

Angela

Near the end of her initial visit to my office, a sudden rift emerged between Angela (not her real name) and me. Until then, the evaluation seemed to have gone very well. Angela, a 20-year-old college senior, had come to see me because of “mood swings.”

“Some days I feel so irritable and sad that it’s hard for me to get out of bed,” she explained. “I lie in bed and cry, though nothing is really wrong.” Angela missed class during these episodes and as a result was in danger of not graduating. Moreover, her boyfriend had become concerned about vague suicidal threats, made during Angela’s “worst” moments. At other times, Angela felt energized: “I’m on the move—I get all of my work done, clean my room, and go to parties until 3 a.m.”

Our discussion openly explored the disruptions this pattern caused to nearly all aspects of Angela’s life, from “bad grades” to concerns about her relationship to worries because her mother suffered from similar mood swings. Thus, I was surprised when Angela reacted angrily to my comment that mood-stabilizing medications might be helpful if it turned out that she suffered from a type of bipolar disorder. “You’ve got it all wrong—I came here for Paxil because I have chronic anxiety disorder.” She explained that she made the appointment after seeing a paroxetine advertisement in *Marie Claire*, which described the “fatigue, restlessness, and irritability of chronic anxiety.”

“You’ve got it all wrong—I came here for Paxil because I have chronic anxiety disorder.”

“I decided that this was me,” Angela explained. “Don’t you think Paxil will help me?”

My first response, although well intentioned, was in part the wrong one: I explained to Angela how many different conditions cause anxiety, how different types of medications are required in different cases, and how a drug such as paroxetine might worsen her mood swings. Only later did I realize that my professionalized response was based on a fantasy that I could create a hermetic clinical interaction free of marketing, image, or direct requests for brand names. I missed the obvious point, that Angela had come to see me expecting to receive a prescription for Paxil because of an advertisement, and my reaction partially discounted the importance of her expectation.

Privileged by retrospection, I recognized that the Paxil advertisement helped shape the conversation that Angela and I were having. For instance, the advertisement provided a language for Angela to express her feelings as symptoms and promoted her realization that treatments existed for a condition for which she had heretofore suffered alone. The advertisement also shaped my understanding of Angela’s narrative: I readily understood the connotations of “irritability” and “fatigue,” and I had in fact seen the same advertisement on television only a few days before. Most important, the Paxil advertisement complicated the interaction between Angela and me, which unavoidably revolved around anticipation of whether paroxetine would be the answer to the question that we suddenly openly shared. This anticipation also threatened to create a division between us—as patient and doctor—if I were to decide that Depakote was better indicated or even that psychotropic medications were not the best treatment for her set of concerns.

If the advertisement played such a role within the seemingly closed confines of our clinical interaction, then its efficacy exposed some of the larger issues encapsulated by the union of medicine and marketing. For instance, psychotropic drugs function as brand-name products, advertised because of competition between Paxil, Zoloft, Celexa, and other drugs with brand names whose advertisements Angela and I had (as knowledgeable consumers) probably seen as well. Psychotropic medications also carry gen-

der connotations: the paroxetine advertisement appeared in a women's magazine and depicted a woman very much like this young woman, who appeared in her white male doctor's office. And psychopharmaceuticals conveyed the promise of "enhancement," to use bioethicist Erik Parens's term (1) for the illusion that psychotropic drugs treat problems with grades, boyfriends, and a host of other issues well beyond the realm of a drug's known chemical effects. These and countless other tensions were surely with us in the room, and they influenced the meanings that Angela and I ascribed to psychotropic medications as a result.

How, then, could I answer Angela's question about whether Paxil would help her? My answer, I realized, was that I did not know the answer because I did not know what Paxil meant within the context of our interaction. Neither Angela nor I had yet done the work of translating the drug's many clinical and cultural variables into the specific meaning of "Paxil" in our conversation. Rather than taking "Paxil" at face value, we needed to first explore the expectations, assumptions, and desires embedded within Angela's request. Why did she identify with the advertisement? What in the advertisement made her think that the medication would be helpful, and what changes did she anticipate as a result? How did her answers connect with my own expectations for her treatment?

Answering Angela's question with my own set of questions meant tacitly acknowledging that marketing factors and advertising campaigns can shape descriptions of symptoms and understandings of treatments. Like never before, current direct-to-consumer advertisements catalyze a host of clinical situations that seem antithetical to psychiatric principles that hold to meanings constructed within the therapeutic dialogue as sacrosanct. Yet only by letting advertisements into the examination room, so to speak, can clinicians reclaim expertise in the desires and expectations so well identified by the advertisements themselves. In the process, clinicians can begin to translate general discussions of the anxieties upon which all pharmaceutical advertisements depend into the unique meanings of these drugs for each individual patient.

Reference

1. Parens E: Is better always good? the Enhancement Project. *Hastings Cent Rep* 1998; 28:S1-S17

JONATHAN M. METZL, M.D., PH.D.

Address reprint requests to Dr. Metzl, Program in Culture, Health, and Medicine, University of Michigan, 2203 Lane Hall, Ann Arbor, MI 48109-1290; jmetzl@umich.edu (e-mail).