

“All on the List”: Uptake in Talk about Depression¹

Kimberly Emmons, Case Western Reserve University

*“Approximately 19 million Americans experience depression, yet only 1 in 10 will ever seek treatment. The DEPRESSION SELF-SCREENER is a simple 20-question quiz that can help identify common symptoms of depression and their severity. Remember—depression is more than just feeling down. It is a real medical condition that can be effectively treated, but first you must seek help.”*² (Lexapro® depression self-assessment tool)

*“You know when they [medical and pharmaceutical websites] list the symptoms, it’s 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 you’re like ‘Oh, I am depressed. I need help.’”*³ (“Claire,” depression study participant)

The introduction to the Lexapro® self-assessment tool frames an important recent rhetorical intervention into U.S. healthcare: the combination of direct-to-consumer marketing with patient education efforts. In Claire’s reaction to websites that list the symptoms for depression, she demonstrates the power of such tools for promoting recognition and encouraging help-seeking behaviors. In this chapter, I am interested in the discursive construction of depression and of the social interactions among pharmaceutical companies (like Forest Pharmaceuticals, makers of Lexapro), prospective patients (like Claire), and healthcare providers. In the following pages, I argue that the now ubiquitous genres of the symptoms checklist and the self-diagnostic quiz⁴ organize a complex, rhetorical relationship among these principal figures in the narrative of mental health and that they help construct depression itself as an illness. Tracing these genres’ origins in two distinct social contexts – women’s popular magazines and medical professionals’ diagnostic guidelines – I consider what happens when these genres are translated into the new persuasive context of direct-to-consumer advertising. Such translations involve two interrelated rhetorical processes, which I will call “generic uptake” and “discursive uptake.” These shape both the institutional and personal roles available in

relation to depression and also the definition and recognition of the illness itself. “Generic uptake,” the transference of one rhetorical form and its uses to a new social setting, transmits the patterns of social organization (e.g., the positions of authority and expertise) typical of the genre’s former location. “Discursive uptake,” the repeated use of specific words, phrases, and grammatical constructions, affirms the definition of an entity such as depression within sanctioned linguistic frameworks. In the following analysis, both processes work to construct the depressed patient as female and socially isolated. This construction becomes particularly important when I turn my attention to the conversations among women experiencing mild to moderate depression. In these conversations, the processes of generic and discursive uptake encourage self-diagnosis and an uncritical acceptance of the illness paradigm. In Claire’s comments above, the shifting pronouns – from “they” to “you” to “I” – indicate the strength of her personal investment in and identification with the label *depressed*. Such identification, for Claire, questions neither the social roles (the expertise of the website, the external location of “help”) embedded in the genre, nor the content of the list itself. Thus, within the processes of generic and discursive uptake, *experiences* become *symptoms* and *individuals* become *patients*. For the medical rhetorician, then, an analysis of these discursive processes affords an opportunity to study the interactions among genres, texts, and social actors.

Genres and Uptakes

Recent work in rhetorical genre theory suggests that genres are not neutral forms into which content is poured. While a traditional view sees genres as sets of formal features that define texts as, for example, sonnets, detective stories, or self-help quizzes, rhetorical genre theorists see these forms as conditioning the production of texts *and* social interactions within

various social contexts. As Carolyn Miller describes them, genres are forms of social action (31). Typical forms (such as the diagnostic quiz) develop within social contexts to answer perceived needs and to accomplish the goals of the communities that use them. Genres (and the individual texts that enact them) consequently become prime artifacts in analyses of key social interactions within communities.⁵

For scholars such as Anne Freadman, interactions among genres are as significant as individual examples of the genres themselves.⁶ Genres must be answered by subsequent genres – they must secure their own “uptakes” – in order to have social force and meaning. For instance, a doctor’s recommendation of a particular medication must be followed by an official prescription (and that prescription must be conveyed to the drug store) in order for the recommendation to result in the dispensation of the medication. At each of these points in the transaction, “uptake” operates as a recognition of the previous text and an enactment of the text that follows from it. “Uptake,” then, is a rhetorical process that can be identified through the textual traces it leaves behind; individual uptakes are visible in the ways that texts position themselves in relation to other texts. Thus, “uptake” points our attention toward an ideologically charged space *between* genres and texts; it calls for an analysis of the circulations in addition to the singular texts that construct our discursive worlds.

Freadman extends the traditional speech act theory use of the term “uptake,” which sees uptake as an interlocutor’s simple recognition of a speaker’s meaningful intention, by suggesting that uptakes are imbued with “long, ramified, intertextual, and intergeneric memories” (40). Uptakes’ memories cause specific texts to appear natural or inevitable within any given local, historical moment. This naturalization – for example, the apparently logical extrapolation of illness (a diagnosis of depression) from quiz results – ensures that potential patients and even

medical professionals will expect and perform specific uptakes (diagnosis, prescription, treatment) and ignore or not recognize others (analyses of social dynamics). Yet, Freedman observes, uptakes can fail to conform to their generic expectations, and in these moments uptakes can modify their discursive and generic contexts. This possibility – the fact that a text cannot ultimately guarantee its own uptake – offers a place for individual agency and rhetorical action. While overtly persuasive texts such as pharmaceutical advertisements attempt to secure the uptake of consumer purchases (and are quite often successful), they are also subject to unauthorized or partial uptakes, as when the consumer uses the text as an occasion for a conversation with a friend (who may be unpersuaded) rather than a doctor (who may not prescribe the medication in any case). Within the discourses of depression, the processes of uptake operate on both generic and discursive levels: “generic uptake” accounts for the charged spaces between and among forms and contexts, while “discursive uptake” explores features of texts that make the complex passage through these spaces. In the following pages, I consider the self-diagnostic quiz for depression – a hybrid genre that takes up two distinct sets of social practices – and I argue that this genre helps organize and construct women’s experiences of depression.

Generic Uptake & the Regulation of Social Interaction

Readers of women’s magazines are quite familiar with the genre of the self-help quiz. These usually brief, multiple-choice tests – “Who’s Your Celebrity Love Match?” and “What’s your Girlfriend Style?” and “Are You Too Picky?”⁷ – are a staple of popular women’s magazines and websites, and they offer relationship or social advice based on the respondent’s final score (answers of “A” = 5 points, and so forth). In these quizzes, the “results” are often

aggregated and reported in a few broad categories. For example, after completing the “Are You Too Picky?” quiz, a woman might read her evaluation under the headings: “You Deserve Better” or “Impossible to Please.” Rhetorically, these social diagnostics suggest to women not only that their experiences are shared (by others in their category) but also that these experiences can be usefully understood through a short series of multiple-choice questions.

In another sphere, medical professionals will recognize the genre of the diagnostic checklist meant to guide their therapeutic decision-making. Indeed, in psychiatric medicine, the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), first published in 1952, has become the final arbiter of mental health and illness in the United States.⁸ The current DSM, the text revision of the fourth edition (DSM-IV-TR), contains both lists of symptoms and indications of disease thresholds. According to the DSM-IV-TR, a patient must exhibit five of nine symptoms for a duration of two weeks or more to qualify for a diagnosis of “Major Depression Disorder.” Rhetorically, these professional diagnostics offer sanctioned interpretations of symptoms, legitimize courses of treatment, and verify eligibility for insurance reimbursement.

Read side by side, these two genres – the self-help quiz and the professional diagnostic – strongly echo each other. While there are formal differences – for example, the use of multiple choice answers in the case of self-help quizzes, and the nominalizations of the DSM-IV-TR (“markedly diminished interest or pleasure” [356]) – the primary difference between these genres is the context in which they are found. Popular women’s magazines, available at local grocery and convenience stores, represent themselves as ephemeral and transitory guides to life, love, and work. The DSM-IV-TR, while publicly available, is certainly an example of a specialized discourse, used primarily by healthcare providers for the purposes of record keeping and documentation.⁹ Because these contexts vary so starkly, the two genres have historically

operated quite independently. In recent decades, however, the explosion of direct-to-consumer advertising¹⁰ has effected the uptake (and merger) of these two genres into a new context that works to redefine the traditional relationships among pharmaceutical companies, prospective patients, and healthcare providers.

In the case of depression, the development of a new class of antidepressants – the selective serotonin reuptake inhibitors (the SSRIs such as Prozac® and Zoloft®) – in the late 1980s and 1990s has coincided with the rapid increase in pharmaceutical marketing and a popular fascination with depression¹¹ in the United States. Most antidepressants now have dedicated websites, which offer versions of a depression quiz or checklist that asks the respondent to rate her (or, much less frequently, his) symptoms.¹² Such quizzes produce a “printable version” that the respondent is directed to take to her doctor for additional evaluation and possible treatment.¹³ These quizzes are the result of generic uptakes that have combined the genres of the self-help quiz and the diagnostic checklist, drawing on the social interactions of both. By enumerating symptoms rather than experiences and by addressing a serious, medical topic, the self-diagnostic quiz appropriates the authority of the diagnostic rubric, establishing itself as a representative of the expert system of psychiatry. At the same time, however, the self-diagnostic quiz deploys a multiple-choice format and first- and second-person forms of address to create an affiliative relationship with its readers. Thus, the uptake of these genres works to establish new social relationships and patterns of interaction.

The evolution of these generic uptakes can be traced in antidepressant advertisements, indicating the refinement of the genre as it is adapted to its new context and purpose. In early direct-to-consumer advertisements, the checklist is not clearly separated from the text of the advertisements; the uptake of the form itself seems to lag behind the uptake of the content. In a

1998 Prozac print advertisement, a narrative description of depression provides readers with information they are presumed to lack.

Depression can make you feel all alone in the world. Especially when you're around people who think depression is all in your head. Well, it's not. Depression is a real illness with real causes. It can appear suddenly, for no apparent reason. Or it can be triggered by stressful life events, like losing a job or having a chronic illness.

When you're clinically depressed, one thing that can happen is the level of serotonin (a chemical in your body) may drop. *So you may have trouble sleeping. Feel unusually sad or irritable. Find it hard to concentrate. Lose your appetite. Lack energy. Or have trouble feeling pleasure.*

These are some of the symptoms that can point to depression—especially if they last for more than a couple of weeks and if normal, everyday life feels like too much to handle. (Prozac advertisement, emphasis added)

In this advertisement, the symptoms that “can point to depression” are listed as possible outcomes of a drop in serotonin. The symptoms themselves are mere indicators of the underlying illness; they are included for informational purposes. The Prozac ad goes on to claim Prozac as the “medicine doctors now prescribe most often,” an implied persuasive appeal that nevertheless gives grammatical agency to doctors themselves. Similarly, the advertisement cautions that “[o]nly your doctor can decide if Prozac is right for you – or for someone you love.” While clearly a promotional text, this advertisement nevertheless maintains the traditional doctor-patient social roles: the doctor will decide; the patient is to be educated.

By contrast, a 2001 print advertisement for Zoloft presents its case more forcefully and indicates a significant shift away from the traditional doctor-patient consultancy. In this

advertisement, the symptoms are listed in bold-face type at the top of the advertisement. Not only are they presented as a list – more akin to the professional diagnostic’s format – they are also phrased as items within the consumer’s knowledge (rather than the physician/expert’s):

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. (Zoloft advertisement)

This initial invitation to self-diagnosis is partially countermanded by a smaller print statement that “[o]nly your doctor can diagnose depression,” but the overall message to consumers in this advertisement is that *they* and not their doctors understand and interpret their own symptoms. Commanding the reader to “Talk to your doctor about ZOLOFT,” the advertisement explicitly enters the social interaction between doctors and patients. Instead of deferring to the doctor’s judgment, the Zoloft campaign tagline – “When you know more about what’s wrong, you can help make it right” – places the consumer (“you”) and the pharmaceutical company (the providers of this education) into more active roles in making healthcare decisions. As the Zoloft advertisement has adopted the form as well as the content of the genre of the diagnostic checklist, it has assumed some of the professional authority traditionally associated with the medical tool, and yet, drawing on the popular self-help genre, it has also established a personal relationship with its readers, whose self-knowledge becomes a primary focus for the encounters.

Pharmaceutical websites tend to use the interactive format of the quiz rather than the static listing of symptoms, and have therefore adopted the social-interactional style of that genre most explicitly. On the Prozac website, the reader is directed to select one of four answers to questions such as: “I am more irritable than usual” and “I still enjoy the things I used to do.” When all of the answers are complete (and only then, the form will not let you submit a partial quiz), the user clicks on a “Get Your Score” button and is answered by a short message that reads: “You scored a [Number]. If you score 50 or higher, consider printing the results of your test to show your doctor.” This emphasis on a “score” is highly reminiscent of popular relationship quizzes, which seek to group readers according to broad categories, but the insertion of a threshold reinforces the diagnostic authority of the quiz. A user scoring above 50 is encouraged to display the “results” – a pseudo-scientific term for what amounts simply to the standardized text of each answer – for medical interpretation. Here, the quiz becomes analogous to an x-ray or the physical evidence of an illness, and the website becomes a referring physician, suggesting a specialized consultation. Pharmaceutical websites and other direct-to-consumer advertising texts have taken up both the symptoms list and the interactive quiz, as well as their accompanying social organizations. Combining the authority of the symptoms list with the affiliation and assumption of self-knowledge of the relationship quiz, the new genre of the self-diagnostic quiz participates in and helps shape the interactions between doctors and potential patients. The generic uptake repositions the actors within healthcare interactions; the discursive uptake (of specific symptoms for depression) helps define the contours of the illness itself, as we shall see in the next section.

The Discourse of Symptoms: Gendering Depression

Whereas the forms of discourse – like the symptoms list or quiz – help shape the social interactions possible among participants, the specific articulations themselves – the words, images and grammatical constructions – help define the object (in this case depression or the depressed patient) itself. Here, too, the process of uptake operates to guide the selection and organization of appropriate locutions. The cultural memory of uptake sanctions both disease and patient identities. As the genre of the symptoms list has been taken up and transformed into a self-diagnostic quiz on pharmaceutical websites and in print media, it has consistently marked the illness and its sufferers as feminine and isolated from proper social functioning. Turning now to these instances of “discursive uptake,” I argue that the process of uptake encodes the institutionally recognizable form of illness and therefore restricts the available means for self-representation (as we shall see in the conversations about depression in the following section).

In *The Birth of the Clinic*, Michel Foucault writes that “[t]here is disease only in the element of the visible and therefore storable” (95). Yet, as he explains in *Madness and Civilization*, the visible is discursively organized and constructed; the symptoms of manic depression are observable only after “the construction of explanatory images” which organize and validate the symptoms as “truth” (135). Thus, Foucault demonstrates that the practices of recognition (of illness) are historically conditioned by the discourses that both develop from and also shape our powers of observation. Indeed, symptoms for depression can only be recognized once the concept *depression* has structured the ways we look for (and find) them; and, further, the concept itself encodes a culturally and historically mediated reality. Thus, a close examination of the conditions of recognition – in this case via the self-diagnostic quiz – offers insight into the content of the concept itself.¹⁴

The list of depression's symptoms may be neither neutral nor historically and culturally stable, but it does condition our ability to recognize depression as an illness.¹⁵ According to the DSM-IV-TR, the major symptoms of depression are the following: depressed mood, loss of pleasure, weight changes, sleep disruptions, psychomotor agitation or retardation, fatigue, feelings of worthlessness, difficulty concentrating, and thoughts of suicide. Many of these symptoms, as mental health professionals sometimes recognize, are more likely to be identified in women than in men.¹⁶ This apparent diagnostic bias may be partially explained by a critical reading of the language of the questionnaires and checklists that help define the illness. This language, I argue, reflects the processes of discursive uptake, which work to codify the concept of *depression*.

The translations that occur in the processes of converting medical categories (as represented in the DSM-IV-TR) into quiz questions help define depression as a feminine disease. Table 1 compares the language of the DSM-IV-TR to that of three currently circulating versions of self-diagnostic tools – a quiz from Prozac.com based on the Zung Depression scale, a quiz from Zoloft.com based on PRIME-MD™, and a questionnaire (the CES-D) developed by the National Institute of Mental Health.¹⁷ While scientific studies have validated each of these tools, little rhetorical attention has been paid to any of them. For the purposes of this analysis, I wish to suggest that the three quizzes make consequential revisions to the scientific language of the DSM-IV-TR. Scholars such as Greg Meyers have traced the movement of text from scientific and disciplinary contexts into the public sphere; the articulations and translations I am pointing out here are not unique to depression. They are, however, skewed toward stereotypically feminine behaviors and emotions in some cases. For example, the DSM-IV-TR describes the symptom of “weight changes” as a “change of more than 5% of body weight in a month.” In the

quizzes, this is translated into “losing weight” (Zung), “poor appetite” (PRIME-MD), and “not feeling like eating” (CES-D). While these may in fact be “more accessible” criteria for patients and/or doctors, I would argue that a focus on *eating* is not the same thing as a focus on rapid and drastic changes in *weight*. Further, women in our society are much more likely to notice their eating habits and to focus on “losing weight” as part of their self-image maintenance.¹⁸ In addition, only the PRIME-MD includes “overeating” in this category – the others simply ignore the possibility of weight *gain* as a symptom of depression. Similarly, the “Agitation/Retardation” symptom goes from “psychomotor agitation or retardation” in the DSM-IV-TR to “Moving or speaking so slowly that other people notice” in the questionnaire based on the PRIME-MD and to “I talked less than usual” in the CES-D. Again, the emphasis on speaking takes up the gender stereotype that women are more verbal than men. The symptoms of depression as the questionnaires currently define them are, I am arguing, skewed toward such gendered behaviors.

The language of these various symptoms lists focuses on excesses of emotion; depression is often conceptualized as the far end of a spectrum of grief and sadness. Yet this ambiguity – where does “normal” grief end and depression begin? – leads to difficulties when diagnostic precision is assumed to be the result of valuing responses to these questions. The translation of “depressed mood” (DSM-IV-TR) into “crying spells” (Zung, CES-D) may in fact make the criterion more concrete. But, it also focuses attention on a specific behavior, crying, that is more socially acceptable for women than it is for men. Further, the characterization of the episodes as “spells” evokes feminine emotional turmoil and collocates with children and immaturity, suggesting that depression sufferers are helpless and infantile. The symptoms quizzes recast the observation of a patient’s “tearful” appearance in the DSM-IV-TR as an uncontrollable storm,

performing uptakes of emotional commonplaces that help to feminize the illness and its sufferers.

Table 1: Comparison of Selected Symptoms in Checklists for Depression¹⁹

Symptom	DSM-IV-TR	Zung (Prozac.com)	PRIME-MD™ (Zoloft.com)	CES-D (NIMH)
Depressed Mood	<ul style="list-style-type: none"> 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). 	<ul style="list-style-type: none"> I feel downhearted, blue, and sad I have crying spells or feel like it I feel hopeful about the future I am more irritable than usual My life is pretty full 	<ul style="list-style-type: none"> Feeling down, depressed, or hopeless 	<ul style="list-style-type: none"> I felt that I could not shake off the blues even with help from my family I felt depressed I felt hopeful about the future I was happy I felt lonely I had crying spells
Loss of Pleasure	<ul style="list-style-type: none"> 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) 	<ul style="list-style-type: none"> I enjoy looking at, talking to, and being with attractive men/women I find it easy to do the things I used to I still enjoy the things I used to do 	<ul style="list-style-type: none"> Little interest or pleasure in doing things 	<ul style="list-style-type: none"> I enjoyed life
Weight Changes	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> I eat as much as I used to I notice that I am losing weight 	<ul style="list-style-type: none"> Poor appetite or overeating 	<ul style="list-style-type: none"> I did not feel like eating; my appetite was poor
Agitation/Retardation	<ul style="list-style-type: none"> Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down) 	<ul style="list-style-type: none"> My heart beats faster than usual I feel restless and can't keep still 	<ul style="list-style-type: none"> Moving or speaking so slowly that other people notice. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual 	<ul style="list-style-type: none"> I talked less than usual
Feelings of Worthlessness	<ul style="list-style-type: none"> Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick) 	<ul style="list-style-type: none"> I feel that I am useful and needed 	<ul style="list-style-type: none"> Feeling bad about yourself, or feeling that you are a failure or have let yourself or your family down 	<ul style="list-style-type: none"> I felt that I was just as good as other people I thought my life had been a failure I felt that people disliked me

Beyond the emphasis on feelings, the symptoms lists also draw out social and family relationships as being significant factors in the diagnosis of depression. The DSM-IV-TR criteria note in several places that symptoms may be self-reported or observed by others, but no mentions of peers or family are made. In contrast, all three of the questionnaires refer to social groups and families. The Zung quiz refers to the enjoyment of “looking at, talking to, and being with attractive men/women.” This item – one of the “reverse” questions in the quiz that helps

ensure readers are carefully attending to each question – clearly indicates that one should enjoy these social activities. The PRIME-MD asks about “feeling that you...have let yourself or your family down,” introducing the family unit into the diagnostic apparatus. Similarly, the CES-D asks about “the blues” which cannot be shaken “even with the help from my family” and also about feelings that “people disliked me.” Each of these quiz items helps reinforce the “healthiness” of social relationships, and marks the failures of such relationships as potential symptoms of illness. Significantly, the transformation of the impersonal diagnostic criteria of the DSM-IV-TR into first-person statements (Zung, CES-D) reinforces the personal responsibility of the individual, while it simultaneously removes the possibility of peer and family reporting of symptoms. Thus, the individual is rhetorically isolated even as she is asked to rate her social functioning. Here, traces of both discursive and generic uptake reveal the construction of depression as an illness and as a set of available social roles.

An emphasis on the individual’s responsibility for adequate social functioning as well as the repetition of feminized descriptions of symptoms for depression is embedded in the ways we describe the illness. Through the rhetorical practices of discursive and generic uptake, the texts used to diagnose and identify depression regulate not only what counts as illness but also what roles we expect of patients and healthcare providers in relation to it. When individuals take up “the list” of symptoms for depression, as they do in the interviews described below, they begin the process of de-narrativizing their own experiences. Giving up the particularities of their individual encounters with these symptoms, their uptakes of “the list” leave unchallenged the ideological implications of the definition inherent in it. Further, these uptakes vest the individuals with responsibility for managing their new medical conditions, usually through pharmaceutical interventions.

Defining the Self: Generic Uptake in Women's Talk about Depression

A theory of uptake implies that individuals participate – through their spoken and written interactions – in the construction of their illness identities. To accept the label *depressed* is to take up the implied and explicit definitions of that illness identity. To take up the genre of the symptoms list is to accept crucial elements of its authority and its social explanatory powers. In an effort to understand how individual women might be taking up the discourses and genres surrounding depression, I conducted two interviews with groups of women experiencing moderate symptoms of depression. This study,²⁰ conducted in summer 2002 on the campus of a research university in the Northwest, involves four undergraduate and three graduate students who were identified using the NIH's CES-D depression scale. At the time of the interviews, the women scored in a range slightly below the level of clinical depression and were therefore experiencing symptoms of depression but were not undergoing treatment for it. As such, these women represent the “worried well,” the likely targets for direct-to-consumer advertising like that described above.

The group interview format of this study provided an opportunity for the women to talk to each other as much as to me, allowing me to capture their reactions to and reiterations of each other's statements. The interviews were semi-structured, meaning that there were a few broad questions that I asked to initiate conversation – including “How did you hear about this study?” and “What have you read about depression?” – but that the conversations were left to follow the paths directed by the interviewees themselves as much as possible. The transcripts of these interviews, each approximately one hundred minutes long, provide concrete evidence of women's uptakes of the discourses and genres of depression.

In the interviews, the women refer to the symptoms of depression as established facts and as a coherent unit: “the list.” In their conversations, the women take up the genre of the symptoms list as a single (and stable) entity, rather than interrogating (or even enumerating) its contents. By doing so, they participate in the de-narrativization of the illness. As the noted psychiatrist and medical anthropologist Arthur Kleinman has argued, the reduction of suffering (an experiential entity) to symptoms (diagnostic entities) is a move that empties suffering of its social and moral significance: a move he deems “very dangerous” (“Who We Are”). For Kleinman, the shorthand of symptoms masks the complexities of lived experiences and ignores the value of suffering to promote ethical social behaviors. The generic uptake of “the list” consequently represents a challenge to patient self-definition; without delineating the specific symptoms, the women appear to accept and recirculate the gendered construction of depression itself.

This emptying or forgetting of the narrative trajectory of one’s illness experiences is very clear in the ways that the women in this study make use of the symptoms list. The list itself seems to hold power as a synecdoche for a larger expert system of diagnosis and treatment. It operates at the level of a dead metaphor, being evoked by the women in this study as a self-evident and transparent frame that signals their illness identities. In fact, the symptoms list at times eclipses the expertise of mental health professionals themselves. Not only do the women identify the list of symptoms as a single discursive unit, but they also set the authority of this list against and above the authority of health care professionals. About an hour and a half into the Group 1 interview, Claire, a graduate student in the humanities, relates her recent visit to the campus health center (Figure 1). In Claire’s narrative, an important feature is the erasure of her individual symptoms in favor of the more generalized “list.” She reports that the campus health

professional asked her questions to which she responded with her symptoms, “which were all on the list.” Here, Claire assumes a common knowledge of a stable (and complete) list of symptoms of depression. By bracketing her own experience in this way, she accepts the diagnosis offered by the symptoms list itself; she translates her particular experiences into a set of medically visible symptoms. Further, she casts doubt on the reliability of the health center professional (whom she calls “a woman in there”) because the professional does not immediately recognize Claire’s symptoms as fulfilling the checklist for depression. Instead, Claire reports that the healthcare provider “didn’t [...] say ‘you’re depressed’.” Thus, the symptoms list carries more diagnostic certainty than the healthcare provider. Claire’s interaction with the campus health center is structured by her use of the symptoms list as an interpretative and self-diagnostic tool. The healthcare provider seems to agree with the list’s diagnosis and recommends appropriate treatment, but Claire’s representation of this encounter displays her confidence in the list of symptoms and foregrounds her own rhetorical presentation and self-definition (via “the list”) as occurring prior to the healthcare encounter.

KE	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 (.) she didn’t, you know, say ‘you’re depressed’ she said (.) she said it sounded that way and, and recommended counseling and medication

Figure 1: Group 1 Interview (85:00)

Claire repeats the elision of individual symptoms of depression again a few minutes later in the interview, when she describes a television commercial for a research study. In Figure 2, Claire reports the content of the commercial, but this time she replaces the details of the symptoms of depression with: “blah blah blah.” She again relies on her interlocutors’ shared

knowledge of the symptoms rather than elaborating on them as individual entities. Treating the symptoms in this way, Claire adopts an uncritical stance towards them: they form part of a common stock of facts, rather than a culturally determined set of guidelines. Further, her identification with the commercial also signals her acceptance of the illness identity offered by the list of symptoms: she believes she is depressed, and she believes this because her symptoms match a uniform list that represents a single diagnosis. Yet, the list itself may in fact hide additional important symptoms²¹ and also social and environmental contexts that are relevant to health and illness experiences. Symptoms are based in discrete individual experiences, but when they are grouped together as abstract entities, they lose this specificity. Further, this abstraction renders unnecessary the possible explanations: “feelings of hopelessness” described as a single symptom are divorced from their possible social causes (e.g., the loss of a job or a loved one, or the experience of racial or economic inequality). The value of the symptoms list is its ability to help individuals such as Claire recognize their healthcare needs; the danger of this list appears in its ability to seem complete and to keep individuals from recognizing other healthcare options.

KE	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 Seattle Research Study where you can be a volunteer (xx)
KE	What's the commercial like, [...] 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
KE	And, did you identify [with it?
Claire	[Mmmmm hmmm

Figure 2: Group 1 Interview (87:30)

In the second group interview, the women discuss the experience of interacting with a symptoms questionnaire. In Figure 3, I ask the women about their reactions to this form. Initially, Stephanie, an undergraduate humanities major, expresses her frustration with the genre – she “wanted to check between the boxes” rather than conforming to the genre’s four categories (less than 1 day, 1-2 days, 3-4 days, 5-7 days). But as the conversation continues, Mei, an undergraduate health sciences major, reports that the experience of filling in the survey helps her clarify her experiences as part of the illness, depression. The women in this study were chosen specifically because they did *not* score high enough on the CES-D index to be considered clinically depressed, so it is notable that the form itself still works to validate Mei’s personal sense that she is, in fact, depressed. Mei admits that she would not necessarily be able to write down all of her symptoms, but that she recognizes them when she sees them in the CES-D. This recognition suggests that the genre itself does both rhetorical and diagnostic work for the individuals who use it. The women use the form as a means of articulating something they feel but for which they do not have terminology, but, in the process, they also consent to the form’s diagnostic imperative. In Figure 3, Stephanie finds the form “convenient” and “validating.” The genre indicates to her that others feel as she does; the authority of the form works to help her define her own experiences.

The women in this study reveal themselves to be active participants in their own discursive construction as depressed (or not depressed) individuals. Their uptakes of the symptoms list as a single unit suggest that this genre has, indeed, become a significant determiner of illness identity. To qualify for diagnosis, one must have symptoms “on the list” and must represent oneself through that rhetorical lens in order to be recognized. More significantly, the women in this study make use of the genre of the symptoms list to create

personally meaningful identities. Especially in Figure 3, Stephanie and Mei find the genre a useful tool for categorizing and explaining their experiences. These self-constructed meanings are not, however, uncomplicated or free from rhetorical valences. They accept the validity and stability of the definition of depression, and they adopt institutionally recognizable language that implies a narrow range of possible (pharmaceutical) interventions.

KE	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
[...]	
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
KE	That's I-
Steph	It was kind of a convenient compartment- compartmentalizing um experience, oh, yes, this is what this is. Oh, wow, other people feel – this is so validating
Mei	((laughs)) yeah

Figure 3: Group 2 Interview (42:30)

The growth of the self-diagnostic quiz as both a marketing vehicle and an educational tool raises important questions for medical rhetoricians. The women in this study confirm the importance of this new genre in the construction and comprehension of depression as an illness, but they also suggest that it imparts certainty and medical authority that the individual texts within the genre often deny (as seen in the legal disclaimers and notices). How, then, does a genre take up the social functions – primarily of diagnosis and prescription – that were

traditionally performed only by physicians? As I have argued here, part of the answer lies in the process of “generic uptake,” wherein a typical form is transferred from one social venue to another, bringing with it not only textual strategies but also social organizations. As pharmaceutical campaigns realized the effectiveness of their new hybrid genre – the self-diagnostic quiz that takes up both professional diagnostics and popular self-help queries – they began to exploit a new rhetorical position within the healthcare system. Individual readers of such advertising (and educational) materials similarly began to make use of the new genre as a part of their own self-definition. This genre thus becomes an important site for rhetorical investigation, directing our gaze toward the ongoing reconfiguration of healthcare in the United States.

Depression is a phenomenon that is known and largely experienced through the discourse – and, crucially, I hope to have demonstrated here, the genres – in which it is expressed and reported. What comes to be recognized as illness (rather than, for example, as “normal” sadness or grief) is a construction of repeated textual performances. Each text, from diagnostic definition to patient rehearsal of symptoms, reinforces the stability of that construction. The processes of uptake provide the warrants that legitimize rhetorical performances within the discourse of depression. As individuals interact with the texts and genres, they take up the social roles available to them, the contours of the illness itself, and, eventually, they may also take up the material (pharmaceutical) responses to depression. Such uptakes indicate the ideological management of individuals’ experiences by encouraging new patient activism, by transforming narrative events into medical symptoms, and by promoting pharmaceutical interventions. Nevertheless, these uptakes also provide occasions for the construction of personally meaningful self-representations and recognitions, as they seem to be doing for Mei and Stephanie.

Observing the ways that discourses and genres are taken up by individuals allows the medical rhetorician an opportunity to explore the rhetorical construction of health and illness. In recent decades, the public fascination and preoccupation with depression has resulted in a rich array of texts to inform, persuade, console, and treat individuals suffering from it. Within these texts, the genre of the symptoms list has become the authoritative marker of illness; within this genre, the discursive construction of depression as both feminine and socially isolated has been embedded and largely ignored. In both cases, the result for individuals has been that they must accept and work within the boundaries of the concept, *depression*, to seek understanding, recognition, and treatment. Thus, attention paid to the genres – from the DSM-IV-TR to the online self-diagnostic quiz – that help construct illnesses such as depression encourages more nuanced interpretations of how individuals interact with healthcare systems.

Appendix: Transcription Conventions

EXAMPLE	EXPLANATION
Sp 1 I thought you [were saying] Sp 2 [no, I] was talking	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>I mean</i> 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.
(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.
[...]	Ellipses within square brackets indicate a break in the transcript

Notes

¹ I am very grateful to Stuart Brown, Barbara Heifferon, and Kurt Koenigsberger for their very insightful comments on earlier versions of this essay.

² Introduction to the self-diagnostic quiz available on the Lexapro® website: <http://www.lexapro.com/english/understanding_depression/screener.aspx>. Although this tool is not intended to provide a medical diagnosis (as the legal disclaimer attached to the site makes clear), the persuasive appeal – that the reader recognize her/his depression as an illness, that the reader should seek (pharmaceutical) help – is apparent. The second epigraph highlights the ways such tools are interpreted and used by individuals suffering from symptoms of depression.

³ Claire, a graduate student in the humanities, responds to a group discussion about the use of medical and pharmaceutical websites (Group 1 Interview, 92:00).

⁴ For example, Prozac.com describes its self-assessment tool as an "[e]asy to use quiz to help you determine if you may be depressed and chart your symptoms and treatment." See: http://www.prozac.com/common_pages/self_assessment.jsp

⁵ For example, Catherine Schryer identifies competing ideologies within a veterinary school by analyzing the laboratory and clinical genres. For more on genre theory see the foundational collections edited by Freedman and Medway; Bishop and Ostrom; and Coe, Lingard and Teslenko.

⁶ See, for example, Bazerman, “Discursively Structured Activities” and Bawarshi, *Genre and the Invention of the Writer* (especially chapter 5).

⁷ These and other quizzes are available in the “Love & Sex” sub-section of the “women’s community online” iVillage.com (<http://www.ivillage.com>). Additional, health-related quizzes are available from the “Health & Well-Being” sub-section of the same site.

⁸ For a provocative analysis of the DSM, see Kutchins and Kirk.

⁹ See, for example, Berkenkotter; Berkenkotter and Ravotas.

¹⁰ In 1997, the United States Federal Drug Administration released guidelines for direct-to-consumer advertising that significantly relaxed the regulation of such marketing efforts. See, for example, Findlay, *Prescription Drugs and Mass Media Advertising*.

¹¹ As evidence of such popular interest, consider memoirs like Elizabeth Wurtzel’s *Prozac Nation* (1994), which became a feature film of the same name (2001), and nonfiction best-sellers like Peter Kramer’s *Listening to Prozac* (1993).

¹² The use of the feminine pronoun here is intentional – women are more likely to search for health information online. According to the Health on the Net Foundation (<http://www.hon.ch/Survey/febMar2001/survey.html>), 72% of patients in the United States who responded to their recent internet usage survey were women.

¹³ See, for example, the Pfizer’s “Depression Checklist” (available from the Zoloft website): http://www.zoloft.com/zoloft/zoloft.portal?_nfpb=true&_pageLabel=depr_checklist

¹⁴ For example, the familiarity of this form to readers of women’s magazines may add to the feminization of the illness itself.

¹⁵ For a discussion of the cultural variability of depression, see Kleinman and Good.

¹⁶ As part of this study, I interviewed four mental health professionals, who spent a significant amount of time talking about the different presentations of depression in women and in men. According to Laurie, a psychologist, many men who initially appear to have problems with violence and anger turn out to be, in her professional opinion, severely depressed. For Ellen, a psychiatrist, women are likely to become depressed because they are often “trapped into roles of being helpless” (Mental Health Professionals Interview, 78:30). In this conversation, the mental health professionals discuss a range of factors that influence the higher rates of depression for

women, but they also discuss the possibility that they are just “tuned to not looking for” depression in men.

¹⁷ The measurement tools upon which these quizzes are based were developed in 1965 (Zung), 1973 (CES-D), and 1995 (PRIME-MD). The DSM-IV-TR was published in 2000. Pfizer, the manufacturers of Zoloft supported the development of the PRIME-MD. Given the disparate publication dates of the underlying measurement tools and the uncertainties of the exact dates of the quiz versions (though the websites have appeared only recently), tracing an “uptake timeline” from one document to the next would be fruitless. Rather, I mean to suggest that *all* of these documents participate in the processes of discursive uptake that help reinforce the current (2006) definition of depression.

¹⁸ Further, the Prozac.com quiz (Zung) directs the following: “If you are on a diet, answer statements 5 and 7 as if you were not.”

¹⁹ Information in Table 1 taken from: American Psychological Association, *DSM-IV-TR* “Checklist for Major Depressive Episode” (356); “Zung Assessment Tool,” Available: http://prozac.com/common_pages/quiz.jsp; “Depression Checklist,” Available: http://www.zoloft.com/zoloft/zoloft.portal?_nfpb=true&_pageLabel=depr_checklist; Center for Epidemiologic Studies, National Institute of Mental Health, *CES-D*.

²⁰ Human Subjects (IRB) application number: 01-1159-C01, entitled “Women, Language and Depression.” All names in this manuscript are pseudonyms; identifying features have been modified to protect the confidentiality of the study subjects.

²¹ The mental health professionals in this study suggested, for example, that aggression and excessive anger were sometimes linked to an underlying depressive disorder.

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