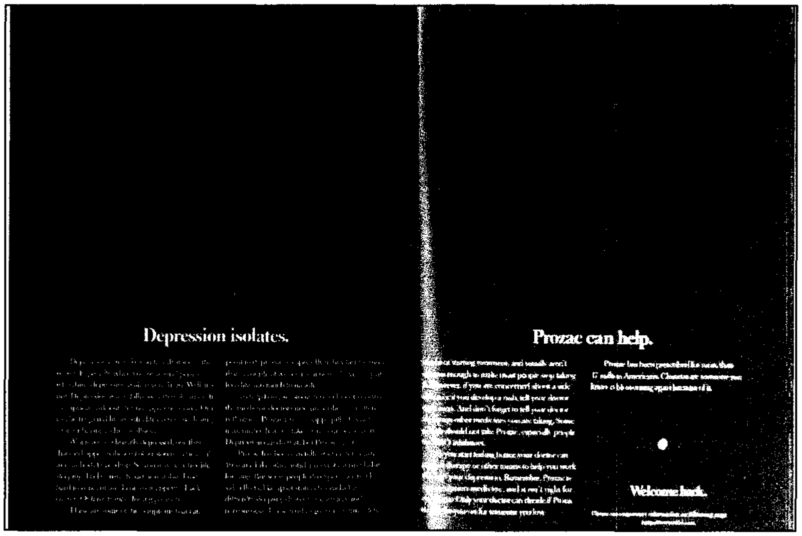
Depression isolates.
Prozac can help.
Welcome back.

Figure 1.5: Prozac Advertisement (*Time* Feb. 9, 1998)
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Woloshin et al. describe two main appeals in the advertisements they studied. First, nearly sixty percent of the advertisements appealed to a "desire to get back to normal," while another seven percent focused on a feared outcome. In the advertisements collected in this study, the first appeal—to normality—is very strong. But with the antidepressant medications, the return to normality is explicitly tied to regaining a lost "self." This can be seen in the slogans of Zoloft ("You know when you're not feeling like yourself."); Celexa ("CELEXA is a prescription medication for depression that may help you get back to what matters most: being yourself again"); and Paxil ("Feeling balanced, more like 'yourself,' is within reach."). These appeals to regaining a sense of "self" are important, it seems to me, because they tie symptoms of depression to a sense of alienation. Not only is it unhealthy to lose interest in things you enjoy (a symptom of depression), this loss of interest indicates a loss of your self. Woloshin et al. also note that thirty-nine percent of the advertisements they studied "encouraged people to consider a medical cause for their experiences" (1144). According to Woloshin et al., this leads to a greater medicalization of everyday symptoms.[26] One of the difficulties of depression is that it can sometimes be seen as just a serious case of "the blues," and therefore it is difficult to find concrete symptoms of depression. Thus, the ads do begin to medicalize behaviors like tiredness, restlessness, and loss of appetite. Strikingly, none of the advertisements in my corpus mentioned suicidal ideation or thoughts of death, which are serious symptoms of depression. In addition to avoiding the negative impact of the morbid symptoms themselves, this omission signals an attempt to broaden the consumer base for these medications. According to the ads, the drugs treat symptoms that may be less severe than such thoughts of death. In the advertisements for Kira, an herbal supplement, the headlines proclaim that the product is appropriate for "Women Coping with Career and Family" and for moments "When Life Pushes you Off-Balance." Thus, normal emotional experiences are drawn into the medical and pharmacologically treatable realm.

In addition, the symptoms listed in the advertisements are often embedded in second-person address statements as in the Zoloft advertisement: "You're tired all the time. You may feel sad, hopeless...and lose interest in things you once loved. You may feel anxious and can't even sleep. Your daily activities and relationships suffer. You know when you just don't feel right." Here, the symptoms are personalized and made less clear by being summed up with the ambiguous "not feeling right." In the PaxilCR advertisement, the women and her family are separated by the symptoms, which are written into the space between: "Depressed Mood. Loss of Interest. Sleep Problems. Difficulty Concentrating. Agitation. Restlessness." Only in the smaller print below the picture do we learn that these symptoms must persist for two weeks before they qualify as symptoms of depression. Thus, the antidepressant advertisements do help medicalize common experiences, and they encourage a view of women as specifically troubled by these experiences.

The three corpora that make up this preliminary study—books on depression, news magazine articles, and pharmaceutical advertisements—provide a sense of some of the many rhetorical systems that mediate experiences of depression. Each of these texts articulates aspects of the predominant habitus, concretizing ideologies and reinforcing attitudes and physical realities. In particular, three main points have been made: first, the corpora all support a claim that depression has been gendered female in our current understanding. Not only are images of women used more frequently in the texts on depression, the ways that depression is characterized are also feminized. Second, depression is seen as an individual, isolated experience. Texts maintain this premise in a variety of ways: by picturing a lone protagonist in the case of memoirs, by depicting a depressed patient either alone (as in the Celexa ad) or in opposition to her family (as in the PaxilCR ad), and by denying nurturing or care taking roles to men and family members. Finally, the third piece of the dominant habitus is a rhetorical explosion that directs action toward pharmaceutical/chemical interventions. This is best exemplified in the PaxilCR ad (Figure 1.2), where the language itself literally becomes "what is standing between you and your life." Here, the woman is trapped by the linguistic signs for her symptoms, and her response is limited to the commodified solution of medication. Altogether, these corpora provide a background against which to understand current experiences of depression; thus I turn now to the language practices of individuals.

"Lifeworld" Discourse

Following Smith, I argue that "[d]iscourse and ideology can be investigated as actual social relations ongoingly organized in and by the activities of actual people" (D. Smith 160). Studying the language of individuals is not unprecedented, but it is not often the focus of critical discourse analysts' attentions. More often, the talk between doctors and their patients is seen as the appropriate place to investigate language practices around health and illness.[27] Two book-length studies, both published in the last ten years, provide a justification for a serious consideration of the language of mental health encounters. Kathleen Warden Ferrara's 1994 discourse analysis of the therapy session, *Therapeutic Ways With Words*, uses narrative and conversational analyses to explore and map the discursive features of patient-therapist interactions. Ferrara focuses on the joint production of meaning through the participants' use of "two cohesive aspects of discourse, repetition and contiguity, for strategic and social purposes" (5). She argues that her work not only illuminates a relatively "opaque" field of discourse (the therapy session) but also adds to our understandings of discourse interaction in general. Importantly, Ferrara reminds us that there is "a need for an understanding of the health care practices of not only exotic cultures, but of the tacit assumptions underlying Western culture and its health practices as well" (4). While medical anthropologists have worked on cross-cultural health care practices, Ferrara reminds us that our own practices are just as important as areas for study. Ferrara's work offers a starting point for discourse analysis of medical encounters—she follows Labov and Fanshel's work on the discursive practices of therapy sessions—and highlights important rhetorical features. Nevertheless, Ferrara does not engage in critical discourse analysis. Indeed, she relies on conversation analysis to support her conclusions. Thus, her work leaves room for a more critical examination of language, for an analysis which acknowledges and foregrounds its political and social location(s).

The second study, Dana Crowley Jack's *Silencing the Self*, published in 1991, directs the attention of psychologists and academics toward the words of patients, in this case depressed women.[28] Given growing suspicion of institutional and "expert" discourse that characterized feminist analyses of the 1980s, Jack's move back to the women themselves is an important one. She asserts: "In order to understand how a woman's external and internal worlds affect and depress her, we must learn about how she sees and interprets them" (23). To this end, Jack performs a metaphorical and thematic analysis on the narratives (collected via interview) of twelve women. This work is an important first step in reinserting women's voices into the conversation about their health, and highlights the need for questioning traditional psychological descriptors of patients. For example, the women in Jack's study seem to transform classic definitions: "dependent" behaviors become not passive acceptance and reliance on their (male) partners but active attempts to construct meaningful intimate relationships.

In Jack's study, the silencing which accompanies depression is not always imposed by a patriarchal society, but is also a self-induced repression. As Foucault has demonstrated, however, practices of self-regulation may not be less influenced by dominant ideologies like patriarchy (*Discipline*). Nevertheless, Jack argues that, rather than being dependent on their intimate relationships, these women "describe their depression as precipitated...by the recognition that they have lost themselves in trying to establish an intimacy that was never attained" (27). This rhetorical shift—from passive dependent to active agent—is an important and relevant one. However, the redefinition that Jack is suggesting still ties depression securely to failed relationships—changing the direction of its approach, from a failure due to passive acceptance of a bad relationship to a failure due to active pursuit of an unresponsive relationship, does not necessarily alter its fundamental structure. Jack relies heavily on essentialist notions[29] of women's "selves" being defined relationally (while men are more autonomous), a reduction that is appealing because it allows her to revalue women's roles within traditional relationships. Nevertheless, this heavy emphasis on relational self-construction may be obscuring other features of the patients' discourses. While in some cases depression may indeed be linked directly to a failed relationship, this still seems too easy a resolution to me. One of the difficulties of Jack's study is its reiteration of women as *part of* relationships (with men). This focus moves away from the experience of depression to a more general description of women's roles in society (public and private). Thus, Ferrara and Jack provide useful starting places for a discussion of the language that surrounds depression, but neither articulates their position in terms of power *and* language.

Terry Threadgold, in *Feminist Poetics,* explores this power of discourses to naturalize and sanction their subjects, while enabling the forgetting of other possibilities.[30] She writes that, "Discipline and discourse then both position and 'produce' the subject, investing the subject with a desire for power, a will to know and a practiced body that remembers and forgets, escapes and returns to, the practices that form it" (25). Importantly, she continues, "The disciplined body is a very forgetful body. It forgets gender, class, colour, while at the same time providing invaluable technologies for remembering them" (28). Threadgold's project, as a feminist rearticulation of both structural (poetics) and post-structural (*poeisis*) theories, is to re-embody texts, to remind our forgetful bodies of their material existences, even as they are instantiated and contested via discursive maneuvers.[31] Threadgold's challenge to us is to (re)embody our theoretical analyses, to recognize that "both interpersonal and textual grammar [are] intimately related to the overt resources of the embodied subject who speaks and writes, reads and listens" (169). This process is for Threadgold one of constant re-tellings. She writes:

> We have somehow to teach the pleasure of storying, and thus the desire to see what it might be like in someone else's story, and to try to understand when we get there. And we have to subvert, not fulfill, the desire for tidy endings and clear beginnings...It is certainly a strategy which is neither apolitical, nor irresponsible, nor patriarchal. It is a feminist strategy for performing a politics of gender, race and class, which will not be built on the basis of patriarchal theories, and it is a way of telling differently the story of femininity, and a multitude of other stories, including those of masculinity. But it will only work as strategy when men read its stories as serious theory, and engage with it on those terms. Until they do, a whole range of serious gender issues will simply be left off the agenda. (133)

In other words, as scholars, we must retrain ourselves to take pleasure in contingencies and to view subject positions as in process, as always subject to interpretations from other positionalities. Threadgold's final warning, that these stories are not (yet) valued as theories, highlights the importance of including the embodied stories of women (and men) within our privileged (academic) discourses. Threadgold's critique of theory and its reliance on abstractions away from the body does not entirely discount the value of both structural and post-structural approaches to texts. Rather, she encourages an approach that blends the two while maintaining the embodied stories at the center of analysis.

For critical language analysts, the doctor's office has proven to be a productive site for inquiries into language and power. While I agree that this is an important avenue for research, I am interested in moving outside of this institutional frame. The fact that these interviews are highly structured and are confined to specific social roles presents a problem for understanding how individuals might make daily use of the discourses that surround them. In the doctor-patient interview, some discourses will be perceived to be relevant, while others will be left off the table. In the current project, I am exploring how individuals use the language of the media, popular books, and pharmaceutical advertising in their conversations about depression. In Eliot Mishler's work, *The Discourse of Medicine,* he describes conflicts between the language of doctors and the language of their patients. Calling the language of patients the discourse of the "lifeworld," Mishler points out places where this language comes into conflict with the discourse of "medicine." In this study, language from a variety of worlds intersects in the "everyday" talk of women about their health and illness. These intersections help articulate the "lifeworld" that Mishler describes as intervening in doctor-patient conversations.[32] In other words, this project offers a more complete description of how women construct their "lifeworlds" using the linguistic and rhetorical resources available to them. For the purposes of this project, I am departing somewhat from the theoretical definition of "lifeworld" as it has been developed by Jürgen Habermas. Instead of opposing everyday consciousness with systemic consciousness, I am using "lifeworld" to connote discursive commonplaces.

Interview Methodology

Given Mishler's claims about the conflicts between doctors' medical discourse and patients' lifeworld discourse, this project explores what might be influencing patients' lifeworld discourse. As the discussion of DTC advertisements and news media above suggested, there are gendered representations of depression currently circulating. This study was designed to examine the uses of these ideological notions made by individuals.[33] Study subjects were recruited by flyers posted around the University campus, and thus the participants were all connected to the university community. The study involved two kinds of participants, women suffering from symptoms of depression and mental health professionals. Study participants in the first group (women suffering from symptoms of depression) were required to be between the ages of 18 and 59, and were evaluated using the Center for Epidemiological Studies Depression Scale (CES-D) to determine their depression score (see Appendix C). For this study, I was interested in patients who did not meet the criteria for a clinical diagnosis of depression. Instead, I was interested in talking with women who had some of the symptoms of what is commonly referred to as "the blues." The CES-D screening instrument was used to identify women with appropriate levels of depressive symptoms. Citing Weissman et al. and Schulberg et al., Brown and Robinson suggest that scores between 11 and 29 on the CES-D indicate levels of depressive symptoms appropriate for my study. Brown and Robinson write: "A literature review suggested that this range [11-29] of CES-D scores would be likely to capture women with the presence of mild to moderate depressive symptoms and eliminate women with severe symptomology or clinical depression" (177). This population of women, those who were experiencing enough of the symptoms of depression to be aware of them, but who were not currently under a doctor's care, were my chosen subjects, because they are the likely targets of the DTC advertising of antidepressants. Further, they are not yet familiar with the medical discourse on depression, allowing me to study common sense rather than clinically conditioned articulations of depression.

A total of seven women participated in this portion of the study. They were divided into two groups for interviews, Group 1 included four women, Group 2 included three. All of the women who participated in this study were University students (some undergraduate, some graduate students). Group 1 included Paige, who had just finished her humanities undergraduate degree; Claire, a graduate student in the humanities; Su-Ting, a graduate student in the health sciences; and Tiffany, a senior undergraduate in the humanities. Group 2 included Mei, a senior undergraduate in the health sciences; Jennifer, a graduate student in the sciences; and Stephanie, an undergraduate in the humanities. (For more information about the study participants, please see Appendix D.) A group interview format was chosen to elicit more natural conversation than would have been likely between each subject and me as "interviewer." The women in both groups did end up interacting with each other and thus provided some conversational data. See below for the interview procedures.

The second category of subjects in this study included four mental health professionals. This group interview was intended to provide a sample of the professional register of discourse on depression. These women were recruited from the University environment and were all finished or nearly finished with their advanced degrees. The mental health professionals group included Laurie, a psychologist; Ellen, a psychiatrist; Joan, a social worker; and Betty, a psychiatric nurse. Details about these study subjects are also included in Appendix D.

Interview Procedures

This study employed the ethnographic interview as its main tool. The ethnographic interview, as described and studied by scholars such as James Spradley, Elliot Mishler, and Ruthellen Josselson, is a structured interview process that gathers demographic and situational information from subjects. This process allows subjects to use their own terms and conceptual frameworks to describe their situations and experiences, which in turn allows the researcher to develop a more complex and potentially more authentic picture of the subject's experiences. In order to maintain the flexibility of the process, the ethnographic interview may depart from a prepared script depending on the direction and topics the subject(s) wish to pursue. For this study, an ethnographic interview methodology was employed to allow the conversations to grow more organically out of the topics that were most relevant to the subjects.

Subjects in the first category ("women") were asked two broad kinds of questions—questions about what they had seen and/or read about depression, and questions about their own experiences with feelings of depression. Thus, subjects were asked questions like: What have you read about depression? Have you seen any advertisements for medications for depression? Do you think of yourself as depressed? What does it feel like when you are down? Subjects in the second category ("mental health professionals") were asked information about their education and professional training and about their experiences in dealing with people who were depressed. Questions included: What is your definition of depression? How do you know a client is depressed? What kinds of resources do you recommend to people who are depressed (especially books or literature)? How do the clients you work with describe their experiences with and feelings about depression? Discussion with subjects in this second category focused on their professional lives, as this group was intended to represent the everyday language use of the mental health industry (and not the general public). This register is not, however, a representation of scientific or research discourse; it is professional speech among peers, and it operates on shared assumptions of clinical expertise. All of the interviews were audiotape recorded and transcribed (see Appendix E for transcription conventions) by me. Throughout this study, participants have been assigned pseudonyms and identifying details such as place names and undergraduate majors have been generalized (e.g., "City Hospital" and "humanities major") to further insure the confidentiality of participants. My own name (Kim) is used to identify me in the transcripts.

Chapter Overview

The following chapters focus on the interviews conducted in June and July 2002. These interviews provide evidence of how the individuals use of the discourses that surround them. To discuss these transcripts, I am building on the concept of "uptake" as a means of locating moments in the conversations where the individuals are responding to the circulating discourses on depression. In conversation analysis, uptake is the mechanism that facilitates the orderly transfer of turns. If I speak and you do not acknowledge that I have spoken (by word or gesture) then I am likely to assume you either did not hear me or did not realize I was talking to you, and so uptake failed to happen. In this case, I am likely to add something to my initial turn to make you understand that you are the target of my talk. When you give a signal that you have understood me, or taken your turn, uptake has been secured. Within conversation analysis, the theorizing of uptake has been focused on single speech situations. This notion of uptake has been built on by genre theorist Anne Freadman to account for a more socially situated form of response ("Anyone," "Uptake"). In this project, I combine Freadman's notion of uptake with conversation analysts' focus on talk-in-interaction to account for the ways that the interviews I conducted participate in the circulating ideologies about depression.

The chapters that follow this introduction engage with the notion of uptake and investigate its potential as a method of analyzing conversation critically. In chapter two, I historicize the concept of uptake and explore the ways that it is evidenced in the transcripts of my interviews. Importantly, chapter two begins to provide an explanation of conversational power. Freadman suggests that uptake imposes power in two main ways, through processes of selection and of translation. Selection is how each uptake chooses the topic to which it responds. This involves the construction of the speaking-subject as well as the object of her speech. These processes of selection necessarily involve the habitus, or what Freadman calls uptake's memory, which restricts potential uptakes. So, looking at the selection(s) can give us insight into the quality of that memory. In the analyses of the transcripts that follow chapter two, I investigate the quality of uptake's memory in a variety of ways. Chapter three considers how uptakes use norms and cultural/discursive objects, like the "emotional woman." Focusing on the collaborative way that such objects are brought into the conversations, I argue that their repetition has important consequences for the women themselves. In chapter four, I address the directionality of uptake's memory. Using Carol Berkenkotter's notion of "genre expectations," and what Anis Bawarshi calls "alpha genres," I explore the traces and anticipations of the controlling genres of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR) and of related symptoms lists for depression. Chapters three and four thus address questions of selection and circulation of uptakes.

Chapter five bridges Freedman's notions of selection and translation, focusing on moments of intertextuality. This final chapter explores how such references involve translations of appropriate subjectivities. In both conscious and unconscious citations, the women in my interviews drew on a variety of texts to support their claims about depression. For Freadman, translation occurs when a particular genre's conventions are transported into a new genre system. For my project, issues of translation are most clear when we look at the DTC advertisements that seem to take genres of doctor-patient interaction and translate them into the economic setting of advertising. This translation draws on the power of the doctor but nullifies it at the same time. The patient is the one that is placed "in power," for example, to "go talk to your doctor about Zoloft." The doctor becomes less of an actor in his/her own scene. Thus, DTC ads are not *only* educational, they are also a means of exerting (economic) power over individuals and reshaping the doctor-patient relationship. This dissertation concludes by examining processes of translation and by suggesting potential avenues for future research using uptake as a unit of analysis.

CHAPTER TWO

UPTAKE AND/AS MULTIDIRECTIONAL DISCURSIVE POWER

As chapter one demonstrated, the textual production surrounding depression in the United States is both diverse and prodigious. Rhetorically, depression has evoked numerous responses perhaps because of its very inexpressibility. The goal of this project, then, is to determine how individuals negotiate such a crowded discursive terrain. The interviews and corpus selections involved in this project seek to capture a moment in the circulation of language about depression in order to investigate the discursive subjectivities of "healthy" and "ill" women at this particular moment. Clearly, this study cannot stand for all women, all sufferers of depression, or even for all of the experiences of the women who participated in the project. What it can do, however, is provide a place (both spatial and temporal) within the constellation of discourses on depression from which to explore the uses of those discourses.

At least since J.L. Austin's mid-century lectures on *How to Do Things with Words*, we have known that language is not merely a reflection of the physical world.[1] Rather, language has the power to alter relationships and material realities. How then, we must ask, are linguistic signs translated into material signs like pharmaceuticals? How are they thus inscribed on the body? In the case of medical encounters, the relationship between sign and body manifests itself in the consultation that interprets patient *talk* as *symptoms* and responds with a *prescription*, which becomes *medication* within the ensuing interaction with a pharmacist. These transitions—from conversation to diagnosis to medication—implicate language in more than just communicative practice; these transitions hint at the physical ramifications of language use. In the case of depression, we are confronted with an illness[2] that has very few definitive somatic indications; rather, we have an illness that is characterized by a lack of interest, a lack of pleasure, and an impoverished vocabulary.[3] If, as Andrew Solomon writes, we have access to depression "only in metaphor and allegory" (16), then we must ask ourselves what effects these approximations have on medical, social, and personal responses to the illness itself.

In the end, this project explores what discursive resources are available to women when they are experiencing symptoms of depression. Given the saturation of our current society with messages from pharmaceutical companies, celebrity memoirs, public health agencies, popular media, and even alternative medical practices, we might assume that women are able to locate themselves within the discourse of depression in a variety of ways. But, as chapter one suggested, there are a few main messages about depression that seem to dominate current social awareness: depression is a chemical, mechanical malfunction of the brain, and depression is something individuals must cure themselves through the work of various self-help procedures. In addition, women are receiving images of themselves as isolated, problematic, and unproductive within these discourses. This dissertation explores such discursive constructions and develops a methodology for investigating them critically. In the next sections, I outline the theoretical basis for such a methodology.

A Model of Conversational Uptake

In this study of actual language practices, my unit of analysis will be uptake. Rather than focus on the discourse analyst's traditional unit, the phrase or clause, or the conversation analyst's utterance, I have chosen to explore the multidirectional processes of uptake because I believe this helps articulate a methodology through which conversations can be analyzed textually and critically. In the simplest terms, uptake involves putting forward topics or genres and responding to the topics or genres of others. Every utterance is, therefore, necessarily an uptake not only of its immediate conversational precursor, but also of its cultural and social location. Uptakes are concrete conversational actions that perform the dispositions of the speaker's habitus, and they are dependent on future uptakes to continue their performances. Uptakes can, in this interactional model, be successful, unsuccessful or even partial, depending on additional uptakes by one's interlocutors. But, uptakes are more than simple conversational moves, they are also instantiations of discursive power. Here, I draw heavily on Freadman's theorizing of generic uptake, which is imbued with what she calls "cultural memory." For Freadman, uptakes operate in the liminal spaces between individuals and cultures, drawing on personal and social histories (and futures). Uptakes are, then, both the act and the action of instantiating social relationships. They are legitimized by a multiply determined cultural memory, which operates on the level of Bourdieu's habitus. This dissertation is one uptake of Freadman's work, just as the conversations staged in my interviews were uptakes of the study design documents.

Operating at once on and through individuals and cultures, uptakes are neither infinite nor freely chosen. Within any given local, historical moment, specific uptakes will appear natural or inevitable. This is so because of the operation of uptake's memory, a set of habits and dispositions much like Bordieu's habitus that motivate individual actions and responses. In uptakes of discourses on depression, the concept of memory adds a sense of embodiment to the notion of the habitus. Further, uptakes' memories are capable of crossing social class lines, making them flexible tools for instantiating a predominant habitus shared by a variety of individuals. Paul Antze and Michael Lambeck's collection, *Tense Past*, provides a useful definition of "memory as practice, not as the pregiven object of our gaze but as the act of gazing and the objects it generates" (xii). Further, Antze and Lambeck argue that "memory implies identity, the self caught between its roles as subject and object of memory, the telling and the told" (xix). Thus, memory is a powerful and bodily practice that entails both active and passive self-construction.[4] For a theory of uptake, then, memory functions at both an individual and a collective social level.

For my project, it is this potential for both individual and social determination that makes uptake a productive analytical location. Viewing moments of uptake as sites where individuals enact the subjectivities available to them, I argue that these moments offer evidence of the conversational enactment of discursive power. In Smith's analysis of the discourse of femininity and individuals' practices in relation to it, she argues for women as "secret agents," performing beyond the public scene of discourse. Smith writes: "For while the subject-in-discourse is denied agency, there is another subject who is here speaking in her capacity as a knowledgeable practitioner of the discourse of femininity. . . .Behind the subject-in-discourse is another subject who is also clearly a member of the discourse, but at another level of its organization" (192-3). In this passage, Smith refers to the active work performed by women in subjecting themselves to the physical appearance dictated by the discourse of femininity. In this work, Smith argues, women are "fully…agent[s]" (193). Given the western equation of agency with autonomy described by Bawarshi (5), it is at first hard to see the complex agency Smith's scenario might enact. Women, in the practices of producing themselves as fully subjected subjects of "femininity" nevertheless actively negotiate and perform their knowledge of what "femininity" means in their particular social, historical moment. What I find intriguing in this analysis of agency is the implication of women in constructing and performing the discourses that subject them. Far from demoralizing, Smith argues, this form of agency actually provides many of the practices (consumer, material, physical) that many women enjoy.

In my project, I want to expand Smith's concept of the "secret agent" by combining it with Bawarshi's "double agent." Bawarshi characterizes the student writer as a double agent, as "both an agent *of* his or her desires and actions and an agent *on behalf* of already existing desires and actions" (50). In my project, I consider moments of uptake to be places where speakers are similarly situated, both as agents of their own stories and as articulators of larger cultural discourses. Uptake—when a particular topic or ideology is invoked and enacted—offers the site for examining these multidirectional impositions of power. Thus, in this project, I expand Freadman's concept of generic uptake and cultural memory into a viable methodology for understanding complex discourse critically. In the next sections, I will explore the intellectual history of uptake before returning to its use in my own project.

Critical Discourse Analysis

My use of uptake as a moment to locate discursive power is informed first by the field of critical discourse analysis (CDA). In *Media Discourse*, Norman Fairclough asserts that "language use—any text—is always simultaneously constitutive of (1) social identities, (2) social relations and (3) systems of knowledge and belief" (55). These three functions of language use are, roughly, the focus of critical discourse analysts' attentions. Developing from work in critical linguistics and discourse analysis, CDA ties its analyses to issues of power. Comparing CDA to cultural studies, Thomas Huckin writes that "CDA puts more emphasis both on the fine-grained details of text and on the political aspects of discursive manipulation" (157). For my project, CDA serves as the original methodology because of its interest in both textual specifics and institutional (power) structures. Nevertheless, this project seeks to extend CDA's objects of study. As Huckin explains, CDA has "focused mainly on public written texts such as news reports, feature articles, advice columns, political speeches, tabloid stories, and advertising brochures" (157). And, although Teun van Dijk's *Communicating Racism* does include the language of individuals, it is far more common to retain a focus on public texts. This focus has benefited critical discourse analysts because it is in these places that institutional power is often cemented. What van Dijk's study, and I hope this one, contributes to the theorizing of discursive power, is an accounting of how institutional power and ideologies are implicated in the daily discursive practices of individuals.

Lilie Chouliaraki and Norman Fairclough describe the contemporary phase of social life as "late modern" society. Part of what defines this late modern period is the proliferation of information and the circulation of discourses enacting social practices. Chouliaraki and Fairclough write: "It is an important characteristic of the economic, social and cultural changes of late modernity that they exist as *discourses* as well as processes that are taking place outside discourse, and that the processes that are taking place outside discourse are substantively shaped by these discourses" (4). What is significant in the current social moment is the proliferation and, to some extent, consolidation, of discourses surrounding our practices. In the case of depression, the traditional "expert" voices of medicine and science are joined by Internet cafes and chat rooms, tell-all memoirs, drug advertisements, patient advocacy pamphlets, and the narratives of depressed men and women. These many discourses are made exceedingly accessible by the ever-widening communication technologies of late modernity. In this social moment, then, a discussion of a single discourse is impossible. Instead, the interactions between discourses must become the focus of our attention if we are to understand and critique the social practices that construct representations of mental health and illness.

In the case of depression, there seems to be a proliferation and collision of discourses—memoirs such as Wurtzel's *Prozac Nation* and celebrity revelations like those contained in the September 2001 issue of *Rosie* magazine[5] seem to be given added force by the omnipresent drug advertising of antidepressants such as Zoloft and Paxil. The personal narrative of this disorder has in some ways been co-opted by the pharmaceutical industry's move toward public "education" and marketing. Instead of completing the doctor-patient interaction within the medical encounter, we are increasingly experiencing the interventions of the discourses of drug therapy. In the context of a life spent trying to understand her own depression, Wurtzel writes of the current popularity of Prozac: "I can't get away from some sense that after years of trying to get people to take depression seriously—of saying, I have a *disease*, I need *help*—now it has gone beyond the point of recognition as a real problem to become something that appears totally trivial" (302). To understand this phenomenon, then, we must explore the discourses deployed by the pharmaceutical companies and their social impact(s). Locating depression (the disorder) at the nexus of medical, social, and personal discourses, this project critiques the gendered representations and proliferating messages that have brought depression its current public visibility.

In *Discourse in Late Modernity*, Chouliaraki and Fairclough propose that CDA can enhance other forms of social critique by focusing on the discursive moments of social practices. All social practices, they argue, have reflexive dimensions—"people always generate representations of what they do as part of what they do" (22)—and these reflexive dimensions are discursive. Chouliaraki and Fairclough view CDA as a form of "explanatory critique," a procedure that "takes the general form of showing (a) a problem, which may be either cognitive…or an unmet need…(b) what obstacles there are to it being tackled; in some cases (c) what the function (including ideological function) of the misrepresentation or unmet need is in sustaining existing social arrangements; and (d) possible ways of removing the obstacles" (33). For Chouliaraki and Fairclough, CDA is a methodology that addresses social problems through textual analyses. Such problems are described, enacted, and maintained through discursive practices; the analyst's job is to identify and critique the institutional and cultural mechanisms that naturalize problems and obstruct equitable solutions. This project, then, falls under the rubric of CDA: it is an interested critique of the language surrounding depression, and it argues for a closer attention to the role of conversational uptake in perpetrating gender stereotypes and assumptions. As chapter one began to demonstrate, one of the problems in the language used to describe and interact with depression is the repetition of gender stereotypes. Further, the discourses on depression maintain a social isolation that exhorts individuals to address depression within themselves, rather than as a social or community problem. The rest of this project works to explore both the function of these misrepresentations and the structures that reproduce them. In part, as Chouliaraki and Fairclough argue, these discursive structures are a product of the current late modern moment. They write: "[S]ocial consciousness has become 'externalised' …people have to turn to specialized systems and the experts who organize them for information, know-how, ways of reasoning, etc." (44). These specialized systems are inhabited and maintained by individual users.[6] Uptakes are moments when individuals bring these external systems of knowledge into current circulation. These uptakes result in the maintenance of such ideological systems and in their internalization by individuals. Thus, uptakes are the intersections between individual speaking subjects and external systems of knowledge.

As a result of this location, uptakes are a site for double agency: they are both the subjectification of individuals to dominant discourses and also their potential rearticulation of those discourses. In Fairclough's terms, language use itself contains both of these possibilities. Language use, he writes, is "constitutive both in conventional ways which help to reproduce and maintain existing social identities, relations and systems of knowledge and belief, and in creative ways which help to transform them" (*Media* 55). One possible mechanism for both of these possibilities is what Fairclough calls the processes of "recontextualization" (41). This process, whereby pieces of discourse are brought into new communicative settings, for example when scientific studies are reported in general news media,[7] necessarily involves changes to the original discourse, and can potentially serve as a moment of rearticulation and redefinition. Thus, through textual movement, individuals (and systems) potentially generate "creative" practices that are capable of altering the system itself. While particular events are characterized by their "time-space parameters" (Fairclough, *Media* 36), the interconnections between events have not been fully studied. These parameters are not just a concern within particular genres or speech events, they are also implicated in the movements of recontextualization and rearticulation. Drawing on different communicative events in a single conversation, for example a temporally bound doctor-patient encounter and a less stable news article representing several scientific studies, involves eliding the differences between the two events. Such elision, it seems to me, is an important further area for study. How should critical discourse analysts account for these daily practices of individuals? Specifically, these time-space discontinuities, I am arguing, are part of the creative (and restrictive) power of discourse.

When individuals draw on multiple communicative events, they potentially disrupt the events' original locations. Such disruptions allow individuals to create current meanings that are relevant to them. For example, an individual may combine a current conversation with a friend, in which the friend complains of not feeling "quite right," with a previously read pharmaceutical advertisement promising to restore one's sense of self. This combination, obviously the goal of much DTC advertising, creates a meaning by linking these two separate events. What is missing from this scenario may be a series of other texts that could have entered the interaction: an FDA warning letter, informing the pharmaceutical company that it's ad promises unsubstantiated benefits; or a research study that highlights adverse reactions to the medication. Ultimately, the connections that are made in each moment—the commonplaces that are developed—draw on a variety of texts, which are variably long-lived in the public or individual consciousness. Thus, noting which texts are cited by individuals provides an opportunity to investigate practices of meaning making, and it offers insight into the operations of uptake's memory.

According to Huckin, CDA works to demystify the workings of expert and institutional systems of power. In his description of CDA, Huckin asserts that "the main purpose of critical discourse analysis is to understand how people are manipulated by public discourse and thereby subjected to abuses of power" (158). This description, though accurate, has come to seem particularly one-sided to me; it ignores processes through which individuals participate in their own subjugation. Further, to see only how people are subjugated by power leaves out the very real struggles (and successes) of individuals in living their daily lives. Indeed, Chouliaraki and Fairclough suggest that the "mediated quasi-interactions" that make up late modern systems of information and expertise are not *completely* subjecting for individuals. Chouliaraki and Fairclough remind us that "there is always a dialectic of colonization/appropriation" (45). In other words, the discourses that shape our social realities are available for rearticulation—we can (and do) create hybrid texts and new meanings from the web of preformed significations that the systems provide. This leads to the possibility for change and "emancipation" inherent in CDA projects—by understanding the operations of systemic discourses, we can better learn to listen to the ways that individuals are appropriating and making use of them. As a result of this closer attention to individuals' practices, remedies for institutional impositions of power can potentially be developed.

The moves of colonization and appropriation could be read as binary oppositions, leading to definitional difficulties. How, one might ask, can the two moves be differentiated and identified? In the interviews that I conducted for this study, I found that, rather than operating dialectically, individual communicative efforts often display both moves simultaneously. This duality seems characteristic of all discursive practices. A woman might say, for example, "I honestly do think I have a chemical imbalance sometimes" (Stephanie, G2 76:54), using the phrase "chemical imbalance," directly from pharmaceutical advertising. Is she being colonized by this powerful discourse, believing her symptoms are explainable in a particular, commodified way? Or, is she making use of the phrase to categorize and thereby control her personal experience? In my analysis, I was often tempted to read such moments from the critical discourse analyst's perspective of identifying the misuses of power. However, it became clear to me in my conversations with these women about depression that having expert systems like pharmaceutical "consumer education" campaigns was both comforting and productive. The women are, as the following chapters will demonstrate, actively working in and through the discourses that surround them. In the example above, Stephanie seems to recognize that the phrase "chemical imbalance" is an imposition from another discourse, but she is using that term to further her own understanding. For me, uptake offers a multidirectional mechanism for discursive power, incorporating practices of colonization and appropriation, as well as requiring a subject that is both subject *to* the discourses and also the subject *of* particular actions. Thus, uptake encourages an analysis that inherently generates and works to understand contradictions like those experienced by the women in my study.

Speech Act Theory

Austin's posthumously published lectures on *How to Do Things with Words* sets forth a theory of language's performativity. It is from this foundation that Freadman derives her version of uptake. Thus, it is worth reconsidering what philosophers of language have said about the concept of uptake. Although these comments are necessarily abbreviated, I am following Freadman in arguing that the formulation of uptake as it is represented by Austin and his student John Searle, and by H. P. Grice, is not sufficient for a complex analysis. These philosophers have not fully accounted for the implications of context, and I would like to push their view of the agency and scope of uptake itself. At the outset, however, I must acknowledge that uptake occupies a rather limited place in all of these scholars' work. Their concern with meaning, implicature, and rules for comprehension have left uptake itself somewhat undertheorized.

The theory of speech acts, as it is outlined by Austin and elaborated by Searle, suggests that utterances perform three distinct kinds of acts. First, an utterance is said to perform a locutionary act, which amounts to the words having both sense and reference. Second, an illocutionary act carries the force of a speaker's intention to perform a conventionalized social action like promising or betting. Finally, a perlocutionary act achieves an effect in the hearer, and is thus said to be the consequence of the utterance (Austin 121). Certainly, statements may perform all three of these acts simultaneously. The issue of uptake is introduced by Austin as one of the tests for an utterance's illocutionary force. He writes: "An effect must be achieved on the audience if the illocutionary act is to be carried out....Generally the effect amounts to bringing about the understanding of the meaning and of the force of the locution. So the performance of an illocutionary act involves the securing of *uptake*" (Austin 116-7, his emphasis). Thus, Austin defines uptake as the comprehension by the hearer of the force of the utterance.

Because of the interest in comprehension, scholars following Austin have focused much of their attention on meaning. Searle elaborates on Austin's system to suggest that "what we can mean is at least sometimes a function of what we are saying" (*Speech Acts* 45). This assertion, that there is sometimes a correspondence between linguistic form and intended meaning, can be problematic. Nevertheless, for the purposes of this discussion, uptake requires the comprehension of some part of the speaker's meaning. For Searle, meaning "is more than a matter of intention, it is at least sometimes a matter of convention" (45). Thus, illocutionary acts are successful not only because they are understood by hearers as intending to mean something, but also because the conventions of a given speech situation enable a particular meaning to be expected. In a similar way, Grice notes the importance of uptake in his retrospective epilogue to

Studies in the Way of Words. He writes that his theory articulates an analyzed version of an intention "toward some form of 'uptake' (or a passable substitute therefor), when [it] claim[s] that in meaning$_{NN}$ a hearer is intended to recognize himself as intended to be the subject of a particular form of acceptance, and to take on such an acceptance for that reason." (352). Here, Grice suggests that in "non-natural meaning," that is meaning directed not at concrete objects but at concepts, the hearer is intended to recognize herself as the target for a speaker's utterance. She (the hearer) must recognize the attitude inherent in that utterance and accept it. This formulation makes uptake more than the process of recognition and comprehension of an action directed at the hearer by the speaker. It suggests that in addition to comprehending, the hearer must take on (accept) the intended attitude because of her comprehension. Thus, Grice moves uptake toward a perlocutionary act.[8] Both Searle and Grice have been critiqued for their emphasis on speaker intentions. As David Bogen points out, "By beginning from the perspective of intentionalist semantics, the theory of speech acts commits itself to a monological account of meaning-adequate expression, thereby ignoring entirely the constitutive role of contextual considerations in the situated production and recognition of intelligible utterances" (70). In other words, locating meaning within the intentions of the speaker or even within the comprehension of the hearer does not account for the wide breadth of context that in fact informs our communicative practices. Despite Searle's description of the conventional aspects of an utterance, context is often bracketed out of Speech Act Theory.

In addition, Austin's formulation of uptake is a relatively passive understanding of speaker intentions. Even if we adopt Grice's term of acceptance, uptake does little more than register the hearer's presence in the speech situation. In the terms of Kent Bach and Robert Harnish, "Uptake involves [the Hearer's] attributing to [the Speaker] a communicative (R-)intention" (294 n.2). In their terminology, an (R-)intention, a reflexive-intention, is the move whereby a speaker secures the recognition of her illocutionary intention (uptake) in a hearer because the hearer is expected to recognize that the speaker intends to produce a certain effect in the hearer, an effect that the hearer must discern. So, uptake is secured by the hearer assuming that the speaker intends to convey an attitude, and, as a result, the hearer comprehends that attitude. Although this complex reading of intentions and comprehension does suggest that uptake is not simply the passive acceptance of a speaker's illocutionary force, it still seems to me to be bounded to a very narrow definition of speech situation and participant roles. Where, I will ask below, is the place for cross-situational memory?

To summarize, in Speech Act Theory (Austin), "uptake" is the comprehension of an illocutionary force, and is a necessary condition of the force becoming an *act*. An illocutionary act is the effect of, for example, a *promise* when I say "I promise to take you to the zoo tomorrow." If you hear this and understand that I am actually promising (and not lying or joking) then you have performed an "uptake" of my utterance. So, uptake is the necessary comprehension of the illocution, and it requires the speech situation to be "serious" and conventionally appropriate. The problem with this version of uptake is that it seems to rely only narrowly on the context or "conventional" aspects of utterance (Searle). It is bound to the particular speech situation, and historicity is limited to the rules of a particular kind of speech act. In addition, it seems bound too tightly to the speaker's intention and the hearer's comprehension of this intention (Grice). My own articulation of uptake, following Freadman, considers it to be an initiating as well as a reciprocating activity.

Conversation Analysis

Building on the concept of talk-in-interaction, the belief that talk is best studied in real, concrete speech situations, Conversation Analysis (CA) looks at strips of naturally occurring conversation to determine the interactional patterns and rules. By establishing patterns, conversation analysts can determine how speakers handle specific speech situations differently, for example, the discovery that business calls do not invoke the same ritualized greetings as personal calls. Within the framework of CA, uptake has been defined as a process in turn taking. Essentially, uptake is the response to another's utterance; it signals the successful completion of one turn and the beginning of a subsequent turn. In a recent analysis of conversational extensions, Cecilia Ford, Barbara Fox, and Sandra Thompson conclude that such extensions—for example additional noun phrases added to what seemed a complete conversational turn—are doing the "interactional work…[of] pursuing uptake by continuing the action of the just possibly-completed turn. In other words, they are attempted solutions to a lack of displayed recipiency" (19). Thus, for Ford, Fox, and Thompson, uptake requires one's interlocutors to acknowledge, verbally or physically (as in returning one's gaze) the completion of one's turn. When that acknowledgement is not forthcoming, a variety of extensions are used to (re)cue the uptake. Here, uptake seems to be reduced to the orderly progression of turn taking.

Just as my critique of Speech Act Theory focused on the way that context was ignored, my critique of CA focuses on the limitations of uptake to a very specific instance of turn-taking. Within a particular conversation, the workings of uptake are certainly important. Nevertheless, this definition of uptake cannot (and is not intended to) account for the imposition of discursive power across speech settings. Margaret Wetherell summarizes this critique in a recent *Discourse and Society* article. She argues that "the problem with conversation analysis is that they rarely raise their eyes from the next turn in the conversation, and, further, this is not an entire conversation or sizeable slice of social life but usually a tiny fragment" (402). A further explanation of the "context critique" of CA is offered by Anthony Giddens. In discussing the work of Erving Goffman, Giddens suggests that "Goffman is able to show some of the limitations involved in thinking of talk in terms of statements calling forth replies" (267). Additionally, Giddens argues that a mechanical version of uptake—the process involving turn taking and call-and-response pairs—cannot take into account "that both speakers and listeners depend upon a saturated physical and social context for making sense of what is said" (267). This suggests that uptake may involve more contextual, social awareness than is implied in typical CA projects.

Charles Goodwin elaborates this idea in his analysis of two physical/spatial scenes: young girls playing hopscotch and archaeologists classifying color. In his conclusion, Goodwin states that "context is not simply a set of features presupposed or invoked by a strip of talk, but is itself a dynamic, temporally unfolding process accomplished through the ongoing rearrangement of structures in the talk, participants' bodies, relevant artifacts, spaces, and features of the material surround that are the focus of the participants' scrutiny" (1519). Thus, Goodwin accounts for physical and temporal context for communicative interaction. To some extent, such a focus on games and repeated experiences does lend itself to a notion of conventional context in much the same way as Searle seems to be advocating in his theory of Background. For Searle, absurd meanings are precluded not by the formal features of an utterance, but by "the fact that you have a certain sort of knowledge about how the world works, you have a certain set of abilities for coping with the world, and those abilities are not and could not be included as part of the literal meaning of the sentence" (*Construction* 131). Thus, critiques of CA might lead to a more robust theory of context-in-interaction.

Nevertheless, discussions of context come dangerously close to relying on the container metaphor: that events happen *in* a context, but do not necessarily interact *with*, or change that context. Nikolas Rose argues that systems of language use must become the focus of our analysis. He notes that treating language and context as separate phenomenon divests both of much of their power. Instead, he argues, "[w]hat needs to be analyzed is the mode of relation to oneself enjoined in definite practices and procedures, links, flows, lines of force that constitute persons, and run across, through, and around them in particular machinations of forces....this is not a call for a more delicate and subtle locating of communication 'in its social context', but for a rejection of the binary form that separates out language only in order to reembed it contextually in a world that is reduced to a kind of cultural background to meaning" (181-2). Here, Rose is arguing more radically that language and context need not be studied as separate, interlocking phenomenon, but that they are fundamentally articulated within each other. Thus, we should consider context only insofar as it is embedded in language, and language insofar as it instantiates context. Such an analysis necessarily requires that we have a means of understanding power beyond an individual speech act or speech situation. I believe that Freadman's version of uptake begins to account for the multidirectional control exerted by discursive systems. In my own analysis, I draw on the CA position that uptake occurs on a conversational level. However, I am combining this feature with Speech Act Theory's focus on intention and conventional meaning. Ultimately, I argue that both definitions need to reach beyond single speech occasions and situations, as Freadman's generic uptake does.

Performativity

To expand uptakes across situations, I follow Freadman in drawing on theories of performativity. For Judith Butler, identity is a matter of performance rather than essential, stable definition.[9] Butler takes Austin's idea of speech act beyond the realm of linguistic performance to all forms of semiotic representation. Thus, speech becomes part of the performance of, for example, gender, but is not the final arbiter of it. In *Excitable Speech,* Butler discusses the diffusion of power along the lines of Chouliaraki and Fairclough's expert systems. "The bureaucratic and disciplinary diffusion of sovereign power," Butler writes, "produces a terrain of discursive power that operates without a subject, but that constitutes the subject in the course of its operation" (34). Thus, for Butler, we are not the originators of discourses that constitute our subjectivities, and we are not finally able to control the meanings of our utterances. "If a performative provisionally succeeds," Butler argues, "then it is not because an intention successfully governs the action of speech, but only because that action echoes prior actions, and *accumulates the force of authority through the repetition or citation of a prior and authoritative set of practices*" (51, her emphasis). This idea of actions echoing prior actions is akin to what Freadman calls uptake's memory—utterances gain their power through citationality, historicity and futurity.

The unmooring of meaning from speaker intentions happens in part because the moment of utterance is linked in a chain to previous and future occasions. According to Butler, following Austin, illocutionary acts proceed by means of convention. And, "[t]he ritual dimension of convention implies that the moment of utterance is informed by the prior and, indeed, future moments that are occluded by the moment itself. Who speaks when convention speaks? In what time does convention speak? In some sense, it is an inherited set of voices, an echo of others who speak as the 'I'" (25). Thus, the speaking subject becomes linked to other past and future speakers of the same words. This temporal confusion provokes both the power of discourse—individual speech acts cannot fully divest themselves of the assertions of past power—and its possibilities—individual speech acts can call forth *both* past *and* future utterances. This is where Butler locates the radical possibility in speech acts; they contain the potential for new meanings. Butler writes: "the possibility for the speech act to take on a non-ordinary meaning, to function in contexts where it has not belonged, is precisely the political promise of the performative" (151). The possibility that utterances may be called forth in a chain that extends both forwards and backwards evokes what Freadman calls the memory of uptake. It is the possibility of all instances coinciding and redefining themselves that is important to Butler. Freadman's memory of uptake, offering as it does an explanation of how speech situations recur and are reused across social settings, suggests a similar complication of performativity. Nevertheless, the iterative processes of performance allow uptake to operate across speech situations and to evoke cultural as well as individual meanings.

Anne Freadman: Generic Uptake

To theorize power multidirectionally requires an agent of articulation between ideology and practice. Such an agent would be both action and actor, both the process through which power is legitimized and the material effects of such power. Here, Freadman's (re)articulation of uptake provides a useful model: it is the term Freadman uses to describe the "bi-directional" relationship between any two texts, a relationship that, for her, instantiates a genre ("Uptake" 40). Thus, uptake is both relating texts to each other and the relations between them. More specifically, however, Freadman is concerned with the qualities of such uptakes and with the contextual, cultural "memories" which, to some extent, motivate them. Each uptake selects and defines the object to which it responds, and this selection process is shaped by contextual conventions and expectations. Nevertheless, uptake is not the simple response to an exigency; it is not an inevitable next text within a predefined system. Rather, uptake is a productive process that constitutes that with which it engages and thus has the potential to reshape and re-construe previous discursive entities. The potential for rearticulation is, for Freadman, the means through which uptakes exert power, particularly when an uptake crosses generic boundaries. Thus, selective memory and generic crossing are key processes in the operation of discursive power; they offer concrete moments for analysis and exploration. To simplify, each instance of speaking or writing is an instance of uptake—each utterance must justify its articulation by referencing some prior statement or statements.[10] Nevertheless, uptake is neither so simple, nor so innocent, for the way a statement contextualizes itself is by translating previous statements. These translations exert power over discursive objects by virtue of their ability to select particular objects and ignore others; this process, Freadman argues, relies on a complex cultural memory that naturalizes specific translations.

Freadman, in her analysis of the myriad textual constructions of and responses to the hanging of Ronald Ryan in Australia in 1967, introduces the possibility of an intergeneric network of textual circulation ("Green Tarpaulin"). As Freadman's work demonstrates, much can be learned from drawing together diverse genres to examine the socio-discursive formation of particular entities: for Freadman, capital punishment in Australia; for my project, definitions of depression in the United States. In her study of myriad texts produced in and around Ryan's death, Freadman identifies uptake as an intertextual process that more than references other discourses; it actively selects, defines, and instantiates particular subjects. This is the process whereby the jury verdict leads to a sentence which is then variously appealed (legally) and criticized (in the media) but is ultimately enacted on Ryan's body via his hanging. Here, the textual and the physical are dramatically intertwined. The discursive is embodied. For the women in my study, the discursive object of an "emotional woman" becomes a physical reality when the interviewees set up rhetorical equivalencies between themselves and their emotions.[11] Freadman notes that "uptakes...have memories—long, ramified, intertextual, and intergeneric memories" ("Uptake" 40). The memory of a particular uptake is what motivates specific objects to be selected and reiterated while others are ignored; this is the operation of discursive power. Importantly, memory also involves forgetting—the strategic forgetting imposed by discourses and discipline—and for Freadman's study, the penal system deployed the memory of uptake by forgetting past judicial contexts in order to justify Ryan's execution. In Ryan's case, a second uptake from the largely sympathetic public remembered other contexts, arguing, albeit unsuccessfully, for the commutation of his sentence.

Freadman's articulation of uptake requires attention to more than institutional or intra-generic texts; it focuses on the ways that varied cultural texts come into conversation with each other. The multiplicity of sources Freadman emphasizes is echoed in my project's interest in multiple sites of discourses on women and depression. In addition, Freadman's expansion of Austinian Speech Act Theory allows us to attribute agency to the utterances which are complicated by infelicitous conditions, contexts and histories. Freadman argues that:

> Austin sets aside the heterogeneous antecedents and sequels of an utterance in the interests of philosophical rigor and classificatory clarity….It is an effective strategy of power. I want to say that we do not understand this strategy, nor do we understand its power to produce intentional outcomes, unless we understand that what it does is to block and select the memory that generates uptake. ("Uptake" 48)

Thus, Freadman calls for a reinsertion of the histories and futures of utterances in an effort to expose the power exercised through uptakes.

A brief demonstration of this historical-cultural power can be found in the example of what Dale Spender calls the "male monopoly on meaning." Spender writes:

> A woman who may spend more than twelve to fifteen hours per day (seven days a week) in cleaning, cooking and caring for children, who may have interrupted nights and demanding days in which there are no rest periods, can find herself saying "Oh, I don't work. I'm only a housewife." This demonstrates the male monopoly on meaning, for in the face of overwhelming evidence to the contrary, such women have learned to deny the realities of their own life (in which they work harder and longer than men in general,

> according to the UN statistics) and to take on the male definitions of the world in which the only *real* work that is performed, is undertaken by men. (25)

What Spender defines as the male monopoly on meaning is cemented through the everyday statements of women that they "don't work." In Freadman's terms, this statement is explainable if the women's statements are taken to be uptakes of the circulating cultural ideologies. By taking up the idea of women's domestic labor as "not work," the women participate in an uptake that ultimately works to (re)subject them to the power of patriarchy. Thus, women, through their uptakes, come to speak the words of their own oppression, and to rearticulate the structures that oppress them.

As the previous pages have shown, uptake can productively be defined as more than a comprehension of the illocutionary force of a speaker's intention. Moving beyond Austin's individual speech situation, uptake participates not only in the linguistic work that occurs within what Freadman calls a "ceremonial" (similar to Wittgenstein's "language games"), but in the work that occurs *across* ceremonials. This movement explains how powerful discourses can exert their control over and across their boundaries. For Freadman, this version of uptake helps explain both why the Australian public continues to perceive the Ryan case as an abuse of power, and why Ryan's death sentence was not commuted. In the first instance, the persistent feeling of the Australian public that an abuse of power had occurred, Bolte's (the state premier) control of the uptake—by disallowing various forms of evidence from the clemency hearings—explains the sense of abused justice. The public expected that the clemency hearing would "take up multiple, quite heterogeneous texts, not all of them generated from the trial," like prisoner's record of conduct, and church and community petitions (47). However, because of Bolte's decisions to block such testimony, "the clemency deliberations were held as if they were solely the uptake of the formal sentence" (48). Here, it is the power of uptake to select its object that constituted an abuse of power.

In the second case, the sentence of death was upheld not only because of Bolte's selection of only specific texts as relevant to the clemency hearings, but also because he successfully invoked a judicial genre within his political ceremonial. In this case, Bolte summoned the judge who had issued a stay of execution (following the discovery of a new witness) into the premier's office and examined him as if the judge were a witness. By doing so, Bolte controlled the possible subjectivities available to the judge: he becomes a state's witness, thereby nullifying his traditional judicial power as a judge. Freadman writes: "Bolte had imitated the forms of a court hearing outside the jurisdictional frame that validates them; that is, he had made a nonserious use of them. But this nonserious use had a very serious effect" (46), namely that it exerted governmental power over the judicial system. Bolte's nonserious use of forensic rhetoric, in Freadman's analysis, has the effect of "confirming the disempowerment of one jurisdiction and the power of the other" (47). In these examples, Freadman articulates uptake's two processes of discursive control: selection of objects for response, and translation of genres across settings.

For Freadman, uptake helps explain abuses of power by providing mechanisms whereby genres are translated across jurisdictions or ceremonies. Freadman's description of uptake focuses on the level of genres and ceremonies; she is not interested in the individual uptakes that occur in daily conversation. In my project, I am extending the notion of uptake to include such moments because it seems to me that the operations of power work on the micro level as well as on the level of genres. In conversations, as well as between genres, uptakes provide two mechanisms for asserting power: selection and translation. In the interviews that I conducted, both of these processes are evident. In the following section, I will explore these operations and apply them specifically to the discourses on depression.

Uptakes of Depression

As the previous pages have argued, uptake has the potential to exert the power of contextual definition by selecting particular objects as "the subject of conversation." Further, uptakes have cultural memories. (This document is an uptake of the interviews I conducted; it is also an uptake of Freadman's work.) Thus, what is selected as the appropriate topic of conversation is not based on the whims of the interlocutors, but on a historical, social memory of what and how things are talked about. This is necessarily limiting, and I read moments of conversational decomposition in the interviews as places where the individuals have run out of useful uptakes. About an hour and a half into the Group 1 interview, we began talking about pharmaceutical advertisements. Paige, a senior humanities major, describes her frustration (Figure 2.1) at identifying with the popular Zoloft commercial, which depicts a spherical creature against a black background (see Figure 1.4). She expresses contradictory reactions to the commercial: first, she identifies with the commercial; then, she also understands that the commercial is attempting to sell her a drug and not to help her resolve her depression. These conflicting responses—both uptakes of the commercial: one of the surface features, one of the presumed intention of the advertisement—end in an exasperated "u::ah:". Paige's linguistic resources do not include a response adequate to these two interpretations of the commercial. I read this moment as a place where Paige cannot articulate an uptake of the commercial because there seem to her to be no other responses besides the two she finds unsatisfactory. Additionally, Paige's conflicting uptakes of the commercial are also an uptake of the immediate speech context in which we were discussing whether DTC advertisements do any "good" for individuals.

Paige	so: like commercials even when I identify with the Zoloft commercial, I identify things that I look at. It also really pisses me off because it's *not* like the guy who made that wants to get in my life and help me out. He wants to fucking sell me drugs you know like u::ah:

Figure 2.1: Women, Group 1 (90:45)

Following this chain, Paige's uptake offers evidence of the work going on in this conversation. She is not simply acquiescing to the powerful discourse of the advertisement. Rather, she is pushing herself to make sense of contradictory meanings. Her frustration, then, can also be seen as a sign of a potential uptake that disrupts the cultural scripts inherent in the commercial. Further, the contradictions inherent in Paige's response are an indication of the complexity of uptake's memory. Both responses, identification and rejection, are legitimized by the memory that motivates Paige's uptake at this moment in the conversation. Their incommensurability leads to the breakdown of her articulation.

Because uptake operates within all conversations—on the level of conversational turn-taking as well as on the level of response to cultural discourses—one of the difficulties for this project that must be acknowledged is that the women participating in my interviews saw themselves as responding to, taking up, my intended speech situation. This can be seen most clearly in moments when the women seem to be providing the "right answer" to my questions. Because this was an official university study, because the women were recruited from a university setting, and because the interviews took place in a university building, the women quite naturally assumed the role of students throughout the interview process. This was evident (Figure 2.2) when I asked Group 2 how they would know if they had a "chemical imbalance." My intention was to elicit their understanding of what constituted a "chemical imbalance," but the women were reluctant to answer the question. One explanation for this reluctance is that they assumed my question was of the teacher-variety that expects a specific answer. This becomes

Kim	So, how would you know if you: had a chemical imbalance? What,	[how would you?]
		|
Mei		[I don't know how]
	to diagnose it ((laughs)) so	

Figure 2.2: Women, Group 2 (76:09)

clear when Mei claims to be unable "to diagnose it." She is disavowing the special skills of a physician who can diagnose patients with illnesses. Following Mei's response, I had to redefine my question to ask what the women *thought* constituted a chemical imbalance.

In addition, uptakes can be refused or only partially executed. In one instance in the mental health professionals group, the notion of depression as a "chemical imbalance" is introduced by Joan, the social worker. This is the only time in the mental health professionals transcript that the phrase is used. However, the offered topic is ignored by the other members of the group. In fact, Laurie, the psychologist, continues her own turn that preceded Joan's offered topic. This refusal of uptake is an important function of memory. Some topics are not validated by a particular discursive memory. For the other mental health professionals, those both medically and psychologically trained, Joan's offer of "chemical imbalance" is not a valid topic for discussion, so it is not taken up. This choice relies on the professional (and therefore collective) memory of the individuals; it relies on their dispositions toward explanations of depression. Partial uptakes are also governed by this kind of disciplinary memory. In the mental health professionals interview, I asked about how patient interviews might be reported to health insurance agencies. This question, informed by my own rhetorical training, was intended to elicit

Kim	So, one of the things that, that um (.) I'm interested in has to do with not just how you talk (.) *to* clients but then how you then report (1.0) on clients, or to whom do you have to report this [...] how do you characterize depression differently in those two settings? When you're talking with a client you're talking I'm assuming using their language and trying to figure out what they have to say. How do you then translate that into the officialdom that we're all stuck in? (2.5)
Betty	Well, fortunately for insurance companies and for social security who I have to deal with a lot, a DSM-IV diagnosis is sufficient.
Ellen	Mmm Hmmm

Figure 2.3: Mental Health Professionals (58:09)

some reflection on genres of reporting. However, as Figure 2.3 shows, it elicited only the categorical response of DSM-IV categories. The mental health professionals heard my question as a request for codified, sanctioned reporting measures dictated by their professions. Thus, their uptake of my question was only partial.

Despite these difficulties—the potential for multiple uptakes depending on the backgrounds of the interlocutors and the possibility of partial or mis-uptake—the concept retains merit within my project. It demonstrates that specific discursive objects continue to be selected in the conversations; it provides a means of analyzing the power exerted by the dominant discourses that nevertheless credits individuals with a variety of response possibilities. In the next pages, I will define what a conversational uptake might look like, beyond the conversation analysts' definition of responding to a previous turn, and beyond Austin's definition of the comprehension of a speaker's illocutionary force. As Figure 2.2 demonstrates, Austin's comprehension model is indeed implicated in the workings of uptake. Without a perception of my intention, Mei would not have answered in the way that she did. Nevertheless, I want to argue that there is more going on in this example than simply that Mei was miscued by my question. I want to argue that she is accepting one of the subject positions available in the discourses on depression: the subject position of disempowered student/patient. This role acceptance is, I am arguing, part of the process of uptake. It operates beyond the adjacency pair of question and response; it is more than the physical context of a university study conducted on a university campus.

One of the qualities of uptake that is implied in Freadman's account is the quality of collectivity. Freadman describes the collective responses of Australians to Ryan's death, and she indicates that uptake participates in such a process of group-think. In my transcripts, uptake becomes more powerful as it is produced collaboratively. This is perhaps inherent in the CA model of uptake. If a statement is not taken up by future conversational turns, uptake has failed.

Markers in my transcripts of this process of collaboration include increased overlapping talk and back-channeling. Figure 2.4 provides an example of how the women in Group 2 construct a definition of one of the symptoms of depression, what they call "lack of motivation." Here, Mei and Stephanie reinforce each other's definitions of the symptom by deploying discourse markers like "yeah" and "I know" as well as by inserting phrases that show support of the other's turn. These are not interruptions in the sense of stopping the flow of talk, rather, they are markers of agreement and support.[12] Moments of collective uptake are generally signaled by shorter conversational turns, greater overlap, and increased back-channeling among participants. These moments mark places where the interviews broke out of narrative turns and began to participate in a collective definition of an object, in the case of Figure 2.4, the

object is "lack of motivation." The collective nature of these uptakes can be read in Stephanie's agreement, "That's a big one for me," and in Mei's "yeah, yes I hate that cycle." Further, the two

Mei	well, but well because I tried not to think about it ((laughs)) because I guess like okay when I feel like I have de- depression it would be because I, my lack of motivation I think [yeah that's the (main) thing]
Steph	[That's a big one for me, self motivation]
Mei	because that cycles, you know, you don't do what you want to do or what you think you *should* do and then you end up feeling bad about yourself [about everything]
Steph	[worse about it] and then you don't do it more=
Mei	=yeah, yes I hate [that cycle]
Steph	[like I play computer ga]mes for [all day]
Mei	[yeah I know] I, postponing my, my studies and then just like just so that I could not think about something and just y'know be. Yeah, I think that's why I watch TV so much, it's a addiction almost, but ((laughs))
Steph	computer games, TV, same thing ((laughs))

Figure 2.4: Women, Group 2 (10:40)

women work together to define the object, "lack of motivation," each providing part of the evidence for its existence as a symptom of depression. Beyond this description of the features of conversational uptake, however, the concept itself affords the opportunity to investigate the operation of discursive power. In the following sections, I elaborate on the two processes that Freadman identifies as mechanisms of power: selection and translation.

Uptake as Selection

In this project, the detailed interview transcripts and corpus selections provide ample data on the processes of selection, which will be my primary focus in chapters three and four. Nevertheless, as Freadman rightly notes, in moments of discursive translation the imposition of power is often most obvious. I will address instances of translation in the next section and in chapter five. First, however, I will consider how uptakes select the object of conversation. In this selection process, not only is the topic of conversation influenced, but the speaker herself is constrained to a specified speaking role. As Spender's example demonstrates, when women take up the discursive concept of "work" they are positioned outside of its active production by virtue of previous definitions of "work." Similarly, when women draw on discursive constructions of depression, particularly those directly linked to expert systems of knowledge, they are therefore placing themselves in disempowered speaking positions.

Uptakes, Freadman argues, have long, cultural, intertextual memories. It is the memory of uptake, I am arguing, that gives it power beyond individual speech situations. Uptake's memory marshals the power of selection by enforcing both remembering and forgetting of strategic objects. It is through the memory of uptake that particular subject positions become solidified. In the following three chapters, I will address three characteristics of uptake's memory and the selections this memory entails. First, I will explore the cultural memory of uptake in the ways the women draw on norms and stereotypes in their conversations (chapter three); then, I will consider the directionality of uptake's memory, drawing on Carol Berkenkotter's notion of "genre expectations" to explore how memory is both cataphoric and anaphoric, works both forwards and backwards (chapter four); finally, I will explore the intertextual nature of uptake's memory, considering how other texts are drawn upon to construct an understanding of depression (chapter five). Together, these chapters explore the workings of discursive power through a range of genres and speech situations.

In chapter three, I will consider how uptake selects objects to be the topic of conversation from broadly defined cultural norms. Particular ceremonies, according to Freadman, require specific behaviors or manners; when playing tennis, one must agree to a set of rules for conduct and for what "counts" as a fair shot. Such norms and standards of behavior may differ from one ceremony to another, but individuals inevitably carry forward what they have learned to be successful in one situation to others. Such norms are referenced when one is confronted with a new situation, and interacting with new participants. The power of norms leads often to the construction of particular accepted stereotypes and beliefs about individuals. For example, women have been considered more prone to depression and hysteria than men. These assumptions have led to acceptable statements about women's emotional states. Figure 2.5 comes from the Group 1 interview, where Tiffany and Claire discuss the differences between

Claire	You know women are more sensitive too=
Tiff	=yeah that's true women are *definitely* mor- more sensitive
Kim	What do you mean by that?
Tiff	They're more willing to show it I mean they're more willing to like like *feel* the feeling you know what I mean? like? be: the feeling ((laugh)) like I don't know that was a really bad description ((laugh))

Figure 2.5: Women, Group 1 (46:18)

men's and women's emotions. Claire begins by describing women as "more sensitive," and Tiffany concurs, adding that women are more likely to "be: the feeling" than men. In this excerpt, the two women are selecting and describing a particular discursive object, what I call "the emotional woman." In doing so, they not only reiterate that stereotype, they also set up a particular subject position for themselves as women. This is the first move of uptake's memory: to select commonplaces as subjects for conversation, thereby imposing particular worldviews and subjectivities on themselves and others.

Chapter four addresses the directionality of uptake's memory. Freadman derives her concept of uptake from both Austinian Speech Act Theory and from recent development in genre theory. Because of this latter focus, Freadman is particularly interested in the interactions between genres within a particular activity or ceremony. For her, uptake is the link between any two texts in such a system. Because texts themselves respond to recurring rhetorical situations, they develop typified forms of response (based in large part on what has worked in the past). Genres, therefore, are both the structuring force behind particular kinds of texts and the actions that those texts perform in response to their rhetorical situations. Carol Berkenkotter's work on the genres of psychology supports a concept of "generic anticipation." This concept accounts for the ways that closely related genres seem to anticipate their neighboring texts. For example, Berkenkotter looks at the ways that a therapist's interview notes are translated into an intake report that evidences an anticipation of DSM-IV category labels. Thus, the DSM-IV becomes the controlling genre in the interaction, organizing to some extent the interactions of participants. In chapter four, I address this idea of a controlling genre and consider how the interviews conducted for this study anticipate other genres and rhetorical forms. Figure 2.3 demonstrated the power of the DSM-IV for the mental health professionals. By explaining their reporting procedures entirely in terms of the codes of the DSM-IV, the mental health professionals display the necessity of such generic anticipation. In their interactions with patients, therefore, they must negotiate present symptoms and future reporting exigencies. This discussion helps illuminate how the memory of uptake operates in a nonlinear fashion. What is "remembered" and thereby brought into active conversation is sometimes a future moment in the discourse.

Uptake as Translation

Freadman's second assertion about the power of uptake is that it works through generic translation. For her, when a genre's rules of engagement are evoked outside of the traditional scene or jurisdiction, that evocation may be, in Austin's terms, nonserious, but it is not without power. In the Ryan case, for example, the premier chooses to call the judge into his office and assumes the position of a prosecuting attorney. In this setting, outside of the traditional scene of judicial authority, the "courtroom" thus instantiated cannot have judicial force. What is does have, however, is political force; it silences the judge's authority and subsumes him into the role of state's witness. Thus, translations across genres are uptakes that invoke power precisely because they seem to be denied their original setting's jurisdiction.

In the case of discourses on depression, such translations occur in the embodiment of discourses and the physical effects of medication on the body. As Freadman notes in the Ryan case, the ultimate translation is from death sentence into physical hanging. It is in this moment when the language is written on the body of the condemned man; it is in this moment that uptake ceases to be rhetorical and becomes physical. For depression, one such physical translation became more accessible when Prozac and its cousin antidepressants were created to address levels of serotonin in the brain. This class of antidepressants, the selective serotnonin reuptake inhibitors (SSRIs) has been found to produce fewer side effects and more positive results than earlier treatments for depression. The term "reuptake inhibitors" describes the action of the drugs: they block the reabsorption of serotonin in the brain, thus increasing the levels of serotonin circulating at any one time. For the current project, this terminology echoes some of the imposition of power inherent in uptake itself: if a drug can be designed that blocks the uptake of the chemical serotonin, so, too, can a discourse be constructed to block the uptake of particular beliefs about depression.

In addition to considering how the translation of words and images (as in pharmaceutical advertising) into physical realities (taking a medication), another translation occurs within the data presented here. That translations happens among the various systems that are deemed "expert." As consumers of healthcare information become more educated, they are relying on new and different systems of expertise. These systems are shifting the balance of power from a medical institutional space to a broader social and rhetorical one. The particularly clever way that pharmaceutical advertisers have capitalized on this move is evidenced by the fact that the women in this study understood the medical explanations of depression solely from the information contained in DTC advertisements. This translation—of medical expertise from the bodies of physicians into the pixels of a television advertisement—seems fraught with difficulties. In chapter five, I consider processes of translation that are implicated in intertextual references. This discussion engages with what is cited explicitly by the women being interviewed, and with those pieces of discourse that can be traced to other scenes, like the pharmaceutical advertisements. In Figure 2.6, Stephanie explicitly states that she is presenting information she learned in a Women Studies course at the university. In this excerpt, Stephanie makes the interesting move of

Steph	U:m:, women studies have told me: that it's taught and that self-esteem of girls once they reach puberty plummets and it doesn't do that for boys and a lot of a lot of the um texts say that it's body image. And the the demands on women to be *pretty* be *what*ever society wants them to be are so great that girls don't meet them and get depressed. That's that's what I've heard. (1.8) And read.

Figure 2.6: Women, Group 2 (56:38)

introducing this new knowledge, but distancing herself from its accuracy, saying "that's what I've heard." Thus, her uptake in this turn involves not only selection of what she wants to say—that girls' self esteem is related to society's demands for beauty—it also involves a complex negotiation of subjectivities. In this example, Stephanie evokes her student subject position, but she also controls that position by offering the knowledge gained in the classroom as a possible topic for conversation. This second move suggests that individuals can use uptakes as moments to introduce information without claiming authorship or full responsibility for it. Nevertheless, such recontextualizations bring with them the echoes (memories) of their former locations—here, Stephanie is returned to her student status with the disclaimer "That's, that's what I've heard." Additional examples of discursive translation, especially within DTC advertisements are the subject of chapter five. Taken together, chapters three through five offer a detailed account for how the memory of uptake provides a means of establishing power across discursive settings.

This chapter has articulated how moments of conversational uptake can be productive sites for critical analysis. I have argued, following Freadman, that uptakes are necessarily implicated in the dispersal of discursive power through practices of selection and translation. Additionally, I have suggested that uptakes provide an opportunity to see power as multidirectional. Not only are discourses themselves instantiated via uptake, individuals are also required to inhabit particular subjectivities through their own conversational uptakes. In the next chapter, I will explore the selection of one discursive object—the emotional woman—in the transcripts of women talking about depression.

CHAPTER THREE

(RE)CONSTRUCTING "THE EMOTIONAL WOMAN" VIA CONVERSATIONAL UPTAKES

Chapter two described how Freadman's concept of generic uptake can be productively applied to conversations in order to explore the imposition of power multidirectionally. Understanding uptake as more than the progression of communication via turn taking, I have argued that the choice to respond in a conversation involves negotiating and situating one's talk in an already crowded discursive space. To speak of depression is also to rely on various dispositions toward health and illness, toward gender expectations, and toward one's current speech situation. Responding linguistically to the physical reality of symptoms of depression invokes the cultural memory of uptake; it rearticulates common sense knowledge and thereby limits the possible subjectivities available. In this chapter, I focus on uptake's processes of selection, the mechanisms through which objects are chosen and (re)circulated through conversational topics. To speak on any subject is, necessarily, to select and define that subject in ways that are commensurate with the speaker's habitus. In this process, the subject is naturalized in its form, making it hard for the speaker to recognize any alternative form. Nevertheless, such selection is always a single choice among many possibilities. This is not to say that selection is wholly autonomous or infinite. Rather, it is to point out that any selection is an imposition of definitional power. Further, the operation of uptake's memory, linked to the dispositions of one's habitus, ensures that selections will proceed without the conscious deliberations of the speaking (and listening) individuals.

In this chapter, I argue that one such object selected in conversations about depression is a definition of women as emotional and sensitive beings. From a feminist standpoint, this finding is not surprising—it has long been documented that sexism did not disappear with 1970s consciousness raising efforts. But, considering how conversational uptakes contribute to the (re)circulation of such stereotypes, this project points to the difficulty of excising such stereotypes from our discursive and material practices, because through these daily practices women participate in their own subjectification. This chapter begins by confronting the appearance of gender neutrality in information about depression. Without the surface features of sexist language practice—"universal" masculine pronouns, overtly misogynistic gender representations—one might be tempted to assume that gendered power relationships are becoming less relevant in our healthcare practices. On the contrary, as this chapter will argue, women continue to be targeted with specific messages about their responsibility for their own and other's emotional and physical health, and with their vulnerability to emotional difficulties.

Chapter one identified a number of discursive constructions relating to women and depression; it argued that one of the major effects of intertextuality in this case is the creation and stabilization of images and commonplaces like "the emotional woman" and the chemical causes of depression. Such images operate as ideological formations against which daily practice must define itself. In this chapter, I turn to the discursive practices of women experiencing symptoms of depression to investigate how individuals use such ideological formations. I begin with the assumption that the women who participated in my interviews negotiate both linguistically and physically a sense of themselves against and through the discourses described in chapter one. These positions, while clearly imperfect and sometimes even painful for the individuals, offer a more complex place to begin analysis than monolithic power structures like the American Psychological Association. In other words, the interviews included in this study offer an alternative model for exploring power multidirectionally—they suggest that oral and less structured discourses are places to locate the impositions of and negotiations with power.

This chapter examines a variety of uptake texts—the artifacts through which we can analyze uptakes themselves—to investigate the quality of memory as it relates to the discourses on women and depression. Essentially, I argue, stock characters like "the emotional woman" are readily available because they are continually selected in instances of uptake. Part of the motivation for such selections lies in a gendered ideology that expects and constructs women's (over) emotionality. To ground my exploration of uptake's ideological memory, I also invoke an embodied critique, an analysis of the practices of individuals and their consequences. In other words, this analysis will proceed in two directions: from the perspective of uptake, it will consider how the discourses examined collectively construct the (overly) emotional woman who is particularly prone to depression; from the perspective of an embodied critique, the analysis will also consider how women make use of this constructed object in their own understandings and articulations of themselves.

Combining analyses of official, public texts and of individuals' talk allows this project to develop a more complex picture of the discursive world surrounding women and depression. Importantly, this combination emphasizes the ubiquity of uptake; it suggests that ideologies are perpetuated through individuals' talk as well as through institutional documents. Further, the texts discussed below demonstrate the gendered character of uptake as it operates within this particular discursive field. Building on Freadman's observation that uptakes have cultural memories, this chapter argues that in the case of depression, uptake's memory operates to maintain views of women as overly emotional, and that individual women rely on this image in their own self-representations. Beyond these implications, the transcripts analyzed here also provide evidence of uptake functioning collectively among the groups of women interviewed. Significantly, these moments of collective uptake seem to build momentum around their objects (e.g., "the perfect housewife"), and also to build community among the speakers. Thus, this chapter not only furthers the discussion of women and depression in the United States, it also offers evidence of the productive, collaborative capacities of uptake.

Uptake and Self-Representation

As outlined in chapter one, a variety of texts can be examined for their contributions to the discursive construction of concepts like *women* and *depression*. For this project, key texts include: the *Diagnostic and Statistical Manual of Mental Disorders, IV* (DSM-IV-TR), often called the psychiatric bible; government informational pamphlets, like those produced by the National Institute of Mental Health (NIMH); news articles; and pharmaceutical advertisements, which are directed both at medical professionals and at consumers. In each of these media, as chapter one has argued, ideas about women and depression—that women are more "prone" to depression, that biological and chemical processes are primary in causing and exacerbating depression, that the illness is a solitary, individual disease—circulate through explicit and implicit intertextual references. Any analysis of the kinds of statements made about women and depression reveals more than themes and assumptions; it reveals something about the social regulation of the concepts themselves. Building on these observations, the following analysis owes much to the work of French social theorist and historian of science Michel Foucault, particularly his conceptions of discourses as groups of statements that may be made about particular social objects.[1] This notion of permission, implied by the modal *may*, enables Foucault's "discourse" to become an action rather than a static collection of words and phrases. In *The Archaeology of Knowledge,* Foucault argues that discourses are not unified by their mutual object (e.g., madness), but by "the interplay of the rules that make possible the appearance of objects during a given period of time" (32-33). Thus, an analysis of discourse in the Foucaultian sense is always a situated, contextual process that engages in the specificities of time and location in order to explore the possible realities: to study depression in the early twenty-first century is far different than to do so at the turn of the nineteenth.

The following analysis engages both with the discursive objects of "the emotional woman" and her relationships to "depression," and with the real struggles of individuals to locate themselves within and through these discourses. The women interviewed insert their voices at times as mouthpieces for discursive constructions like "the emotional woman," and at other times as subjects struggling with their own self-definitions. These two conflicting rhetorical gestures give evidence to the interconnections between and among the statements that comprise the discourses of depression. As Foucault claims, "there is no statement in general, no free, neutral, independent statement" (*Archaeology* 99); the women's speech shows intertextuality to be a constitutive factor in their self-representations. But, as Foucault warns, "to add a statement to a pre-existing series of statements is to perform a complicated and costly gesture" (209). In this study, the complications and costs are evidenced by the difficulties the women have in articulating their experiences with symptoms of depression: intertextual borrowings from, for example, symptoms lists, may prove an expedient measure for community recognition, but they also require an acceptance of terminology that may seem less individually accurate. On the other hand, to suggest something about one's own symptoms of depression that is not part of the discursive commonplace is to risk being silenced and/or mis-recognized.[2] Thus, to talk within the discourse of depression is to choose particular rhetorical embodiments and to forget others. Here, the memory of uptake operates to authorize utterances that participate in the predominant habitus.

In the interviews, the women appear to be performing acts of self-fashioning in the Foucaultian sense. This process, described in Foucault's later works and highlighted by feminists like Lois McNay, Susan Bordo, and Sandra Bartkey, involves the active construction of a "self" in and through available discourses. In a 1984 interview, Foucault describes his interest "in how the subject constitutes itself in an active fashion through practices of the self" (*Ethics* 291). He describes these practices as "models that [one] finds in his culture and are proposed, suggested, imposed upon him by his culture, his society, and his social group" (291). Thus, for Foucault, discursive self-fashioning is an active process that engages with and arranges the cultural discourses available to a subject. This version of the self suggests some of the power of discursive constructions like "the emotional woman," while allowing individuals room in which to live their daily lives by negotiating, as opposed to being dominated by, these same constructions. The interviews conducted for this study offer evidence of this kind of discursive self-fashioning. Although the interviews conducted for this project should not be construed as naturally occurring discourse—most of the women had not met each other before the interviews and the presence of a microphone, a researcher, and the "study atmosphere" created an artificial setting—the fact that all three groups of women talked to each other rather than strictly to me, the interviewer, suggests that these samples of discourse represent something less formal and institutional than traditional encounters with powerful systems. As such, the language transcribed and presented here gives evidence of how these specific women articulate their understandings of their experiences with depression and of how they make use of their linguistic and rhetorical surroundings.

Freadman's formulation of the memory of uptake is key to an analysis of discourses of/on women and depression; it generates the question: what kind of memories do these uptakes share? As the following examples will show, in discourses on women and depression, uptake's memory is influenced by cultural ideas both about gender and about emotions and emotionality. The texts analyzed below participate in the discourses on depression, keeping images of the overly emotional woman in play and blocking alternative explanations (e.g., social and environmental) for women's greater vulnerability to depression. In addition, the transcripts included in this discussion offer evidence for the collective production of uptake—both as a process gathering momentum via group interaction and as a means of making conscious the ideological pressures inherent in the discourse.

In the next section, "Gender Neutrality and Women's Depression," I consider the recent "de-sexing" of medical and scientific texts. While there is no longer overt evidence of sexist practices in documents like the DSM-IV-TR, I argue that depression is nevertheless gendered female.[3] This discussion draws on the interview with mental health professionals, and on other expert texts. Using the language from the interviews and other texts, I offer the analysis that women's "proneness" to depression is an inevitable consequence of social expectations for them. Following this analysis of apparent gender neutrality, a section entitled "The Gendered Production of Knowledge About Depression" provides a more detailed case study of two NIMH pamphlets on depression, one directed at a general audience, the other specifically at women. Beyond the charade of gender neutrality, these pamphlets demonstrate additional predispositions towards women and women's emotionality. Then, using all of these texts as the background for discourse on women and depression, I turn to the interviews of women experiencing symptoms of depression. These interviews provide evidence of individuals' participation in the uptake of stereotypical images of women's emotionality. These uptakes, I argue, have physical consequences for the women, who begin to use them as the bases for their own self-representations. In addition to these consequences, the transcripts also display the collectivity of uptake, which exaggerates and complicates commonplace notions about gender. At some points in the interviews, this collective uptake reaches the point of the absurd and the women laugh as they become conscious of their own implication in the stereotypical uptakes. The chapter concludes by exploring these collective uptakes and by suggesting that the discursive manipulation of women's emotions is instigated and mediated by the women's awareness of their own participation.

"Gender Neutrality" and Women's Depression

While the motivations of government pamphlets (to inform the public, to demarcate scientific knowledge) and pharmaceutical advertisements (to establish a wide need for their product) are necessarily quite different, they also act within a larger social network of statements about what it means to be healthy and/or ill, about what it means to be female, and about what it means to be happy in the current social moment. This social moment additionally adheres to a surface-level "gender neutrality." While a historical survey could produce any number of overtly sexist medical constructions of women, recent efforts by feminists and others have successfully and rather radically altered our language practices.[4] In fact, Joan Busfield finds in her analysis of gender and mental health that "official psychiatric classifications of mental disorders, which are developed both for diagnostic and statistical purposes, nowadays maintain a clear and conscious universalism in relation to gender in their formal descriptions of symptoms of each disorder" (102). This conscious universalism remains consistent in the psychiatric bible, the DSM-IV-TR and in a variety of other official documents like those produced by NIMH. Indeed, in a pamphlet directed specifically at women, *Depression: What Every Woman Should Know*, NIMH maintains an almost ludicrous gender neutrality. Here, where a use of *she* might be appropriate given the directed nature of the information, the pronoun *she* is never used, the possessive *her* only twice in over 5,000 words. Given this neutrality, one might wonder how stereotypical versions of women as more emotional are perpetuated. Busfield argues that medical classification is more fundamentally gendered in the way it constructs its categories. She writes: "I want to suggest that once we look beyond the surface descriptions we find an indirect relation...between gender and the official constructions of mental disorder. This is because, although formally described in universal terms, the characterization of specific disorders refers to mental life and behaviour that is to a greater or less extent gendered" (103). Thus, women are targeted by particular diagnoses because these more closely reflect women's emotional lives. Busfield's argument is one about the "*construction* of categories of disorder around gendered feelings, thoughts and behaviours" (103, her italics). Thus, she provides a key critique of apparently universal descriptions, arguing that, because of the way the symptoms are described, women are more likely to be diagnosed with disorders like anxiety and depression.

Turning to the DSM-IV-TR itself, we can see a focus on "gender" only in terms of women in the description of Major Depressive Episodes.[5] The DSM-IV-TR (a revision of the fourth major edition of this text) includes sections delineating "Specific Culture, Age and Gender Features." For Major Depressive Episodes, the gender specific information is linked exclusively to women's menstrual cycles. The text reads:

> Women are at significantly greater risk than men to develop Major Depressive Episodes at some point during their lives, with the greatest differences found in studies conducted in the United States and Europe. This increased differential risk emerges during adolescence and may coincide with the onset of puberty. Thereafter, a significant proportion of women report a worsening of the symptoms of a Major Depressive Episode several days before the onset of menses. Studies indicate that depressive episodes occur twice as frequently in women as in men. See the corresponding sections of the texts for Major Depressive Disorder … Bipolar I Disorder…and Bipolar II Disorder…for specific information on gender. (354)

Though more detailed information is promised under the specific disorders, the additional information adds very little to one's understanding of how depression can be different in women and men. Under Major Depressive Disorder, the section adds only that: "Major Depressive Disorder (Single or Recurrent) is twice as common in adolescent and adult females as in adolescent and adult males. In prepubertal children, boys and girls are equally affected" (372). The implication here is clearly that puberty brings about the differences in women's and men's depression rates. Thus, women's vulnerability is tied to their hormonal cycles, a move that centers gender differences in biology and suppresses any social explanations or contributing factors. For the DSM-IV-TR, the only salient gender information about women is linked to their menstrual cycles; this emphasis has been even more pronounced in professional battles over the relatively new diagnosis of Premenstrual Dysphoric Disorder (PMDD). Pharmaceutical companies like Eli Lilly have clearly made the link between depression and various forms of PMDD; in 2000, Lilly repackaged its top selling antidepressant Prozac as Sarafem (complete with a new lavender and pink capsule) and launched a new marketing campaign that targeted women. The near merging of categories of depression and PMDD further indicates the gendered conceptions of both disorders. And, while women's hormonal fluctuations and consequent mood changes remain such a central item for psychological and pharmaceutical regulation, it is not hard to understand how women like those interviewed for this study have come to view themselves as overly emotional and in need of (external) help.

Psychologists and mental health professionals have sought to help women in a variety of ways over the last century.[6] And, while some of this diagnostic and therapeutic energy has been focused on men as well as women, some categories of mental illness like depression have emerged as primarily feminine. One of the contributing factors to a view of women as more depressed than men is a nearly universal reliance on statistical measurements. As ubiquitous as these figures are, however, they do not take into account manner or degree of depression. Indeed, the cultural understanding of women's proneness to depression allows statements like Nolen-

Hoeksema's—that "no matter how you define depression," women show more than men (6)—to remain unquestioned. This is extraordinary given both the variety of measurement tools and the myriad extenuating circumstances such as care seeking behavior, and changing definitions of depression, which could interfere with the veracity of generalizing across studies as Nolen-Hoeksema does.

In the professional interview that I conducted for this study, the statistics showing women to be more depressed than men are given as the primary reasons for considering depression a "woman's disease." In fact, all of the professionals took the statistics as the only proof necessary for women's proneness to depression. After hearing Laurie, the psychologist, talk of depression as primarily a woman's disease, I asked her to explain what she meant (Figure 3.1). In this excerpt, the reliance on and acceptance of statistics is universal—all of the women supply the figures of women's higher rates of diagnosis. While Laurie initially equivocates and cannot draw

Kim	Laurie you said earlier a- as sort of an aside um depression is a woman's disease?
Laurie	mmm hmmm
Kim	why?
Laurie	two to uh (.) three to one two to one two to one three to one, one way or the other
Others	(two to one)
Laurie	mmm? yeah I was going to say that it it depends on sort of age groupings and things like that but it I mean it's just you know mine are all women. You said that you predominantly saw what eighty percent women I mean I think we see women that are depressed. And and men we see men who are depressed but they don't generally get their first I mean I was thinking of all the perpetrators I see they all, *none* of them have a depression diagnosis *until* they've been in perpetrator treatment for a while and you start stripping away the anger and you start finding out where that anger came from and then you un- you just rip off this, this sort of façade and you see this in*cred*ible amount of depression but it's buried deep and the first thing you see is because they're violent so they come up with anger management and all sorts of things like that. Which are not really very good treatments any more we know.

Figure 3.1: Mental Health Professionals (77:29)

the exact statistic, she is nevertheless confident that the statistic is the (only) answer to my question about why depression is “a woman’s disease.” At this point in the interview, I was surprised by the speed with which my question was answered and set aside. Studying the transcript, it becomes clear that for these medical and mental health professionals, the currency of research statistics is the highest, most reliable evidence available. My surprise in the interview, therefore, marks a moment when our disciplinary biases were misaligned. I asked for candid thoughts about why depression might be characterized as feminine; Laurie answered from her position as a mental health professional, well versed in the currency of research and statistics. Here, Freadman’s interest in an uptake that crosses generic boundaries becomes particularly relevant. The statistic (an element of research and scientific genres) has been taken up and used in the conversation to settle the question unequivocally. This is an operation of power—Laurie’s statistic need not even be accurate (she fumbled around for the exact figure) because the power of evoking a statistic is recognized and reaffirmed by her colleagues, who also contribute the numbers in a form of affirmation and back channeling. In this way, the circulation of numerical data about depression forecloses other kinds of talk that might have been possible; the statistics have become commonplaces within the discourses of depression.

Following immediately on this discussion of statistics, Laurie turns the discussion to men, a shift in topic that further reinforces the power of the numbers. Figure 3.2 continues the conversation in Figure 3.1, adding more voices to the discussion of what makes depression a women’s disease. Though Ellen estimates at least half of her drug study participants are depressed men, and Joan brings up her questions of bias in the statistics, none of the women challenges the validity of the statement that women are twice as likely to be depressed as men. Figure 3.2 ends with Laurie affirming that she “likes depression” because it allows her to address gender and social role formation. With this utterance, she reiterates the conversational

Ellen well I think there's also um a reason that women may have more depression and I think that it's: um societal that you are in a more that as a women I think we are still (1.4) um frequently trapped into roles of being helpless or we're expected to be helpless and I think that that's a real set up for somebody becoming depressed

Others mmm hmmm

Joan I wonder too (.) how mu:ch of the two to one has to do with the sort of what you were talking about like the fact that don't see men coming saying I'm feeling depressed. Like I wonder how much of [it is sort of like]

|

Laurie [or how much we're tuned] to not looking for it I mean [that that]

|

Joan [right]

Laurie gets back to your suggestion about the bias

Joan right=

Laurie =is how much we're really not looking for depression in men because when we first see men at least for me the first thing that triggers is not depression. I start with a sort of my wide net and go down where it's almost when I see women the first thing I do is start with depression and go out

Joan Mmm Hmmm

Laurie and that's pr*obab*ly more my bias than anyone else's

Joan well it's a lot of people's bias I would guess

Ellen I mean I I see men who (.) present saying they're depressed um and in the drug studies I would say probably fifty-fifty that you know men and women and um um (1.0) you know they don't all qualify for the study because of a variety of reasons but (.) um (.) and I'll bet you see a lot of men who come in and say that they're depressed

Betty well some yeah it's it's mostly women that come in and say they're depressed but but the men who end up being depressed a lot of them come in and with all kinds of somatic complaints

Ellen mm hmmm

Betty and a it's a it's a it's then you need to figure out you know is this depression or do they have a real physical problem or what's really going on

Laurie yeah and I, me- for me an- it's one of the reasons I like depression because I think it pulls together sort of what Ellen said in society and the way we treat and raise women. Or girls to women.

Figure 3.2: Mental Health Professionals (78:30)

assumption that the statistics are inviolable. This is a demonstration of the power of uptake's memory to smooth over, as it were, the contradiction inherent in the statements of the mental health professionals. The operation of uptake's memory to naturalize these contradictory pieces of information—that women are twice as likely to be depressed as men, but that male depression is masked by violence and alcoholism, and therefore not necessarily less frequent—is one of the most powerful impositions of power available to uptake. It ensures a "strategic forgetting" as well as a logic for interpreting other data within this sphere. Laurie describes her own clinical experience, where the anger of male perpetrators seems to mask an underlying depression, which suggests that her statistics might not be an accurate representation of the depressed population. Ellen brings the discussion back to women and depression by suggesting that social factors can "trap" women into "being helpless," which is a "real set up for somebody becoming depressed." The others agree with this social constructionist model of depression, and Joan returns to the statistics in order to question how they reflect gendered presentations of illness. Laurie overlaps Joan's turn in order to consider individual bias in diagnoses, revealing that she encounters women with an initial assessment of depression and then moves "outward" from there. For men, Laurie explains, she starts from a "wide net" and eventually narrows her diagnosis to depression if applicable. Though she is clearly conscious of her diagnostic bias, Laurie's initial reaction to women (as being more likely to be depressed) suggests an uptake of a particular idea about women and their vulnerability to the disorder. Further, the directionality of her metaphors, which place depression at the center (especially for women, but also for men), indicate her understanding of the illness as an almost internal feature of her patients. The image of "going out" from depression for women parallels the concerns (see below) of the other women I interviewed, that depression may somehow be a core part of themselves rather than an illness.

Ellen and Betty offer examples that counter the statistics showing women to be twice as likely to be depressed as men, but these examples do not carry the institutional weight to discredit the statistics. Ellen's studies draw "a lot of men who come in and say that they're depressed," and Betty, a psychiatric nurse, sees men more often presenting with somatic complaints, which, interestingly, may be "real physical problems" or the result of depression. Here, Betty participates in the mind/body dichotomy that seems to privilege physical illnesses as more legitimate. In this interview, the mental health professionals show an awareness of social factors that influence both experiences and diagnoses of depression. Nevertheless, they also rely on statistics to establish the higher population of depressed women. Further, they appear to participate in a cultural uptake of gendered ideas about emotions—women are more likely to be depressed, men are more likely to be angry (violent) or physically ill. In the next section, I examine other texts that complicate the social uptake of "women's emotionality."

The Gendered Production of Knowledge About Depression

The previous section demonstrated that efforts at "gender neutrality" in language choice do not necessarily result in more equitable practice. In fact, as the professional interview shows, depression is widely assumed to be a woman' disease. Given this assumption, it is important to consider the images of women that are being circulated in talk about depression and are available for the cultural memory of uptake. To begin such an analysis, I turn now to two NIMH pamphlets on depression. As the following analysis suggests, women's emotions are constructed as an inevitable burden and, ultimately, they become a source for generalized suspicion of women themselves. In 2000, NIMH published two pamphlets on depression: *Depression* and *Depression: What Every Woman Should Know.* At first glance, one might assume that these are complementary publications—the latter being a more specific rendition of issues related directly to women. However, upon closer examination, they appear to offer much the same content through five major sections: Introduction/Definitions, Causes of Depression, Treatment, Self-Help, and Further Information/Resources. The distribution of information (based on word count) in each of these categories is roughly equivalent across the two pamphlets (see Table 3.1). The women's pamphlet spends more space on Causes of Depression (33% as opposed to 26%) due to a greater specificity and range of possibilities discussed. On the other hand, the general pamphlet spends significantly more of its space on treatment information (39% as opposed to 27%) in large part because of a sub-section regarding side effects from medication that does not appear in the women's pamphlet. Finally, the women's pamphlet has an additional "Helpful Books" sub-section in the Further Information/Resources category, an inclusion that is telling because of the heavy emphasis on personal narrative/memoir genres in this bibliography. Despite these differences, the pamphlets seem to cover the same information—types of depression are described, many times in exactly the same language, various theories about reasons for depression are discussed, and the basic advice (that depression is a treatable illness) remains consistent.

Table 3.1: Comparison of NIMH Text Distribution Across Major Sections

	GENERAL AUDIENCE		FOR WOMEN	
	Words	% of Total	Words	% of Total
Introduction/Definitions	715	13.98%	699	13.83%
Causes of Depression	1,327	25.94%	1,688	33.41%
Treatment	1,986	38.82%	1,386	27.43%
Self Help	518	10.13%	341	6.75%
Further Information	570	11.14%	939	18.58%
Total Words	5,116		5,053	

Given that these two pamphlets are very similar in structure and informational content, the question—Why are there two separate vehicles for this content?—becomes very important. To answer this question, we must also ask how messages get transformed/translated between the two texts. Looking at the first sentences of each of the pamphlets illuminates their rhetorical differences. The general pamphlet begins with: "In any given 1-year period, 9.5 percent of the population, or about 18.8 million American adults, suffer from a depressive illness. The economic cost for this disorder is high, but the cost in human suffering cannot be estimated." The women's pamphlet begins with: "Life is full of emotional ups and downs. But when the 'down' times are long lasting or interfere with your ability to function, you may be suffering from a common, serious illness-depression." In the general pamphlet, objective-sounding information delineates costs of the illness—a rhetorical choice that values productive labor (or its loss in economic terms) and that gestures toward "human suffering" without quantifying it. In contrast, the women's pamphlet starts immediately with emotional language, an uptake of the commonplace that for women emotional fluctuations are inevitable. Significantly, the women's pamphlet immediately personalizes its language by using the second-person address: "you may be suffering." This personal address serves not only to invite the reader to view herself as possibly depressed, but also to reinforce the idea that women's lives are naturally and inevitably filled with changing emotions. Thus, only women whose "down times" interfere with their "ability to function" are encouraged to consider themselves as depressed. "Normal" emotions are expected of women; excessive emotions are a sign of illness. The contrast between objective-sounding language in the general pamphlet and emotional language in the women's pamphlet remains relatively consistent throughout the texts, as I will demonstrate below.

Given the fact that the women's pamphlet is subtitled "What Every Woman Should Know," there are a few curious informational and rhetorical omissions from it. Factually, the general pamphlet contains a section on common antidepressant side effects (e.g., headache and nausea) and information about them (e.g., that these will usually be temporary, and that if they are more than transient, you should contact your doctor). The omission of this information from the women's pamphlet is troubling; it suggests, perhaps, that women are not necessarily making informed choices about their medications. A number of lexical/rhetorical choices also differentiate the two pamphlets (and thus their audiences) in even more subtle and damaging ways. The general pamphlet repeats the claim that "people don't just snap out of depressions" three times, which is significant considering the brevity of the pamphlet. At the beginning of the general pamphlet, we are greeted with the statement that: "A depressive disorder is not the same as a passing blue mood. It is not a sign of personal weakness or a condition that can be willed or wished away. People with a depressive illness cannot merely 'pull themselves together' and get better." In contrast, the women's pamphlet spends a lot of its time acknowledging the unavoidability of blue moods, which, ostensibly, can be "gotten over" and are inevitable for women in any case. In an even stronger instance, the general pamphlet goes so far as to address the audience directly: "Do not accuse the depressed person of faking illness or of laziness, or expect him or her 'to snap out of it.' Eventually, with treatment, most people do get better. Keep that in mind, and keep reassuring the depressed person that, with time and help, he or she will feel better." Nowhere in the women's pamphlet are we given this advice—in fact, the women's pamphlet never mentions the possibility that depression is hard to shake, only that life itself is turbulent. Thus, the women's pamphlet figures its audience as needing to cope with "blue moods" and other emotional issues, but not as needing to have compassion for sufferers of depression. The general pamphlet's emphasis on depression as something one cannot "snap out of" evokes the commonplace that excessive emotions are frivolous and self-indulgent in order to deny this assertion, framing the excesses instead as part of the medical condition. In the women's pamphlet, the status of emotions is more ambiguous and not always an indication of illness. Both of these pamphlets are participating in the uptake of social definitions of gendered emotionality.

In another curious rhetorical move, the general pamphlet emphasizes the active roles of families and caretakers in the treatment of depression, while the women's pamphlet fails to mention families as anything other than environmental factors in the depression. The general pamphlet encourages family support for new mothers: "Treatment by a sympathetic physician and the family's emotional support for the new mother are prime considerations in aiding her to recover her physical and mental well-being and her ability to care for and enjoy the infant." And for men: "Even if a man realizes that he is depressed, he may be less willing than a woman to seek help. Encouragement and support from concerned family members can make a difference." On the other hand, the women's pamphlet uses *family* as an object-noun ("There may be biological and environmental risk factors for depression resulting from growing up in a dysfunctional family.") or as an adjective ("family problems" and "family doctor"). The women's pamphlet avoids talking of care-taking in part, I argue, because it is *women* who provide these services. Thus, when the caretakers themselves are sick, they have few resources available to them. Given the absence of advice for families of depressed women and the emphasis on patience required of the general pamphlet's audience, the emotional burden of American families falls disproportionately on women. That is, women most "naturally" take on the caretaking assigned in the general pamphlet and the absence of caretakers in the women's pamphlet speaks to the women's primary role in emotional care.

The final and most insidious category of differences between the two pamphlets includes a series of inconsistencies between the two documents that seem to belie their objective stance. Though it is clear that the pamphlets have moved toward gender-neutral language (avoiding both of the terms "men" and "women" in favor of "patient" "individual" and "one"), there are places, like the curious transformation of families from subjects to objects, that help construct an emotional female subjectivity. The most blatant of these rhetorical forms is contained in the opening statement from the women's brochure described above. Life's "ups and downs" are not ever explicitly mentioned in the general pamphlet. In the women's brochure, however, not only is this the opening remark, it seems to serve as a cautionary note to women: be careful not to mistake "normal" emotional fluctuations for depression. This sense returns near the end of the brochure with the admonition that "Of course, treatment will not eliminate life's inevitable stresses and ups and downs. But it can greatly enhance the ability to manage such challenges and lead to greater enjoyment of life." The women's pamphlet thus reifies the fact that women's lives are going to remain volatile and emotional, even with appropriate treatment.

While women are figured as having to deal with a lot of "normal suffering," the general pamphlet suggests that suffering is quite often "unnecessary." Consider the following two statements: "Depressive illnesses often interfere with normal functioning and cause pain and suffering not only to those who have a disorder, but also to those who care about them. Serious depression can destroy family life as well as the life of the ill person. But much of this suffering is unnecessary" (*General*); and "Up to a point, such feelings [irritability due to stressful life situations, sadness over a 'lost loved one'] are simply a part of human experience. But when these feelings increase in duration and intensity and an individual is unable to function as usual, what seemed a temporary mood may have become a clinical illness" (*Women*). The contrast between unnecessary suffering that interferes with normal functioning and temporary moods and low feelings that are "simply a part of human experience" clearly participates in the uptake of women's greater emotional vulnerability.

In descriptions of forms of depression, the two pamphlets encode societal suspicions of women's emotions. In the descriptions of dysthymia (a less severe but more chronic form of depression) and mania (the "up" side of bipolar/manic depressive illness) the women's pamphlet contains particularly pointed critiques of female subjectivities. The general pamphlet describes dysthymia as "A less severe type of depression,...involving long-term, chronic symptoms that do not disable, but keep one from functioning well or from feeling good" (*General*). The women's pamphlet suggests that "In dysthymia, the same symptoms [as in major depression] are present though milder and last at least 2 years. People with dysthymia are frequently lacking in zest and enthusiasm for life, living a joyless and fatigued existence that seems almost a natural outgrowth of their personalities." Clearly, the statement about symptoms seeming to be a natural outgrowth of their personalities operates as a not-so-subtle reminder to women that they must concern themselves with how they please (or in this case displease) others. Similarly, in the description of mania, the women's pamphlet contains very explicit pejorative terminology. The general pamphlet reads: "Mania often affects thinking, judgment, and social behavior in ways that cause serious problems and embarrassment. For example, the individual in a manic phase may feel elated, full of grand schemes that might range from unwise business decisions to romantic sprees" (*General*). The women's pamphlet describes mania this way: "During manic episodes, people may become overly active, talkative, euphoric, irritable, spend money irresponsibly, and get involved in sexual misadventures" (*Women*). The translation of "unwise business decisions" into "spending money irresponsibly" is more than a semantic choice. Women are not given agency over the money they are spending and there is a distinctly "shopping mall" aura to this phrase that "business decisions" lacks. Similarly, the translation of "romantic sprees" (something that has a cavalier, but not necessarily sordid connotation) into "getting involved in sexual misadventures" seems designed to contain female sexuality.

While institutional brochures like *Depression* and *Depression: What Every Woman Should Know* undoubtedly provide useful and necessary information to consumers of mental health care and their families and friends, they also work to reinforce a version of femininity that may be neither accurate nor healthy. Calling attention to the assumptions this discourse makes about women—their lack of agency, their particularly emotional lives, and even their apparent lack of caretakers for themselves—should prompt us to consider how these assumptions condition the memory of uptake, how they are continually (re)circulated via uptakes in conversation, media, and even diagnosis. A recent advertisement for the antidepressant Celexa (see Figure 1.3) boldly asks: "What's Behind That Smile?" The advertisement features a smiling woman, photographed from the shoulders up, looking directly into the camera. There must be something making her so serene, this advertisement seems to imply. In the end, this picture and its caption hint at the female subjectivity that is constructed within the NIMH pamphlets: it is a subjectivity that is gentle (soft focus and flowers frame the woman's face) and yet dangerous (something is *behind* the serenity, something which must be contained). Thus, this ad deploys societal suspicions of and expectations for emotional women—that they take steps to keep those emotions within acceptable parameters.

"The Emotional Woman"

The previous sections explored the uptake of ideas about women's emotions, arguing that discussions of women and depression serve to reinforce definitions of women as more emotional and therefore more prone to depression than men. These uptakes are the subject of *Gender, Emotion, and the Family* by psychologist Leslie Brody. For Brody, the equation, stated in one of her section titles as "He's Mad, She's Sad" (229) represents the core of a large body of research on gender and emotion. While Brody cites numerous studies that examine emotional development in children, emotional expression in adults, and other cultural and biological investigations, her research returns again and again to the commonplaces of angry men and unhappy women. How, she asks, are these correlations constructed and maintained? Part of the answer is contained in the words available in a specific culture to delineate the categories of expression. In their article entitled, "Gender, Sadness, and Depression," social-psychologists Robyn Fivush and Janine Buckner explain this idea:

> The emotion vocabulary available through the culture fundamentally influences how individuals within that culture categorize emotional experience. And the ways in which the causes and consequences of emotional experience are discussed form the emotion scripts which, in turn, modulate an understanding of how emotions are integrated into the ongoing interactions of everyday life. (233)

In their study of sadness, Fivush and Buckner note that "both men and women believe that women experience and express emotions more frequently and more intensely than do men" (234). This notion of an excessively emotional woman, who is also excessively verbal, is certainly present in the current U.S. cultural consciousness. Such images contribute to what Brody calls "display rules" (229), the acceptable emotional expressions for each gender. These rules, she continues, are reinforced and "transmitted not only by parents, but also by other socialization agents, such as peers, with whom being popular comes from expressing emotions in gender stereotypic ways" (4). Brody also names other factors, including media representations and biological and genetic factors. Her analysis is nuanced and complicated because it resists simplification into a single causal relationship between any of the factors and gendered emotions. Nevertheless, the results of these complex processes are, more often than not, angry men and sad women.

Brody explains such gendered emotional states as adaptive.[7] She writes, "To help women adapt to their lower power and their role as child caretakers, cultures encourage them to express warmth and discourage them from expressing aggression. To help men adapt to their higher power and their role as providers, cultures encourage them to express aggression and discourage them from expressing vulnerability and warmth" (227). This argument accounts for women's greater expression of sadness, grief, and hopelessness (94-95) and suggests that via sublimation women's aggression is translated into depression. This is similar to Dana Crowley

Jack's argument in *Silencing the Self,* that women end up enacting aggression against themselves. Jack describes the internal aggression of women as the result of "splitting women into two." Such a division, she continues, "creates a conviction that a woman's problems are internal and idiosyncratic, and turns her energies to self-battle, diverting her from recognizing larger destructive social patterns and from waging more constructive battles" (180). Women, Jack argues, display their aggression and frustration as self-mutilation, manifested through depression. Thus, scholarship on gender and emotion has developed complex models for how women and men experience and express their emotions.[8] In the end, this scholarship points to the availability of images of "emotional women" against which individual women must define themselves. Therefore, I turn now to the language of the interviews to explore how the "emotional woman" is taken up and used in the interviewee's self- and other-representations.

The following analysis begins with statements made by each of the groups interviewed about the quantity and quality of women's emotions. For this study, three groups of women were interviewed: two groups of women experiencing symptoms of depression and one group of mental health professionals. In the following analysis, I will refer to the latter group as the mental health professionals and to the former two groups as Groups 1 and 2. In the mental health professionals group, four women participated: Laurie, a psychologist; Ellen, a psychiatrist; Betty, a psychiatric nurse; and Joan, a social worker. In the two groups of women experiencing symptoms of depression, the first group (Group 1) had four participants: Su-Ting, a master's student in the health sciences; Paige, an undergraduate student in the humanities; Claire, a master's student in the humanities, and Tiffany, an undergraduate student in the humanities. In the second group (Group 2), the three participants were: Mei, an undergraduate in health sciences; Jennifer, a graduate student in the hard sciences; and Stephanie, an undergraduate in the humanities. (See Appendix D for more information about study participants.) Below, I argue that the women are participating in the construction of "the emotional woman" through their discursive uptakes of such a figure. Importantly, however, these uptakes have material consequences for the individual women—while describing women in general as more emotional, they additionally begin to define themselves through their own (excesses of) emotions. Thus, the uptake and circulation of an idea about women's greater emotionality is quickly complicated by the women's rhetorical self-representations, which rely on these ideas.

In the interviews conducted for this study, all three groups express a belief in the excessive emotionality of women. Specifically, women apparently depend on (and value) their emotional lives to a much greater extent than do men. In Group 1, the women take up both gendered images of emotion: the emotional woman and the stoic (unfeeling) man. After over half an hour of discussion, Tiffany suggests that sometimes she wishes she "was that cocky bastard in class that seems to like have no problem being like I'm so cool" (G1 45:30). For Tiffany, "coolness" is associated with a male stereotype who does not express emotions or even seem to feel them at all. She expresses this wish in response to Claire's comments about how her own mother is always encouraging her to "love herself." Claire goes so far as to suggest that her mother has told her that "until you love yourself you know this is the way you're going to feel" (G1 45:00), implying that Claire's feelings of depression are her own fault. In frustration with Claire's mother, Tiffany expresses her desire to be the "cocky bastard" who seems to be "so cool." At this point in the discussion, I asked the group if they thought these feelings of depression were gendered (Figure 3.3). Following up on her description of men's stoicism, Tiffany explains that although men may have the same feelings as women do, "they sometimes don't let [those feelings] get out." She goes on to suggest that the man she was seeing was depressed *because* of this inability to "get out" (and get over, one senses) his emotions. In the subsequent talk, Claire brings up the idea that women are more "sensitive," which Tiffany defines as being "willing to…*feel* the feeling." Interestingly, for Tiffany, this collapses into an equation between women and their feelings: "I mean like *be:* the feeling." This move, from a greater capacity to feel the emotion to an equivalence with the emotion, demonstrates the dangers of the cultural uptake of "the emotional woman." For Tiffany, women are their feelings, whereas men can (and should) exert control over their own feelings.

Kim	Do you think it's gendered? You say your mother loves herself so
Tiff	[((laughs))]
	|
Claire	[I don't believe] her but I'm just saying what she said (.) I think guys you know personally [I mean just]
	|
Tiff	[I think] they hide it. I know guys that like I mean like they have bigger egos or whatever and they definitely show it more like their more cocky bastard side or whatever you call it. But um I don't know I mean I think they have feelings *too* that they sometimes don't let get out like the reason I broke up with the person I was with when I moved here was cause he got *way* off the deep end in depression because of his own family problems and I'm like you know what ((laugh)) I'm sorry but you love yourself or not like love yourself but you love being depressed enough that I can't handle being with you (.) you know so. They do. Get depressed.(xxx)
Claire	You know women are more sensitive too=
Tiff	=yeah that's true women are *definitely* mor- more sensitive
Kim	What do you mean by that?
Tiff	They're more willing to show it I mean they're more willing to like like *feel* the feeling you know what I mean? like? *be:* the feeling ((laugh)) like I don't know that was a really bad description ((laugh))
Paige	((laugh)) sorry (3.0)
Claire	Well I I think, was only talking about feelings (about gender and) women usually want to talk about it more
Paige	I think women don't I think men feel things too but (2.0) I think an emotional life is really (.) important for women and most women have really *rich* emotional lives (2.0) but I think that um that's not (.) the case for most men (xx) I think that men's lives are rich in other ways so that sometimes causes a conflict (.) when men and women get together.

Figure 3.3 Women, Group 1 (45:30)

In addition to a greater emotionality, these women also express a belief in women's greater verbal abilities. Claire suggests that women's emotionality may be a verbalization process—that women "want to talk about [feelings] more." Paige continues this line of reasoning by suggesting that "most women have really rich emotional lives." These comments work together to display what Fivush and Buckner identify as a cultural belief in women's greater capacity for feeling emotions and for verbalizing them. The women, particularly Paige, express a sense that emotional lives provide self-definitions for women; depression threatens not only women's mental health but also their identities. The frequent uses of the discourse marker "you know" in Figure 3.3 indicate the status of these utterances. First, the marker functions as a collaborative measure designed to include the other participants in the definition. Claire seems to use the device as an invitation for another conversant to speak, as Tiffany does, overlapping Claire's first utterance. Additionally, the frequent use of "you know" also functions as a marker of the collective memory of these uptakes—as in Tiffany's appeal for validation of her definition of women as more "willing to show" their feelings. She inserts "you know what I mean" in the middle of her utterance, appealing to an assumed collective agreement about women's natures.

In a less serious moment in the mental health professionals interview, Laurie and Ellen laugh about their beliefs that women are more articulate and emotional than men. Figure 3.4 picks up with the final turn in Figure 3.2 above, where the women were talking about why depression is a "woman's disease." This excerpt is accompanied by laughter and higher volume and pitch ranges, indicating its break from the discussion immediately preceding it. The women in this interview knew each other professionally and socially prior to the taping, perhaps a factor in establishing this tone. Nevertheless, this excerpt shows Laurie and Ellen participating in the uptake of "the emotional woman." While it is possible that Laurie and Ellen are drawing on professional and personal experiences as evidence for their claims about women's greater capacity (and availability) for emotion, the laughter seems to indicate an awareness of the cultural stereotypes being invoked. Indeed, at this point the collective uptake is both more intense—signaled by Laurie's "God yes"—and more conscious—signaled by Ellen's "really" that closes the excerpt. The women seem to be collectively acknowledging their uptake of "the emotional woman" as a solidarity measure; they also collectively define women as more articulate and mature than men, who are by implication insensitive and mute. The laughter is reinforced as a positive group dynamic near the end of the professional interview when Ellen describes the effect a male participant would have had on the interview. In there had been a man present, she suggests, "it would have been um pretty boring" (MHP 121:27) and the discussion would have been more clinical and scientific. Thus, the professional interview serves as a community building exercise for the women present, and the collective uptake of "the emotional woman" functions in the excerpt above as a means of reinforcing the relationships among them.

Laurie	yeah and I me- for me an- it's one of the reasons I like depression because I think it pulls together sort of what Ellen said in society and the way we treat and raise women. Or girls to women
Ellen	Mmm Hmm
Laurie	it's also then society's view of women but for me it's also biology I mean you cannot convince me that my brain is like a man's brain. (2.0) It's better. We all know that
Others	((laughs))
Ellen	we're certainly more articulate than they are
Laurie	certainly God yes. And I have feelings. And I can use the word commitment in a sentence
Others	((laughing))
Ellen	really
Laurie	I'm different

Figure 3.4: Mental Health Professionals (80:32)

In the Groups 1 and 2 interviews, statements about women's greater capacity for emotion are used as the basis for self-awareness, as was seen in Tiffany's equation of women with feelings above (Figure 3.3). In that Group 1 interview, both Claire and Paige identify themselves as "sad" and "emotional" people. Further, these qualities are negatively valued, as Claire says in Figure

3.5. Here, Claire describes her depression as a direct result of her tendency to be "over-emotional." She explains that she expected this interview to be "an opportunity to talk" about things that are bothering her, signaling her comfort with and expectation of talk as a form of therapy. Thus, Claire demonstrates a reliance on verbal exchange for emotional relief. This attitude can be read as part of Claire's discursive self-formation, particularly when, several minutes later, Paige returns to Claire's statement and asks whether the depression she is feeling colors her self-representation (Figure 3.6). Here, over-emotion becomes more than an attribute; Paige wonders if it is "just who I am." This, then, is the danger of the uptake of "the emotional woman"—that woman *becomes* the emotion and she cannot separate herself from her emotional states. Such a lack of separation resists the classification of depression as an illness that can be treated (either via medicine or other forms of therapy) and leads toward an identification with the depression, a resignation that is both sign and symptom of the disorder. This resignation is a

Claire	Well, I've always been an over-emotional person so I've had dealings with being sa:d and (.) um depressed for quite a while. And I just thought maybe this would be an opportunity to talk about some of the issues that are bothering me.

Figure 3.5: Women, Group 1 (5:00)

Paige	Can I ask you a question? (1.0) Like, um sorry um you said earlier that you were that you feel like you're an over emotional person. Do you think that that's your nature or do you think that's (2.0) a st- like a stage that you're in because you feel depressed now or what?
Claire	That's a good question I know I've always been sensitive like I was really sensitive in high school and (1.0) ((sigh)) but when I think about it now that you've asked I think I have been way more emotional this pas:t year or so and maybe that is because I'm (2.0) in a depressed state or something I don't know: cause I wasn't as like crying at little things or being angry at little things or something. I wasn't like that in high school so, I don't know (3.4)
Paige	I wonder about it because I think (1.2) I don't know (.) I don't think I'm like a (1.4) I don't know a: like a moody person but (xxx things) I feel maybe I feel like I cry more than is acceptable ((laughing)) sometimes like um but (1.5) I just was like wondering if it's because I'm (really) depressed and I don't know it or because (1.0) that's just who I am (.)

Figure 3.6: Women, Group 1 (14:35)

form of self-regulation and can been seen in the use of judgmental terms by the women. Paige clearly measures her sadness against a perceived norm, saying she feels that she cries "more than is acceptable." At this point, Paige is attempting to regulate her quantity of sadness, not the causes of it. The "emotional woman" is acceptable only if her emotions are kept within an appropriate range.

This sense of self-regulation is echoed in the Group 2 interview, when Jennifer describes changes she made to her personality when she entered graduate school. In Figure 3.7, Jennifer clearly responds to the underlying power dynamics of her new situation—emotionality is not valued in her field and she attempts to change herself to fit the ideal of a scientist. Here, it is interesting how being "very emotional" is linked for Jennifer to a concern for "grooming" and fashion. In essence, these parallels suggest that emotion and physical appearance are keys to femininity, equally external and yet intrinsic to what it means to be a woman. The exterior concerns of fashion are the signifiers that Jennifer uses to indicate femininity and feminine behavior—not only trivializing what it means to be "feminine," but also signaling her conflict over the internal and external worlds she is negotiating. Some of this turmoil is indicated in Jennifer's first turn in this transcript—she begins by suggesting that she has just "remembered" something important. For Jennifer, the changes she has made to herself are rational—"in [her] own brain"—and they are remembered within the context of the interview. Jennifer's formulation, that her altered personality was "concocted" within her own brain suggests the power and scope of internalization that occurs with the uptake of gendered commonplaces. Further, the implication here is that in the course of her daily life Jennifer forgets the changes that she made to herself. Thus, the collective discussion that triggers her statements in Figure 3.7 can be read as a moment of conscious awareness of gendered commonplaces about emotionality. Jennifer does not step outside the stereotypes of femininity as physical appearance, but she does become aware

Jenn You brought up a really good point that I'd forgotten that I remember, I mean since I've gone back to school and started this career change and being I mean it's still a very male dominated world out there. And um, I fe- I somehow in my own brain concocted that I needed to be more rational, less emotional, um less feminine to be treated seriously.

Mei Ohh

Jenn And, and yeah. And I feel that I've [lost my]
|
Steph [(fairness?)]

Jenn femininity that I am a *woman*. And, I I think I'm also that's one of my things that I'm striving towards to to get back. In my twenties, I was always very emotional, um very feminine and um uh I mean I used to pour on the makeup and y'know do my hair and everything and do the nails and somewhere that that just got lo:st. And I don't know how to dress anymore I don't know how to go shopping ((laughs)) [y'know]
|
Mei [Did you] change because you felt that you *need*ed to or you you didn't really [want to?]
|
Jenn [Somehow] it it just came about when I started this Science career. I don't know how it came, y'know maybe be- because I got more busy and that happens too, people become women become more busy and they they y'know spend less time on grooming themselves. But, um, yeah I- (1.5) I don't know ((laughs))

Figure 3.7: Women, Group 2 (60:59)

of her own self-representation in the context of her graduate school community. In this way, Jennifer demonstrates the potential of collective uptake for drawing attention to its object.

Drawing attention to gendered ideologies as they interact with depression is one of the goals of this project. Currently, television advertisements, internet self-diagnostic tests, media reports, and a boom in memoir publishing all contribute to a hyper-awareness of depression. What, then, is the *content* of our awareness of depression? Jill Astbury claims that depression is "a potent social metaphor that directs attention to an emotional state in which it feels impossible for one's unhappiness ever to be transformed" (29). For me, the danger of this metaphor is specifically that it directs attention toward an emotional state that is already overdetermined and gendered. As the transcripts discussed above show, women are already figured as suffering from emotional states, states that are both isolating and self-regulating. Perhaps depression must be re-figured as a metaphor that directs attention outward, toward social interactions and uptakes that perpetuate these emotional states among women. To explore this possibility, the next section considers the social regulation of emotion, specifically the edict to be happy.

Should We Be Happy? The Control of Emotion

Thinking of depression as a means of exploring the social control of emotion returns us to the ideas introduced by Paige (Figure 3.6, above) of acceptability and appropriate emotional displays. Throughout the interviews, a common theme emerged around social expectations of happiness. This comes, in part, from the marketing efforts of pharmaceutical companies, which offer idealized happiness as the benefit of their products. Clearly, it is not simply the pharmaceutical ads that attempt to market and reinforce happiness as a product, a right, and a responsibility. Television, popular media, and a variety of social beliefs also validate such notions. Nevertheless, the direct linkage of happiness with a marketable commodity in the case of pharmaceutical ads is notable for its attempt to quantify joy as a product for sale. In a 2001 *Newsweek* article, Geoffrey Cowley and Anne Underwood suggest that happiness itself is an economic experience for the pharmaceutical industry. They write: "Prozac has brought the pharmaceutical industry immeasurable joy since its debut in the late 1980s. The drug and its cousins—Zoloft, Paxil and the rest—now generate $8 billion in sales each year" (100). Cowley and Underwood thus reiterate the economic and cultural capital to be had in producing a product that promises happiness. For the women in my interviews, these promises were translated into a variety of social expectations. In the Group 1 interview, I asked the women what it felt like to be down or depressed. Among the answers is Tiffany's cited below (Figure 3.8). She includes in her definition a number of expectations she feels are imposed on her. In this excerpt, Tiffany

Tiff	Well I'd say it's mostly me not feeling (1.0) it's the opposite of good for me like you know what I mean like there's this thing I'm supposed to be? Like kinda you know I'm supposed to be a happy person I'm supposed to have good *grades* I'm supposed to be *pretty* I'm supposed to you know whatever it is I'm supposed to be doing. If um I'm having a bad day it's normally because I think I'm not whatever one of those things I think I should be? So sometimes it works to like, like I'll get dressed up or something and then like some guy will give me their number and I'll be like ah okay I'm a good person still ((laughs)) you know what I mean? like kinda pushing it off onto something (1.2) helps to kinda like (.) I don't know yeah it's the opposite of good

Figure 3.8: Women, Group 1 (39:25)

clearly understands her feelings of depression as something deviant—"I'm supposed to be a happy person," she says, indicating that when she is not, she is not fulfilling her expected role. While she claims responsibility for these expectations, describing them as "those things I think I should be," she clearly participates in a stereotypically feminine role-playing activity to pull herself out of her depression. She equates being "a good person" with receiving heterosexual male approval in the form of a phone number. Thus, Tiffany articulates both the understanding that she "should be happy," and the socially sanctioned, exterior approval that allows her to achieve happiness, at least on a temporary basis. Thus, Tiffany participates in the uptake of an idea of happiness that relies on stereotypical gender roles.

In the Group 2 interview, Jennifer links the origins of an expectation of happiness to pharmaceutical interventions. She begins her turn (Figure 3.9) by musing on why women might be more depressed than men—a topic that had come up in the conversation preceding this excerpt. Here, Jennifer begins her turn by displaying a vision of women as over-worked and managing a variety of different tasks. But, as she continues this turn, Jennifer seems to realize the stereotypes upon which she is drawing. As she brings up Valium and then the pharmaceutical companies, Jennifer evinces a more conscious understanding of the uptake she is making—that women *should* be happy, but that they need help (external, pharmaceutical) to be so. Mei and Stephanie join in this discussion by picking up on the stereotypical "housewife" image. Here, the uptake begins to gather momentum, with various back-channeled responses like gagging noises and Jennifer's statement "Stepford wives." Here, as the uptake becomes more collective, the women also indicate their awareness of it as a powerful gesture. Just as Ellen and Laurie seem to be using uptake to build solidarity (in Figure 3.4), here Mei, Jennifer, and Stephanie are sharing a common image. This collective uptake functions both to bring the group together (notice the increase in overlapping talk) and to make the group aware of the (stereotypical) object they are selecting in their talk (the "housewife").

Jenn	I guess I take a different take on it, that women these days y'know um are just doing so much more and they're so spread thin and they're worrying about a lot more different things than men are. They're taking care of the household, they're taking care of the kids, they're y'know career women um and it it's just a lot of responsibility, and I don't know if that has any kind of effect on it um, but I know but women, housewives and um what was it in the 50's when Valium was a big thing, and I don't know Is it, is it something that the pharmaceutical companies are just targeting women? To make them think that y'know they need it and to be happy because everybody should be *happy* all the time? So, I- I don't know
Mei	Or maybe it yeah, if that's like the housewives will see the happy y'know (1.0) person at home y'know husband comes home and y'know just [be this this (x) Yeah]
Steph	[((gagging sound))]
Jenn	[Stepford wives]
Steph	[(xx) puke]
Mei	[Maybe like do-] Maybe some um mothers have certain like uh pressure to to be something like that, to be the (.) person in the family to keep everyone happy (0.8) and so (1.2) uh I mean so then they they have to be happy ((laughs)) to do that y'know it's hard for them if they're not (.) and yeah, and also yeah because if if (.) um (.) women are like have their career and then they become a mother then that transition may also be difficult

Figure 3.9: Women, Group 2 (58:32)

In a similar moment in the professional interview, the happiness promised by the pharmaceutical companies is the impetus for another collective uptake. In Figure 3.10, Joan, the social worker, brings up the topic of media representations. Here again, the image of a 1950s-era happiness is invoked to explain the impossibility of the ad's promised emotional state.

Joan	And I think in the media in general there's this, this whole portrayal of lives as consisting nearly exclusively in like wonderfully happy giddy moments
Ellen	exactly, like the 50s still
Joan	and, and I mean people know that that's not how their lives are and then they see a commercial that says do you not feel happy all the time and they're like Hey, I don't feel happy all the time, I'm getting cheated out of my all the time happiness
Ellen	Exactly.
Joan	((laughs))
Ellen	My life is not happy the way everybody else's is. You know it's the
Laurie	Yeah, everybody else is happy but me
Others	Mmm Hmmm Yeah
Ellen	And you're supposed to be ecstatic all the time
Joan	Right
Laurie	Yeah.
Joan	Well, I, yeah
Laurie	Well aren't you? ((laughing)) isn't that the requirement?
Betty	I think there'd be a lot more people on antidepressants if that was one of the requirements that you had to be happy [all the time]
Laurie	[all the time]
Joan	oh but I think a lot of people are, are street drug users because of that I mean
Laurie	Yeah

Figure 3.10: Mental Health Professionals (51:54)

Interestingly, Joan's definition moves from "life consisting…[of] happy giddy moments" to "all the time happiness"; and Ellen increases the magnitude to being "ecstatic all the time." These moves verge on the hyperbolic and the women acknowledge this in their laughter. This laughter, I argue, indicates an awareness of the uptake that is occurring. For these women, the expectation of happiness is both ridiculous and also a major cause of drug seeking behavior. For Joan, "a lot of people are, are street drug users" because of their expectation for happiness. Thus, this excerpt gives evidence of how uptake can be a consciously examined phenomenon, particularly in moments where groups examine beliefs together.

The collective uptakes of happiness as social priority are a consequence of what Rose describes as "technologies of the self." Considering an advertisement classified under the title "Self-Help," Rose argues that "Self-help, today, entails an alliance between professionals claiming to provide an objective, rational answer to the question of how one should conduct a life to ensure normality, contentment, and success, and individuals seeking to shape a 'life-style', not in order to conform to social conventions but in the hope of personal happiness and an improved quality of life" (156-7). Here, Rose articulates an important transformation of practices of the self, from conformity with social norms to self-regulation for the purpose of achieving happiness (which is, of course, a socially constructed, if naturalized, norm). This new social expectation—for personal fulfillment—is evidenced in many of the pharmaceutical advertisements collected for this study.

In a 1998 ad for Prozac (see Figure 1.5), the two-page layout depicts a barren tree on one page and a tree in full foliage on the facing page. The copy lets us know that "Chances are someone you know is blossoming again because of [Prozac]." The image (both actual and rhetorical) of blossoming is an important constituent of happiness, implying as it does health, growth and physical beauty (flowers and other delicate and pretty things blossom). In the currently ubiquitous television ads for Zoloft (see Figure 1.4), the depressed patient is represented as a spherical creature (variously described by the women in the interviews as a "rock" and a "ball") who sighs and weeps before it is helped by Zoloft to bounce and frolic with its ladybug friend. This action is, of course, accompanied by a soundtrack to match. The Zoloft ad defines happiness as active, energetic, and enthusiastic (the bouncing creature reminds one of a puppy or small child in its fascination with the ladybug). These and other ads are, as the mental health professionals suggest, pointing toward happiness (and care-free lives) as not only the desired state, but also a particularly feminine incarnation. Prozac causes one to "bloom" or flower; Zoloft allows one to frolic with one's friends. Both of these depictions turn on the stereotypically feminine traits of beauty and social interaction.

This social emphasis is reiterated by a diminutive friend: for Prozac, a friendly bird perches in the healthy tree; for Zoloft, the ladybug's allure is only fully enjoyed with the chemical help of the drug. In each case, the smallness of the "friend" should be noted—when many have recognized the severe isolation of depression, it is curious that the ads seem to reinforce the solitary nature both of one's health and illness. The bird and the ladybug are clearly not peers to their depressed companions, and even in health can offer only the "cute" happiness of a pet or other creature to be cared for. The implication of this is that happiness is something that should be achieved and maintained by oneself alone, or with minimal help from one's community. Here again, the role of caretaker is reiterated and the patient is encouraged to fulfill this role herself. The metonym of the drug, standing in for a range of medical and chemical interventions, quickly becomes the single promise of happiness. In these ads and others, the only visible cause of joy is the pill. Commenting on the advertised promise of happiness encapsulated, Ellen, the psychiatrist, points out that the antidepressants are not actually "happy pills" (Figure 3.11). Despite Ellen's description of the physical and emotional effects of antidepressants, and despite Joan's reformulation of them as "normal pills" (a phrase which gets lost in subsequent discussion), the idea of the pills as "happy drugs" is reinforced in a variety of media. Press articles, like "In Search of Joy" (Ferguson) and "Inside the Happiness Business" (Kirkpatrick), rely on the assumption that antidepressants offer more than dissolving depression, they offer overt happiness. Indeed, as the following example shows, the women in Group 2 seem to believe that

Ellen	Yea:h and I- I think that's it's so: amazingly subtle that way that's why it's so it's such a misnomer to call it a happy pill
Others	Mmm Hmmm
Ellen	because you take one and you don't feel happy [you don't feel]
Joan	[it's a normal pill]
Ellen	any different

Figure 3.11: Mental Health Professionals (92:51)

the drugs have the potential to alter their moods toward the positive. Statements like Stephanie's below suggest an important power struggle between the promises of drug companies (for a generic happiness) and the desires of women to retain control over their emotional states. In this excerpt (Figure 3.12), Jennifer hopes the drugs could make her happy; Stephanie hopes they would not alter her sense of self. Both women acknowledge the possible power of the drugs, but they are conflicted about the significance of that power. In the interviews conducted for this study, the women all express varying levels of suspicion about the drugs, a response that suggests they are actively negotiating their ways through the rhetorical claims and promises of the advertisements. Nevertheless, all of the women also displays a sense of their own emotionality that relies heavily on the stereotypical versions of "emotional women." And, while moments of collective uptake offer the women a chance to recognize their participation in these uptakes, very few of these stereotypes are altered or actively critiqued.

Kim	So, do you think the pills (1.6) would make you happy? (2.5)
Jenn	I would hope so ((laughs))
Steph	I just thought I would hope *not* because I, I um I put a really huge value on honesty and to me honesty of my feelings is one of the most important things of a character trait that I have. Um, and that if I was something, if these drugs made me something I'm not normally I don't want them.

Figure 3.12: Women, Group 2 (82:22)

Conclusion: Uptake's Gendered Memory

Though feminists have accomplished a great deal towards gender equity in recent decades—not least in the area of gender-neutral language use—women still accept the cultural perception of women as dangerously emotional. When Jennifer describes her efforts to reshape her emotional and physical self in order to be more acceptable to her chosen profession (Figure 3.7), she is responding both to the power structures of her field and also to societal understandings of women. The analysis of NIMH pamphlets above shows some of these perceptions are embedded rhetorically in the ostensibly neutral informational documents produced by government agencies. Indeed, as Freadman argues, the power of uptake is in its choice of particular objects to keep in rhetorical play. In the case of depression, uptake functions by remembering an emotional, somewhat unstable (and usually hormonally influenced) woman. Thus, the object of such discourse becomes not only a universalized female body but, eventually, the individual bodies of the women in this study. They, too, perform particular kinds of uptake when they choose to present themselves as "sensitive" or "emotional." Texts like the DSM-IV-TR, the NIMH pamphlets, pharmaceutical advertising, and the talk of the individual women reference each other by calling forth a particular construction of the emotional woman. Thus, uptake becomes the mechanism through which these texts participate in selecting and refining the possibilities for those suffering from depression.

In this chapter, I have focused primarily on the language of the women that I interviewed. This focus has allowed me to incorporate their stories into my analysis; it has allowed me to provide an embodied argument. Though language runs the risk of being an abstraction away from the body, Tiffany's equation of women with their feelings demonstrates how language can have significant material consequences. In fact, as uptake's selective memory comes into play, the objects that are selected (or forgotten) reinforce gendered ideologies, which are used by the women in this study to construct their own self-representations. Because language plays such an integral role in our interactions, it becomes a primary source for investigating possible re-tellings. As the collective uptakes discussed above suggest, group interactions may well contain the possibilities for negotiating alternative stories and contingent explanations. Considering how individuals participate in the circulation of ideas like the "emotional woman" allows us to develop a more grounded and a more complicated theory of the circulation of discursive power.

This chapter has explored uptake's processes of selection. I have argued that selection occurs in part through the cultural, ideological memory of uptake that constrains the possible objects that may be chosen for conversation. Further, I have argued that the process of selection imposes power multidirectionally: when they describe women in general as overly emotional, the women in this study are not only selecting "the emotional woman" as a discursive object, they are also selecting particular subjectivities for themselves. Thus, uptake's selection is implicated in the dispersal of power both discursively and materially. Uptake's processes of selection work multidirectionally: on the objects articulated through the discourse, on the dispositions of the habitus, and on the individuals themselves. In the next chapter, I will consider another aspect of the directionality of uptake's memory. In the interviews, particular genres seem to organize the presentation of information. Uptakes that anticipate genres like the DSM-IV-TR, can be described as having future memories, while uptakes that rely on historical experiences, for example Figure 3.9, where Jennifer remembers the over prescribing of valium might be seen to have more traditional recall memories. In the next chapter, then, I explore these practices of uptake's memory.

CHAPTER FOUR

DIAGNOSTIC UPTAKES AND THE SHIFTING RHETORIC OF EXPERTISE

In the previous chapter, I argued that in performing uptakes throughout the interviews, all three groups articulated the discursive object of "the emotional woman." Through repetitions of emotional vocabulary and monitoring of their own and others' social roles, all of the women in this study reinforced a stereotypical emotional vulnerability for women, including themselves. In this chapter, I further explore the directionality of such selection practices. Here, I will explore the construction of a different discursive object, the diagnosis of depression, to determine how such objects are selected not only from a reservoir of past entities but also in anticipation of future possibilities. In this chapter, I will draw on the notion of a controlling genre, a text that acts as organizing mechanism for the tasks and participants who use it, to explore how individual uptakes can be seen to anticipate the demands of such controlling genres. Therefore, I will begin with a discussion of the DSM-IV-TR,[1] the primary genre legitimating diagnoses of depression. Using data from the mental health professionals' interview, I will demonstrate that the DSM-IV-TR does, indeed, function in this role in the content of the professionals' official practices. However, competing definitions of depression are advanced in this interview, particularly by Joan, the social worker, and I further argue that the mental health professionals' uptakes of these alternative definitions indicates a conflict in their predominant habitus. This conflict stems from a competing form of expertise, the symptoms list, which is commonly found on the internet and in pharmaceutical advertisements. When the mental health professionals make a diagnosis, therefore, they must take up a definition of depression that is informed in a variety of ways: in anticipation of the diagnostic categories contained in the DSM-IV-TR, in recall of their professional experience, and in parallel response to current popularized terminology and rubrics.

Following this discussion, I explore the interviews with the women who were experiencing symptoms of depression. These women, I argue, rely less on the DSM-IV-TR as a guide for their own conceptions of diagnosis and more on its popularized cousin the symptoms list. In their uptakes of the discursive object of diagnosis, these women make both explicit and implicit references to the genre of the symptoms list. The uptakes are not straightforward acceptances of the expert systems represented by the symptoms lists. Rather, they demonstrate how the women are consciously using such texts to develop an understanding of their own experiences. This analysis of uptakes suggests that, in addition to displaying a multidirectional memory, uptakes afford these women moments to position themselves within the discursive spaces available to them. In other words, uptakes represent moments of complicated agency for their speakers: they simultaneously perform subjectification (to the discourses) and subject-hood (of/over the multiple choices). Finally, the idea of uptake's memory being multidirectional is complemented by the series of metaphors used by the women in the interviews. Characterizing depression as a "journey," these women articulated their sense of being in transit through a discursive, material, and emotional world. Thus, I conclude this chapter with an examination of these metaphors.

To understand the symptoms list, we must consider how it is situated at the nexus of competing institutional, professional, and personal expectations. For standardization of research protocols and consistency of mental healthcare, the symptoms list is essential in regulating the boundaries of depression. For individuals struggling with depression, the symptoms list provides an articulation and codification of individual experiences. Thus, the list becomes a signifier not only of the illness it purports to define, but also of social roles (doctors, patients) institutional structures (research funding, insurance coverage) and behavioral norms (mental health versus illness). As such, the symptoms list becomes an important site through which to examine the memory of uptake. Further, the symptoms list is only one genre within a larger system of genres interrelated by their common use in mental health settings. Such genre systems, according to Carol Berkenkotter, are defined by the "intertextual activity" of the texts within them ("Genre Systems" 330). Following this definition, the relationship between the symptoms list and the DSM-IV-TR is cemented not only because practitioners use both in completing their daily clinical tasks, but also because of the intertextual borrowings between the two genres. "The texts that we see in a genre system," Berkenkotter writes, "are responsive to, refer to, index, or anticipate other texts" (330). In her work, Berkenkotter identifies the "generic expectations" (334) deployed by a therapist as she translates a spoken patient interview into her own notes, then into an initial intake report, and finally into a health insurance claim form. These translations are facilitated and to some extent motivated by the therapist's knowledge of the generic forms into which she must categorize her patients' experiences. These translations provide evidence for uptake's cataphoric memory. Borrowing from Berkenkotter's description of genre systems, I have labeled this form of memory "generic anticipation."

Generic Anticipation

In Berkenkotter's analysis, the therapist's genre of the initial assessment is read as the recontextualization of notes taken during the therapy session, which are, themselves, a recontexutalization of the spoken genres of the interview ("Genre Systems").[2] Thus, for Berkenkotter, the initial assessment gains meaning through citing and reformulating previous genres and by anticipating its place in future genre systems (e.g., insurance claims processing). Nevertheless, in Berkenkotter's formulation, such recontextualizations occur within a closely aligned set of genres—the initial assessment is indexed by its relation to the therapy session, to the meta-genre of the DSM-IV, and to the material requirements of insurance categories.[3] Thus, each genre within the set (or in Charles Bazerman's terms, the genre system) bears a relationship to the others. Further, this relationship is constructed hierarchically; some genres, like the DSM-IV, have more power to structure those around them. In the interviews conducted for this study, the DSM-IV was explicitly and implicitly identified as such a controlling genre. In terms of uptake, when the topic of depression is selected by the participants, the possible articulations of depression are partially restricted to those consonant with the definition of depression outlined in the DSM-IV.

According to the DSM-IV-TR, a "Major Depressive Disorder is characterized by one or more Major Depressive Episodes (i.e., at least 2 weeks of depressed mood or loss of interest accompanied by at least four additional symptoms of depression" (345). In other words, to receive a sanctioned diagnosis of depression, one must have five of nine symptoms, have been experiencing these symptoms for at least two weeks, and have experienced "clinically significant distress or impairment" due to these symptoms (356). The nine symptoms of depression are:

> (1) depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). **Note**: In children or adolescents, can be irritable mood.
>
> (2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)
>
> (3) significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. **Note:** In children, consider failure to make expected weight gains.

> (4) insomnia or hypersomnia nearly every day
>
> (5) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
>
> (6) fatigue or loss of energy nearly every day
>
> (7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
>
> (8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
>
> (9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide
>
> (356)

These symptoms must, according to the DSM-IV-TR, cause significant "distress or some interference in social, occupational, or other important areas of functioning" (351). This emphasis on community and social functioning—whether in the context of productive labor (occupational) or social interaction, highlights the normative desire for interaction. Depression, then, becomes a retreat or withdrawal from social functioning. Indeed, four of the nine criteria can be established by the report of others rather than the individual him/herself. This community involvement becomes strangely truncated within the psychotherapeutic and biomedical models of treatment, which usually emphasize individual symptoms and solutions.

Critiques of the DSM-IV

In *The Selling of DSM*, Stuart Kirk and Herb Kutchins describe the process of developing the third edition of the DSM as a "revolution" in psychiatry. Examining rhetorical maneuvers, political lobbying, and other social machinations, Kirk and Kutchins argue that the DSM-III, published in 1980, took an essentially *clinical* problem—diagnostic reliability—and transformed it into a complex, mystified *research* problem. With this move, the DSM-III transformed psychiatric practice into a science based on constant revision of the diagnostic criteria. Further, the publishing of the DSM-III appears to have silenced debates about the issue of reliability, even though, as Kirk and Kutchins conclude, "reliability may be an interminable issue" (248). Thus, the manual itself has produced a simulacrum of reliable diagnosis; research studies are funded, conducted, and reported based on assumptions that the criteria listed in the current version of the DSM are adequate and reliable. Thus, the DSM-IV-TR, which participates in the long textual history of diagnostic nosologies, can be critiqued for the ways that it purports to assimilate diverse knowledge about mental health and illness.

In their second study, *Making Us Crazy*, Kutchins and Kirk document additional social and rhetorical maneuvers that led to the revisions in the DSM-IV. In this study, Kutchins and Kirk focus on the increasingly complicated processes of revision that the manual undergoes with each successive edition. "Changing the psychiatric nosology," they write, "involves struggles among constituencies and requires a balancing of conflicting interests" (37). The notion of negotiations among "constituencies" disrupts the idea that the DSM-IV might be an objective, disinterested document. In response to such constituencies, homosexuality was expelled from the DSM-IV and Post-Traumatic Stress Disorder was included. In both cases, Kutchins and Kirk argue, the political and social circumstances surrounding the revisions were extremely influential. Further, the DSM-IV sought to introduce cultural sensitivity into the descriptions of various disorders. However, as Kutchins and Kirk point out, in these sections of the manual, "[t]here is an implicit assumption that the clinician is from the dominant culture and the client is a member of a minority group" (253). Further, the DSM-IV attempts to medicalize vast areas of daily experience. For Kutchins and Kirk, "mental disorders constitute a small part of what is described in the current *Diagnostic and Statistical Manual of Mental Disorders*" (264). This critique is very relevant for a consideration of the conversations about depression recorded for this study—the women are unsure if their experiences constitute an illness, yet many of their uptakes of diagnostic criteria impose illness subjectivities.

In a feminist examination of psychodiagnosis, Hannah Lerman reminds us that "[t]he process of diagnosis...is inevitably linked as much—if not more—to the personality, theoretical orientation, and cultural circumstances of the therapist...as it is to the personality and circumstances of the patient" (5). Lerman's cautionary statement further erodes the objectivity of psychodiagnosis; her rallying cry is for including alternative explanations and realities within the realm of diagnosis. A similar feminist critique of diagnostic validity, suggested by my analysis in chapter three, is that emotional norms for women and men predispose them to different forms of "illness." Further, as Joan Busfield suggests, "the wide range of evidence of gender differences in emotional expression in Western culture is likely to contaminate the measurement of depression" (94). In addition to the concerns about influences on "objective" diagnoses, feminists have focused critical energy on explore the ways that science has been used historically to control women's minds and bodies. Jill Astbury's *Crazy for You*, published in 1996, offers this kind of analysis, considering diagnoses like hysteria, depression, and battered child syndrome.

This chapter considers the organizing power of symptoms lists for depression—the means by which diagnostic reliability is purportedly ensured. But, as Rose argues, such lists necessarily involve submitting the self to the medical gaze. He highlights the processes of observation involved in the development of a list of criteria for the assessment of child development. He writes:

> The work of Arnold Gesell and his collaborators demonstrates clearly the procedures by which childhood is first made *visible*, in relation to the normalization of behavioral space within the clinic, then *inscribable* through the refinement of procedures for documenting individuality, then *assessable* through the construction of scales, charts, and observation schedules....These developmental scales were not simply a means of assessment. They provided a new way of thinking about childhood and a new way of seeing children. (111)

As this example demonstrates, the rubric derived from clinical observation soon becomes a self-perpetuating structure against which both "normal" and "abnormal" behaviors can be judged. A parallel analysis suggests that the listing of symptoms for depression is neither an innocent nor necessarily an empowering advance in our understanding of the illness. Nevertheless, the DSM-IV-TR and its corollary the symptoms list has become an organizing genre for both psychiatry and everyday self-help. The following sections will, therefore, explore how this genre is taken up in the conversations among mental health professionals and women experiencing symptoms of depression.

Professional Diagnoses

The mental health professionals—for whom the DSM-IV-TR codifies and legitimizes their discipline—acknowledge and critique their own reliance on the DSM-IV-TR. Even when bemoaning the arbitrariness of the DSM-IV-TR, however, the mental health professionals acknowledge the role it plays in structuring diagnosis, treatment, and even health insurance reimbursement. In Figure 4.1, Betty provides anecdotal evidence for the ways that the DSM restricts only certain individuals from access to medications. Thus, for Betty and the others, the

DSM-IV-TR is a controlling genre that shapes the real practices of their work. These women are very aware of their own anticipation of the manual—Betty suggests that patients must be "run through" the DSM-IV diagnosis criteria in order to "qualify" for treatment in her program. Though, of course, as this example also shows, there are different standards of "running through" the criteria, depending on *who* you are and *what* (health care) system you belong to.

Betty	Yeah I have a lot of people that come in and tell me that they are depressed but when I run through the (.) DSM-IV diagnoses or symptoms with them (0.8) they don't even qualify as dysthymic sometimes. But they feel *depressed* and um that doesn't qualify as a diagnosis or as eligible for medications. How*ever* I have friends who I would consider not depressed who are on the medications=
Joan	=absolutely=
Ellen	=oh yeah=
Betty	=so, ((laughs)) I don't know I, I guess it depends on who you are and what insurance you have and=
Laurie	=what system you're in

Figure 4.1: Mental Health Professionals (6:21)

Although the mental health professionals are apparently aware of the systemic inconsistencies of diagnosing depression (as seen by Betty's example above of some people apparently having access to medications/treatment without adequate DSM-IV-TR symptoms), they acknowledge the official translation of their interview into a single DSM-IV-TR diagnostic code as inevitable for reporting purposes. In an effort to elicit talk about these translation issues, I asked the mental health professionals about the differences between how they talk with clients about their depression and how they reported to official agencies about these interviews (Figure 4.2). In response to this question, Betty characterizes the necessity of a DSM-IV-TR diagnosis (indicated by a numeric code) as a fortunate reduction of paperwork. The other mental health professionals agree that this simple code is "sufficient" for official reporting. DSM-IV-TR diagnostic codes cross-reference mental illnesses across four axes; thus, much information is reduced to a single numeric indicator. Such a reduction may indeed be a "sufficient" response to the requirements of official insurance forms, but as indicated above, those to whom this numeric identifier is assigned may be of varying levels of symptoms, despite the standardization implied by the codes themselves. Thus, in this segment of the interview, the mental health professionals seem to be resisting the interpretive pressures of the insurance claim forms by providing only minimalist responses when required to do so. Nevertheless, it is clear that the DSM diagnostic code, as the legitimization of each diagnosis, becomes a controlling factor in shaping interactions with clients (or at least with clients' insurance companies). That is, because the code must ultimately be entered as the signifier of an acknowledged illness, interactions between mental health professionals and their clients must anticipate this outcome. As I argued in chapter two, the excerpt in Figure 4.2 demonstrates a partial uptake of my question. Essentially, the mental health professionals characterize their "translations" of patient data to insurance forms as the simple recording of a code. Nevertheless, as various critiques of the DSM-IV-TR have suggested, this transmission of a single code actually encapsulates a variety of rhetorical

Kim	So, one of the things that, that um (.) I'm interested in has to do with not just how you talk (.) *to* clients but then how you then report (1.0) on clients, or to whom do you have to report this [...] how do you characterize depression differently in those two settings? When you're talking with a client you're talking I'm assuming using their language and trying to figure out what they have to say. How do you then translate that into the officialdom that we're all stuck in? (2.5)
Betty	Well, fortunately for insurance companies and for social security who I have to deal with a lot, a DSM-IV diagnosis is sufficient.
Ellen	Mmm Hmmm
Betty	that's all I need to put on the paperwork is the DSM-IV diagnosis=
Laurie	=the class diagnosis
Ellen	Me too, and I, I generally don't go into it any more if I do fill out a form (.) for social security I have the client with me when I fill it out and I also tell the client how I'm diagnosing them

Figure 4.2: Mental Health Professionals (58:09)

practices. Thus, the code itself may be "enough" to satisfy reporting requirements, but it organizes particular social relationships and medical practices. If a patient does not meet the criteria for a code, there is little discursive room for an alternative uptake of the patient's condition.

At several points throughout the interview, the mental health professionals openly critiqued the DSM-IV-TR as either arbitrary or unhelpful. At one point, Joan and Laurie describe the difficulties of diagnosing children with depression. Laurie points out that in the past, "you certainly didn't diagnose a kid as depressed. Um, y'know one just didn't believe that kids could *be* depressed" (MHP 17:00). Joan agrees, suggesting that the "DSM still only applies to like 18 and over" (MHP 17:18). Together, Joan's and Laurie's statements reflect their sense that the DSM does not provide comprehensive information. However, Joan's assertion that the it does not apply to children is not actually supported by the current version of the manual. In the DSM-IV-TR, an entire section is devoted to "Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence" (39-134). This section is augmented throughout the text by comments elaborating on age-specific features of mental illnesses. Nevertheless, Joan's belief that the DSM-IV-TR does not apply to children is rooted in her disciplinary background as well as in her personal experience; it is rooted in the memory of her uptakes of the official guide. Laurie's contribution that she has seen changes in mental health practice throughout her career further substantiates the critique of the DSM-IV-TR as an evolving (rather than as a stable, singularly authoritative) document.

About ten minutes into the interview, Laurie expresses frustration with the formula through which the DSM-IV-TR articulates depression. She asserts that her own professional judgment is not augmented by the DSM formula. In Figure 4.3, Laurie's critique of the DSM-IV-

TR focuses on its arbitrary quantification of symptoms and duration as adequate measures of depression. In a similar move, Kenneth Kendler and Charles Gardner report that, in their study of approximately 2,000 pairs of twins, the boundaries of major depression are not as clear as the DSM-IV criteria would imply. Kendler and Gardner write that "taken one at a time, three major 'gate-keeping' DSM-IV criteria for major depression—symptom number, impairment, and duration—do not appear to carve nature at its joints. . . .our result suggest that if a discrete depressive syndrome exists in nature, the current DSM-IV criteria that we evaluated do not perform well in detecting it" (176). Thus, Kendler and Gardner suggest that the DSM-IV criteria arbitrarily identify a set of symptoms as major depression. More accurate, they contend, would be a model wherein symptoms form a continuum. They conclude by suggesting "that our current DSM-IV diagnostic conventions for major depression … may be arbitrary and not reflective of a natural discontinuity in depressive symptoms as experienced in the general population" (177). Thus, the identification of one precise level of symptoms as major depression may be inaccurate—a few less symptoms may be equally predictive of mental illness. Results such as these affirm Laurie's suspicions about the DSM-IV-TR criteria, and highlight the artificial control that the DSM-IV-TR exerts over understandings of the experience of depression. In this instance, diagnosis involves the uptake of DSM-IV-TR criteria, and though the mental health professionals express frustration with this document, these uptakes are justified in their memory (in this case a form of professional judgment) of institutional necessity.

Laurie [...] it's tough, DSM is tough. I don't I, I still hate the DSM and it's (x) I mean it's how long have you had it? How many of the symptoms? If you meet our checklist you're there, but I y'know (1.7) I think it- like everyone around this table, when I see someone who is depressed I *know* it (2.0) and I spend time talking with them and I *know* it, I mean they are depressed and I don't need a DSM-IV to tell me that it's been two weeks and X number of symptoms

Figure 4.3: Mental Health Professionals (9:27)

When pushed, Laurie elaborates on her assertion that when she sees someone who is depressed, she "just knows" it. After some discussion with the others, Laurie admits that she doesn't *always* know immediately if someone is depressed. I asked her to clarify (Figure 4.4), saying, "When you say, when I see someone who's depressed, I know it *how* do you know it?" In this excerpt, both Joan and Betty assert their professional judgment about clients who are depressed. Both seem to be relying on their clinical experiences, which are a manifestation of uptake's (unconscious) recall memory. By operating on the level of intuition, and informed by clinical practice, the uptake of a diagnosis of depression illustrates the operation of a longitudinal memory. Further, the mental health professionals articulate such uptakes as instinctual phenomenon: For Betty, those who are truly depressed "stand out like a sore thumb." For Laurie, depressed clients trigger a response in her, a recognition that there are incongruities in the client's presentation. Implicit to these professional definitions of depression is a shared belief that true depression is a recognizable to the trained clinician, even if it is not necessarily a quantifiable phenomenon.

Figure 4.4 demonstrates another function of uptake's historical memory: the negotiation of subjectivities. After Laurie's first turn concludes with "it's how it makes me feel," I take up this statement with a classic therapist's follow-up question. Taking up Laurie's turn as incomplete story-telling, I asked, "How does it make you feel?" The question shifts the dynamics of the interview, momentarily placing Laurie in the disempowered position of patient. Her recognition of this shift and reassertion of her expert status occurs in her ironic reply "Thank you for asking." The laughter which follows this exchange (including my own) serves as a re-establishment of participant roles: Laurie, Betty, Ellen, and Joan are experts to whom I have appealed for specialized knowledge. Thus, uptakes like mine of key phrases carry with them appropriate subjectivities that can be inhabited (or rejected) through conversational negotiation.

Laurie	Well that was also somewhat arrogant, 'cause you're right, you don't always know it. But you know there's usually something that in (x) it's usually something in me (.) tha:t it's a way I respond and the way I start *feeling* (.) about what this person needs and what I'm you know it's sort of like they evoke feelings within me that help me begin to recognize what that is in terms of the depression. And you're right because it may be that I'm looking at depression I may be looking at something you know much more complex than that which is you know some of the stuff Betty deals with with the co-morbid disorders. Because it maybe it looked like depression on the surface but when you start peeling away there's something else there. But generally it's how it makes me feel.
Kim	How does it make you feel?
Laurie	Thank you for asking
Others	((laughs))
Laurie	U:m:, (1.4) how to define it. It is a feeling that (3.0) that there's consistency between what they're saying, how they're saying it and how they look. (1.8) And it, it's it's it's and it's that doesn't mean that they're you know down and you: it may be um I'm thinking of this person that I was talking to recently who was clearly depressed and has maybe some other flavors but everything ended in "tee hee"
Ellen	Mmmm Hmmm
Laurie	everything's just fine tee hee. We're just going to do this tee hee hee. You know and it's it's like she's talking about these rather major things in her life (.) and it's and every*thing* ends in a tee hee and it just you know it sort of (.) you know *hits* every button of- of me that says this is wrong. You know, this does not feel right and, and when you say something devastating you should feel (.) you should be responding with sadness and she's responding with sadness but then tee heeing it so no one will know. And I mean and literally the words she uses are "tee hee"
Betty	((laughs))
Laurie	Been there?
Betty	Well, the people that I see primarily are coming in and telling me they're depressed but they have a co-occurring substance abuse and it's really hard to tell. You know. I'm [finding out]
	|
Joan	[absolutely]
Betty	I'm not a I'm, I'm relatively new at this whole diagnosis game (1.9) a:nd I'm finding out that if somebody walks into my office and is truly depressed they stand out like a sore thumb. You can tell it the minute they walk in to your office. But if they have a, like a co-occurring substance abuse problem it's muddy. Th- there's nothing that stands out, it's all very unclear and it's just you kind of have to guess at really what's going on. So it- I'm really *amazed* at the difference between the two groups and how *easy* it is to diagnose somebody who is truly depressed. (.) Rather than somebody who has a substance abuse so it, I'm in the process of learning about all this, so

Figure 4.4: Mental Health Professionals (11:05)

Even though they are skeptical of the DSM-IV-TR diagnostic criteria, both Betty and Laurie agree that depression can be recognized and articulated via their professional judgment. This visibility is, as Foucault argued in *Birth of the Clinic*, highly discursively constructed and contained. With the advent of the clinic, with its rationalized, segmented attention to symptoms and manifestations, disease becomes valid only after it has been seen and stated. Foucault writes:

> The descriptive act is, by right a 'seizure of being' (*une prize d'être*), and, inversely, being does not appear in symptomatic and therefore essential manifestations without offering itself to the mastery of a language that is the very speech of things. In the medicine of species, the nature of a disease and its description could not correspond without an intermediate stage that formed the 'picture' with its two dimensions; in clinical medicine, *to be seen* and *to be spoken* immediately communicate in the manifest truth of the disease of which it is precisely the whole *being*. There is disease only in the element of the visible and therefore statable. (95)

Here, Foucault explores the ways that language restores a "virtual identity" between "the visible and the manifest" (96). In other words, the language identifying something as disease helps maintain the sense of objective truth for diagnosis. The interpretation of one set of observations as 'depression' becomes naturalized through the discourse, eliding both alternative diagnoses and also additional symptoms.[4] For the mental health professionals in my study, the recognition of clients as 'depressed', performed via the professional memory of uptake, enables their disciplinary work. And, though these professionals express dissatisfaction with the DSM-IV-TR itself as an authoritative genre, they nevertheless rely on its forms of clinical interpretation to complete their work, demonstrating the discursive and material power the document exerts.

An empathetic definition of depression, one that nevertheless acknowledges the DSM-IV-TR's authority, occurs to Joan, the social worker. In Figure 4.5, elicited at the beginning of the interview, after I asked the group to define depression, Joan articulates a definition of depression that is separate from the DSM-IV-TR. Joan makes an interesting and important distinction here between "professional life" where, presumably, the DSM-IV-TR answers definitional questions and another form of life in which depression is understandable, but not clinical. For Joan, there are gradations of happiness/unhappiness that require attention and empathy that may not be covered by official diagnoses. This adds an interesting dimension to discussions of generic anticipation. In this passage, Joan clearly recognizes the organizational influence of the DSM on her professional life. Nevertheless, she makes room for an alternative definition. Joan maintains this distinction between kinds of depression—between "clinical" and other forms of depression—while the other mental health professionals do not seem to divide depression in this way. Though they do distinguish between "DSM diagnosable" depressions and depressions that may or may not be technically diagnosable, Ellen, Laurie and Betty do not label these gradations as "clinical" or "non-clinical." Instead, they seem to take for granted that the DSM guidelines are arbitrary, and focus on the work that they and their clients can do together. The DSM criteria are resisted most strongly by Laurie, who "hates the DSM" (Figure 4.3); the criteria are most strongly adhered to by Betty, who is "relatively new at this diagnosis" (Figure 4.4). Nevertheless, Joan positions herself outside of the medical/diagnostic community when she divides depressions as "clinical" (presumably outside of her purview) and "other" kinds of

Joan	Well I think it is easy to talk about depression in a way that doesn't necessarily maybe have like a (1.5) clinical:? component, but (.) sort of is still valid, I mean I know in terms of like the kids that I've worked with, and the settings that I've worked on (1.1) we definitely had kids who were diagnosed as depressed but then we also saw lots of kids who weren't really that happy. But they weren't depressed and so (1.8) I don't know, it's it's easy just in like a (.) aside from professional life to understand what that *means* or to have a, I guess a *sense* of what that means without necessarily meaning what it means in the DSM-IV. That's my initial reaction to that question.

Figure 4.5: Mental Health Professionals (3:35)

depressions. By locating herself outside of the clinical community, Joan allows herself the flexibility to take up alternative definitions of depression. Throughout this interview, Joan introduces topics and explanations that are modified, ignored, or rejected by the other participants. These topics often resemble the kinds of talk that are common in the interviews with women experiencing symptoms of depression. In Figure 4.5, Joan seems to be describing two competing understandings of depression, one clinical and professional, and one more circumstantial. In my reading of these transcripts, the latter understanding is allied mot closely with a "consumer empowerment" movement that is developing diagnostic and explanatory mechanisms outside the clinical realm. Symptoms questionnaires contained on many drug company web sties are an example of this transference of diagnosis outside of the doctor's office. For the mental health professionals, genres like the symptoms list and DTC advertising seem to be participating in a system of knowledge formation that competes with their own clinical expertise.[5] Laurie, the psychologist, most strongly responds to this competition as a threat to her authority. About an hour into the interview, the conversation addressed direct to consumer (DTC) advertising. In the following excerpt, Betty brings up the concern that patents may be acting as their own physicians, and Laurie responds with a critique of DTC advertising (Figure 4.6). Here, Laurie is extremely critical of the repackaging of Prozac as Sarafem for Premenstrual Dysphoric Disorder (a severe form of PMS).[6] She articulates a concern that the commercials are influencing patients to demand particular treatments. Betty, the psychiatric nurse, is also concerned specifically with the possibility that patients will self-diagnose. This anxiety suggests that the DTC ads are encroaching on the clinical expertise of the mental health professionals. Just prior to the conversation in Figure 4.6, Laurie makes an interesting statement of her resentment of DTC advertising. Speaking of the ads, she says: "I also find it intrusive between my relationship with a patient to have them tell (.) the patient what they need to know so they can go in and go tell your doctor" (MHP 47:01). Thus, Laurie identifies advertisements as seeking to tell consumers "what they need to know," a practice that not only usurps her own expert status, but also interferes with the relationship she has built with patients. While the other mental health

Betty	((laughs)) And I'd hate to think that people are diagnosing themselves
Ellen	Yeah. Yeah.
Betty	based on what they see in the commercials, but I guess that happens.
Laurie	and see that hadn't, I, I I hadn't thought of it the other way and I think that those were good but the one of the things that I don't like about the commercials is that they show, they show then the happiness I mean it's sort of like I mean the implication is this is the drug that is going to make you happy, [this is the drug]
Joan	[absolutely]
Laurie	or, or I particularly liked it when Prozac came out as Sarafen, it's not Sarafen that's for gas
Ellen	SarafeM:
Laurie	SarafeM for PMS I mean that's sort of like, excuse me, it's Prozac
Others	Mmm Hmmm
Ellen	well or Zyban
Laurie	Yeah I mean yeah it's sort of like they, they gave it a different name and pretended it wasn't what it was and it was sort of like no, this is this is Prozac folks, it's just prozac for PMS versus Prozac for (.) depression. And there's actually no good literature that says that for PMS it's all that effective. It's certainly effective probably for the *depression* that goes with PMS, but then that's for the depression not for the PMS. (.) So I'd say- I don't know, I mean it- it's (0.5) it's difficult particularly when people want drugs that you've seen not work for the particular, I mean it's sort of like well the commercial says I should have this one (1.7)
Betty	or if [they start diagnosing]
Laurie	[and maybe you've seen that one not be a good drug]
Betty	or if they start diagnosing themselves.
Laurie	Yeah
Betty	and wanting that particular medication, that's the down side for me.

Figure 4.6: Mental Health Professionals (50:20)

professionals suggest ways that these advertisements can be useful for consumers, they all react to them with suspicion and concern. These reactions indicate a conflict between the knowledge dissemination systems of traditional doctor-patient communication and more recent consumer education mechanisms.

The advertisements and other forms of consumer information (e.g., NIMH pamphlets) have developed an imperative tone that seeks to impel particular action. This tone and the ubiquity of the information can be read as the development of an alternate expert system: patients are directed by the ads as much as or more than by their own individual doctors. Laurie responds to this when she objects to the ads telling her patients, “go tell your doctor.” In addition to encouraging consumers to discuss their depressive symptoms with their healthcare providers, advertisements for pharmaceuticals often direct consumers to ask about a specific drug. A recent ad for Zoloft urges: “Talk to your doctor about ZOLOFT, the #1 prescribed brand of its kind” (Figure 1.4). In a soft blue headline, a recent Celexa ad directs consumers to “Ask your doctor about treating depression with Celexa” (Figure 1.3). In both of these advertisements, the specific brand name is linked to the imperative command, directing not only action, but also the content of the communication itself. It is this directiveness that Laurie and others critique in the interview.

Another byproduct of the multiple discourses on depression in the assumption of common definitions. Ellen, the psychiatrist, comments on her patients’ use of terms like *depression* and *co-dependent* with the belief that these are uncomplicated terms. In Figure 4.7, Ellen shares that her patients express dissatisfaction with her expertise when she asks them to provide more concrete definitions of terms like *depression*. She relates changes she has made to her own communicative practices to accommodate these moments of discontinuity. The existence of such code words or assumed common knowledge suggests that the popular discourse has successfully entered the professional interactions as well as the public domain.

Ellen	Yeah. (1.8) Well I think that the other thing I, I keep thinking about what the title of your, or what the, my thought about your (1.5) your study is too, and that's that you know what do people mean when they say they're depressed? And what does that word *mean*? And I keep thinking of how many different definitions it is and when somebody tells me they're depressed it means something different from somebody else who is equally depressed and (.) um means something. And I think that you know at first when I was first starting out and I would say well, you know, what does that mean to you? It seemed like a lot of people would get sort of put off by that and say, well, I'm depressed, don't you know what that means. You know? And uh sort of like,
Laurie	Dummy, don't you know?
Ellen	Yeah, or I'm uh (.) co-dependent and um (1.2) so I um now I ask them to tell me how they know when they're getting depressed and um, um what, what clues do they get, what's the first thing that they notice that's letting them know that this is not good. Um and it, that's sort of also how I want to train them so that they can come back and tell me, OK, I'm (.) ran a red light the other day and I thought I was the most awful person on earth and that's a clue to me that I'm depressed. Um:. (2.5) But I think it means a lot of different things to a lot of different people.

Figure 4.7: Mental Health Professionals (36:29)

Turning now to the women interviewed in this study, a similar conflict of expert discourses can be detected. As chapter five argues, part of the manifestation of depression is a lack of power, evidenced by the deferral to experts of various kinds. Nevertheless, the women included in my study demonstrated varied views toward medical and pharmaceutical authority. In the following section, I explore the ways that the women talked about their experiences with symptoms of depression. In part, this discussion explores the ways the women's talk anticipates and reflects the DSM-IV-TR as a defining genre. Though the women did not identify the DSM-IV-TR in their discussions, much of how they described the symptoms of depression fits specifically into the categories outlined in the DSM-IV-TR. This can be read as akin to the generic anticipation of more closely related genres like the patient interview and diagnostic report. Because the DSM-IV-TR shapes so much of what counts as mental health and illness, its implication in the talk of the women is to some extent inevitable.[7] This demonstrates the cultural and not necessarily individual memory involved in uptakes of diagnoses of depression. More interestingly, however, this section explores moments when the women's talk departs from the discursive models available to them. Thus, this section will conclude with an analysis of the women's strategies of self-articulation.

Women's Diagnostic Uptakes

The women interviewed for this study have varying levels of previous contact with mental health professionals. None of them, however, have been recently diagnosed with or are under treatment for depression. This group thus represents individuals on the borders of institutional discourses on depression. While they all report significant levels of symptoms, none is currently in treatment with a healthcare provider. As such, these women represent an interested consumer base, but not an already medicalized one. Thus, their language patterns represent an important source of evidence for the ways expert discourses are available to be taken up and used by individuals. In the two interviews included in this study, the women attribute expert status both to healthcare professionals and to the discursive constructions of symptoms lists and informational sources (e.g., web sites, pamphlets, advertisements). As is the case for the mental health professionals, there are some conflicting beliefs about how these expert systems function.

In part, the women in my study express a tension between information about and diagnosis of depression. In the Group 1 interview, Tiffany displays this conflict in response to my question about whether primary care providers could or should encourage their patients to talk about their symptoms of depression (Figure 4.8). In this excerpt, Tiffany supplies the story of her friend who counsels families who have lost a child as a way to suggest the importance of information and support at moments of tragedy and grief. She does not, however, like the idea of "doctors diagnosing depression" more often. For her, the danger of such a move is that the expert pronouncement may in fact increase one's depression. At other points in the interviews, however, the women express a desire to have a medical professional provide perspective, validation, or interpretation of their symptoms. Thus, the women's relationships to the expertise of medical professionals are complicated and not unidirectional.

Kim	Do you think that there is something that your doctor could say to you that would get you to talk about (.) these feelings? I'm thinking there's a big push for y'know getting general practitioners to diagnosis depression more often. Um (.) do you [think]

Tiff	[Well not] necessarily like depression but I know somebody who's jo:b it is is to um talk to families who've lost a child at the Children's hosptial area? And um so every day she gets to go to work and talk to people who are really really depressed because their child or something some other relative died. And um I mean so at least there they're trying to have counselors on hand for the pe- people's families and I mean I guess that's a good place to have somebody because that's a time when they might need guidance because y'know obviously they have gone through it before or maybe they have but probably they haven't um but doctors diagnosing? depression I mean I don't know if that's necessary. That might be taking it too far cause then they might diagnose people that don't *have* depression

Kim	um hmmm

Tiff	you know I mean like like cause maybe sometimes if somebody says that you're sad like the doctor said oh well because you have AB and I think you are a really sad person you might become more sad ((laughs)) I don't know

Figure 4.8: Women, Group 1 (83:05)

One of the most striking features of these interviews is the power that the symptoms lists held as synecdoches for a larger expert system. In fact, these lists often seem to be more powerful than the mental health professionals themselves. Indeed, the women participating in this study were first screened using one version of the symptoms list, a move that further complicates their understanding of the discursive tools available to them. About an hour and a half into the Group 1 interview, Claire relates her recent visit to the campus health center (Figure 4.9). In this reported interaction, it is important that Claire identifies her symptoms as all "on the list" as she recounts her visit to the health center. Interestingly, the health care provider does not diagnose Claire with depression, but simply affirms that "it sounds that way." This move, I argue, privileges the listing of symptoms and the rhetorical presentation over a clinical examination and diagnosis. In this way, the symptoms lists seem to represent more salient

Kim Do you guys have experience with the doctors here? Have you talked about any of these feelings with a doctor?

Claire I was in last month I went to Campus Health and talked to a woman in there and she asked me questions and I told her my symptoms which are all on the list and (1.0) she didn't you know say you're depressed she said (1.0) she said it sounded that way and, and recommended counseling and medication

Figure 4.9: Women, Group 1 (85:01)

knowledge than the individual healthcare provider herself. Thus, the competition between expert systems is being played out in the lives of women suffering from symptoms of depression. In Claire's narrative, another important feature is the erasure of her individual symptoms in favor of the more generalized "list." Here, Claire is assuming a common knowledge of a stable (and complete) list of symptoms of depression. By bracketing her own experience in this way, she is in essence accepting the diagnosis offered by the symptoms list itself. Claire does this again a few minutes later in the interview when she is describing a commercial she saw on television for a research study on depression (Figure 4.10). Here, Claire reports the content of the commercial, again bracketing off any details of symptoms with "blah blah blah." This is significant not only because it affirms the coherence and unity of the symptoms list, but also because it enables a rhetorical forgetting of the specifics of the list. Part of the power of uptake, as I argued in chapter three, is the ability to enforce a forgetfulness about alternative constructions.

Kim So have you seen? What other commercials have you seen? Have you seen any other ads for?

Claire Well I've seen the: 292, 292-CARE City Research Study where you can be a volunteer (xxx)

Kim What's the commercial like, do you what do you remember [about it]
|
Claire [It just] tells you the symptoms, do you blah blah blah if so, you may be eligible for this um depression study

Figure 4.10: Women, Group 1 (87:32)

In the interviews, the women had a predictably difficult time articulating their own experiences with depression. As scholars and sufferers like Solomon, Styron, and Wurtzel have lamented, *depression* is a slippery word that can hardly contain the experiences of its victims. As I argue below, the symptoms of depression are difficult to articulate but when such articulations occur, they generally conform to the diagnostic criteria of the DSM-IV-TR. At one point, in the first consumer interview, the listing of symptoms was rapid and concise; this conversation (Figure 4.11) occurred about an hour into the interview. In this excerpt, Claire and Paige collaborate on a list of symptoms that is notable for its brevity and lack of metaphor or narrativization. Importantly, this listing occurs within the rhetorical frame of expert discourse. The passage beings with my question, "What do the psychology books say about depression?" And, it continues with Claire's framing of the expert knowledge of "brochures and web sites." This episode further supports the strength of symptoms lists as a discursive expert, constructing our understanding of depression, and it point to a selective memory for uptake.

Kim	So what do the psychology books sa:y about depression?
Su	Some the:ories and um it's hard to understand but I need to remember all of them, you know. I think I would like things more clinically yeah so it's hard to, I think the theory is hard to apply to um my study (1.7) it's just too abstract I don't know (4.0)
Claire	You know like brochures and web sites that list the symptoms
Kim	What are they, what are the symptoms?
Claire	sleeping too much or to little, eating too much or too little (1.0) crying um feeling sa:d (2.0) you know (xxxxx)
Paige	Yeah, Not enjoying activities that you [normally like to do]
Claire	[(xxx) not being] motivated not having energy

Figure 4.11: Women, Group 1 (56:21)

Outside of this rhetorical frame, however, the women spend more time adding descriptive and narrative details to their explanations of what it feels like to be depressed. Many of these descriptions mirror the DSM-IV-TR categories. Importantly, however, in both interviews, depression is characterized as irrational. Outside of the expert frame, wherein the women are concise in their reports about what depression means, the women suggest that it is the unreasonableness of feelings that characterize them as depression. In the Group 1 interview, Su-Ting describes depression as feeling bad without explanation (Figure 4.12), and in the Group 2 interview, Mei and Stephanie collaboratively define depression as having no understandable motivation (Figure 4.13). In both of these examples, it is the failure of communication with others that characterizes depression as irrational. In Figure 4.13, Mei participates in the psychotherapeutic model of depression, stating that "they way you perceive things I think is all screwed up, I guess." This model, as chapter two suggested, further isolates the individual whose perceptions and cognitions are deemed faulty.

Su	I think depression for me is still like all the bad feelings come together=
Others	=mmmm=
Su	=kinda like not for some specific reason (xxx) How do you explain this to others? because there are not reasons (xxx)

Figure 4.12: Women, Group 1 (19:03)

At other points in the interviews, the DSM-IV-TR categories are more or less maintained in the descriptions of symptoms. In the first consumer interview, both Claire and Paige tell stories about friends and family members whom they consider to be depressed. Paige describes a friend who "doesn't eat very much" and who "doesn't look very, like not very active" (G1 51:35). Similarly, Claire describes her mother's loss of appetite after her father passed away, saying "she quit eating. She ate way less than she would normally eat" (G1 53:00). For the women

Kim	so, um, (0.3) we've talked a little bit about this but describe what it feels like. When you're down. What, what is that? What (x) and whether you call it depression or you call it the blues or you call it whatever. What's it feel like?
Mei	well, loneliness um lack of motivation um and jus: (.) I guess loss of power because you feel like I mean I feel so bad how can I get better or like it'll take me so much effort to get better ((laughs)) just and (x) so you don't really want to do anything because you just don't you don't have the energy just like oh (life) wallowing in self pity I I think=
Steph	=that's really good
Mei	((laughs)) so I uh and I think it's all jus ah god I don't know why like that hap- see I think part of it is chemical though because it's I mean uh if I think about it in a clearer head like then I'm like why was I so sad? or what,
Mei	[why does that little thing bother me so much?]
	|
Steph	[yeah what happened to me? It's ridiculous]
Mei	maybe a relationship at work is um why is that? I mean it's like even though I'm not (.)closely with these with these people or I mean just (0.3) I think so when I'm depressed I see (.) I overthink things also. Because I'm spending too much time by myself. And I think that's bad when you over-analyze things I mean you think of some things that it doesn't I mean that weren't true or like that or just you know the way you perceive things I think is all screwed up, I guess((laughs))

Figure 4.13: Women, Group 2 (21:03)

themselves, a lot of the symptoms reported included things that the DSM-IV-TR might classify as a "loss of interest or pleasure." In the Group 2 interview, Jennifer and Mei collaborate on a definition of depression as retreat (Figure 4.14). In this excerpt, Jennifer and Mei emphasize the loss of social interaction when they are depressed. Not only are they less interested in doing things that they enjoy, they are less likely to be with friends during these periods. This social isolation is one of the recurring themes of these interviews, and it reflects one of the concerns of a predominant habitus that defines normality as sociability and interaction.

Despite these echoes of the DSM-IV-TR and the controlling definitions of depression, the women in this study were actively constructing their own experiences with depression. Thus, these interviews suggest that the discourses that shape our social realities are available for

Jenn I've noticed that um there were times where I spent a lot time alone and just like y'know sleeping in till you know past noon. Um vegging out and watching television like all day and it would be like a *beau*tiful day outside and I just would not go outside um and I just felt like um (.) nothing could motivate me out of that apartment. Um I just didn't want to do anything=

Mei =yeah and don't you feel like the world is so much happier than you too? ((laughs))

Jenn Yeah, I guess I really didn't think about it, it was just like I just didn't want to do anything I didn't *feel* anything to do anything and even if I had plans with people I, I would break them because I didn't want to be um just kind of there co-existing with them? And not being able to feel and enjoy anything.

Mei Mmmm Hmmm

Jenn So I would just kind of like [isolate myself away]

Mei [Yeah I think like] if I was feeling bad and then I, I one of the reasons I don't want to hang out with them (x) other people is because I mean I think that they would want to see the happy me then

Jenn right

Mei I mean cause then it's probably I think that oh well they're not going to like me if I'm all depressed ((laughs)) and you know sad and I'm not help- I'm not making the situat- their uh night out any better I mean it's you know I think it I think about you know all the what their perceptions of me and and how bad it's going to be if I'm a not as outgoing as I [usually am]

Figure 4.14: Women, Group 2 (22:45)

rearticulation—we can (and do) create hybrid texts and new meanings from the web of preformed significations that the systems provide. In this vein, the women in my study are not always passively accepting the categories assigned to them by the expert discourses of mental health professionals and symptoms lists. About an hour and a half into the Group 1 interview, I asked the women whether the information that they had sought about depression did any "good" for them. Paige and Claire both emphasize that the information seeking is part of "a process" for helping themselves (Figure 4.15). In this excerpt, Claire asserts that the symptoms lists provide a validation and explanation of one's feelings. For her, this signals a push to seek help from professionals for your symptoms—the discursive tools provide a way of recognizing the

Paige	Well the websites that I went to (1.6) didn't do any material good for me but it did, (x) it was part of the process that was for me a, a dealing with my problems. Um and so yeah in that sense it did help me.
Claire	you know when they list the symptoms its like if somebody feels sad but they're not sure if they're completely depressed so they go look it up and then you read all the symptoms and they, you're like oh I am depressed I need help. Whereas my mom would say something like oh you know any time somebody thinks there's something wrong with them and they read about the symptoms they convince themselves that they're that *is* their problem so I don't know if it's, for me I mean I went there I thought those were my symptoms and it helped me think (.) yeah this is a problem and it (.) I don't know if (xxx)

Figure 4.15: Women, Group 1 (91:15)

collection of symptoms as depression. Thus, Claire seems to be taking up the symptoms list as an occasion for self-diagnosis. This uptake explicitly rejects her mother's explanation of lists as self-fulfilling prophecies in favor of an explanation that gives Claire some definition control over her own experiences.

Beyond these engagements with the forms of the symptoms lists, the women in my study also struggled with the content of the lists themselves. Following the conversation reported in Figure 4.15, I asked whether there were symptoms that were not listed on the ads or web sites. The women's responses are included in Figure 4.16. Paige's response—that wanting to hurt herself—is not on the list of symptoms, is met with skepticism from Claire and Tiffany, who clearly see this as equivalent to "thoughts of suicide." Paige refutes this equation, however, and suggests that her feelings were more complicated than thoughts of death. Her initial response to my question suggests also that the popular listing of symptoms does not include suicidal thoughts. This is true in most of the pharmaceutical advertising—in these ads, there is rarely a mention of suicide or harm to self. Instead, these ads talk of "not feeling like yourself" and other euphemisms. Here, Rose's critique of projects appealing to a "unified coherent self-centered subject" is particularly relevant. Rose writes that such projects urge "each of us to assert our self and take responsibility for our self," further arguing that these promptings reveal a fundamental incoherence to the self rather than an idealized version toward which we should strive (4). In a sense, then, Paige understands the pressures of the norm of self-striving. If the lists included the symptom of wanting to hurt yourself, they would be in violation of the modern project of asserting a return to a unified self. Her elaboration in response to Claire and Tiffany is also telling in that it puts a more complicated interpretation on the symptom of thoughts of suicide.

Kim	Are there symptoms that you: feel that aren't listed? In the ads or on the websites? (5.2)
Paige	Wanting to hurt myself
Kim	Mmmmm
Paige	But they probably wouldn't say that otherwise people wouldn't go buy drugs [(that's a turn off)] |
Claire	[Aren't thoughts] thoughts of suicide on the list?
Paige	Oh I don't know
Tiff	Thoughts of suicide is probably on the list I mean
Paige	That's a hard one to admit to yourself and like thinking about suicide for me is not the same as wanting like wanting to hurt myself manifested itself in a lot of ways not just like physical
Claire	Oh
Paige	Like, likenot speaking to people

Figure 4.16: Women, Group 1 (92:13)

In order to qualify for my study, the women filled out the National Institute of Mental Health's Center for Epidemiological Studies Depression (CES-D) index. Similar to the symptoms lists being discussed in this chapter, this twenty-six question survey asks participants to rate how often they have felt a series of things over the past two weeks. I asked the women in the Group 2 interview explicitly about their experience with filling out this survey (Figure 4.17). At this moment, Stephanie relates her desire to check "between the boxes" on the form,

Kim	When you filled out in the screening materials for this study that symptoms questionnaire? Tell me a little bit about (.) your reaction to that. It was the check boxes, I've felt this way rarely, sometimes=
Steph	=I wanted to check between the boxes. Like okay, last week this happened, oh that's not quite the same the same as 3 or 4 it was kind of 2 and 3, I probably tried, but I- I've kind of forced them into categories for simplicity's sake (2.2)
Kim	And did you have any reactions to the particular you know I can't remember what all the
Steph	Yeah, thank god that doesn't happen to me ((laughs))
Mei	((laughs))
Kim	So, which ones?
Steph	Um, (1.0) I think mostly changing in eating habits and sleeping habits, cause my, I, I put on there that my sleeping habits are disrupted but that's because I've a back injury and I can't sleep anyway. And that al- also contributes to depression is *pain*.

Figure 4.17: Women, Group 2 (42:32)

suggesting that the form itself is not the most accurate of measures. Further, she describes her process of filling out the form as "forcing [her feelings] into categories." She also describes feeling thankful that she did not experience some of the symptoms. These reactions suggest an active, albeit a highly determined, engagement with the survey, rather than a passive acceptance of the categories and choices. A few minutes later, Mei describes the validating sense she got from the survey (Figure 4.18). Such validation seems to be a part of the rhetorical construction of experiences with depression; the language of symptoms provides assurance and explanation. In Figure 4.18, Stephanie and Mei discuss the symptoms questionnaire as having reassuring them that their experiences are normal. Mei in particular finds that the symptoms list helps her understand her own feelings. Thus, the power of the rhetorical construction is reinforced for her. She describes the process as "giving myself feedback on my own behavior." Similarly, Stephanie describes the process as a "convenient...compartmentalizing um experience" as "validating."

These productive uptakes of the symptoms lists indicate the operation of uptake's memory in selecting cultural models for self-representation.

Mei	Well I just I guess it was just nice like how oh, I mean if you asked me to write it out I might not have written all the symptoms? But then checking (the box) was like yeah yeah I do have that ((laughs)) and like=
Steph	=yes that, oh yea that on occasion too=
Mei	=yeah. So
Kim	That's I-
Steph	It was kind of a convenient compatment- compartmentalizing um experience. Oh (.) yes (.) this is what this is. Oh, wow, other people feel. This is so validating
Mei	((laughs)) yeah
Kim	interesting. So, do you remember anything in particular that you, that the [phrasing]
Steph	[um]
Kim	on the form
Steph	I think it might have been fear and hopelessness, I'm not sure if those two were on there, I know fear was I'm not sure it was helpless or hopeless or one of the two, something like that was oh (1.0) oh okay, it's not just that I'm actually think I'm a failure, it could possibly be that this is *weird*, this is not *normal*. Oh.
Mei	I think it was nice to- if I fill it, if I have to write down what symptoms I have then I *really* recognize it and then it's like oh yeah, so okay so I should uh eat more or something ((laughs)) or something like that you know just like, it I don't know. It helped me it's like giving myself feedback on the, my own behavior.

Figure 4.18: Women, Group 2 (43:47)

Conclusion: Routes to Healing

As this discussion of the women's uses of the symptoms lists has shown, these rhetorical constructions are viewed by the women as a tool through which they can interpret their own feelings. Far from being completely restricted by these lists, the women actively engage with the constraints of the lists in order to find common ground from which to speak about their symptoms. This project has sought to revalue the daily actions of individuals within and through the discourses that surround them. One of the most powerful pieces of evidence for the work that the women are producing is their use of metaphors of journey in their talk.[8] As Lakoff and Johnson have demonstrated, the metaphor of travel is highly productive in western culture. At times, the women used this metaphor for their own struggles with depression. Paige, who admitted to being seriously depressed a year prior to the interview, describes her recovery as "getting myself back on track" (G1 9:13). Conversely, Tiffany uses the metaphor of journey to describe depression itself, suggesting that she may not be as depressed as some of the other women in the group. She says, "Maybe I'm just not far enough along" (G1 44:34). In both cases, recovery from depression and depression itself are figured as pathways along which one travels.

Another place where the journey metaphor surfaces in these interviews is in the women's discussion of possible treatment options. The women discussed feeling at odds with their lives, of "lacking a direction in your life" (Mei, G2 48:42). Jennifer discusses wanting to seek out a mental health professional to gain some perspective on her life (Figure 4.19). Throughout the interview, Jennifer has talked at length about feeling ready to talk to someone about her feelings, about "reaching to the point of maybe I need to talk to a professional who *has* heard a lot of pro- you know these problems and can make some sort of generalizations or guide me to- to do the right thing to get me out of it" (G2 39:09). In the Figure 4.19, Jennifer talks explicitly about the

Jenn	[I think I just, I need to hear it's] reassurance because it's like maybe I have the solutions and I've thought about them, but I haven't- I just don't actively do them because I just want somebody else to tell me=
Mei	=So, yeah=
Jenn	=that it's okay, that it, that this is you know what you should do this is the path you should take instead of you know I might have three different paths and I'm just not sure which one you know, there are it's the decisions in life that you make and you want to make sure that you make the right ones, um (1.0) and not have any regrets, so, yeah=

Figure 4.19: Women, Group 2 (92:29)

numerous paths that she feels she is choosing between. She also talks about seeking the advice of a professional as "reaching a point", indicating that her struggles with symptoms of depression have brought her to a physical location from which a mental health professional might help her move on.

Beyond these indications of space, the women in the interviews referred to taking medications for depression as "going down that route." In the Group 1 interview, Claire relates a friends' experiences on Prozac, which make her "fearful of taking Prozac a:nd I was like there's got to be another way besides drugs" (G1 72:36). Here, Claire talks about wanting an alternative to drug therapy, another "way" to proceed. Similarly, Jennifer in the second interview talks about the medications, saying "They're a lot better now than they once were, um, but I didn't really want to go that route just yet, I'm , you know" (G2 5:39). In both cases, the "route" of drug therapy is not seen as desired direction, but both women see this as a potential option. I read these references to routes and pathways as hopeful—the women are visualizing options for themselves and their future. And, though they are suspicious of the drug therapies, they seem to be balancing and exploring a number of options.

In the next chapter, I ask the question of just how far along the "route" of drug therapy the women have actually traveled. While none of the women in my study were currently taking medication for depression, they were all well aware of the various pharmaceuticals. This awareness manifested itself in a variety of ways, both explicitly (in the women's abilities to name particular brands) and implicitly (in the women's uses of the biomedical model as explanatory). In the next chapter, I will ask how the language used by these women indicates a participation in the culture of drug therapy, and I will ask how this participation indicates uptake's practices of intertextuality and translation.

CHAPTER FIVE

INTERTEXTUALITY, TRANSLATION, AND UPTAKE

In the previous two chapters, I have argued that individuals participate in the dispersal of discursive power via the selections executed in their uptakes. Through uptake, topics are selected and carried into conversational negotiation. Further, as chapter four demonstrated, the memory of uptake, which functions as a constraint on the possible objects selected, operates multidirectionally and intertextually. Not only do individuals remember previous speech situations and generic activities when they engage in uptake, they are also influenced by the anticipation of future genre structures and dispositions. In other words, talking about depression is not simply a means of sharing one's own lived experiences, it is also a process of articulating those experiences in and through the discourses that are culturally available. Some of those discourses, moreover, may be future oriented, as in the anticipation of a doctor's questions before one visits the clinic. Thus, I have argued that, in the case of women talking about depression, conversational uptakes select and define the illness experience as gendered, isolated, and consisting of a set of discrete symptoms.

In this chapter, I consider a second mechanism implicated in uptakes: processes of translation. In Freadman's model of generic uptake, translations occur when genres are evoked outside of their intended settings, as when legal proceedings are imitated outside of the courtroom. Far from being an innocent—or in Austin's term, nonserious—utterance, such translations do impose power on the situation and its participants. In the case of conversation, such translations occur in moments of intertextual borrowing. Borrowing pieces of discourse from one setting into another is not a matter of simply importing words or phrases; rather, it is an inhabitation of particular subjectivities. Borrowing or inhabiting a particular set of discursive practices enables (and disables) individual (and collective) social actions. This chapter argues that intertextuality concretizes the workings of uptake. Intertextual references reinforce (or deny) individuals' roles as experts or novices, and they provide evidence of the effects of uptake in speech situations. Intertextuality substantiates the power of uptake; it provides the trace evidence of uptake's selection and definition of specific discursive objects. Further, it brings the subjectivities and dispositions of its former locations into the current moment. Thus, intertextual references are translated into new settings, and, in turn, exert additional translational pressures on those new settings.

Various post-structural scholars have viewed intertextuality in this dynamic way. To begin, Foucault provides a rationale for viewing all statements as part of a complex system of discourse. In *The Archaeology of Knowledge,* he writes: "there is no statement in general, no free, neutral, independent statement; but a statement always belongs to a series or a whole, always plays a role among other statements, deriving support from them and distinguishing itself from them; it is always part of a network of statements" (99). This definition of discourse as a web of interconnected statements helps clarify the idea that uptake's memory operates beyond individual speech situations. In other words, uptakes must engage with a whole structure of discursive options, and they are therefore socially and not purely individually initiated. Structures, for Foucault, extend beyond individuals' utterances to their historical and cultural situations. Thus, a single conversational uptake is implicated in a series of previous and future discursive realities. It cannot occur without responding to the statements that have already been made, nor can it occur without anticipating future utterances.

This sense of discourses as a series of interconnected statements is similar to Bakhtin's concept of heteroglossia and Kristeva's articulation of intertextuality. For Bakhtin, complex genres (like the novel) contain a multiplicity of voices, their language comes not from a single register or source, but is always inhabited by its context. "When a member of a speaking collective comes upon a word," Bakhtin writes, "it is not as a neutral word of language, not as a word free from the aspirations and evaluations of others, uninhabited by others' voices. . . .The word enters his context from another context, permeated with the interpretations of others. His own thought finds the word already inhabited" (*Problems* 202). This inhabitation of texts by others parallels the Foucaultian system whereby statements acquire meaning in their relationships, for Bahktin in their dialogues, with other texts. Thus, Bakhtinian heteroglossia involves multiple voices speaking through each text. For the concept of uptake, this multivocality is important because it allows broader agency for individual uptakes. One speaker's uptake is simultaneously her own and an articulation of a broader cultural memory.

In Kristeva's work, heteroglossia is transformed into intertextuality; voices speaking through a text are transformed into the references and citations that constitute all texts. Commenting on Bakhtin's theory of dialogic texts, Kristeva argues that "any text is constructed as a mosaic of quotations; any text is the absorption and transformation of another" (*Desire* 66). Nevertheless, such quotations are neither transparent nor simple citations. Rather, they involve both translation and transformation. In the process of their citation, texts are redefined within new speech situations. For Foucault, all utterances involve such processes of translation. He writes in *Discourse on Language* that "to speak is to translate what one knows" (209). Thus, for Foucault, speaking involves redefining and articulating the contents of discursive memory in each utterance. Similarly, Kristeva's theory of intertextuality involves the creation of new meaning *through* previous texts.

Norman Fairclough, in *Discourse and Social Change*, argues that "'intertextuality' sees texts historically as transforming the past—existing conventions and prior texts—into the present" (85). What becomes important for Fairclough and other critical discourse analysts is that these translations cannot be neutral. Fairclough writes:

> The relationship between intertextuality and hegemony is important. The concept of intertextuality points to the productivity of texts, to how texts can transform prior texts and restructure existing conventions (genres, discourses) to generate new ones. But this productivity is not in practice available to people as a limitless space for textual innovation and play: it is socially limited and constrained, and conditional upon relations of power. (102-3)

And thus, critical discourse analysts return always to issues of power and to abuses of it. For van Dijk, "CDA focuses on the *abuse* of...power and especially on *dominance*, that is, on the ways control over discourse is abused to control people's beliefs and actions in the interest of dominant groups, and against the best interests or the will of the others" ("Critical"). Through mechanisms (and abuses) of power, subjects are both formed and controlled and the textual components of this process form the basis for investigation.

For critical discourse analysts and literary scholars alike, the analysis of intertextuality is a political move. As Michael Worton and Judith Still, editors of *Intertextuality: Theories and Practice,* suggest: "The analysis of intertextuality...is inevitably political in its assertion that—at the very least—the 'textual' and the 'extra-textual' inhabit each other, or that—more radically—the 'extra-textual' is another kind of text" (33). Worton and Still see the "extra-textual" as the collection of cultural, social and historical beliefs and attitudes evoked within textual practices. Thus, norms and conventions are viewed as extra-textual objects, which are, in a theory of intertextuality, readable and analyzable. Thus, intertextuality radically disrupts the notion of a singular text and of a unified, guaranteed reception/reading of any text because both the production (writing) and the reception/reproduction (reading) of texts are imbued with the echoes of previous texts, social beliefs, values and so forth.

In the previous two chapters, I have argued that conversational uptakes in the interviews have constituted two such extra-textual objects: the emotional woman and diagnoses of depression. These objects are both authored and authorized in the discourses of individuals and institutions. This combination of agency—both individual and institutional—suggests that intertextual references are not entirely controlled by the individuals who articulate them. Fairclough reminds us that not all social actors have the same access to rearticulation via intertextuality. He writes: "The theory of intertextuality cannot itself account for these social limitations, so it needs to be combined with a theory of power relations and how they shape (and are shaped by) social structures and practices" (*Discourse* 103). I am arguing that the concept of uptake provides the necessary link between intertextuality and theories of power. Uptake is motivated by its memory, which is saturated with both cultural and individual historicity. Each person's uptakes are necessarily both the product of her generalized social status and access to specific systems, and the product of her individual history of generic interactions. The moment of uptake—a response to a situated exigency—both enables and constrains the utterance text that will be (re)produced. Uptake's cultural memory, like theories of hegemony, enacts particular power structures and limits the subjectivities of the interlocutors. Further, this memory articulates a situated practice of power that is flexible enough to account for a variety of multidirectional impositions. In other words, uptakes enable individuals to make sense of their experiences and to participate in social and institutional structures. These processes, always multiple, work simultaneously to limit and to enable discursive action.

Intertextuality and Traces of Uptake's Memory

Part of the hegemonic power of intertextuality lies in the ways that such traces of other texts and moments carry not only the echo of their former locations, but also the particular subjectivities arrayed around them. In other words, the recognition (conscious or unconscious) of intertextual borrowings is possible only through the appropriate shared knowledge. As Fairclough argues, texts postulate interpretive positions, and therefore subjects, capable of making sense of them (*Discourse* 135). To understand a text as coherent, one must inhabit a subjectivity with specific knowledge and attitudes about that knowledge. This positioning is key to Freadman's formulation of uptake: the selection and simultaneous construction of an object through discourse which instantiates genres as social actions. Uptake works not only on the object but also on the subject in that any selection is also a foreclosure of other possibilities. This is the bidirectionality of uptake. Intertextuality, then, becomes a trace of uptake's memory. Moments of textual borrowing signal not only the interconnectedness of discourses, but also the selective memory of uptakes. This memory justifies the choice of particular pieces of discourses and thereby constructs a worldview that enables certain subjectivities. Thus, an attention to intertextuality helps identify the quality of uptake's memory. The following section explores this definition of intertextuality as textual evidence for uptake's memory.

Chapter four addressed the differential power controlled by the women I interviewed. The mental health professionals, positioned as experts within the discourses on depression, demonstrated their abilities to diagnose and interpret symptoms. In this chapter, I begin my examination of intertextual practices with this group. For the mental health professionals, intertextuality works both explicitly and implicitly to affirm their disciplinary status. This first section thus explores how the mental health professionals position themselves in their talk, how they consciously reference additional texts, and how they participate in the circulation of the generalized biomedical and psychotherapeutic discourses. Following this discussion of mental health professionals, I turn to the interviews and to the intertextual practices of women suffering from symptoms of depression. In contrast to the mental health professionals, the women control very little power within the discourses on depression. Despite their first-hand experiential expertise, these women have fewer discursive options available to them. This section investigates how the women situate themselves as novices within the discourse, how they acknowledge a series of school and expert texts, and how they become mouthpieces for the biomedical and psychotherapeutic discourses. This analysis suggests that the available uptakes for women experiencing symptoms of depression are limited to those that maximize individual responsibility while minimizing collective support structures.

Noting specific references in the women's conversations to language common in direct-to-consumer (DTC) advertisements and popular media, this chapter concludes with an analysis of the epideictic rhetoric contained in DTC advertisements. In the context of current debates about the educational value of DTC advertising, this project offers concrete evidence of how individuals engage with the content of such ads. As chapter four demonstrated, symptoms lists have the power to structure and identify particular experiences as medically observable symptoms. Further, as the women articulated, this power can be experienced as both limiting and validating. Similarly, the women's uses of the language of DTC advertising are complex and, at times, ambiguous. As this chapter argues, however, the ads do little to empower the women within the discourses on depression. They do, however, structure and direct the way the women understand their experiences and treatment options. As such, DTC advertisements can be seen to be far more persuasive than educational. These processes of persuasion are amplified by the ways that the DTC ads translate traditional medical authority into the realm of consumer products. This is only one of the translations that occurs in the interviews under discussion here. As chapters three and four have demonstrated, the psychotherapeutic discourse of self-help has successfully been rendered commonplace for both professionals and women experiencing symptoms of depression. For the purposes of this study, however, I will focus on the translations and intertextual uses of one key phrase of the biomedical discourse, "chemical imbalance." As a case study, this phrase displays many of the operations of discursive power inherent in practices of uptake.

I will discuss two kinds of intertextuality in this chapter—the overt citation of texts and sources of knowledge beyond individual experience, and the seemingly unconscious use of words, phrases, and key terms from external discourses. The first kind of intertextuality, that which is explicitly marked and identified by the speakers, does much of the work of constituting the subjectivities of these speakers. As we will see below, the individuals help mark themselves as either "professionals" or "students" by the ways that they incorporate other texts into their talk. In his study of the expression of racial prejudice in talk, van Dijk notes the importance of people's attribution of pieces of knowledge to particular sources. "Using people's own accounts of their sources," he writes, "shows us when, where, how, and why such source mentions are made, and especially how people have interpreted, stored, and retrieved information attributed to specific sources" (*Communicating* 390). In the case of talk about depression, the women explicitly cite sources ranging form parents and friends to classroom discussions. These citations indicate the highly rhetorical nature of women's emotional experiences. Further, they provide evidence of the cultural memory motivating uptakes.

The second kind of intertextuality, citation of words, phrases, and imagistic language from various discourses, is a less conscious and therefore potentially more hegemonic operation. This quoting of other sources without attribution is indicative of the power of uptake's memory to naturalize some discursive objects as "common sense." Together, these two kinds of intertextuality provide traces of the available uptakes for each group of participants; as is reflected in the terms I have chosen to refer to these groups, the mental health professionals are situated as scholars, while the women are positioned as novices within the discourses on depression. In each case, however, I will demonstrate the ways that particular uptakes are prescribed for each group.

Disciplinary Uptakes

The design of this study, by purposefully recruiting a group of mental health practitioners, facilitated a collective identity for the mental health professionals as "experts." Further, in the opening of the interview, I acknowledged the expert status of these participants, asking "how you in your professional guise would define depression" (MHP 3:50). Thus, it is not surprising that this group of women defined themselves in terms of their work and expertise. Nevertheless, the mental health professionals reinforce their status through a variety of conversational strategies, including claiming the power to name, assess, diagnose, and treat patients. Further, the mental health professionals explicitly reference a variety of disciplinary sources of knowledge including journals, research studies, and conferences. Finally, the mental health professionals participate in the biomedical and psychotherapeutic discourses by defining their own professional work as productive of mental health. The following analysis draws on the mental health professionals interview to demonstrate these disciplinary uptakes and to explore the impact of recontextualizing such disciplinary knowledge on the expert subjectivities available to them.

The power to name is inherently the power to assert a set of subjectivities for your interlocutors. As part of their expert status, the mental health professionals clearly control this definitional project. About twenty minutes into the interview, I asked the group what they called individuals they saw in their professional capacity. As Figure 5.1 shows, there is general agreement that individuals who seek out these professionals are named by the professionals. Laurie, the psychologist, makes an interesting move at the end of this passage—she notes that there was a "consciousness raising" period when such individuals would only be called clients. This period was, apparently, a moment in time where patients asserted their right to name themselves. Nevertheless, Laurie finishes her turn by saying that she currently uses her own preferred term, "patients." Clearly, the mental health professionals have the power to name, and therefore the power to define those who seek their professional advice. At this point, I repeated my original question about who these individuals might be (Figure 5.2). Betty, the psychiatric nurse, is the first to respond to my question, which was reframed by Laurie as a request for a "portrait of an average client." Betty begins her turn by using the possessive pronoun *mine,* a move that is made at several points in the discussion. Laurie refers to her patients as "my depressives" (Laurie, MHP 42:17), and Joan describes the participants in parenting classes as "my parents" (Joan, MHP 115:55). Such uses of possessive pronouns further solidify the power

Kim	[...] What is your typical client or what's your, (1.5) Do you call them clients? Do you call them (0.7) patients? Do you call them (0.5) cases? I- I'm not sure what the right terminology is, but
Laurie	Probably all three
Others	Yeah
Laurie	At any point in time
Betty	I slip from one to the other
Laurie	I do too
Ellen	Well I say patients almost exclusively
Laurie	Yeah. I can remember it one time when, when consciousness raising was you gotta call them clients and they're always clients. Clients, clients (2.0) but now I call them patients all the time

Figure 5.1: Mental Health Professionals (21:57)

Kim	So who are they? Who do you work with most frequently just on a, since I
Laurie	Portrait of an average client?
Kim	yeah
Betty	Well, mine are um usually substance abusers and have a psychiatric diagnosis any kind of, any kind of psychiatric diagnosis, but most commonly bipolar disorder and schizophrenia. And some depression but not a whole lot.
Kim	Mostly men? Women? M-
Betty	Mostly men. (3.0)
Laurie	And all, and (x) a majority of them on public assistance
Betty	Oh yeah. They're all on public assistance. Except the ones that are in the walk-in clinic and they're applying for public assistance. They're trying to get *on* public assistance and so they come to us because they want us to give them that diagnosis that will get them on public assistance.
Laurie	Right
Betty	And so we have to pick out the ones that have a true diagnosis and those that are trying to get a diagnosis so they can get on funding and it's, um it's it's getting easier for me to pick those people out (.) in a crowd. I can spot 'em in a crowd ((laughs))

Figure 5.2: Mental Health Professionals (22:27)

differential between the professionals and their clients—a relationship that complicates notions of the ownership of illness experience. Betty continues describing her typical patient by asserting her ability to spot the difference between "a true diagnosis and those that are trying to get a diagnosis so they can get on funding." While all of the professionals were conscious of the inequities in insurance funding (as was evident in Figure 4.1), this statement nevertheless emphasizes both Betty's ability to make diagnoses (as is her professional role), and her ability to adjudicate eligibility for public funding. Ellen, the psychiatrist, is the next to describe her patients. In Figure 5.3, Ellen talks about "having a private practice" (ownership) and the people who are in that practice. Ellen's opening turn in Figure 5.3 is the first speech to follow Betty's laughter at the end of Figure 5.2—there is an intervening pause of several seconds between the two.

Ellen	Well, I um (2.0) work with um (1.2) I have a private practice and I do: uh drug studies at the U, um, in the drug studies I am dealing exclusively with people who are depressed. A:nd um so I would say that you know 80% of the people I see are depressed. That may be they're bipolar and depressed, but (.) they're depressed. Um (2.0) and, um (1.0) the, the in my private practice a fair number of people are um (1.0) dual diagnosis, they're also personality disordered but in the um drug studies they're (.) uh only um depressed. A:nd um um (1.0) so that's it's a, it's a interesting mix but I I would say that I you know see about (.) 40 patients a week a:nd um (2.5) at least 80% are depressed (2.5)
Laurie	Men, women?
Ellen	80% women. I don't, I don't see in my private practice I don't see people if they're uh co-morbid substance abuse and I also don't see people, um if I don't like them on the phone and um
Laurie	well, if you're up to 40 patients, you can do that
Ellen	Mmm Hmmm. And they're um um I, I don't see very many men, I just don't. They don't like me, I don't like them and um, um I do fine with the ones that I have but you know (1.4) um (2.0) it's it's kind of nice to be in that position I've done in-patient work with a lot of depression also um, depressed people and um (0.8) so I've, I've seen a huge spectrum of it from people who are catatonic a:nd getting ECT to mild depression

Figure 5.3: Mental Health Professionals (23:37)

In Figures 5.2 and 5.3, both Betty and Ellen start their turns with the contrastive discourse marker *well*. In both cases, *well* functions to justify the speaker's control of the floor, and it might also signal some discomfort with the task of defining "an average client." In subsequent responses to this request, Joan, the social worker, also begins with "well," and Laurie concludes this sequential answering of my question with, "And, mine would be a woman." Thus, this collection of turns casts the mental health professionals in the role of providing testimony or information to me, and they use the marker *well* as a means of indicating the start of turns relying on their professional expertise. This spirit of edification is echoed by Laurie's uptake of my follow-up question to Betty in response to Ellen's first turn in Figure 5.3. Laurie prompts Ellen with the question, "Men, women?" In this repetition of my own prompting of Betty in Figure 5.2, Laurie encourages her colleague to provide a full portrait, indicating her sense that Ellen's expert testimony was not complete.

In Ellen's description of a typical patient, she marks herself as an expert in a number of ways. As noted above, she explains that she has a "private practice," and she also carries out "drug studies at the" University. These job descriptions mark her as both clinician and researcher. Additionally, Ellen asserts her ability to choose patient—a right affirmed by Laurie's interjection that "if [she's] up to 40 patients [per week, she] can do that"—and to refuse to see those she does not like on the phone. Further, Ellen demonstrates her familiarity with a variety of illnesses and conditions, from "people who are catatonic and getting ECT [electroconvulsive "shock" therapy] to mild depression." In this statement, Ellen makes use of her professional gaze, she "has seen a huge spectrum", to corroborate her status as objective viewer. Other markers of her professional status include the use of percentages and phrases like "co-morbid substance abuse." Additionally, Ellen uses the verb "work" several times in this excerpt, as each of the women do throughout the interview. For the mental health professionals, "work" is a highly valued activity—they are respected for the work that they do. This will become important below, where the women seem to characterize their own "work" with friends as non-valued. As the previous two examples showed, the mental health professionals are composing themselves as those in power in interactions with individuals struggling with depression.

The mental health professionals position themselves as experts in relation to the discourses on depression. Even when Ellen reveals her own serious depressions, this personal experience is assimilated by the others into clinical expertise rather than left as experiential authority. When Ellen reveals that she is a sufferer of depression, her personal experiences are used by the group to elaborate on the appropriate use of drugs to treat depression. When Ellen talks of her own illness, she is very positive about her knowledge. As I demonstrate later in this chapter, such assurance is not characteristic of the women experiencing moderate symptoms of depression. Here, however, Ellen's statements are in response to a prolonged critique of the idea that Prozac has become a household name. In Figure 5.4, Joan begins by estimating that a quarter of her peers are "on either Paxil or Prozac." Her statement follows an extended turn by Laurie describing the number of her students who admit to taking antidepressants. The tone of this conversation is decidedly critical of the numbers of individuals receiving medication. Thus, Ellen's first turn in Figure 5.4 begins with a contrastive *well*, signaling her disagreement with the general feeling that antidepressants are being over-prescribed. The astonishment and laughter at

Joan	Probably just under a quarter of the people I know who are (2.0) twenty-two to thirty are on either Paxil or Prozac (.)
Betty	[a quarter?] |
Ellen	[Well I wish I had been at that age]
Laurie	((laughs))
Joan	just under probably
Betty	((laughs))
Ellen	no I was I was very sev- severely depressed at that stage and I
Laurie	and no one would have helped
Ellen	um well I I was in therapy and I was had a very severe post-partum depression and I spent most of a year trying to figure out how to kill myself. A:nd it uh would have been (.) *won*derful if I had had that and I'm one of these people that's gonna need to be on an antidepressant for the rest of my life 'cause I've had four serious episodes of depression and can (1.0) speak from what it really *feels* like to be depressed you know for *me* (1.0) um
Laurie	well and, and those those drugs weren't around when you were first depressed
Ellen	No. They weren't (2.0)
Laurie	you know I do think that that they have revolutionized the ability to treat depression
Ellen	Oh yeah, totally and [and it's wo:nderful]

Figure 5.4: Mental Health Professionals (88:25)

the beginning of Figure 5.4 appear to be in response to the number of Joan's peers who are taking medications. However, it also prompts Ellen to begin her second turn with another contrastive marker, *no*, signaling her desire to set her own experiences against the prevailing attitude of the conversation.

Ellen succeeds in taking the floor with her turn beginning, "No, I was...severely depressed at that stage." At this point, she is deferred to as the experiential expert, a role she assigns herself by saying "[I] can speak from what it really feels like to be depressed." Laurie's response to Ellen's story is to speculate on the availability of drugs to treat the illness at the time of Ellen's first depression. Laurie asserts that the newer antidepressants "have revolutionized the ability to treat depression." Thus, she repairs her previous overgeneralization about the use of prescription drugs and also brings Ellen's personal experience back into the professional frame of treating the illness. In Figure 5.5, which follows a few seconds after Figure 5.4 ends, Laurie continues to speculate on the question of when drug therapies are appropriate. Ellen refutes Laurie's implied claim that too many people are being prescribed Prozac. She uses her personal experience to suggest both that she was severely depressed and that she was reluctant to take the prescribed medication. Through Ellen's narrative, Laurie becomes convinced that drug therapy was appropriate for Ellen, leading her to ask, "Prozac's worked great for you, yeah?" Here, Ellen admits that, in fact, she's now taking a different antidepressant. This leads the conversation back into the professional realm, with Laurie's impression that "people are moving across the drugs." Laurie regains her critical stance on drugs by suggesting that this switching of medications may be due to "just a better side effect profile." Her implication is that switching medication only for fewer side effects is somewhat frivolous behavior. Ellen's response is again to offer an alternative reading, what she calls "the poop out phenomenon." Thought this is clearly not an expert term, Ellen reasserts her status as researcher by saying that she and her team are looking at this phenomenon in a drug study.

Laurie	[...] to me it's always that bugaboo (1.4) when ap*pro*priate it's a good drug it it is just tha:t (3.5) and maybe not so much any more but when it first came out half the world was getting prescribed it by people that weren't appropriate
Ellen	well I, I don't know I I wa:s um an intern at the time in internal medicine a:nd um I um would routinely go up to the top floor of City Hospital and we could get out on the roof and think about jumping. And on my call nights, and um um you know
Laurie	see you were appropriate
Ellen	and it wa:s um (0.2) I was prescribed Prozac and I was very uh adamant that I did *not* want to take this. I did *not* [want to take]
Laurie	[you're kidding]
Ellen	a medication hell no you know and um um I: reluctantly consented to do that for four weeks. And, um then about four weeks later one day (.) I heard myself laugh. And it had been so long since I had laughed and I just thought my God I'm laughing I haven't laughed in (.) so long there's something (.) that I think is funny and that's when I just became such a believer [in (trying)]
Laurie	[stayed on it]=
Ellen	=yeah yeah [how you know miraculous]
Laurie	[Prozac's worked great for you] yeah?
Ellen	well, actually, no it hasn't all this time. Now I'm taking Effexor but
Laurie	okay 'cause that's the other thing we haven't talked about is that that (.) it it does seem to be people are moving across the drugs=
Ellen	=well=
Laurie	=and I think sometimes it's just a better (x) side effect profile
Ellen	well it's also a poop out phenomenon and we're look at that with a drug study at the U

Figure 5.5: Mental Health Professionals (89:55)

Both of Ellen's short narratives about her own illness occur after moments when someone has suggested that antidepressants might be being over-prescribed. First, in response to Laurie and Betty at the beginning of Figure 5.4, Ellen begins her turn with the explicit negation, "no I was I was very sev- severely depressed at that stage." Similarly, after Laurie comments that "when appropriate" the drugs are a good thing, Ellen begins her next turn with "well I, I don't know." In both cases, Ellen is asserting her own personal experience against the statements of her colleagues. In Figures 5.4 and 5.5, Ellen uses her own personal experience to make a case for why antidepressant medications are both necessary and productive. The conversational negotiation among the mental health professionals, however, suggests that this personal evidence must be aligned with their own clinical experiences. Thus, in this interview, personal accounts are incorporated into the professional, disciplinary conversation.

Beyond personal examples, the mental health professionals use explicit textual references to affirm their disciplinary status. Not only do they reference scholarly studies and articles, they use these references in support of their own statements and assertions. For example, about eight minutes into the interview, Laurie, the psychologist, references a study "in JAMA? It was in something. Where they looked at how many of the people post 9-11 got put on Prozac or anyway one of the SSRIs. I mean the number was incredible" (MHP 8:20). JAMA, the *Journal of the American Medical Association*, is a professional journal unlikely to be read by average readers. In addition, Laurie describes the article by describing the study, not the text itself. She says that the authors "looked at how many of the people post 9-11 got put on Prozac", citing the scholarly metaphor of looking/seeing for research. She continues her discussion of the article with another scholarly move, critiquing it (Figure 5.6). In this response to the study, Laurie includes herself in

Laurie	=and it was like everyone assumed because they had been in that trauma that depression was going to follow. And that indeed there *weren't* moderating factors that could sustain people and that they'd need the meds. And so they almost prophylactically were putting people on meds. And so I mean I think that's sort of that that other side of the coin is that we know the meds do work and so I think we're much mo:re likely to use the meds and then if if it y'know if it *fails* look at something else, but (2.2)

Figure 5.6: Mental Health Professionals (8:31)

the community of knowers ("we know the meds do work") but also engages in a scholarly description of the phenomenon of increased prescribing of Prozac since 9/11.

At other points in the interview, the mental health professionals mark their disciplinary status. They reference knowledge that is being created through study as something they are collectively learning. For example, Laurie mentions that "we're just barely discovering how men and women are different biologically" (MHP 81:05). This collective knowledge making—indicated by the first person plural pronoun—is reinforced by references to professional meetings that provide a forum for new research. Ellen references a professional conference in response to a question from Betty about whether there is current research being conducted on the roles of estrogen in depression. Ellen response that "in all the meetings that I go to there's *a lot* said about the role of estrogen" (MHP 82:37). Thus, not only does Ellen use a disciplinary model in answering Betty's question, she also marks her own participation in a variety of professional activities. In these ways, the mental health professionals use other texts and activities to establish their expert status.

Collectively, the mental health professionals also work together to synthesize and discuss ongoing literature on exercise and depression. Such collaborative construction of knowledge occurs through citation and critique of research studies. Figure 5.7 occurs about an hour and forty minutes into the interview. It is important to recognize the differential power between Joan, the Masters of Social Work candidate, and the other mental health professionals. In this excerpt, Joan clearly marks herself outside the realm of scientific inquiry, yet she, too, participates in the analysis of current research. Joan introduces the topic of this discussion by relating a story she had read in a general interest women's magazine. Joan readily admits that she has heard this argument—that "exercise works" for depression—in "probably fifteen different places." This statement combined with her hedging ("I don't know" and "I mean"), rising, question intonation

Joan I, I've heard and from several different sources I'm thinking particularly I subscribe to *Self* magazine which is like a health and fitness magazine um about exercise versu:s drugs alone (.) That that exercise works. And I don't know if that's taking a population that's not *clinical?* Or what but I mean I've heard that probably fifteen different places

Laurie there- there's not there's not a chance in hell A number 1 you get someone who is severely clinically depressed [to exercise] I mean you know
|
Joan [well clearly]

Laurie [they don't have the energy they don't have the umph they don't I mean you know]
|
Joan [they have trouble getting out of bed yeah obviously yeah]

Laurie Alright let's all. So I mean there's that problem is if they're not treating the severe forms of [depression]
|
Joan [yeah]

Laurie the other thing is that they're really. That the literature is really pretty clear with the exercise programs. The ones that are really successful are the ones who exercise as a group where you get everyone together and they're exercising=

Joan =interesting=

Laurie =well gee is that because they're exercising?

Joan Yeah

Laurie [or is that because]
|
Joan [Mmmm Hmmm]

Laurie they're in a group interaction and a group process and they're doing group therapy

Others Yeah

Laurie and and of course the huge critique is they're being treated by group therapy=

Joan =Certainly=

Laurie =if you look at the indi*vid*ual exercise programs they don't look any different

Joan because I would even I mean just ob- obviously um having no like scientific background at all I would say that when you exercise you feel better about yourself you feel like you've accompli- like I would argue that that- that exercising makes you feel better

Figure 5.7: Mental Health Professionals (107:40)

("a population that's not *clinical*?") marks her as an outsider to the discourse of scientific study. In contrast, Laurie jumps in with an authoritative judgment, and uses hedges like "I mean you know" more as a solidarity maneuver than as a marker of uncertainty.

After Laurie's initial reaction to Joan's offered topic, she moves into a more disciplinary stance, citing "the literature" and providing commentary and analysis of what studies have shown. Laurie cites "the huge critique" of exercise programs, that the successful ones are closer to group therapy than purely exercise routines, as a self-evident piece of knowledge ("of course the huge critique is…"). These disciplinary markers—citing literature, providing critique and assuming membership in a community that has the right/knowledge for both of these activities—help reinforce Joan's position outside of the group to the extent that she then clearly sates that she has "no like scientific background at all." This statement prefaces her "common sense" argument that exercise does make one feel better, to which the other mental health professionals agree, but with the condition that this "doesn't cure the depression" in Ellen's words (following Figure 5.7). In this discussion of research connecting exercise to relief from depression, Laurie marks herself as a disciplinary insider, and Joan steps outside of her professional role, relying on common sense rather than on sanctioned research.

Even as Joan is thus made to stand in for an "unscientific" public, this conversation highlights a particularly scholarly engagement with outside textual evidence. Joan introduces something she has read, Laurie and others provide commentary and counter-evidence to bear on this example. Together, the mental health professionals synthesize and critique the published research on exercise and depression. Joan attempts to withdraw her statement that "exercise works" for depression in a turn following Figure 5.7. She says, "Whether or not that [exercise] has anything related to do with people who have clinical depression obviously sounds like it doesn't." At this point, Joan is responding to the weight of evidence against her original proposition, to "the literature" cited by Laurie. Instead of continuing to discount the theory that Joan introduced, however, Laurie shifts her critique to affirm the common sense notion that exercise does make people feel better. Joan's theory is not discredited entirely, and she is not allowed to withdraw the topic. Rather, her original statement is refined and clarified to fit the terms of the mental health professionals' expertise. They engage with this theory in order to more clearly demarcate the boundaries of illness and cure. Depression is not likely to be eradicated by aerobics, but a regular exercise program may make one feel better in the meantime. Thus, the collective response to Joan's topic is to situate it outside of the realm of clinical and research expertise, and to explore the disciplinary boundaries of treatments for depression.

Joan's status as a younger participant and also as a student is reinforced throughout this interview. Though she does contribute knowledge from her area of expertise, she is often silenced or ignored by the other participants, who have more medical training and more years of work experience. In many ways, interactions between Joan and the other members of the interview highlight the differences between members of a disciplinary community and students of those communities. In Figure 5.8, Joan introduces new knowledge about cultural factors that influence depression to the group. Here again, Joan's use of question intonation and her explicit reference to a class in which she had been a student mark her contribution as tentative. Nevertheless, the others agree with her in this case, and Laurie offers a corroborating story about collective community trauma in the case of Native Americans. What seems most striking about Laurie's contribution is that she identifies "some people that are interested in trans-generational trauma in depression." This statement clearly demonstrates intertextual knowledge (of work done on trans-generational trauma) and also links Laurie to a larger community (including "some people") of researchers. To some extent, Joan is doing the same thing when she refers to learning as a collective procedure at the beginning of her turn. Thus, the use of intertextual references by

Joan	an interesting thing we: I learned about last year in a mental disorders class was about (1.3) um the disproportionate amount of African Americans who are diagnosed um with psychotic disorders? And not with depression? And how like cultural factors can influence the wa:y groups will tend to manifest depression and a lot of things that are outwardly look like *anger* and *irritability* can be: depression and sort of a so- a reaction to you know racism institutionalized racism like the way people are treated. I thought that was really interesting too to think about (.) um maybe like a cultural difference in the way people would express depression
Others	mmm hmmm
Laurie	well and there's some people that are interested in the trans-generational (.) um trauma in depression in Native Americans. And I mean and they're really looking at at you know these kids who were shipped away to schools and were sexually abused we know now pretty pretty routinely and physically abused pretty routinely. U:m and and there it went on for their generation and their father's generation and their grandparent's generation and it's gone on five or six generations now and and sort of where that generational trauma and depression is leading. And and and then trying to look at *why* substance abuse is such a big issue. Well maybe it has to do with that the long term you know depressions these people have suffered

Figure 5.8: Mental Health Professionals (75:58)

the mental health professionals helps reinforce community membership. While Joan enacts her student status in this interview, she does not completely relinquish all claims to knowledge. She provides a lot of the back-channeled support for claims made by Laurie and others, and does therefore contribute to the knowledge creation that happens in this group.

In terms of their participation in the biomedical and psychotherapeutic discourses (as described in chapter one), the mental health professionals interact with these discourses through their professional status. That is, they seem often to disregard the biomedical solutions—as can be seen above by their skepticism and critiques of drug therapies—in favor of privileging the work that they are positioned to accomplish with their patients. While there is relatively consistent talk of drug therapies and the need for medications in special cases, the catch phrase of the biomedical discourse, "chemical imbalance" is used only once in this interview. Importantly, it is used by Joan, the social worker. In Figure 5.9, Joan's contribution—that one form of depression is related to "chemical imbalance"—is ignored. This occurs at the beginning of the interview, after I had asked for a definition of depression. Here, Joan's topic gets completely silenced. The general concern about when medication is indicated or useful remains on the table, but the idea of a "chemical imbalance" is neither acknowledged nor commented upon by the other mental health professionals in this interview. What is interesting to me is that this item—"chemical imbalance"—is clearly in play for Joan but not for the other mental health professionals. What is it, then, that stops the circulation of this idea?

Laurie	Yeah I mean I think I see that. I mean I have a lot of friends who I don't consider depressed at all, not a lot. I have some. Um and I also have seen some of my cl- well, clients that (.) that probably aren't depressed but they have a really good insurance. And you know and until that runs out, they will be able to get therapy for, for what they want and, and (x) well I should take, I (need to) go backwards. They are depressed. But they're not, they're not of sufficient depression to, to qualify under DSM. (1.8) But they're depressed. They're unhappy with their lives, I mean there is something in their life that's making them sad and all, bu:t (0.6) but do they probably need to be on the meds and have we, y'know for me is there good clinical research evidence that they oughta be on meds? No. (2.2)
Joan	Well and that brings up an interesting issue too because there's (1.4) for *me:* I feel like there's this sort of depression that's about like chemical imbal:ance and about needing a medi-cation and then I also feel like there is depression that's depression too, I mean it's not any less (1.2) life-impacting but that has to do more with life circumstances and with sort of things that wouldn't necessarily be fixed by medicine? And that wouldn't necessarily have to be fixed by medicine? and so (1.6) you know[(that's the distinction)]
Laurie	[well if you think of] they, they someone did a study. Was it in JAMA? It was in something where they looked at how many of the people post 9-11 got put
Others	[Mmmm Hmmm]
Laurie	[o:n Prozac or anyway] one of the SSRIs I mean the number was incredible=
Joan	=Mmm hmm=
Laurie	=and it was like everyone assumed because they had been in that trauma that depression was going to follow. And that indeed there *weren't* moderating factors that could sustain people and that they'd need the meds. And so they almost prophylactically were putting people on meds. And so I mean I think that's sort of that that other side of the coin is that we know the meds do work and so I think we're much mo:re likely to use the meds and then if if it y'know if it *fails* look at something else, but (2.2)
Joan	Well it's much [easier to use the meds]

Figure 5.9: Mental Health Professionals (7:01)

Part of the answer, I am suggesting, is disciplinarity. The other three participants in the study are clinical professionals: a psychiatrist, a psychologist and a psychiatric nurse. They are more heavily invested in the therapeutic discourses, and they are more controlled by the genre of the DSM-IV-TR. As chapter four demonstrated, the DSM-IV-TR organizes much of the discursive and material practice of these professionals. Thus, the DSM-IV-TR can provide an explanation of why the catchphrase "chemical imbalance" is not taken up by the medically trained professionals. The closest the DSM-IV-TR gets to describing the phenomenon of an "imbalance" in brain chemistry is this: "The pathophysiology of a Major Depressive Episode may involve a dysregulation of a number of neurotransmitter systems, including the serotonin, norepinephrine, dopamine, [and other systems]." The DSM-IV-TR goes on to list other systems that may be affected in depressed individuals, but concludes (with typical academic caution): "None of these changes are present in all individuals in a Major Depressive episode, however, nor is any particular disturbance specific to depression" (353). From this definition, it is clear that a simple "chemical imbalance" is an overly simplified description of the chemical processes implicated in depression.

In addition to the governing power of the DSM-IV-TR, the phrase "chemical imbalance" is not used by the mental health professionals because they are more invested in the ideology of the psychotherapeutic discourse. Though, as chapter one suggested, these two discourses are merging, the mental health professionals clearly prioritize the work of therapy over the synthetic solution of drugs. Nevertheless, as Ellen's personal narrative in Figures 5.5 and 5.6 demonstrated, the use of drugs is considered therapeutic in the appropriate circumstances. Joan voices the tension between pharmaceutical and therapeutic interventions in Figure 5.10. In this example, Joan expresses concern that individuals may lose the opportunity to develop "skills and self-knowledge" if they take medications for their depressions. Ellen refutes this claim, suggesting that medications may be necessary to enable "psychotherapy work." In Ellen's description, the merging of the biomedical and psychotherapeutic discourses is embodied by hybrid therapies, including both medication and talk therapy. In fact, she cites evidence that "structural brain changes" result from psychotherapy as much as from medication. In this statement, Ellen echoes Burns' Introduction to *Feeling Good.* Thus, the sense that depression is a malfunctioning brain provides interpretive power to both discourses. Nevertheless, it is clear in Figure 5.10 that the work of talking and understanding one's self is the primary mechanism of treatment for these mental health professionals. Joan describes necessary "skills and self

Joan	Well and I think one of the really important things that can come from a time like that in your life is that you can ga:in sort of skills and self-knowledge and. That's something that I sort of wonder about (1.6) in terms of the rate at which things get pre*scribed* is, I mean certainly people: who are severely depressed or not even severely depressed need relief from what they're feeling. But on the other hand, people who experience you know a life crisis (.) there's a great opportunity to become- to gain skills and to examine what's going on, I mean often depression is telling you something is not *right* in your *life* and if you ignore that and take a pill:, my sort of my social worky perspective is that you just continue to be living a life that's not meeting your need in some wa:y. And that concerns me.
Ellen	I, I don't think so. I don't think that that's um (2.1) what happens when you take a pill. A:nd um I find that a lot of people um (.) need to have medication in order to begin some psychotherapy work.
Joan	Certainly. [Certainly.]
Ellen	[And um] that they're still going to be unhappy and hurting but um they're then in a position where they can look back and observe themselves better and not feel so much [horrible shame]
Joan	[Absolutely] and, and I definitely thing that that happens for a lot of people. It's that first step that you need to be able to (.) start making the move towards bettering things.
Ellen	Mmm Hmmm. (.) I don't think that it's a um you know I don't think medication is a substitution for therapy at all um and in fact I think there's good evidence now that psychotherapy shows as much in the way of structural brain changes as uh medication does in some cases, but um (2.8) um (2.0) I and I, I *don't* see people avoiding things by taking medication, they may avoid it by using a substance, but I don't think taking Prozac lets them avoid (.) the issues in their life really

Figure 5.10: Mental Health Professionals (31:33)

knowledge," and the desired outcome of "making the move toward bettering things." Similarly, Ellen talks of "psychotherapy work" and the need for patients to "look back and observe themselves better." Thus, the psychotherapeutic discourse is affirmed and characterized as both work and observation. The ideas of developing skills and observing one's life further suggest that the proper management of depression is *self*-management. The mental health professionals characterize themselves as guides for their clients, but the burden of therapy rests with the individual patients. This emphasis on *self* is evident throughout all of the interviews in this study, and corresponds to an individualistic ideology that influences current concepts of health and illness.

After discussing the women's interviews, I will return to issues surrounding the use of direct-to-consumer (DTC) advertising. However, the mental health professionals refer to DTC ads in relation to their professional status and interactions. Thus, I will address some of those references here, before turning to the intertextual practices of the women I interviewed. For the mental health professionals, DTC advertising was brought into the conversation in relation to their work with clients. About forty-five minutes into the conversation, I asked the group about media portrayals and pharmaceutical advertisements. Ellen responds by mentioning the Zoloft advertisement (see Figure 1.4 for a print version of this ad). In response to this and other antidepressant advertisements, Ellen suggests that the images "cheapen and minimize symptoms and makes it look as if its' really very easy u:m just to not worry any more" (MHP 45:34). This critique focuses on the downplaying of symptoms and the assumption that a cure might be "easy." In Figure 5.11, Laurie comments directly on the way that such advertisements affect her relationships with clients. She argues that the ads are "intrusive, particularly because they direct patients to go *tell* your doctor." Such directives encourage individuals to submit themselves to the medical gaze. However, as Joan points out in response, this may actually be a positive step that encourages patients to seek help. The mental health professionals generally acknowledge that the ubiquity of pharmaceutical ads has made it easier to talk about depression, but they are very cautious about the benefits of such texts.

Laurie	[...] I also find it intrusive between my relationship with a patient to have them tell (.) the patient what they need to know so they go in and go *tell* your doctor
Joan	I think though that there's also a positive to (.) the commercials in that they may be the thing that gets somebody to go see someone
Ellen	That's, that's I agree with that. And that they also make it acceptable.
Joan	Mmm Hmmm
Laurie	True
Joan	Now that there's a really wide recognition=
Ellen	=Yeah=
Joan	=that depression exists and that some people you know at least, at least uh lip service to the idea that it's not someone's fault
Ellen	Yeah

Figure 5.11: Mental Health Professionals (47:01)

The DTC advertisements direct patients to submit themselves to the medical gaze, but they also represent a source outside clinical medicine for disseminating information about health issues. In Figure 5.12, Betty describes an ad that warns patients of harmful side effects. In her experiences, this ad has encouraged many patients to ask questions about their medication and to submit to necessary tests. In describing this phenomenon, Betty suggests that patients are taking a more active role in their own healthcare. This is evident in the way she reports a typical encounter: "all of the people [...] have come in [...] and said I heard this medication affects your liver, what're we gonna, what're you gonna do about that?" Though the plural first-person subject slips into the second in this reported speech, it is clear that such encounters are promoting renewed interested among patients about their own healthcare. Following the excerpt in Figure

5.12, Betty concludes that the ad "gets them to go and do the labs" thereby making her job easier. In these ways, the DTC ads are transforming the doctor-patient interactions, even assuming some of the traditional authority and expertise of health professionals themselves.

Betty	I don't watch commercial TV, I only watch PBS or movies so I don't know what these commercials are like. But I have sure had clients come in and ask me for a specific medication because of a commercial that they saw. And the other part of it that I think is kind of interesting is there's I guess there's some commercials out now about Serzone and the, the toxic liver side effects. And I've had people who are on Serzone in fact most of my clients who are taking Serzone come in to me and say I saw=
Ellen	=yeah, [I saw this, should I be worried?]
Betty	[on TV.] Do I need to be worried about it? And [I think]
Laurie	[interesting]
Betty	that's great
Ellen	I do too
Betty	because, because then I can say sure we just need to do liver function tests every once in a while why don't we do it today?
Laurie	And that's why you ought to do liver function tests
Ellen	Mmm Hmm Yeah
Laurie	Interesting. 'cause I had never seen that (0.7) I mean that- when I hear the side effects it's like oh my god why would I ever take one of these drugs, but you, so you're not 'cause I don't see people on drugs 'cause they're excluded from the study so (.) people actually come in and, and
Betty	all of the people
Laurie	use the information
Ellen	oh yeah
Betty	Uh hunh. Yes all of the people I've had on Serzone have come in at one point or another and said I heard that this medication affects your liver, what're we gonna, what're you gonna do about that?
Ellen	Yeah. Is it- should I keep taking it? you know? I hear that there's, yeah.
Betty	So I think that's OK.

Figure 5.12: Mental Health Professionals (48:10)

Much later in the interview, I asked the mental health professionals what changes they had seen since the introduction of Prozac and other SSRI antidepressants. Figure 5.13 includes their remarks. Primarily, as Laurie points out, the mental health professionals find that it is easier to talk about depression now. Ellen admits that she would not have disclosed her own depression to a similar group ten years ago. Joan reiterates the comfort that her peer group feels about

Kim	um have you noticed (0.3) changes in the way we can talk about depression since the SSRIs [became?] |
Laurie	[yes]
Kim	So what are the changes?
Laurie	A) you talk about it
Ellen	I would never have said that I have a history of depression in a group like this ten years ago
Betty	Mmm Hmmm it's much more accepted now. With all the commercials on TV=
Joan	=Mmm Hmmm
Betty	and everybody has access- so easy access to antidepressants that it's kind of OK to be depressed, I think
Laurie	Or at least it's certainly OK to be on depressive drugs. I don't know that people under*stand* dep- you know the lay person understands depression any better but they think it's OK to be on depressive drugs so they think that (1.5) depression's OK somehow
Joan	well I think generally I mean in terms of just like my social reference group like (.) I mean the only way that I *know* that probably just under a fourth of the people I know are on Paxil or Valium is because people talk about it and it's talked about in a really non stigma I mean you know. People talk about, oh I have this huge anxiety problem or you know gosh this past year I've just felt just totally wro:ng you know and I finally, you know am seeing someone and so I definitely think that at least for depression and anxiety there's a whole lot of recognition that A) that that happens to people and B) that you can deal with it with medicine and therapy and (.) that's just the people that I like hang out with and spend time with that's really
Laurie	I also think that's a real different generational thing
Joan	I'm sure

Figure 5.13: Mental Health Professionals (97:57)

discussing depression and anxiety. Though these comments are not attributed directly to the surge in DTC advertising, that connection was made elsewhere in the transcript. What Figure 5.13 shows, however, is that the increase in people taking and talking about antidepressants has decreased the social stigma attached to depression and anxiety. Yet, as Laurie suggest, this acceptance is additionally a generational phenomenon.[1] Further, the comments between Betty and Laurie about whether it is *depression* that is more acceptable or whether it is *antidepressants* is a question that is often overlooked in arguments about the value of DTC advertisements.

The use of intertextual references, both explicit (e.g., research citations) and implicit (e.g., therapy as "work") in the talk of mental health professionals primarily function to reinforce their professional and expert status. Through their conversation, the mental health professionals asserted their control over issues of diagnosis and patient selection. Further, the discussion of hypotheses like the link between exercise and depression relief occurs within the framework of research and academic documentation. These qualities are in marked contrast to the modes of intertextual references employed by the women experiencing symptoms of depression. In terms of the recontextualization and translation of the mental health professional's uptakes, most of the instances discussed here have drawn on resources from the system of discourses defining their professional lives, and few surprising translations actually occur. When Ellen describes her personal experiences with depression (Figures 5.4 and 5.5), there is the possibility that the conversation will be modified away from the professional register. However, Laurie's comments draw this narrative back into the frame of professional discourse. Thus, in this case the power of translation can be redirected by other participants. For the group of women suffering form symptoms of depression, however, translations occur between the discourse of psycho-pharmaceutical advertising and the conversational self-representations. The women, as the next section argues, are less able to direct the impact of such translations.

Experiential Uptakes

One might assume that the women experiencing symptoms of depression who were recruited for this study would provide evidence of their experiential authority. However, the setting of this study on a university campus contributed to the women's inhabitation of student subjectivities. Further, as a group of individuals experiencing symptoms but not being clinically diagnosed, these women were to some extent unsure of their authority to speak about depression. A final complicating factor is that depression itself seems to be characterized by a loss of self-confidence, and therefore, the women's positioning of themselves as students and novices is not unexpected. Nevertheless, there is a striking difference between the experts's professional self-representations and the ways the women reiterate their novice status in these interviews. The following section examines the two interviews with women experiencing symptoms of depression for the ways that this novice status is maintained through intertextual references.

The women suffering from symptoms of depression in my study made very few claims to expertise, even while referencing their own personal experiences. One of the striking features of their talk was the shift from the personal pronoun ("I feel") to a universal ("you feel"). Part of what marks depression is a disinterest in oneself, and a distancing from one's feelings, so this grammatical shift is not unexpected in the women. Nevertheless, it also works with other discourse features that indicate a novice or student status. One of the recurring parts of the consumer interviews is an appeal to outside experts—this takes the form of either references to mental/medical professionals or to outside peers, family members, and friends. Although family members and friends are not exactly experts on depression, the women in these interviews often placed such individuals in the roles of advice-giver or therapist. In this way, even a family member is often granted a measure of authority or interpretive power that the woman denies herself. In Figure 5.14, Claire responds to my question of who the group talked to about their feelings. She references both an intimate confidant, her fiancé, and a more traditional expert, the counselor. In Figure 5.14, Claire suggests that she can talk about her depression with her fiancé because he has "seen [her] cry" and knows some of her emotional history. Thus, her personal relationship provides support when she is feeling down. Nevertheless, Claire wishes that she could afford to go see a counselor. In such a visit, Claire would expect the counselor to "give me their feedback," indicating work beyond understanding and empathy. These two kinds of talk are thus of different value to Claire: from her fiancé, she expects support; from a counselor, she expects feedback and advice.

Claire	I can talk about it with my fiancé because he he's seen: me cry: and he knows the issues that are bothering me and I can talk to him about (xxx) and and I don't have any friends that I can talk to about it and I wish I could afford to see a counselor but I can't right now (2.0) if I could I would talk to them about it and uh want them to give me their feedback

Figure 5.14: Women, Group 1 (26:36)

Much later in the interview, Claire returns to the topic of consulting someone about her feelings. In Figure 5.15, Claire talks about two separate times when she has sought counseling.

Kim	Do you guys have experience with the doctors here? Have you talked about any of these feelings with a doctor?
Claire	I was in last month I went to Campus Health and talked to a woman in there and she asked me questions and I told her my symptoms which are all on the list and (1.0) she didn't you know say you're depressed she said (1.0) she said it sounded that way and, and recommended counseling and medication
Kim	Hmmmm
Su	So how do you feel? (xxx) do you think you need that kind of help?
Claire	When I went to a counselor once (.) a couple of years ago and (1.0) she kinda put together her own theory of what was going on and it had nothing to do with what I, what I *knew* was making me upset and so I mean I know it just helps me know to talk about it but (.) like the medication I'm still not sure if (0.8) if that's what it's going to come down to if that's what I need.

Figure 5.15: Women, Group 1 (85:01)

In response to my initial question about whether or not anyone in the group had consulted a doctor, Claire makes an interesting narrative move. She describes her encounter with a health care provider who asked questions and then seems to affirm Claire's own self-diagnosis of depression. According to Claire, the health care provider "didn't you know say you're depressed, she said...it sounded that way." This would seem to affirm Claire's interpretation of her own symptoms, yet the health care provider does not make a specific diagnosis. Nevertheless, the health care provider is the one who had both the power to affirm Claire's self-diagnosis and the power to recommend treatment. Following this turn, Su-Ting asks Claire if she agrees with the health care provider's recommendations for seeking help. Claire avoids answering directly by telling another story of an encounter with a counselor a few years earlier. In this encounter, the counselor "creates her own theory of what was going on" for Claire. This theory, according to Claire, "had nothing to do with what I what I knew was making me upset." But, Claire continues in the same breath that "I know it just helps me know to talk about it"—seemingly contradicting her own judgment that the counselor's scenario was not accurate.

In a move that similarly relinquishes power, Jennifer, in the second consumer interview, talks about needing a "professional" to help her gain insight into her feelings. After a long description of talking to friends, Jennifer concludes that "maybe I need to talk to a professional who *has* heard a lot of pro- you know these problems and can make some sort of generalizations or guide me to- to do the right thing to get me out of it" (G2 39:00). Later in the interview, Jennifer talks about wanting a professional to help her clarify her plans (G2 92:00). In both instances, Jennifer relies on the psychotherapeutic discourse to define the help she wants: guidance and clarity. In a more straightforward example of deferral to expert authority, Mei states that she would talk to a general practitioner about her feelings "if I wanted to ask his advice of whether I would need to seek some help maybe" (G2 40:00). In both of these cases, the women defer to the expertise of mental health professionals; they characterize such encounters as providing "feedback," as "guid[ing] me" and as offering "advice." These forms of interaction mark some forms of "help" as work and therefore more highly valued. The notion of value is both affective and monetary as Claire's statement in Figure 5.14 demonstrates.

In addition to appealing directly to professionals, the women in my interviews used other people as guides on their depression. There were several references to friends and family members' theories and ideas about depression. In the second interview, there were several theories attributed to individuals outside of the interview, suggesting the need for social support and guidance. At one point, Jennifer talks about a friends' theory that tutoring others could help one feel less depressed to which Mei agrees that it is one way to feel better (G2 20:45). At another point, Stephanie relates a conversation with a friend that she has found useful in understanding her own depression (Figure 5.16). Ultimately, Stephanie agrees with her friend's (external) character assessment, but she agrees with it only after "step[ping] back" and "thinking about it for *months*." These distancing moves, both physical and temporal, accomplish a necessary objectivity for Stephanie. She is not ready to accept her friend's statement in the moment, but has had time to consider its validity since the conversation. Further, in retelling this story in the context of a study interview, Stephanie is able to use the reported speech of another to make a statement about her own depression. This indirect statement indicates a desire to gain authority from outside sources. In the Group 1 interview, Claire makes references to her own mother's interpretations in a similar way. About forty minutes into the interview, Claire uses her

Steph	My friend Jill said something to me that was very useful, she's the one that that takes the Zoloft and is um suffers from depression too. She said, you know, you're too hard on yourself. The reason you're depressed is that you're too hard on yourself. And I, I stepped back from that and I've been thinking about it for *months*, I mean she said that I don't know six months ago, I'm still thinking about it. (1.0) She's right.

Figure 5.16: Women, Group 2 (94:07)

mother's judgment—that she dwells on sad things—as the interpretation of her action (Figure 5.17). In this example, Claire seems to be agreeing with her mother's assessment. However, about half an hour later, Claire rejects her mother's belief that positive thinking is the answer to depression (Figure 5.18). In this turn, Claire articulates a classically depressed outlook on life. "Why be optimistic?" she asks. Claire's rejection of her mother's philosophy stands in for her rejection of a broader range of cognitive therapy, which emphasizes the need to change pessimistic patterns of thought. For example, Ellen McGrath describes the importance of avoiding "emotional victimization," in her self-help book *When Feeling Bad is Good*. "How we think determines how we feel," she writes. "If we think like victims, we're going to feel like victims" (105). As Claire's own experiences have shown her, however, this simple solution is not failsafe. Nevertheless, part of her rejection of this philosophy, embodied by her mother, is undoubtedly an effect of the illness itself. Thus, the control Claire asserts over definitions serves only to further define her as depressed and therefore less powerful. For other women in these interviews, a similar pattern holds. Others' ideas are rejected at times (a sign of discursive control), but this never occurs when the judgment is a negative assessment of the depressed individual.

Claire	When I get sa:d ((sigh)) I don't try and ignore it or do something else I my mom used to tell me that I like *dwell* on it. So I'll put sad music on and read some sad poems and *think* about it until I make myself cry and cry about ((breath out)) it and

Figure 5.17: Women, Group 1 (38:32)

Claire	I don't know um like (1.2) the thinking negatively and versus thinking positively I mean I my mom thinks that it is that easy to turn the switch and if you think positively, things will begin to look that way ((laughs)) and I mean I kind of I'm going against that cause like I feel like well why be optimistic if in the end it doesn't turn out the way you want it and so you're back where you started.

Figure 5.18: Women, Group 1 (70:31)

As I have so far argued, the two groups of study subjects position themselves very differently with regard to their own expertise and their entitlement to speak about depression. The mental health professionals signal their professional status in a variety of ways, including demonstrating their control over naming patients and choosing which patients to help. Additionally, the mental health professionals characterize their interactions with patients as *work*. Thus, they describe their own efforts as part of a system of productive labor. In contrast, the women experiencing symptoms of depression were more likely to seek professional advice or expertise than to claim these activities as active work on their parts. And, thought this is likely a result of their depression and not necessarily a reflection of all of the uptakes potentially available to them, the fact that these women do not claim much authority is indicative of their perceptions of their rhetorical options. Thus, the interviews included in this study reinforce a model of social interaction wherein experts have the power to define and interpret the behaviors and feelings of patients.

The women, despite being among peers, choose to represent themselves as almost exclusively students and tentative knowers. As seen in the previous section, the women are unlikely to claim authoritative knowledge, even of their own experiences. In moments of explicit intertextuality, moments when other texts or authorities are invoked, the women often place these sources in positions of power. While these choices may be one of the manifestations of the women's struggles with their illness, they are also indicative of the kinds of uptake available to these women. When asked what materials they had read about depression, the women seem most comfortable citing textbooks and informational web sites. In the Group 1 interview, I gave several examples of possible texts that the women may have seen. In Figure 5.19, the women discuss two very different sources of information. Su-Ting initially brings up textbooks as a source of knowledge, but when questioned about what these books say about depression, she says, “it’s hard to understand.” Similarly, when Tiffany brings up Freud, the women share a mutual dislike for him, primarily (for Tiffany at least) because he is required reading for a class. This emphasis on classroom learning and knowledge is echoed throughout the interviews; it is perhaps an artifact of the way subjects were recruited (via flyer on and around a university campus) and the way the interviews were conducted (participants knew I was a graduate student and researcher). The student subjectivity that the women inhabit is likely also part of the powerlessness that characterizes depression. It is also, however, one of the few subject positions available to individuals who are experiencing symptoms but are not under the care of a doctor.

Kim	So let’s talk a little bit about stuff you’ve read cause I’m an English major, and we read stuff, so what have you (0.4) read about (0.3) depressions, emotions, any of those things and anything is fair gam:e billboards (.) you know self help books, memoirs, websites. What kind of stuff have you looked at? Or been told to look at? Or or stumbled upon?
Su	Psychology books (xxx) I mean in the college [class]
Tiff	[yeah] that’s some of the stuff I looked at (.) oh and Freud and I hate Freud [that’s only because]
Paige	[yeah ((laugh))]
Tiff	I have to read him ((laugh)) sorry [(xxxx)]
Su	[It’s really] hard and I don’t know what he thinks about=
Tiff	=yeah I don’t really yeah (xxx so I don’t think that counts?)
Kim	So what do the psychology books sa:y about depression?
Su	Some the:ories and um it’s hard to understand but I need to remember all of them, you know. I think I would like things more clinically yeah. It’s hard to, I think the theory is hard to apply to um my study (1.7) it’s just too abstract I don’t know (4.0)
Claire	You know like brochures and websites that list the symptoms

Figure 5.19: Women, Group 1 (55:34)

Even more straightforward informational genres like the “brochures and websites” that Claire mentions above are designed to list and define the symptoms and therefore place the reader in the position of learner with respect to her own experiences. She consults such materials in order to recognize and categorize what she is feeling. Thus, when the women are asked to take up the topic of depression, one of the few positions the discourse seems to allow is that of student.

For Stephanie in the Group 2 interview, the student subjectivity seems most comfortable. She references a psychology class as the author of some of her knowledge; saying "I read somewhere probably back in that psychology class I took" (G2 11:37). Thus, textbooks and course materials, serve as one of the main organizational tools for knowledge about depression for women like Stephanie. She continues to reference courses she has taken, citing them as giving her a frame from which to interpret events and cultural values. In particular, she cites various Women Studies courses. In Figure 5.20, Stephanie makes the argument that depression is a learned behavior, an inevitable consequence of not being able to live up to society's demands for beauty. Stephanie ends this turn by back-pedaling, saying "that's that's what I've heard. And read." Thus, she is able to advance the theory without claiming it for herself. The women in this interview spend several minutes talking about whether or not this theory (about women's self-image) is true for them. They do not, however, discuss this theory in the context of other theories or research, as the mental health professionals do above. As the discussion continues, Stephanie is asked whether men face the same pressures as women. Again, she reframes her answer in terms of classroom/expert knowledge by saying "what [she has] read, heard, been lectured to about" men (Figure 5.21). Stephanie takes expert knowledge as the starting point for a discussion. She does not, however, offer any sort of critique of that knowledge based on other

Steph	U:m:, women studies have told me: that it's taught and that self-esteem of girls once they reach puberty plummets and it doesn't do that for boys and a lot of a lot of the um texts say that it's body image. And the the demands on women to be *pretty* be *what*ever society wants them to be are so great that girls don't meet them and get depressed. That's that's what I've heard. (1.8) And read.

Figure 5.20: Women, Group 2 (56:38)

research. Instead, she provides a personal example as commentary on the expert knowledge. In Figure 5.21, Stephanie also performs the gendered role of relationship work. She minimizes the negative judgment of her last boyfriend by saying, "he's very *if you want to use the word* feminine." Clearly, she is distancing herself from such judgments, a move that is enhanced by her following comments about the boyfriend's security in himself. Nevertheless, Stephanie concludes her turn with very broad statements about men in general. This intertextual reference (to lectures and coursework) serves as a point of personal reflection and not an engagement with a scholarly or disciplinary community.

Steph	Um, to address your question about men, what I have read, heard, been lectured to about is that men also face incredible societal pressure to be something. A:nd usually they achieve it unless they resist it, which some men do um (versus) my last boyfriend who's a very emotional guy he's (1.6) he's very if you want to use the word feminine, he is um but he's but he doesn't consider himself less of a man because of it, he's just that secure in his person that he is. Um I think, I think okay um that a lot of men are insecure a:nd that society says that they shouldn't be emotional because women are like that and there's also that negative tune that's put on emotional, that men shouldn't be that because they're *men*. That um, men don't (.) want to be looked and seen as *weak* and *feminine*.

Figure 5.21: Women, Group 2 (59:58)

The women's uptakes of depression place them in subjectivities without much power or control over interpretive schemes. This becomes more obvious when the uptake are no longer marked or attributed to outside sources. At times, the women incorporate words or phrases associated with the biomedical and psychotherapeutic discourses. These moments provide a site to view the power of translation across settings. By drawing on these discourses, the women call forth the attitudes and presuppositions of the discourses. Uptakes of phrases like "chemical imbalance" demonstrate the reframing of the women's experiences in terms of the larger biomedical discourse. Such uptakes have become commonsensical to the women and to society's understandings of mental health and illness.

The Practice of "Common Sense"

Common sense maxims provide one place to analyze the workings of hegemonic power. For Fairclough, the "ideologies embedded in discursive practices are most effective when they become naturalized, and achieve the status of 'common sense'" (*Discourse* 87). Thus, common sense may be read as the ultimate colonization, to use Chouliaraki and Fairclough's term, of thinking. Nevertheless, as Billig et al. have argued, common sense is inherently contradictory. Citing such opposing maxims as "absence makes the heart grow fonder" and "out of sight, out of mind," Billig et al. suggest that "[t]he contrary themes of common sense provide more than the seeds for arguments; they also provide the seeds for thought itself" (17). In Jonathan Shotter's interpretation of this argument, "lived ideologies gain their power to motivate interminable argument just because they do *not* consist, in *systems* of thought, but in 'themes' with mutually contrary sub-themes to them, such as freedom *and* necessity; individual *and* society; subjectivity *and* objectivity" (69). Thus, for Shotter, "common sense is a great repository of culturally developed, two-sided resources" (174). This "dilemmatic and rhetorical nature of thinking" (Billig et al. 6) offers an explanation for why uptakes may appear to be contradictory. Further, it suggests such contradictions are inherent in all social interaction.

This view of common sense helps explain how both the biomedical and the psychotherapeutic discourses are used as resources in the women's talk. Though these are, to some extent, competing explanatory and treatment possibilities for depression, individuals are likely to draw on both as the situation changes. Thus, the uptake of both discourses by one individual signals not the "hopeless confusion of common sense" (Billig et al. 16), as some social psychologists would read it, but rather as the natural outcome of an active, thinking, social subject. Nevertheless, when individuals do not consciously acknowledge the contradictory ideologies of their common sense beliefs, they are liable to be co-opted by those ideologies.

Thus, I turn now to moments of unacknowledged intertextuality to explore how the women make use of and are used by the discourses of depression described in chapter one. As these discourses (the biomedical and the psychotherapeutic) are reframed through intertextual borrowing, the women participate in an uptake of ideology that constructs both their understanding of depression and their views of themselves.

The discourse of mechanical, biochemical realities, was quite evident in both of the interviews I conducted with women suffering from symptoms of depression. In the excerpt below (Figure 5.22), Stephanie and Jennifer respond to a question from me about whether there are "kinds" or "types" of depression. Stephanie speaks first. In this example, she makes a distinction that is affirmed by all of the women in my study—that there are gradations to depression. For her, *depression* itself is a more persistent form of "everybody's occasional blues." Jennifer affirms this definition, but adds the biomedical component to it by suggesting that there must be "some chemical imbalance of some sort." Here, the two women areconstructing a definition of clinical depression that places it in the extra-ordinary realm of brain chemistry and extreme sadness.

Steph	Um, clinically, I read somewhere probably back in that psychology class I took a million years ago about really hard-core depression that was the things like you don't function in society to: things like SAD which I read more about, seasonal affective disorder. Um, which I seem to think I had until: this (.) last go around of it and I don't really know um (1.4) and that I, I assume that some people well, everyone gets depressed on occasion but I assume that depression is persistent and that's what makes it different from everybody's occasional blues. (3.9)
Jenn	I guess I think about it as if it's um clinical in the sense that it, it (1.0) not *must* be but I, I guess yeah that there's some chemical imbalance of some sort.

Figure 5.22: Women, Group 2 (11:35)

In Figure 5.23, the connection between drugs as therapeutic for depression and the identification of "chemical imbalances" is made explicit. This comes from the Group 1 interview, after I asked the women whether or not they used the word *depression* to describe their own feelings. The interaction between Su-Ting and Claire demonstrates the link between the biomedical discourse and its implied solution (drugs). When Su-Ting suggests that Claire might try medication for her symptoms, Claire makes the immediate link to "if…you've like a chemical imbalance." The connection between drug therapy and the model of a neurochemical imbalance is clearly made for Claire in this interview, as it is for others as well. Her response to Su-Ting's suggestion is also similar to Stephanie's and Jennifer's definition of "clinical depression" (in Figure 5.22, above)—Claire seems to believe that medication will only work if one has a chemical imbalance—something that she is not sure that she has. In both of these examples, the phrase "chemical imbalance" is used to demarcate a specific, clinical (or more serious) form of depression. This is the key phrase of the biomedical discourse of depression.

Su	Yeah because one of my relatives are diagnosed (.) were diagnosed depression or bipolar or yeah I don't know what the diagnosis but I know she was hospitalized so I don't like to use the word depression to express this feeling because I think people must be insane or need to take some medicine, yeah (.)
Claire	yeah, that's what my mom says=
Tiff	=Mmmm hmmm
Claire	when I when I tried telling her I really wanted help I wanted a friend to, talk to and she's like it's a *mental* issue Claire and (2.2) why can't you just fix it yourself? she? acted like (2.2) it's all in your head she said but I didn't think that that was the case ((breath out))
Su	(then maybe?) medication can help (1.3) I don't mean you should try I just say (1.0) it's (if that could help)
Claire	Yeah if it's you've like a chemical imbalance (.)
Tiff	but sometimes it's not
Claire	yah (well I don't know how you) know unless you try the medication and it works or something

Figure 5.23: Women, Group 1 (22:51)

The combination of a mechanical metaphor ("chemical imbalance") and a convenient commodified solution seems both "obvious" and "natural" to the women. Nevertheless, the women in my study are not always so convinced by this discourse. In the Group 1 interview, Paige talks about her suspicions of the drug companies and other "consumer" discourse. (Earlier in the interview, she confesses to not trusting "medical language" and "the language of capitalism".) She proceeds to explore the notion of "chemical" imbalances in an extended monologue (Figure 5.24). Here, Claire questions Paige's statement that "offering drugs" with the symptoms lists (as in drug commercials on TV) is not helpful for individuals. Claire asks: "What if it's chemical?" Paige's response deconstructs the notion that depression might be "just chemical" in words that echo Andrew Solomon's. In his "atlas of depression," he attempts to debunk the myth that serotonin levels are directly responsible for depression—the "it's just chemical" explanation. He writes: "'I'm depressed but it's just chemical' is a sentence equivalent

Paige	Well I think that it is different for every person and that's why I sometimes feel like (.) that's why I *always* feel like (0.4) offering drugs with the symptoms is a way to get around finding the solutions that people need.
Claire	(Don't you, what if) it is a chemical?
Paige	It *is* chemical I mean like I don't know biology enough to know (1.0) what (.) the neurological processes that are going on. But neither do the scientists involved. Like these pamphlets that my doctor gave me, but I don't know they were um (1.0) the ones that are always advertised: Zoloft and Xanax and um Pro-zac um and they had you know like the little drug company write ups on on each one and (1.2) In some way they affect serotonin and the way that they affect serotonin is unknown in the language of the drug companies. And like it's, it's *clear* that there's something in my mind, a chemical process in the mind that has something to do with the way I feel because that's what (1.0) that's what the chemical (.) equivalent of emotions is, is some sort of chemical process in my mind. But if (0.3) if you can convince yourself to be happy there's a chemical process that goes with that (2.0) and if you can convince yourself to change the way (.) the ways you think or the things that you do (1.0) that contribute to you feeling sad, that's also a chemical process. So it's a chemical solution the same as (.) as taking a pill except that, I mean, this is my theory ((laugh))=
Claire	=Is that what you did after that summer?=
Paige	= [Well (.)]
Claire	[You kind] of just talked yourself out of it?

Figure 5.24: Women, Group 1 (62:10)

to 'I'm murderous but it's just chemical' or 'I'm intelligent but it's just chemical.' Everything about a person is just chemical if one wants to think in those terms" (22). For Paige, as for Solomon, the so-called solution of "it's just chemical" is not an adequate response. Paige rejects the notion that depression is somehow simply chemical are therefore not under her conscious control. In response to Paige's "theory," Claire makes an interesting move, referring back to a "bad summer" during which Paige had been very depressed. Claire asks if Paige "kind of just talked [herself] out of it." Here, it seems that Claire is picking up on Paige's statement that "if you can convince yourself to be happy" you will affect the chemical balance(s) in your brain. For Claire, this equals "talking yourself out of" your emotional state. Statements like these participate in the psychotherapeutic discourse.

In the interviews, the women also gave voice to the discourse of therapy and self-help, particularly in reference to their own experiences with symptoms of depression. This discourse is characterized by references to talk as work and as a process through which one can learn a new set of skills or new ways of dealing with the world. In Figure 5.25, Mei begins by suggesting that if she herself does not have a chemical imbalance, then she should learn how to "deal" with her feelings. What is interesting in this example is the way that both Mei and Stephanie are mirroring the language of self-help and cognitive therapy. They rely on the ethic of individual effort, signaled by the repeated use of the personal pronoun *I*. Stephanie says that "depressed people just take [negative events] much harder than everyone else." Further, both she and Mei talk here and elsewhere in the interview about needing to "learn how" to deal with their emotions. Mei says: "you just need to I mean learn to think about things or to talk through things." Similarly, Stephanie talks about "skills that you need." This rhetoric of learning and developing skills is exactly the language of cognitive therapy. Burns writes, in the introduction to his book: "Instead of moping and feeling miserable, you can now proceed to get better, using the methods outlined in this book." (27) Here, and elsewhere in the book, Burns sets out methods and techniques that can help you overcome and transform unhealthy cognitions. These methods include recognizing negative thinking patterns and training yourself to stop them.

Mei Yeah I think if I mean if there is no chemical imbalance in my mind then I should be able
to control my feelings and if I can't *learn* to do that then how am I? I mean I don't want
to, am I going to be on antidepressants for the rest of my life? [Then]
|
Steph [That's] also very
unacceptable=

Mei =Yeah, so I mean it's just you just need to I mean learn to, to think about
things or to talk through things and do it. I think you need to heal yourself or at least you
know through (.) therapy or, or with friends or with a health care professional. But I
don't think drugs are, I mean if you're suicidal. Or if there was like a you were going to
cause any harm to yourself or something then I think you should take 'em but (.) I mean,
you know if your mother died or something and then you're really depressed, I don't
even know if that's a whether you would want to take antidepressants because then
[I mean you need]
|
Steph [(You need to work through it)]

Mei a you need to work through your feelings you need to=

Steph =(like you don't) I guess it's also
(those ones who) deal with learning how to deal with negative impacts on your
[li:fe]
|
Mei [You need to learn]

Steph It seems that depressed people just take them so much harder than everyone else and
maybe it's just a, a lack of being able to deal with them and that there's skills that you
need or that you lack. And that taking drugs won't help you deal with it.

Figure 5.25: Women, Group 2 (73:44)

The psychotherapeutic discourse is particularly prevalent in the interviews—the women talk about *talk* as an important component of healing from depression. They do not, however, seem to consider the kind of talk that the interviews represented as the same kind of therapeutic endeavor. Neither do they consider talking with friends to be healing in the same way. Although this is found by most of the women to be a way of alleviating some of their symptoms of depression, it is not a "skill" or a "technique" of healing. Instead, the women collaboratively develop a version of talk-as-therapy that differentiates it from everyday conversation and discussion.

Consequences of Intertextuality

The uptake of these two discourses on depression has serious consequences for the women I interviewed. In the case of the biomedical discourse, the repeated use of the phrase "chemical imbalance" helped the women demarcate levels of severity for their depression. In the following excerpt from Group 2, I asked the women how they would know if they had a chemical imbalance (Figure 5.26). I asked this question near the end of the interview, after the phrase "chemical imbalance" had been used several times by the participants. In this excerpt, it is important to notice that both Mei and Stephanie begin by denying their ability to diagnose themselves. Mei goes so far as to suggest that there might be "tests they could do," referring to hypothetical tests that doctors could perform and interpret. Similarly, Stephanie overlaps this turn of Mei's by saying "we're not shrinks," again disavowing any expert status. In response to these statements, I rephrased my question, giving Mei and Stephanie permission to tell me their thoughts by saying that I was not "looking for the medical answer." In the second half of this excerpt, Mei and Jennifer assert definitions of more severe depression as potential markers of a "chemical imbalance." This is somewhat surprising because the notion of "chemical imbalance" is often perceived as the least self-blaming of depression's causes. One might assume that a "chemical imbalance" would be a preferred explanation, because it signals a mechanical rather than a character fault. Yet, only one of the women in my interviews (Stephanie, Figure 5.26) seemed comfortable using this terminology in reference to herself. Though she admits that she thinks she has a "chemical imbalance," Stephanie is nevertheless unwilling to seek a pharmacological solution. Thus, none of the women in my interviews characterized themselves as both chemically imbalanced and in need of drug therapy. Many of them did, however, wonder if drugs would be necessary in the future. Drugs become a contingency plan, a last resort if things were to get too difficult. The danger of uncritical applications of the biomedical discourse is that it promotes an over-confidence in the drug therapies as an ultimate solution to depression. In Figure 5.26, Stephanie seems to be relying more on the psychotherapeutic than on the biomedical discourse when she suggests that she "should be able to deal with" her depression

Kim	So, how would you know if you: had a chemical imbalance? What, [how would you?]
	|
Mei	[I don't know how] to diagnose it ((laughs)) so
Others	((laughs))
Mei	I don't know, I mean aren't there tests they could do? or I mean? I'm sure cause (2.5) actually yeah, I don't know, [I don't wanna I don't want to]
	|
Steph	[(We're not shrinks) we don't know]
Mei	guess anything so
Kim	I'm, I'm not looking for the medical answer I'm more looking for what you think, uh?
Mei	Oh, like when should you, when would you know that *maybe* it's a chemical [imbalance?]
	|
Kim	[yeah]
Mei	I don't know. If you. Maybe if its' really long term. If there's like nothing going on in your area like, nothing special or horrible be like nothing um
Steph	Well, I honestly do think I have a chemical imbalance sometimes, but I, like I say, I think I should be able to deal with it myself and that's why I wouldn't go and seek help. And somehow I *do* deal with it and I *do* have good days so I guess that's kind of a measure of success.
Jenn	I don't know. I think if the people around me really noticed that I really needed help and um and they were honest enough to say something about it (1.0) um and maybe noticed you know something in my personality that was way different, then maybe I would consider you know um seeking help and (1.5) considering you know, I don't know what the symptoms would be but it would just be so: far different and so extreme

Figure 5.26: Women, Group 2 (76:09)

herself, and earlier in the interview, when she describes her depression as a "character flaw" (G2 50:33). For all of these women, then, both the biomedical and the psychotherapeutic discourses are implicitly drawn upon to help structure the possible responses to and interpretations of their experiences with depression. For Mei and Jennifer, a "chemical imbalance" is likely a more severe depression, and it is also something that the medical world can treat. This is implied both by the tests Mei believes are possible (no physical tests exist at this point, because there is no threshold level of serotonin) and by Jennifer's suggestion that she would consider "seeking help" if her friends noticed a personality change in her. For Stephanie and others, the psychotherapeutic discourse works to convince her that she must deal (alone) with her depression.

The psychotherapeutic discourse also demarcates two kinds of work with relation to depression. The women talk of using friends to discuss and work through their problems. For example, Mei speaks of needing friends to "talk my things, my feelings through" (G2 26:57), and she wants her friends to "help me help myself feel better" (G2 27:09). Here, friends are helping her manage her feelings, but this is nevertheless different from seeking professional help. In a professional sense, help is characterized as advice, perspective, and guidance. Thus, the medical encounter is clearly marked by a power differential that is absent from the cooperative help offered by friends. In addition, terms from popular psychology and self-help are commonly borrowed in the interviews. For example, Paige wishes she were "better adjusted" (G1 80:09), and Mei describes the feeling that "You're still lacking a direction in your life" (G2 48:42). These terms are far from transparent signifiers of specific conditions; rather they bring with them a commitment to self-help and also to self-blame. This desire to fix a faulty self is expressed by many of the women I interviewed. In Figure 5.27, Stephanie is talking about light therapy for seasonal affective disorder, something her mother has suggested she should try. In this excerpt, Stephanie expresses a desire to "fix herself," and Jennifer is looking for "a philosophy, a way of life" in bookstores. These expressions of dissatisfaction with themselves work to reify the individual, solitary nature of depression.

Given that the women in my study are bound primarily to these two discourses of depression—the biomedical ("chemical imbalance") and psychotherapeutic ("talk therapy")—the question arises where do these discourses originate? In the case of "talk therapy," the source seems relatively clearly drawn from cognitive therapy and mainstream versions of it like Burns' *Feeling Good.* In the "biomedical" discourse, however, the origins are not as clear. While neurotransmitters such as serotonin seem likely to be the province of the medical community, the phrase "chemical imbalance" is not. In a brief search of Lexis-Nexis categories, the phrase is used very infrequently in medical journals (Table 5.1). In general news media, however, the phrase co-occurs with the term "depression" much more frequently. Beyond popularizations, there is another realm in which "chemical imbalance" is a familiar phrase: pharmaceutical advertising. In all of the interviews that I conducted, when I asked about advertisements, most of

Steph	She says oh yes, insurance will probably pay for it. Okay that's nice ((breath out)) I I don't think I'm: desperate enough to d- go that route, cause I still think I can fix myself I se- I seem to think it's a character flaw rather than a clinical thing which could be part of it. I don't know. (3.0)
Mei	Yeah, I don't read too much texts on ((laugh)) depression yeah 'cause I don't, (1.5) well, unless, y'know for my own interest but then I I don't yeah I don't feel like I need to I need to get help so that I (x) go research on, on depression, I haven't done anything like that
Jenn	Hmmm, I didn't do anything more intense than just what was on the web and um the words that were used here today are are on on those websites as well and they have al- these little surveys that you take um ((clear throat)) The thing, y'know, what I was always seeking out in the bookstores was a philosophy, a way of life of living=
Kim	=mmm?=
Jenn	=y'know and maybe change my attitude in some way um (0.8) but never really seeking out um textbooks or, on depression or (0.7) or any kind of literature um (1.9) I guess Time magazine had something on anxiety the other day or the other week, um so I read that but (1.0) didn't really affect me in any way. Didn't tell me anything that

Figure 5.27: Women, Group 2 (50:21)

Table 5.1: Collocation of "Depression" and "Chemical Imbalance"[2]

CATEGORY	*1987-1991*	*1992-1996*	*1997-2001*
Medical Journals	1	2	6
General News—Major Newspapers	56	228	341
General News—Magazines & Journals	10	13	31
News Transcripts—All Transcripts	0	28	111

the women remembered seeing the Zoloft ad with the spherical creature against a black background. While most of these references were to the television versions of this ad, a print version has appeared in a variety of magazines, including *Time*, *Newsweek*, *Self* and others (for one version of this ad, see Figure 1.4).

In the Zoloft ad, the phrase "chemical imbalance" is linked with the sketched drawing of "depressed" nerve cells, which have only a few bubbles of serotonin moving between them. On the right, "With Zoloft," the cells are returned to a more healthy (or crowded at least) level of serotonin bubbles. While the women in my study were not necessarily in favor of this depiction of the "chemical imbalance," they all seemed to take it as a medical fact. Mei thinks that the commercial does a bad job explaining the imbalance and that viewers might not understand the "cartoon." Nevertheless, when I asked her how she might know if she had a "chemical imbalance," she suggests (Figure 5.26), "I don't know, aren't there some tests or something?" This is significant because she is clearly collapsing the rhetoric of the advertisement with established medical knowledge (and testability). Thus, the cautionary modal in the advertising copy—"depression *may* be related to an imbalance"—is ignored by Mei and others in their understandings of depression. The women in my study use the phrase "chemical imbalance" for the most part unconsciously, and they seem to associate it with the "expert" discourse of medicine. And, while Paige's protests about everything being "chemical" suggest that there is room for the women to contest the implications of the phrase, there is little evidence in my study that shows the women actively constructing alternative explanations for depression. For current debates about the value of DTC advertising as a vehicle for patient education, these findings are significant.[3]

Supporters of DTC advertising suggest that it supports an "empowered consumer" model of education for more people, a democratization of health care. In addition, proponents suggest that it helps prompt more discussions between patients and physicians. Opponents, on the other hand, suggest that DTC might interfere with the physician-patient interaction because it requires physicians to dissuade patients from attachment to a particular drug/brand. In addition, opponents argue that the actual educational value of DTC ads is low, while the marketing value is clearly proven. In a 1999 FDA survey, 72% of respondents recalled seeing or hearing an advertisement for a prescription drug, and 54% of those would be "very likely" to ask a doctor about the drug if it were for a condition bothering them (Office of Medical Policy). Given that in 1999 $1.8 billion was spent on these ads, there is good reason to be concerned about the value of this expenditure. Nevertheless, according to Blankenhorn, Duckwitz, and Sherr, "When asked what it was about a particular ad that motivated respondents to discuss a medication with their doctor, one respondent in the IMS HEALTH survey answered, 'hope.' For the empowered consumer, healing begins with hope borne of knowledge" (4). Given the ongoing professional debates about the power and value of DTC advertising, one of the rich analyses this study can offer is of individuals' responses to these texts.

In the Group 1 interview, DTC advertising was taken up as a topic for discussion near the end of the interview. In Figure 5.28, Paige introduces the Zoloft advertisement after naming three main antidepressants. (The women's abilities to name specific drugs is another indication of the power of marketing; the drugs named in my interviews were primarily the most widely advertised: Prozac, Zoloft, and Paxil.) In Figure 5.28, Paige and Claire collaborate on a description of the Zoloft commercial. While Paige identifies with the character—the intended translation from screen to viewer—Claire focuses on the explanation of the "chemical imbalance." In both cases, the women apply aspects of the commercial to their own daily lives.

Paige	I think those are the big 3. (2.0) Zoloft has a commercial with the little [guy]
Claire	[Yeah]
Paige	Who bounces arou[nd and]
Claire	[yeah] and explains the you know chemical imbalance, how it works
Kim	What do you think of that commercial?
Claire	It made sense to me for [some reason]
Kim	[The diagram] or the little, guy?
Claire	The, the diagram I was like (.) okay there's not really anything going on in my mind that I should be this depressed about you know I haven't I have it going really well right now so why do I feel sad? *Maybe* it's a chemical imbalance. (4.0)
Tiff	I've never seen this commercial, so
Paige	It's cute
Tiff	((laughs))
Paige	Actually like I don't like to look at it because I really identify with it so it makes me think (.) (xxx)
Kim	What's what do you identify with it or
Paige	about being a little rock who's bouncing into the game and can't smile even though there's a pretty little stick bird or whatever
Tiff	Ohhh

Figure 5.28: Women, Group 1 (86:29)

Nevertheless, the group was not universally positive about these advertisements. As Figure 5.29 shows, Paige is very conflicted about the motivations of the producers of these texts. In this excerpt, Claire points out that the advertisements themselves promote awareness of possible cures, and Paige admits that her own internet research was "part of the process" of her healing. That both of these women experience the DTC advertisement as potentially useful suggests that women's uptakes of such media are motivated by a desire for self-awareness. Yet, these uptakes are not without consequences; the translation from marketing materials to self-representation involves a foreclosure of other potential explanations for one's experiences.

Claire	well that's the *only* way I heard of Zoloft was from seeing the commercials (4.1)
Paige	I guess that's why I I'm naturally distrustful of (1.2) the medical industry um and I'm also distrustful of commercialism (.) and capitalism
Others	Mmmm
Paige	so: like commercials even when I identify with the Zoloft commercial, I identify things that I look at it also really pisses me off because it's *not* like the guy who made that wants to get in my life and help me out. He wants to fucking sell me drugs you know like u::ah
Tiff	that's true
Kim	Do you think those things do (.) any good?
Paige	What things do [you mean?]
Kim	[The] like those commercials and and websites and things
Paige	Well the websites that I went to (0.6) didn't do any material good for me but it did, it (x) was part of the process that was for me a, a dealing with my problems. Um and so yeah in that sense it did help me.

Figure 5.29: Women, Group 1 (90:19)

In the Group 2 interview, Mei describes a similar Prozac advertisement depicting the transfer of serotonin between nerve cells (though she admits later that it may in fact be a Zoloft advertisement). In Figure 5.30, Mei is critical of the effectiveness of the ad, despite its success in getting her to remember it. Her response to the "cartoon" is that "it wasn't very interesting." Further, she argues, the advertisement did not provide information about the effectiveness of the drug. Thus, for Mei at least, the DTC ad does not offer the empowerment of education. Thus, in both of the interviews conducted for this study, women are both aware of the marketing of antidepressant medications and making use of the information in those advertisements. They are also conflicted about the value of such advertising.

Mei	Well I saw the one on Prozac which was kinda funny they like, they outlined like the chemical basis for the function of Prozac. I was like, well? ((laugh)) I mean most people won't know what the heck that that's going on, what's going on or (.) um I don't think it was very effective advertising ((laughs))
Kim	Yeah can you describe it to me?=
Mei	=It was uh, so they had a little cartoon drawing of serotonin coming out from one y'know neuron [and then]
	|
Kim	[uh hunh]
Mei	there's little blocks so that you know serotonin like so what Prozac does is um it (x) it keeps the concentration of serotonin in the synapses of the neurons high so that you know the effect of serotonin lasts longer that it usually does. So they just had a cartoon of that happening and I don- It wasn't very interesting, first of all, people probably changed the channel and then um, and too, I don't think it was, I mean it didn't really say- talk about like how effective it was rather than it just talked about how it works and

Figure 5.30: Women, Group 2 (53:21)

Both groups of women and the mental health professionals found some merit in the practice of advertising medications: patients are encouraged to seek treatment and follow-up procedures, the general public has an easier time discussing mental health issues, and individuals can learn that their experiences have a diagnostic label. Nevertheless, all three groups were suspicious of the power of such advertising. Given the potential for identification with the images in the ads, this suspicion seems justified. Not only do the advertisements medicalize everyday emotional experiences, they tend to portray women as troubled, anxious, and in need of therapeutic intervention.

The use of the phrase "chemical imbalance" is one of the most consistent findings of this study. It speaks to the authority and power of biomedical explanations of depression, and it organizes alternative responses like the psychotherapeutic assertion that talk therapies also promote "structural brain changes." That this phrase is borrowed freely and often into the talk of individuals indicates that the predominant habitus encourages practices of discrete, scientific intervention into emotional and mental health experiences. The use of this phrase additionally points to the trend toward self-diagnosis via symptoms lists documented in chapter four. Such intertextual borrowings do more than indicate a system of interrelated genres; they also define and limit the possible subjectivities for patients and experts. The necessity for the mental health professionals to justify their work as having effects equal to (or greater than) the pharmaceuticals indicates the power of the biomedical discourse. Similarly, the unquestioning faith the women place in drug therapies leads them to reserve such treatments for future use (if necessary). The rhetoric of imbalance—whether chemical or hormonal—participates in a long history of regulating women's more volatile bodies. As the key phrase of our understanding of depression, "chemical imbalance" offers quantitative containment of an individual's defect, and thereby suppresses social and environmental explanations. The biomedical discourse offers limited subjectivities for both experts and patients; it is a discourse that should concern all of us, as it increasingly defines experiences of both health *and* illness.

Conclusion: The Translations of Intertextuality

Intertextuality, the interconnections and citations among texts, is a multi-layered process of translation. In overt or explicit intertextuality, individuals consciously attribute their uptakes to external sources. In the interviews conducted for this study, women experiencing symptoms of depression used this form of intertextuality to make assertions without claiming full responsibility for authoring them. In some cases, classroom knowledge was used in this way to provide answers and interpretive frameworks. In other moments, the women drew on the theories of friends and family members to make sense of their experiences. Both forms of attribution suggest that the women were inhabiting a student or novice subjectivity. While the context of the study undoubtedly contributed to this phenomenon, the discourses on depression also make this a likely subject position for women to inhabit. As chapters one and three argued, women are targeted with a variety of messages about their emotional and mental vulnerability. Combined with the rhetoric of "consumer empowerment" via DTC advertising, such messages place women in a discursive position first to gather information, but then to submit to the medical/institutional gaze for appropriate diagnosis and treatment. For the mental health professionals in this study, explicit intertextuality was used as a means of solidifying professional (and academic) status. Citing professional conferences, research studies, and collective medical knowledge, these women clearly inhabited privileged positions within the discourses on depression. The criticism they collectively leveled at DTC advertising and over-prescribing of pharmaceuticals (especially by general practitioners) is further evidence of the work being done in these conversations to maintain discursive and professional control over definitions of depression.

Implicit intertextuality, the unconscious use of words and phrases from pharmaceutical advertisements and the discourses on depression, was also evident in all of the interviews. For the mental health professionals, references to the "work" of psychotherapy and to the skills of diagnosis and therapy worked to further define their professional roles. For the women experiencing symptoms of depression, implicit intertextual references carried much stronger ideological implications. This is not to argue that the mental health professionals' talk was somehow non-ideological. In fact, their professional status is very dependent on the maintenance of the psychotherapeutic discourse, as this chapter has demonstrated. Rather, the apparent greater impact of implicit intertextuality on the women is an artifact of the design of this study. The mental health professionals interview was designed and carried out to gather professional information form these individuals. The conversation was thus abstracted both from their own lives (for the most part) and also from the specifics of individual patient encounters. In the women's interviews, however, the questions and conversations were more intimately connected with lived experiences. Thus, more of my own analytical attention has been focused on these women's talk.

In this study, women experiencing symptoms of depression made implicit intertextual references to both the biomedical and the psychotherapeutic discourses. They used phrases like "learning how to deal" with their emotions, and talked of "skills" that they wanted to develop. These psychotherapeutic phrases necessarily invoke the personal, isolated nature of individual healing. Further, the use of the phrase "chemical imbalance" without marking its sources indicates that these women have also incorporated the explanatory frame of mechanical malfunctions in their understanding of depression. These unconscious citations work together to shape the women's possible responses to their own experiences: Stephanie feels she might have a "chemical imbalance," but she also feels her depression is a "character flaw"; Claire is unsure whether she "dwells too much" on sad things or whether she needs medication for her symptoms. These contradictory uptakes make clear the opposing dispositions that inform our current daily practices. And, as Billig et al. point out, these contradictions are inherent in the processes of thinking and arguing toward new solutions.

In addition to these contradictions, this chapter has argued that intertextuality is also the practice of translation. Just as uptakes from each discourse bring with them the consequences of that discourse (e.g., self-blame as one result of the psychotherapeutic discourse), the process of citation translates in two directions. The citation must be translated *into* the current discursive moment, but it must also occasion the translation *of* the current moment. In other words, intertextual references may be used in creative and new ways, but they are not free of their original dispositions. Further, some translations cross generic boundaries. These translations, as Freadman demonstrates, often appear innocent or non-consequential. However, they often impose the greatest power on their subjects. In this study, the DTC advertisements seem to perform these kinds of translations. Borrowing the authority of medial and scientific discourse, they seek to translate themselves into a professional/diagnostic subject position. Additionally, in the women's identification with the advertisements, they adopt the role of consumers, accepting the authority of the advertisements. In these ways, intertextuality becomes a trace and a catalyst of the translational power of uptakes. This project suggests that conversational uptakes draw on a variety of resources within and external to the given speech situation; as they adopt the phrases and dispositions of particular discourses, uptakes practice translations on their interlocutors.

CONCLUSION

This dissertation began as an exploration of the rhetorical construction of depression and as an analysis of the ways circulating discourses specifically target women. Drawing together diverse corpora of texts, from pharmaceutical advertisements to memoirs, from news reports to self-help manuals, I have argued that women produce, consume and are featured in the majority of the discourses surrounding depression. As a consequence of this prominence, women are additionally constructed as more emotional, more vulnerable, and more responsible for their own (and others') mental well being. It may certainly be argued that the increased attention to depression, and to depression as a specifically women's disorder, draws much needed resources to women's healthcare issues. Nevertheless, as this project has demonstrated, much of the energy generated by this attention is trapped within the rhetorical traditions of self-help and self-blame. Further, the productive activity that is encouraged by the discourses on depression is the taking of antidepressants or otherwise altering an individual's chemical balances. Thus, active responses to depression are individualized, isolated, and commercialized.

The recent explosion of talk about depression among our general population led me to consider how individuals suffering from symptoms of the disorder were taking up and using pieces of the language. I was convinced that the repeated biomedical and psychotherapeutic discourses must have affected the language practices of individuals suffering from the disorder. This conviction led me to design a study to gather conversational data from women experiencing symptoms of depression, and also to design a study that would step away from the traditional doctor-patient interview. Before a woman seeks professional advice for her symptoms, she spends a lot of time talking with friends, family members, and others about her experiences. I wanted to capture some of this talk, the precursor to institutionalized interactions with healthcare providers, in order to see how the discourses on depression might be affecting women's understandings of their own experiences. Drawing on Mishler's distinction between "lifeworld" and "medical" language in doctor-patient interviews, I was curious to tease apart where I could the origins and effects of discourses on the lifeworld language of individual women. Thus, this project conceives of itself as a bridge between daily conversational practices and institutionalized medical encounters. The women interviewed in this study had experienced varying levels of depressive symptoms, but all of them had spent some time drawing conclusions about their own mental health status. Therefore, the language they chose to describe their experiences offers a window onto the power of particular discourses on depression.

To analyze the effects of discourses on depression, I needed a theoretical apparatus through which to locate moments of discursive circulation. While theories of intertextuality offered evidence for the heteroglossic nature of texts, the interactional production of language in conversation had not fully been addressed by these theories. Freadman's description of generic uptake as the moment when one genre answers another, when both genres are constituted through their mutual references, provided the impetus to study rhetorical structures that respond to and (re)construct discursive objects and beliefs. This project has outlined practices of conversational uptake that illuminate the role of individuals in their own discursive constructions. Beyond the traditional critical discourse analyst's commitment to exposing the linguistic reproduction of ideological norms and beliefs, this project focuses attention on the ways that conversational practices are implicated in the reproduction of predominant dispositions towards depression.

To focus on moments of conversational uptake about depression, I have argued, is to locate the intersections of personal and discursive power. Through their uptakes, individuals select and define the objects of continued conversation. As chapter three argued, these processes of selection have material as well as discursive effects. When women's conversations draw on and re-circulate stereotypical portrayals of women's greater emotionality, there is the potential for the individuals themselves to embody such portrayals. Thus, several of the women describe themselves as "sad" people or as behaving "inappropriately" with respect to their displays of emotion. In addition to such selection of objects in conversations, uptakes operate in response to controlling genres and in anticipation of systemic requirements. As chapter four demonstrated, the organizational power of symptoms lists structures the way that experiences of depression are named and understood. Uptakes of those lists, then, both draw on the cultural-rhetorical circumstances that have led to the lists' proliferation, and they also anticipate the doctor-patient encounters that articulate diagnoses based on the lists.

In each instance of uptake, items are brought into conversation from other cultural and discursive contexts. These rearticulations, then, bring with them a previously defined constellation of subjectivities and participant roles. Thus, some such intertextual borrowings have the potential to impose previous role relationships. As chapter five argued, this potential is exploited very productively by DTC advertising, which draws on both symptoms lists and scientific sounding explanations to borrow the authority of medical experts into the realm of marketing. Further, when individual women take up the catch phrases from pharmaceutical advertisements, a second series of translations occurs. In this case, the women draw on the assumed expertise of explanations—like the "chemical imbalance" that causes depression—to make sense of their own experiences. Through this process, they inhabit not only the patient and novice subjectivities, but also a consumer role. Thus, their uptakes of such phrases entail a series of positionings that influence the way they comprehend and respond to their experiences. As these explorations show, using uptake as the object of study enables us to investigate not only the moment and object of an utterance, but also the multidirectional influences on that moment. In other words, considering uptakes requires a consciousness of the process by which they are legitimated. This entails an attention to the previous and future texts that will interact with a particular discursive moment. Further, it entails an understanding of the cultural memory of uptake.

The power of uptake's memory lies in its simultaneous instantiation as the common sense knowledge of individuals, gathered through their own life experiences and textual interactions, and also as the collective habits and dispositions of social groups. As such, the memory through which individual uptakes are authorized and legitimated rearticulates the relations of power inherent in social interactions. In the case of talk about depression, one of the most striking features of these interactions is the deferral to expert discourses and individuals. As chapters four and five demonstrated, women experiencing symptoms of depression deferred to both the language of the symptoms lists and also to the personal authority of medical professionals. A complicating factor is undoubtedly that depression itself is an illness that divests one of various kinds of personal and social power. Nevertheless, the proliferation of discourses on depression has not opened new spaces from which to speak about it. Rather, the proliferation has further narrowed the available means for discussion. From memoirs that trace a descent from and subsequent return to normality to DTC advertisements, like the one for PaxilCR, that promise consumers that "Your life is waiting!" (see Figure 1.2), the discourses on depression serve to alienate individuals from themselves and thereby encourage them to seek expert advice.

In addition, the embodiment of expertise seems to be shifting in the case of depression; the voices of medical professionals are increasingly mediated by the rhetorics of advertising and symptoms lists. When Claire asserts that her symptoms "are all on the list" before she describes her healthcare provider's diagnosis (Figure 4.9), the placement of the clauses in her narrative is important. For Claire, the visit to the health center was an affirmation of what the symptoms lists had already told her; the lists had already performed the interpretation of her experiences. Thus, the language of symptoms has become, for today's empowered consumer, almost a replacement for the individual authority that has until recently been afforded to medical professionals. Nevertheless, the women in my interviews did defer to the authority and skills of healthcare providers. Not only did they describe scenarios when they would seek the "help" and "advice" of such professionals, they clearly differentiated the kinds of "talk" that were healing for their depressions. While talk with friends and family members was seen as beneficial in the short term, such talk was not potentially a cure for their feelings of depression. In the case of mental health professionals, however, the women expected to receive advice and guidance from these experts. This dichotomy between confidants and experts is enacted via the women's conversational uptakes. In this way, expert and novice subjectivities are actively (re)constructed through discursive practices.

Implications and Areas for Further Study

This study has demonstrated that uptake, as a unit of analysis, has the potential to add to the tools of both conversation and discourse analysis. Concentrating on moments of uptake, whether in individual conversations or between genres, requires the analysis of interactions between moments of discourse. Thus, uptake provides a lens for examining the active construction of ideologies, rather than tracing their effects in static discourses. Further, because uptakes are always available for rearticulation, they offer potential moments of response to (and against) powerful discourses. In this project, conversational uptakes have provided a bridge between everyday linguistic behavior and larger ideological formations. They provide a means of studying a more complicated form of agency, a secret-double-agency that grants individuals the powers to manipulate the discourses that surround them without suggesting that they are ever external to those discourses. In each moment of uptake, the structures of expertise are reestablished, but they are also potentially rearticulated in slightly varied forms. These variations serve as the potential for discursive change and evolution.

Thus, this study articulates a methodology for analyzing conversations critically and intertextually. Future work testing the productivity of this methodology is clearly necessary. Drawing on the connections between various discursive worlds, this study is nevertheless limited in the number and diversity of its participants. Although this project contributes to an understanding of university students' articulations of their experiences with symptoms of depression, it would be very illuminating to collect data from other populations. In particular, much of the medical literature suggests that various populations describe their depressions differently. In a standard handbook on affective disorders, Max Hamilton writes that "less sophisticated patients tend to underplay their mental symptoms and to emphasise their physical ones" (4). This study suggests an alternative reading of such a phenomenon, one that does not require value judgments like "more" and "less" sophistication. For these individuals, because of their experiences, rhetorical repertoire, and the dispositions of their habitus, the available uptakes are different from those of more educated individuals. Rather than seeing this as a lack of sophistication, we ought to see it instead as an opportunity to investigate how linguistic resources vary from one community of practice to another.[1]

In addition to the potential benefits of studying varied groups of individuals, this methodology could be usefully applied to a longitudinal study, following a group of individuals for several years, monitoring how their language practices change as they move into and out of periods of increased and decreased depressive symptoms. To develop this kind of study would allow for greater connections between studies of the doctor-patient dyad and conversational analyses. Adding such a conversational component to studies of therapeutic interactions could potentially provide useful feedback to doctors and patients themselves, in addition to giving discourse analysts more information about how discursive formations are translated into and out of various interactional settings.

Beyond these discursive analyses of depression, the growing field of disability studies provides another area for future research.[2] Simi Linton, in *Claiming Disability*, writes that this growing field of scholarship "explores the critical divisions our society makes in creating the normal versus the pathological, the insider versus the outsider, or the competent citizen versus the ward of the state" (2). These definitions have clear implications in the realm of depression, where pharmaceutical advertisements encourage you to get "yourself" back from the disease. In fact, the connections between mental health and concepts of disability are becoming an important area for study.[3] Mental illness complicates notions of disability because it often has the ability to pass for physical normality. Without the outward markers of disability, mental illness masquerades as normality and therefore is sometimes not considered a disability at all. Nevertheless, as some scholars argue, the bodily management required by depression is similar to that required by other physical disorders like epilepsy or diabetes.

One of the key contributions of this area of scholarly inquiry has been a focus on the medicalization of various physical realities and behaviors. Linton argues that "the medicalization of disability casts human variation as deviance from the norm, as pathological condition, as deficit, and, significantly, as an individual burden and personal tragedy" (11). This notion of personal tragedy is certainly echoed in the discourses on depression, where a sense of isolation becomes one of the most salient features of the illness. However, the medicalization of disability also relies on a system of healthcare that fetishizes difference. David Mitchell and Sharon Snyder write in their introduction to a collection of disability studies scholarship: "Disability studies does not refuse or repress the uncertainties and limitations of biological conditions, but rather it exposes the pleasurable investments under-girding discourses that reproduce, expand, and tediously detail taxonomic catalogs of disability's pathological trajectories" (19). Thus, the project for disability scholars is not to ignore the realities of disability but rather to explore the social ramifications of definitions of disability. Thus, for depression, further research is needed to determine how the physical and emotional body are connected and interact with the social world.

Multidirectional Analyses

This study has developed a methodology for locating moments in the (re)circulation of discourses on depression. In individual and collective instances of uptake, I have argued, we can identify the forms that are circulating and connect individual talk with larger social structures. By linking micro-level conversations to macro-level social structures, uptake offers a concrete unit of analysis that draws our attention to the daily practices that enact discursive power. Further, uptake requires us to view power multidirectionally. Not only do individual uptakes rearticulate discursive objects like "the emotional woman," they also establish interactional roles for the participants in a conversation. Thus, uptakes work on multiple levels: at the level of habitus, they reinforce predominant beliefs and dispositions; at the level of specific discourses, they maintain the validity of particular objects; at the level of conversations, they assign roles to interlocutors; and at the level of individuals, they prescribe available subjectivities. Further, they concretize moments in the discursive circulation, making them available for analysis.

At this late modern moment, we live in a world that is increasingly mediated by external systems and discourses. Thus, as language analysts, we must find ways to examine these systems. Ideas and discursive objects are not contained within single genres or activity systems, just as notions of depression are not contained only within the realm of mental healthcare. Rather, depression has become the topic of television sitcoms, tell-all memoirs, news articles, and casual conversations. Because this circulation is not contained within the activities of a single sphere, it is necessary to find methods of studying movement across spheres. Beyond studies of depression or other health concerns, the movement of discourses from high media to casual conversation (and back again) is and important area for future study.[4] It is the circulation not the individual enunciation of discourses that exerts their stabilizing power on our daily lives.

NOTES

Chapter One: The Circulation of Language About Depression

[1] The distinction between mental and physical conditions is critiqued by the *Diagnostic and Statistical Manual of Mental Disorders*, currently in its fourth edition (DSM-IV-TR), but no alternative terminology is suggested. Under the heading "Definition of *Mental* Disorder," (italics in the original) the DSM-IV-TR reads: "the term *mental disorder* unfortunately implies a distinction between 'mental' disorders and 'physical' disorders that is a reductionistic anachronism of mid/body dualism. A compelling literature documents that there is much 'physical' in 'mental' disorders and much 'mental' in 'physical' disorders. The problem raised by the term 'mental' disorders has been much clearer than its solution, and, unfortunately the term persists in the title of DSM-IV because we have not found an appropriate substitute" (xxx).

[2] As Jann Scheuer argues in a recent *Language in Society* article, combining Bourdieu's concept of the habitus provides "a more systematic approach to text-external contexts" within CDA (143).

[3] Throughout this dissertation, I will be using brand names for a variety of antidepressant medications. Trademarks for each of these brand names are registered by the manufacturers. For reference, the following table lists the brand name, active ingredient, manufacturer, and FDA approval date for the medications mentioned in this dissertation. (Source: http://www.accessdata.fda.gov/scripts/cder/drugcat/)

Brand Name	**Active Ingredient**	**Manufacturer**	**FDA Approval**
Prozac	fluoxetine hydrochloride	Eli Lilly	1987
Zoloft	sertraline hydrochloride	Pfizer	1991
Paxil	paroxetine hydrochloride	GlaxoSmithKline	1992
Remeron	mirtazapine	Organon	1996
Celexa	citalopram hydrobromide	Forest Labs	1998

[4] Discourse analysis has recently begun to be applied in the medical and health fields as well as in the social scientific disciplines. For examples of these applications, see Lupton, "Discourse Analysis"; Lupton and McLean, "Representing Doctors"; Phillips and Henderson, "'Patient was hit...'"; Swann and Ussher, "A Discourse Analytic Approach"; Eade and Bradshaw, "Understanding."

[5] The idea of domestic labor is used as a metaphor for depression in one Prozac ad, published in the *British Journal of Psychiatry* (May 1991). The title reads: "Because depressed patients still have a life to lead." The image, of a kitchen piled with dirty dishes is overlaid with another image of a spotless kitchen. The text of the ad continues: "Prozac controls the patients' depression, whilst leaving them to resume and cope with their normal everyday activities." This advertisement clearly targets women patients, while reinforcing domestic labor and cleanliness as appropriate daily "activities."

[6] The pharmaceutical industry is, obviously, heavily invested in the biomedical discourse. For analyses of the social development and effects of the growing popularity of antidepressants, see Healy, *The Antidepressant Era*; Valinstein, *Blaming the Brain*; Glenmullen, *Prozac Backlash*; Metzl, "Prozac."

[7] For one of the original presentations of the precepts for cognitive therapy, see Beck, "Thinking and Depression I" and "Thinking and Depression II."

[8] In the interview with the mental health professionals, Ellen, the psychiatrist, references similar studies. See Figure 5.10.

[9] The 1990 APA Taskforce on Women and Depression is a good indicator of the attention paid specifically to women's depression. See McGrath and Keita, *Women and Depression* for an overview of the Taskforce findings.

[10] With the *DSM-IIIR* (1987), the APA moved away from the term "mental illness" toward the less clinical "mental disorder." I am intrigued by the dormant metaphor here – that our mental lives are (in their natural/healthy states) "ordered" and logical, and that our difficulties stem from a failure of "order." In addition, there are a variety of "clinical" depressions, and the distinctions among these are another area of concern (for example, is Premenstrual Dysphoric Disorder [PMDD] a form of depression, or another disorder entirely?). For more detailed analyses of how mental disorders are designated, see: Figert, *Women and the Ownership of PMS*; Neimeyer and Rasking, *Constructions of Disorder*; Wenegrat, *Illness and Power*; Wirth-Cauchon, *Women and Borderline Personality Disorder*.

[11] McGrath's book is less interested in social influences on depression than Chesler's – aside from suggesting that societal pressures on women (to be young, to be thin, to be beautiful) exist, McGrath's discussion of "Healthy Depression" focuses on the ways that individuals should learn to cope with these expectations. *When Feeling Bad is Good* is an interesting artifact both for the ways that it tries to demarcate the boundaries of illness and for the ways it reasserts appropriate subjectivities.

[12] Source: Bowker's *Books in Print* database (available: http://www.booksinprint.com/bip/) searched on April 20, 2003. Search terms: "depression" and not "economic" in Keyword Subject category.

[13] Amazon.com Books database, subsection "Health, Mind, & Body" (available: http://www.amazon.com/books) searched on April 20, 2003.

[14] For more on women and advice literature, see: Ehrenreich and English, *For Her Own Good*; Rapping, *The Culture of Recovery*.

[15] This emphasis on weight control is echoed in Ronald Fieve's *Moodswing* (2nd Edition). In his brief history of antidepressants, Fieve lists a variety of "second-generation antidepressants" designed to "help avoid some of the side effects of the early medications." Fieve lists the drugs without comment until he reaches Prozac. "[I]n 1988," he writes "fluoxetine (Prozac), [was introduced] one of the few antidepressants that may be associated with weight loss." (261)

[16] McKay is himself the author of a variety of self-help texts and workbooks (for example, McKay and Fanning, *Self-Esteem*). Thus, his Foreword lends credibility to Dockett's collection and establishes a pedigree for it within the world of self-help.

[17] Another popular version of this genre is the collection of celebrities writing on their own (or their family members') depressions. See, for example, Casey, *Unholy Ghost*; Cronkite, *On the Edge*. For a critique of the gendered lives in autobiographies, see Gergen, "The Social Construction."

[18] Magazine rankings come from the Magazine Publishers of America 2002 fact sheet, available at: http://www.magazine.org/resources/fact_sheets/cs2_9_03.html.

[19] Certainly the phrase "plain old PPD" is worth noting here. The article seems to be trivializing postpartum depression by making such a dire comparison. This is shocking considering the entire article is really about "plain old PPD."

[20] This analysis was suggested to me by Susan Peck MacDonald's presentation at CCCC 2003, and by subsequent email conversations. In her work on hormone replacement therapy, this link between scientific modality and women as examples is even clearer – the women described in news articles are the ones expressing the various health decisions advocated by the study results.

[21] The IMS Report, "Power to the People – Reaching the Smart Market of Empowered Consumers," was not based on a representative sample. The study is described in the report as follows: "IMS HEALTH posted a 17-question survey on the drkoop.com Web site for two weeks in the spring of 2000, when the site was at the height of its popularity. Visitors to the pages of the site…were invited to complete the survey. No incentives were given for participation. Compared to 1999 U.S. demographics, respondents were more likely to be female (69 vs. 51 percent) and older (54 vs. 33 percent were 46 years of age or older)" (Blankenhorn, Duckwitz, and Sherr 4).

[22] In the advertising survey conducted for my own study, this was affirmed by a number of advertisements for WebMD (available: http://www.webmd.com), a popular online source for health information. These ads promoted online discussions with medical professionals and additional non-medical celebrities as opportunities to talk about health issues.

[23] Circulation figures come from the Magazine Publishers of America 2002 fact sheet, available at: http://www.magazine.org/resources/fact_sheets/cs2_9_03.html.

[24] Circulation figures and rank for *Time*, *Newsweek*, and *Reader's Digest* come from the Magazine Publishers of America fact sheets (available at: http://www.magazine.org/resources/Fact-sheets/cs2_9_03.html). The three national magazines included in this study represent the highest circulation general interest magazines in the country. Circulation figures for *The New York Times Magazine* from their web site. The *New York Times* Sunday circulation figure (for 2000) of 1,682,208 is cited on their web site (http://nytadvertising.nytimes.com/).

[25] In an informal survey of other magazines, including medical journals like *The Journal of the American Medical Association,* I have not found many advertisements for antidepressants that picture men alone. When a man is pictured, his wife or family often accompanies him. Women are, however, sometimes depicted alone. The trend toward including women as caregivers in ads depicting men as sufferers of depression conforms to the patterns noted in chapter three, where National Institute of Mental Health pamphlets are examined. In the NIMH pamphlets, caregivers are targeted in general information, but are absent from information targeted at women alone.

[26] For a discussion of this phenomenon as it relates specifically to women, see Nikelly, "Drug Advertisements."

[27] The notable exception if Teun van Dijk's *Communicating Racism.* Examples of studies of doctor-patient discourse include: Labov and Fanshel, *Therapeutic Discourse*; Roberts, *Talking about Treatment*; Maclean, "Approaches"; Wodak, *Disorders*, Chapter 2.

[28] Clearly, this focus on patients' language practices draws on a history of talk therapies. For example. Lisa Capps and Elinor Ochs suggest that an attention to narrative can help agoraphobic patients. In their study of the disorder, Capps and Ochs write that, with guidance, a patient "can learn from listening to her own stories what she already knows. She can gain access to the insights that are hidden in the discursive architecture and grammatical coloring of her tales" (192). Similarly, Jay Efran and Paul Cook describe psychotherapists "as linguist detectives, identifying the language traps within which people have imprisoned themselves" (140). In both of these cases, language is figured as a puzzle to be solved or a trap to be escaped.

[29] All of Jack's interviewees were white, heterosexual women. While her subjects ranged somewhat across social class, one of the difficulties with Jack's qualitative study is that it may not account for other kinds of adult interrelationships.

[30] Antze and Lambeck draw this conclusion in their discussion of memory and identify. They write: "some degree of forgetting may be necessary for the constitution of identity" (xxv).

[31] Another aspect of memory and forgetting is the potential for willful concealment and lying. For an interesting meditation on this, see Slater, *Lying*.

[32] See also Clark and Mishler, "Attending."

[33] Human Subjects (IRB) approval granted May 4, 2002, application number: 01-1159-C 01, entitled "Women, Language, and Depression."

Chapter Two: Uptake and/as Multidirectional Discursive Power

[1] As Freadman points out, the "discovery" that words are performative was not necessarily new in Austin's day ("Uptake" 41). The selective memory that credits the birth of performative language to Austin is the subject of another investigation, but it does point to the ways that a collective, selective memory is at work in our cultural, even academic understandings.

[2] The decision to call depression an "illness" is fraught at this moment in history. While the DSM-IV-TR refers to "mental disorders" to avoid the (perceived) pejorative connotations of "mental illness," others have sought parity for mental and physical conditions, preferring the term "illness" for that purpose. Additionally, feminist critics like Phyllis Chesler have suggested that depression is nothing more than women's natural (and predictable) response to oppressive social relationships. While each of these positions has merit, none seems completely satisfactory to me. While social conditions are, I would argue, part of what can lead to depression, they should not be used to suggest that depression is not a real, physical experience. For the purposes of this study, I assume that depression is a real (and terrible) condition affecting millions every year. Nevertheless, I will challenge both the definitions of depression and how it is portrayed both in institutional and personal communicative practices.

[3] Some psychoanalytic theorists would read the lexical choices in this sentence as symptomatic of women's definitional lack of the phallus. See especially Kristeva, *Black Sun* and *New Maladies*. For a review of the ways depression has historically been interpreted, see Radden, *The Nature of Melancholy*.

[4] For another version of memory, see Michael Lynch and David Bogen's *The Spectacle of History*. In this analysis of testimony during the Iran-Contra hearings, Lynch and Bogen describe "collective memory" (179) and the various forms of "recall" and "documentary" memory that are evoked in the congressional hearings. Their analysis suggests that the concept of memory is flexible enough to incorporate a variety of situated practices.

[5] The cover of the September 2001 issue of *Rosie* magazine reads: "The face of depression; Rosie's own struggle; Plus inspiring stories—and comedian Margaret Cho on getting the last laugh." The issue includes profiles of several women struggling with depression; an interview with Martha Manning, whose book *Undercurrents* deals with her depression; a story about Mike and Mary Wallace, which discusses how their marriage survived the *60-Minutes* anchor's depression; and Rosie's own account of her depression. Together, these personalizations heighten the awareness of depression, but they also focus on individuals' strength in dealing with the illness.

[6] As chapter four will demonstrate, these expert systems are both human (e.g., doctors, nurses) and rhetorical (e.g., symptoms lists).

[7] For a discussion of such recontextualizations, see Fahnestock, "Accommodating Science"; Myers, "Out of the Laboratory."

[8] Searle critiques Grice for this move: "Grice in effect defines meaning in terms of intending to perform a perlocutionary act, but saying something and meaning it is a matter of intending to perform an illocutionary, not necessarily a perlocutionary, act." (*Speech Acts* 44)

[9] See Butler's *Gender Trouble* for an analysis of gendered performances.

[10] Bakhtin's work (*Speech Genres*) makes a similar point about the interplay of voices and texts within a dialogic exchange. For Bakhtin, all utterances are responses to previous statements. Here, I am suggesting that Freadman's definition of uptake provides a mechanism by which these responses inhabit and impose power.

[11] See chapter three for more on the uptake of "the emotional woman."

[12] This argument is based on Jennifer Coates' model of a "collaborative floor," where women's overlapping talk is viewed as co-constructing conversation rather than as interrupting it. See, for example: Coates, "The Collaborative Floor," and *Women Talk.*

Chapter Three: (Re)Constructing "The Emotional Woman" via Conversational Uptakes

[1] Feminists have often critiqued Foucault's theories for their lack of attention to the "gendered character of many disciplinary techniques" (McNay 11) and for their overly passive version of the individual subject. Nevertheless, as Lois McNay points out, "Foucault's theory of the body…is a way of conceiving of the body as a concrete phenomenon without eliding its materiality with a fixed biological or prediscursive essence" (17). In this project, I follow McNay's use of Foucaultian notions of practices of the self as the basis for viewing the body as both concrete and discursively manipulated. For a detailed analysis of the difficulties of adapting Foucault to feminist analyses, see: Deveaux, "Feminism and Empowerment"; Sawicki, *Disciplining Foucault*; and Ramazanoğlu's collection *Up against Foucault.*

[2] Chapter four addresses the diagnosis and definition of depression. Of particular interest are the moments when interviewees moved outside of standard symptoms lists.

[3] My argument here derives from feminist critiques of science and particularly of psychology. See, for example: Astbury, *Crazy for You*; Busfield, *Men, Women, and Madness*; Harding, *Whose Science?*; Clarke and Olesen, *Revisioning Women*; Doyal, *What Makes Women Sick?*; Prior, *Gender and Mental Health.*

[4] See Pauwels *Women Changing Language.*

[5] For an extended critique of the DSM-IV and its predecessors, see: Kirk and Kutchins, *The Selling of DSM*; Kutchins and Kirk, *Making Us Crazy*; Crowe, *Constructing Normality*; McCarthy, "A Psychiatrist Looks"; Wetzel, "Depression: Women-at-Risk"; Wilson, "DSM III"; Davis, "The Encyclopedia"; and also chapter four.

[6] See Ehrenreich and English, *For Her Own Good.*

[7] In addition, the qualities of anger and sadness often parallel the binary oppositions of rationality versus emotionality. For McNay and other feminists, men's supposed rationality allows them to transcend "being defined in terms of [their] biological capacities" (17). In the context of displays of emotion, men similarly are believed to rely on their rationality to transcend over-emotionality. When they cannot, current discourses tell us, they erupt into violence and aggression instead of collapsing inward into depression. This theory of depression, that men's depression is not less frequent than women's, but rather mis-recognized as anger, is most strongly supported by the anecdotes in Terrence Real's *I Don't Want to Talk About It: Overcoming the Secret Legacy of Male Depression.* Similarly, Andrew Solomon in his popular *Noonday Demon*, writes that "Many depressed men are not diagnosed because they tend to deal with feelings of depression not by withdrawing into the silence of despondency, but by withdrawing into the noise of violence, substance abuse, or workaholism" (178). Certainly, the realities of male depression are an area worthy of more attention than I can give them here, but it is important to recognize the ways that these beliefs about male anger serve to further silence men who may feel and express depression via the traditionally female modes of sadness. It is equally important to recognize the ways women are muted by these assumptions; women's depression is figured as internal and silent.

[8] For additional analyses of emotion, see: Davidson, *Anxiety, Depression, and Emotion*; Abu-Lughod and Lutz, "Introduction"; Lutz, *Unnatural Emotions*; Rosenberg, "Language"; Stearns, *American Cool*; Irvine, "Registering Affect."

Chapter Four: Diagnostic Uptakes and the Shifting Rhetoric of Expertise

[1] Throughout this study, I have used the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders*, the text revision of the fourth edition of the manual (published in 2000) for my own analyses. This edition is cited in the text as DSM-IV-TR. Other scholars and the mental health professionals that I interviewed have used earlier editions of the manual, e.g., the DSM-IV (published in 1994). Throughout the text of this dissertation, I have tried to remain faithful to the edition of the DSM being referenced by the participants. Although this leads to some awkward shifts between DSM-IV and DSM-IV-TR, both abbreviations refer to versions of the same document. Each version of the DSM further cements its status as a controlling genre for a wide range of mental health activities.

[2] See also: Berkenkotter and Ravotas, "Genre as Tool" and "New Research Strategies."

[3] For another account of the generation of mental health records, see Reynolds, Mair, and Fischer, *Writing and Reading*.

[4] In *Madness and Civilization*, Foucault discusses how manic depression comes to be observed and understood as a single phenomenon (mania and depression combined, not two illnesses). They key, for Foucault, is the way that the process works: "the enterprise did not proceed from observation to the construction of explanatory images" rather, "the images assured the initial role of synthesis, that their organizing force made possible a structure of perception, in which at last the symptoms could attain their significant value and be organized as the visible presence of the truth" (135). Thus, again, the ideology and the structure of perception(s) allows particular forms of illness to be considered "madness" and others not.

[5] Lilian Furst provides an analysis of the shifting balance of power between doctors and patients. Furst notes that "the balance of power in the medical field is...complicated by the jurisdiction of insurance or managed care companies" (2). Further, she notes that advances in medicine (e.g., better therapies and drugs) have also added to the complex relations between doctors and patients. Thus the traditional "doctor knows best" philosophy no longer applies without question.

[6] For an analysis of the struggles to define PMS as a disorder, see Figert, *Women and the Ownership of PMS.*

[7] This is true not only because of the DSM-IV-TR's ubiquity, but also because it is a recursive document that is developed by researchers and clinicians in response to their professional experiences with patients. Thus, the DSM-IV-TR is itself comprised of a series of uptakes informed by (historical) clinical practice and (anticipated) future research criteria.

[8] An alternative reading of these metaphors of journey is suggested by the artistic and philosophical tradition of visualizing the insane as in transit, e.g., aboard a "ship of fools." The history of containment and travel for mentally ill individuals is echoed in the narrative progression of genres like the memoir. Further, considering this cultural history, it is possible to read the women's use of journey metaphors as participating in a larger cultural narrative/memory that seeks to keep mental illness in transit (and therefore never arriving home). See Sander Gilman (1988) *Disease and Representation* for more on the history of visualizations of illness.

Chapter Five: Intertextuality, Translation, and Uptake

[1] For more on the growing American obsession with mental health and therapy, see Moskowitz, *In Therapy We Trust*; Kovel, "The American Mental Health Industry".

[2] Source: Lexis-Nexis database search 11/2/03.

[3] The FDA has studied current attitudes toward DTC advertising (Office of Medical Policy, 2002). For a review of the medical conversation on DTC advertising, *The Journal of the American Medical Association* carried a series of editorials in 2000 (see Kravitz, "Direct-to-Consumer"; Henney, "Challenges"; Huang, "The Rise"); *The New England Journal of Medicine* carried a similar series of editorials and articles in 2002 (see Rosenthal et al., "Promotion"; Wolfe, "Direct-to-Consumer"; Holmer, "Direct-to-Consumer"); See also Mintzes et al., "Influence"; Brown, "The Diret-to-Consumer Dilemma"; Gilbert, "Drug Firms"; Fletcher and Fletcher, "Pharmaceutical"; Chandrasoma, "Health". For an advertising perspective, see J. Rosenberg, "Doctors' Offices." Finally, for a consideration of college students' drug taking behavior as related to DTC advertising, see Burak and Damico, "College Students."

Conclusion

[1] A very early study of women and depression (Weissman and Paykel, *The Depressed Woman*) does highlight the potential of studying individual communities. Additionally, work with other populations is collected in Cappeliez and Flynn, *Depression and the Social Environment.*

[2] I am grateful to the participants on the DIS-HUM listserv for their suggestions along these lines, particularly Amy Barnard, Claudia Rector, and Diane Wiener for their thoughtful email communications.

[3] See for example, Donaldson, *The Psychiatric Gaze*; Capps and Ochs, *Constructing Panic*; Caminero-Santangelo, *The Madwoman Can't Speak*; Henry, "Depression and Anxiety."

[4] See Coupland and Williams, "Conflicting Discourses."

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APPENDIX A

NEWS MAGAZINE ARTICLES

Magazine	Title	Date	Words
U.S. News and World Report	"When Depression Follows Stroke"	May 2, 1998	754
U.S. News and World Report	"Explaining the Inexplicable"	April 24, 1989	831
U.S. News and World Report	"Beating Depression"	March 5, 1990	3,858
U.S. News and World Report	"Tailoring Treatment for Depression's Many Forms"	March 5, 1990	1,052
Newsweek	"The Promise of Prozac"	March 26, 1990	2,654
U.S. News and World Report	"Charting Premenstrual Woes"	April 15, 1991	1,422
U.S. News and World Report	"Sick, or Just Quirky?"	February 10, 1992	1,381
U.S. News and World Report	"Singing the Prozac Blues"	November 8, 1993	1,800
Newsweek	"The Culture of Prozac"	February 7, 1994	1,649
U.S. News and World Report	"Kindergartners in the Prozac Nation"	November 13, 1995	986
Newsweek	"A Natural Mood Booster"	May 5, 1997	1,111
Newsweek	"Do Kids Need Prozac?"	October 20, 1997	1,191
U.S. News and World Report	"Psychosurgery Redux"	November 3, 1997	1,559
U.S. News and World Report	"Melancholy Nation"	March 8, 1999	4,458
Newsweek	"The 'Sammy' Solution"	March 22, 1999	620
U.S. News and World Report	"The Ancient Rots of Modern Melancholy"	February 14, 2000	807
Newsweek	"Nourishing Your Brain"	April 23, 2001	1,017
Newsweek	"The Baby Blues and Beyond"	July 2, 2001	1,515
Newsweek	"Medicine: Searching for a New and Improved Prozac"	December 31, 2001	762
		Total Words:	**29,427**

APPENDIX B

CORPUS 3: ANTIDEPRESSANT PHARMACEUTICAL ADVERTISEMENTS

Advertisement	**Magazine**	**Date**
Depression (Pfizer)	*New York Times Magazine*	October 24, 1999
Zoloft (Pfizer)	*Newsweek*	June 25, 2001
Zoloft (Pfizer)	*Time*	June 4, 2001
Celexa (Forest Laboratories, Inc.)	*New York Times Magazine*	October 28, 2001
PaxilCR (GlaxoSmithKlein)	*Time*	October 21, 2002
Prozac (Eli Lilly)	*Reader's Digest*	June 1998
Prozac (Eli Lilly)	*Time*	February 9, 1998
Remeron (Organon)	*New York Times Magazine*	October 24, 1999
Remeron (Organon)	*New York Times Magazine*	October 28, 2001
Kira	*Reader's Digest*	February 1998
Kira	*Reader's Digest*	February 1998
	Total Advertisements:	**11**

APPENDIX C

CENTER FOR EPIDEMIOLOGIC STUDIES DEPRESSION SCALE (CES-D)

Below is a list of some of the ways you may have felt or behaved. Please indicate how often you have felt this way during the past week by checking (✓) the appropriate space.

	Rarely or none of the time (less than 1 day)	*Some or a little of the time (1-2 days)*	*Occasionally or a moderate amount of time (3-4 days)*	*All of the time (5-7 days)*
1. I was bothered by things that usually don't bother me.				
2. I did not feel like eating; my appetite was poor.				
3. I felt that I could not shake off the blues even with help from my family.				
4. I felt that I was just as good as other people.				
5. I had trouble keeping my mind on what I was doing.				
6. I felt depressed.				
7. I felt that everything I did was an effort.				
8. I felt hopeful about the future.				
9. I thought my life had been a failure.				
10. I felt fearful.				
11. My sleep was restless.				
12. I was happy.				
13. I talked less than usual.				
14. I felt lonely.				
15. People were unfriendly.				
16. I enjoyed life.				
17. I had crying spells.				
18. I felt sick.				
19. I felt that people disliked me.				
20. I could not get "going."				

Scoring for the CES-D

	Rarely or none of the time (less than 1 day)	*Some or a little of the time (1-2 days)*	*Occasionally or a moderate amount of time (3-4 days)*	*All of the time (5-7 days)*
Items 4, 8, 12, and 16:	3	2	1	0
All other items	0	1	2	3

Total score is the sum of the 20 items. For this study, a score between 11 and 29 was considered mild to moderately depressed.

APPENDIX D

STUDY PARTICIPANTS

The demographic questionnaires that I asked subjects to complete asked very basic questions about age range and education. In addition, I asked subjects if they read any daily newspapers, any weekly news magazines and/or any other magazines on a regular basis. Finally, I asked subjects if they read anything specifically about depression. All transcripts (and the charts below) use pseudonyms, and some identifying features have been generalized to protect the identity of the subjects. The demographic information provided is summarized below.

WOMEN, GROUP 1 (Transcript time markers referenced in the text by G1)

Name	Demographic Details	Regular News/Magazines	Depression Specific Information Sought
Paige	Caucasian female in her early twenties, just finished with her undergraduate education in the humanities. She described her relationship status as single.	*New York Times, Glamour, Health, Utne Reader*	"I've looked at a website for teens dealing with mental/emotional problems. I read some drug company info on antidepressants that my primary care doctor gave me once."
Claire	Caucasian female in her middle twenties, a Master's student in the Humanities. She was engaged to be married at the time of the interview.	*None*	"Some brochures and websites."
Su-Ting	Asian female in her middle twenties, a Master's student in a Health field. She described her relationship status as single.	*None*	"Self-help literature and internet resources."
Tiffany	Caucasian female in her early twenties, a senior undergraduate in the Humanities. She described her relationship status as single.	*None*	None

WOMEN, GROUP 2 (Transcript time markers referenced in the text by G2)

Name	Demographic Details	Regular News/Magazines	Depression Specific Information Sought
Mei	Asian female in her early twenties, a senior undergraduate in a health field. She described her relationship status as single.	*The Daily* [Campus newspaper], *Seattle Times, New York Times (online)*	"No."
Jennifer	Asian female in her early thirties, a Ph.D. candidate in the Sciences. She described her relationship status as "recently started a relationship."	*Time/Newsweek, Scientific American, The New Yorker*	"Internet resources, Magazine Articles."
Stephanie	Caucasian female in her early twenties, majoring in Humanities and Health fields. She described her relationship status as single.	*None*	"I have done limited research about S.A.D. Seasonal Affective Disorder."

MENTAL HEALTH PROFESSIONALS (Transcript time markers referenced in the text by MHP)

Name	Demographic Details	Regular News/Magazines	Depression Specific Information Sought
Ellen	Caucasian female Psychiatrist, completed her Psychiatric residency in Washington State in 1993. She has practiced in her field for 12 years.	*Seattle Post-Intelligencer, American Journal of Psychiatry, Journal of Clinical Psychiatry, Psychiatric Sciences, Journal of the American Psychoanalytic Association*	"Yes"
Betty	Caucasian female Psychiatric Nurse, completed her Master's of Science in Nursing in Washington State in 1982. She has practiced in her field for 28 years.	*Seattle Post-Intelligencer, Psychiatric Services, Martha Stewart Living, Bon Appetit, Gourmet, Country Home*	Blank
Laurie	Caucasian female Psychologist, completed her Ph.D. in Psychology in Washington State in 1984. She has practiced in her field for 32 years.	*New York Times, Seattle Times, Time, Newsweek, National Review, JAMA, NEJM, Martha Stewart Living*	"Scientific articles, internet sites."
Joan	Caucasian female Social Worker, expected to complete her Master's of Social Work in Washington State in 2003.	*Self, Oprah*	"Yes, various articles (& DSM) as assigned for an adult mental disorders class."

APPENDIX E

TRANSCRIPTION CONVENTIONS

For this study, I use primarily the transcription conventions described in *Language and Gender: A Reader,* edited by Jennifer Coates. My conventions are listed here:

EXAMPLE	**EXPLANATION**
Sp 1 I thought you [were saying] Sp 2 [no, I was] talking about	Square brackets around speech indicate that the speakers overlapped for the portions bracketed.
Sp 1 she said= Sp 2 =but you didn't say that	Equals signs indicate "latching" where there is no measurable space between speaker's turns.
Sp 1 I *mean* it	Italics indicate some form of emphasis
Sp 1 Yes: I lo:ve chocolate	A colon following a letter indicates an elongation of the sound of that letter.
(.)	A period in parentheses indicates a pause of one-tenth of a second or less.
(0.5)	Numbers in parentheses indicate silences in seconds and tenths of seconds.
((laughing))	Double parentheses indicate transcriber comments or descriptions.
(x)	A single "x" enclosed in parentheses indicates a hitch or stutter on the part of the speaker.
(xxx)	Several "x"s enclosed in parentheses indicate material that is inaudible or otherwise untranscribable.
(happy)	Words in single parentheses indicate transcriber doubt about exactly what was heard.
[...]	An ellipsis in square brackets indicates a gap in the transcript, i.e., that a speaker's turn has not been included in its entirety.

Curriculum Vitae

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EDUCATION

Ph.D. English, University of Washington — Jun. 2003
Concentration: Language & Rhetoric
Dissertation Title: "More than Blue: Discourses of/on Women and Depression"
Exam Areas: Composition, Genre & Disciplinarity; Discourse Analysis/Critical Discourse Analysis; Language & Gender

M.A. English, University of Washington — Jun. 1999
Master's Essay: "Economies of Prevention: Tamoxifen, Breast Cancer and the Influence of Multiple Discourses on News Reporting"

A.B. English, Princeton University, *Magna cum laude* — May 1995
Thesis title: "Fortissimo: An Exploration into Writing Instruction"
Certificates: Princeton University Teacher Preparation; NJ Certificate of Eligibility with Advanced Standing, Teacher of English & Elementary School Teacher

TEACHING & ADMINISTRATIVE APPOINTMENTS

Instructional Consultant, Center for Instructional Development & Research, University of Washington	Sept. 2001 – Mar. 2003
Huckabay Teaching Fellow appointed to North Seattle Community College, awarded by the Graduate School, University of Washington	Spring 2000
Assistant Director, Expository Writing Program, University of Washington	Jun. 1999 – Jun. 2001
Instructor, Minority Medical Education Program, University of Washington	Summers 1999 – 2001
Teaching Assistant, Department of English, University of Washington	Sept. 1997 – Sept. 2001

GRANTS & AWARDS

W. W. Stout Fellowship	Spring 2003
Susannah J. McMurphy Dissertation Fellowship	Spring 2003
Joan Webber Prize for Distinguished Teaching, 100-Level	Spring 2002
P.E.O. Scholar Award	2002-2003
Departmental Finalist, Alvord Fellowship in the Humanities	Feb. 2002
Presidential Honorary Membership, American Dialect Society	Jan. 2002
Honorable Mention, Joan Webber Prize for Distinguished Teaching, 200-Level	Spring 2001
Huckabay Teaching Fellowship	Spring 2000
New Jersey Commissioner's Distinguished Teacher Candidate Award	Summer 1995

SCHOLARSHIP

Publications

Articles, Essays, & Book Reviews

"Rethinking Genres of Reflection: Student Portfolio Cover Letters and the Narrative of Progress." *Composition Studies* 31.1 (2003): 43-62.

"Notice for *Talking About Treatment*." *Language*. 77.1 (2001): 201-02.

"Review of *Grading in the Post-Process Classroom: From Theory to Practice*." *Journal of Teaching Writing*. 18.1&2 (2000): 137-140.

"Where Stealing is Encouraged." *The Creative Arts at Princeton*. Ed. John McPhee. Princeton, NJ: Humanities Council, 1996. 61-64.

Edited Collection

Co-Editor, with Anne Curzan. *Studying the History of the English Language II: Conversations about the Past and Present*. Volume under consideration for the Topics in English Linguistics series published by Mouton de Gruyter.

Contributing Bibliographer

CCCC Bibliography of Composition and Rhetoric. Ed. Todd Taylor. Carbondale: Southern Illinois UP, 1999.

CCCC Bibliography of Composition and Rhetoric. Ed. Gail Stygall. Carbondale: Southern Illinois UP, 1996-1998.

Conferences, Colloquia, & Lectures

"'The More You Know': Direct to Consumer Advertising, Consumer Education , and Women's Uptake of Discourses on Depression." 1st Communication, Medicine, and Ethics Conference. Cardiff, Wales. Jun. 26, 2003.

"(Re)Locating Writing: Exploring Textual Movement between Home and School." Conference on College Composition and Communication. New York. Mar. 21, 2003.

"Discursive Balancing Acts: The Circulation of Talk about Women and Depression." English Language & Rhetoric Colloquium. University of Washington, Seattle. Nov. 20, 2002.

"(Un)Disciplining Discourse: Investigating Intertextuality In/Through Genres." Western States Composition Conference. University of Washington, Seattle. Oct. 26, 2002.

Guest Lecture with Cliff Solomon, Educational Technologist, UW School of Nursing. "Evaluating Instructional Technology in the School of Nursing." University of Washington Graduate Seminar. Professor Sara Kim. Aug. 8, 2002.

"Feminizing Crisis: National Institute of Mental Health (NIMH) Documents and the Construction of American Women's Depression." 10th Annual American Studies Colloquium Conference. University of Washington, Seattle. May 3, 2002.

"The Rhetoric of Writing Programs." Western States Composition Conference. Arizona State University, Tempe. Oct. 27, 2001.

"'Once I Was Lost, Now I Am Found': Can the Portfolio Cover Letter Avoid the Narrative of Progress?" Writing as a Human Activity. University of California, Santa Barbara. Oct. 6, 2001.

"Gendering Fiction: An Analysis of *Seattle Times* Book Reviews." Comparative Literature Colloquium Conference. University of Washington, Seattle. Apr. 6, 2001.

"Rethinking First-Year Composition: Enabling the Performance of Diversity." Western States Composition Conference. University of Utah, Salt Lake City. Oct. 14, 2000.

"Manna from the Lectern: An Exploration of Student Attitudes Toward Grades." Languaging 2000: A Conference Across Linguistics, Literature, and Writing. University of North Texas, Denton. Mar. 4, 2000.

"Economies of Prevention: Tamoxifen, Breast Cancer and News Reporting." Language & Rhetoric/Language Use & Acquisition Colloquium. University of Washington, Seattle. Jun. 9, 1999.

Scholarship of Teaching & Learning

Conferences, Presentations & Roundtables

"Assessing and Improving Online Discussions Based on Student and Faculty Perspectives" American Association for Higher Education Assessment Conference. Seattle, WA. Jun. 22, 2003.

"'You Can't Say That': Sexually Explicit Language in the Classroom." Practical Pedagogy Colloquium. University of Washington, Seattle. Feb. 26, 2003.

"Creating a Teaching Portfolio." Practical Pedagogy Colloquium. University of Washington, Seattle. Feb. 21, 2002.

"Creating a Course Web Site." Practical Pedagogy Colloquium. University of Washington, Seattle. Nov. 7, 2001.

Topics in Teaching, including "Teaching with Technology," "Presenting Your Work at Academic Conferences," and "The Ph.D. Exam Process." English Graduate Student Organization Roundtables. University of Washington, Seattle. Spring 1999 – present.

"Teaching English 105 in the Computer Integrated Classroom." Orientation for the Computer Integrated Classroom Program. University of Washington, Seattle. May 7, 1999.

Workshops Designed & Led

"Writing Centers: Practice & Pedagogy." Campus Writing Centers Seminar. University of Washington, Seattle. Oct. 9 & 16, 2002.

"Instructional Technology." Pre-Autumn Workshop, International TA Program. University of Washington, Seattle. Sept. 18, 2002.

"Responding to Student Writing." Pre-Autumn Workshop, International TA Program. University of Washington, Seattle. Sept. 18, 2002.

"Leading Discussions." School of Social Work Graduate Seminar. University of Washington, Seattle. Nov. 29, 2001.

"Peer Tutoring in Engineering." University of Washington, Seattle. Oct. 2, 2001.

"Writing Centers: Practice and Pedagogy." Campus Writing Centers Seminar. University of Washington, Seattle. Oct. 17 & 24,18 & 23, 2001.

"The First Day of Class." Women Studies Department Seminar for new Teaching Assistants. University of Washington, Seattle. Sept. 26, 2001.

"Leading Class Discussions." Women Studies Department Seminar for new Teaching Assistants. University of Washington, Seattle. Sept. 24, 2001.

"Teaching with Technology" and "Responding to Student Writing." Pre-Autumn Workshop, International TA Program. University of Washington, Seattle. Sept. 19, 2001.