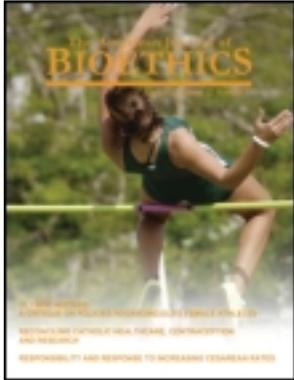


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“Will I Be Pretty, Will I Be Rich?": The Missing Self in Antidepressant Commercials

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Contemplating health decision exceptionalism. In light of closing calls by the authors for further discussion, and with emerging trends in marketing technologies showing no signs of abating, our community faces a slew of important questions, among them whether we should espouse a position of *health decision exceptionalism*. Whereas health information is presently subject to special consideration in the form of heightened privacy protections, the open question here is whether health decisions themselves warrant especial protection, and whether our field should advocate for policies that specifically disallow surreptitious and decided interference in medical, as opposed to other consumer purchasing, decisions (Stark and Fins in press).

With regard to current regulation of online behavioral advertising, in a series of reports drafted by the Federal Trade Commission, including guidelines for industry self-regulation, concerns of health as a special case or exception were confined to restrictions on using private health information as input into the underlying data mining and algorithmic functions (Federal Trade Commission 2009). Seemingly left unexamined were the distinct vulnerabilities and hazards when industry targets individual health—not as input but as output—training sophisticated advertising technologies explicitly on influencing, and perhaps even manipulating and engineering, medical decisions (Stark and Fins in press).

Together with the findings and conclusions of Biegler and Vargas (2013), these emergent trends in health care advertising arouse concerns for the continued integrity of free and informed medical decisions, compelling renewed attention and posing an overdue challenge for our community. If we should collectively deem medical decisions to be substantively different from decisions of which movies to rent or which cereal to purchase, and therefore worthy of special protection, how then do we proceed? What limits do we espouse, what course of action do we undertake, what

role should our community play? While our path on this issue has yet to unfold, we can be assured that our work in protecting medical decisions remains far from over and is, in some ways, only just beginning. ■

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“Will I Be Pretty, Will I Be Rich?": The Missing Self in Antidepressant Commercials

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This undoubted faith in the integrity of the photograph is often rudely shaken; for while photographs may not lie, liars may photograph. (Hine 1909, 3)

In “Ban the Sunset? Nonpropositional Content and the Regulation of Pharmaceutical Advertising,” Paul Biegler and Patrick Vargas (2013) raise concerns about the influence

of direct-to-consumer advertising (DTCA) of prescription pharmaceuticals on viewers’ decisions to use the advertised medicines. Biegler and Vargas point out that the U.S. Food and Drug Administration (FDA) enforces a strict regulatory regime on the propositional content of the commercials by requiring risks and benefits to be outlined and by

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mandating that messages about effectiveness and side effects be presented. Yet no regulations control the nonpropositional content, including imagery, music, and sound effects, causing Biegler and Vargas to ask how such content may foster unjustified beliefs about drug safety and efficacy, and therefore jeopardize the autonomy of viewers' choices by means of evaluative conditioning.

Extending Biegler and Vargas's concerns to the DTCA of antidepressants, I argue that, akin to the influence of their nonpropositional content on viewers' beliefs, the propositional content of these commercials can also trigger some cognitive biases in the viewer. They may implicitly guide the development of unjustified beliefs about drug efficacy and safety.

Consider the commercial for the antidepressant drug Pristiq. A woman with depression appears on screen. She says, "Depression can take so much out of you. I feel like I have to wind myself up just to get out of bed." As she says this, we see a wind-up doll, ostensibly illustrating how she feels. She lists her symptoms: "the sadness, the loss of interest, trouble concentrating, lack of energy." As she does so, we see the doll walking in a robotic fashion, after being wound up. The doll stops intermittently, as its wound up energy expires; it needs to be wound up repeatedly. The patient pauses between symptoms, creating the same stop-start effect. Her eyes are red, as if she is about to cry. A voice-over now describes the chemistry of Pristiq: "Pristiq is thought to work by affecting the levels of two chemicals in the brain, serotonin and norepinephrine." A fast-paced script listing the side effects follows: "Tell your doctor right away if your depression worsens, or if you have unusual changes in behavior and thoughts of suicide. Antidepressants can increase suicidal thoughts and behaviors in children, teens, and young adults. Pristiq is not approved for children under 18. Do not take Pristiq with MAOIs." Of course, while all potential positive effects are enacted on the screen, there is no visual representation of the side effects. We do not, for instance, see anyone on the verge of suicide.

Instead, we witness the woman's transition from depression to health: she smiles, her eyes are clear. She is sitting by a picnic table, watching her young family playing a game in a beautiful park. She sets the wind-up doll aside and directs her attention to engaging with her family; she hugs her kids and smiles happily. The commercial ends as she says: "For me Pristiq is a key to treat my depression."

Such commercials are widespread. Each antidepressant commercial has a similar narrative of a depressed person, who is isolated, sad, and disengaged; with the introduction of the medication, she/he transitions into an engaged and happy life, despite a frightening litany of side effects. Having set the stage, I shall evaluate how the propositional content affects patients' beliefs.

In the Pristiq commercial, depression is individuated as a list of symptoms: sadness, loss of interest, trouble concentrating, lack of energy. This is consistent with how depression is operationally defined in the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, the psychiatric manual used for research, treatment, and administrative purposes.

The symptom-based description of depression is a useful clinical feature of the *DSM* because it picks out the observable features of the patient's experiences and ascertains the reliability of a particular diagnosis across clinical contexts (Tekin 2010; 2011; in press). The diagnostic criteria for depression in the *DSM* include such observable behaviors as sleep disturbance, depressed mood, and so on. If the patient's complaints match these observables, and if the psychiatrist sees fit, the patient is given a diagnosis and an appropriate treatment plan. In addition, the symptom-based descriptions facilitate the development of antidepressants that target specific complaints, such as insomnia, lack of energy, inability to concentrate, and so on.

Under the symptom-based approach, phenomena that describe a particular patient's encounter with depression, individual circumstances that play a role in the emergence or aggravation of her condition and her unique life story are not included because these features are not readily measurable and cannot be generalized across patients. While subjective contingencies, such as personal identity (gender, race, socioeconomic status, etc.), interpersonal relationships, and self-care habits play a crucial role in the onset and the course of depression and are therefore important factors in addressing it (Tekin 2010; in press), the symptom-based account renders these subjective contingencies irrelevant.

The *DSM's* symptom-based schema is widely accepted and disseminated within what I have previously called the *DSM* culture: the interactive social, cultural, and institutional context in which the *DSM*-based schema of mental disorders is put into use outside the clinical context, thereby standardizing the way mental disorder is understood and engaged (Tekin 2010; 2011; in press). The antidepressant commercial is a part of the *DSM* culture. It presents the depression as a symptom cluster, which can be alleviated by using the antidepressants alone. To be clear, as Biegler and Vargas highlight, following the FDA regulations, the propositional content of the commercial is not misleading; it provides information about the symptoms of depression and the possible side effects of the antidepressants. But the information is incomplete. Depression is more than a symptom cluster; the listed symptoms are encountered by an embodied self, situated in a network of subjective contingencies central to the onset and the course of depression.

Further, as research indicates, a combined antidepressant and talk therapy treatment yields the best results for treatment (Whittington, Kendall and Pilling, 2005). Elyn Saks, a schizophrenia sufferer, emphasizes how helpful medications have been in learning to cope with her illness; nevertheless, she says she would not have "had a life" without psychotherapy, psychoanalysis, and the support of friends and family:

Medication has no doubt played a central role in helping me manage my psychosis, but what has allowed me to see the meaning in my struggles—to make sense of everything that happened before and during the course of my illness, and to mobilize what strengths I may possess into a rich and productive life is—talk therapy. (Saks 2007, 331)

We do not get this kind of information in the antidepressant commercials. Rather, they give incomplete information about depression and promise more than they can deliver.

Note also the possible effect of a viewer's cognitive biases. As I argue elsewhere, empirical research in cognitive and social psychology increasingly points to shortsighted reasoning strategies, biases, and opportunistic oversimplifications in human reasoning. In other words, humans consistently make errors of judgment. For example, consider the subjective validation effect, or the Barnum effect. This cognitive bias is defined as the tendency of subjects to identify their personal features with broad characterizations of their personality, even when such characterization is not veridical. A paradigmatic example is a subject's response to astrological projections, personality profiles, and the like. Personality profiles involve such observations as "You have a great need for other people to like and admire you" (Jopling 2000, 40). Nothing in this definition is specific to the individual, yet many believe this is a valid and unique characterization of their personality. The symptom list given by the woman in the antidepressant commercial might trigger a similar cognitive bias. Because the description is general, lacks detail, and provides no room for particular contingencies, the viewer/patient might overidentify her or his experiences with the suggested symptoms and develop unjustified beliefs about the antidepressant's efficacy.

Thus, in addition to evaluative conditioning that might be at work in the antidepressant commercial by way of leading the viewer to associate the positive images of happy people with the antidepressant drug, the proposi-

tional content may also trigger some cognitive biases to elicit unjustified beliefs about antidepressant efficacy. I conclude that both the implicit reasoning processes and evaluative conditioning must be cautioned against in the FDA regulations. ■

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Augmenting the Argument Against Indirect Medical Advertising

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Biegler and Vargas (2013) question the ethical permissibility of particular types of medical advertising. They rightly state that the goal of such advertising is not to accurately convey all relevant information to facilitate making the best decision, but rather the goal is to manipulate people so as to sell the product. In addition, they cite much marketing research showing that seemingly incidental factors, not pertaining directly to the risks and benefits of products, nevertheless can have important effects. But if people are influenced in such indirect ways, their decision-making autonomy is reduced, and this could constitute an ethical breach. To prevent this, it is worthwhile to consider that perhaps some indirect medical advertising should be illegal.

I agree with Biegler and Vargas about the undesirability of indirect medical advertising; however, I believe that their argument can be buttressed in two ways. First, although I find no fault with the marketing literature they cited, there is research in social psychology that demonstrates, more generally, indirect effects on behavior. The combination of the general social psychology research, in concert with the research reviewed by Biegler and Vargas, even more strongly supports the basic premise of strong indirect effects on decision-making and behavior. Second, I question whether an appeal to autonomy is the best route to their conclusion; an appeal to expected utility is less troublesome.

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