CHAPTER SIX

Pharmaceutical Personalities

> This is the idea of "person" (*personne*), the idea of "self" (*moi*). . . . Each one of us finds it natural, clearly determined in the depths of his consciousness, completely furnished with the fundaments of the morality which flows from it. For this simplistic view of its history and present value we must substitute a more precise view.
>
> —Marcel Mauss, "A Category of the Human Mind"

Drugs are inanimate products that cannot literally speak, think, or feel. Nonetheless, pharmaceutical marketers and advertisers attempt to invest psychotropic drugs with attributes that make it possible to think of them as "persons," as if they were social beings with individual personalities and the ability to have nurturing relationships with the patients who take them. However, patients who take these drugs do not necessarily relate to them as friendly living "persons" who take up residence inside them. Patients are as likely to think of drugs as biological tools, whose potency lies in their specific line of action on something in their brains, and whose harmful side effects might need to be moderated by complex cocktails of different drugs.[1] Despite the friendly imagery of advertising, both patients and pharmaceutical marketers and advertisers invest psychotropic drugs with deeply ambivalent meanings. Psychotropic drugs can help us, so it would seem, but they cannot do so without harming us at the same time.

Marketing a Psychotropic Drug

From my interviews with pharmaceutical employees, I learned that developing a personality for the drug begins early in the production phase.

Two executives from the research and production departments of the same company told me with considerable exasperation how demanding and detailed the concerns of marketers about developing a drug's personality could be.

> Marketers worry about having every possible dose form: tablets in different strengths, a liquid form for pediatrics. They want a form that is aesthetically pleasing, looks good, tastes good, and is not too big. Color is important to them also: you never use red for psychotropic drugs! It is said to be bad for psychological or psychiatric problems, signifying danger. Black and gray mean death. Sometimes blue is bad because it can mean poison and can be seen as cold. But then again, light blue or green can be good when you want calm, soothing colors. Kids' taste buds are different from adults, and different cultures have different associations with tastes. A wintergreen flavor we once used is associated in France with the scent of toilet bowl cleaners!

From the point of view of research and production personnel, the preoccupation of sales, marketing, and advertising personnel with the aesthetics of the tablet was understandable but frustrating. Their own work on the drug's chemical formulation was like building the "body" of the drug, and the rest was its "dress." They would cooperate in making this "dress" comforting and comfortable, stylish and aesthetically pleasing, even though the effort seemed superficial to them in comparison with building the body of the tablet itself.

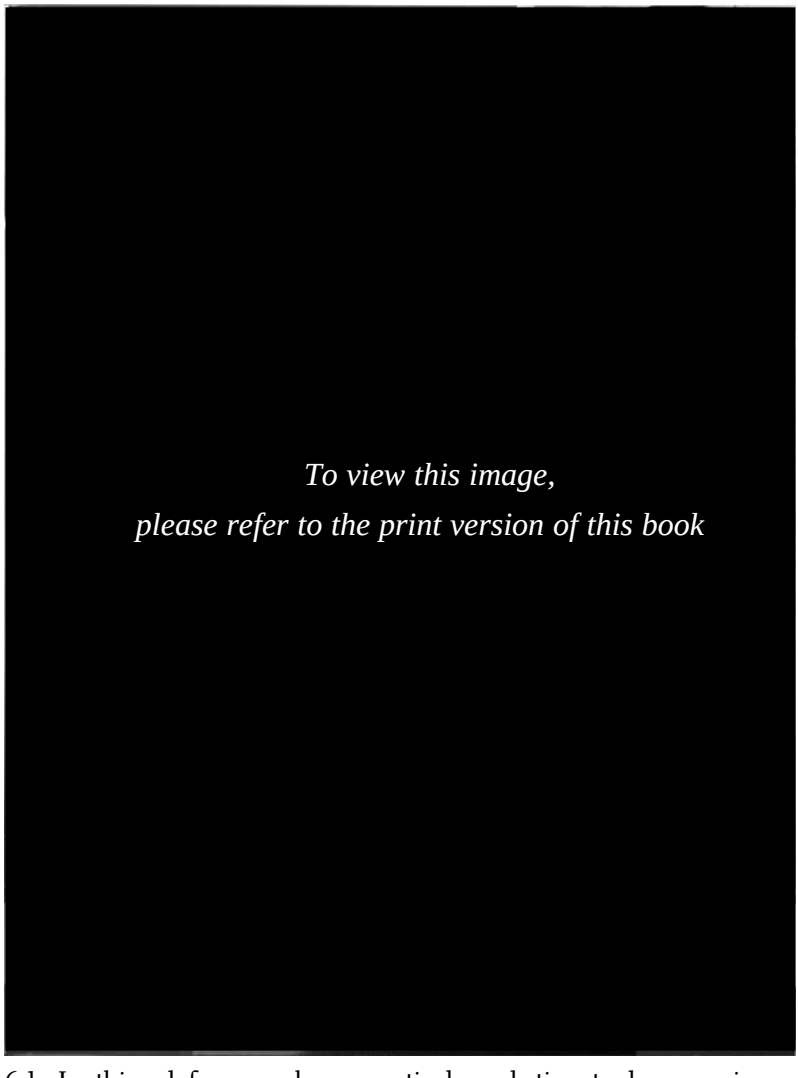
An e-mail from Sarah Taylor, who is widely experienced in pharmaceutical marketing, summarized the importance of investing drugs with specific personality traits, which could, in due course, be combined with each other.

> The antidepressants in particular have capitalized on [different] effects or lack thereof in their competitive branding campaigns. "All the efficacy without losing sleep, sex, etc." One psychiatric group (at Mass General, Boston) even offers their patients a "menu of reasonable choices." This is a descriptive "menu" of all the antidepressants they could prescribe along with a description of the various side effect and efficacy profiles. This is as close to selecting a pill based on its personality as I can think of. Psychiatrists have reacted to these brand-

> ing campaigns in a curious way. Instead of prescribing one antidepressant or the other, they combine the drugs into their favorite "cocktails." In LA, one drug combination became so popular it is called the Hollywood cocktail. It's popular because it utilizes Serzone (somewhat sedating, yet without weight gain, sexual dysfunction, or sleep loss) and Effexor (activating, pep you up so you can "get out of bed in the morning"). This hypermanagement of symptomology to a state that is better than normal or baseline seems like a new kind of medicine to me. In the case of the Hollywood cocktail, the psychs [psychiatrists] are actually inducing a sort of mania or hyper-alertness (at least compared to the person's previous state).

Physicians' readiness to combine the character traits of drugs to optimize a patient's mental state should alert us that however person-like they may seem, drugs are not exactly like persons. Their personality traits are more thing-like than person-like because they can be bought and sold and combined on demand in many ways, more like the parts of a motor or the ingredients of a cake than the personality traits of people. Acknowledging this, an ad in a trade magazine for pharmaceutical marketing shows a plumber installing brands inside a person's head with a wrench.

Because marketers and advertisers make serious efforts to imbue drugs with person-like traits, they quite reasonably also try to foster person-like relationships between drugs and the doctors who prescribe them or the patients who take them. Through the important role of the pharmaceutical sales representative in marketing drugs, a great deal of drug advertising aims to build aesthetic and emotional links with doctors. Here, I will keep my focus on patients by discussing how some ads try to reach through the doctor to the patient. Margaret Connor told me about her experiences as a copywriter for an ad agency: "Pharmaceutical ads use artistic themes because psychiatrists are artistic and this would appeal to them. For Lithium-P,[2] we did a four-month calendar on a poster featuring a portrait of Beethoven and there was even a card you could send in to get a CD of the Ninth Symphony." But she felt this kind of appeal would not be appropriate for consumers.



6.1. In this ad from a pharmaceutical marketing trade magazine, a plumber installs brand-name drugs directly in the brain. Reprinted with permission. *Guide to Pharmaceutical Marketing Services, MedAd News* 21 (September 2002): 29. Courtesy of the Hal Lewis Group, Inc. All rights reserved.

> For example, a client wanted Van Gogh on the cover of a brochure for patients. But you know he committed suicide at the age of thirty-seven! I resisted because [this would make] it sound like you take the drug or you are going to die like he did. In the end, although I resisted, they used the picture, but I did manage to soften the wording.

Margaret also thought it was an ethical problem to put creativity so in the forefront of the ad, because fear of losing creativity is one of the main reasons bipolar patients resist taking Lithium-P: "Why take the drug if you lose that? People enjoy the highs, they feel invincible, they get a lot of work done. We also don't want to scare people off (consumers, that is) about the side effects. So the letter that goes to doctors with the calendar is clear and blunt about side effects, while the consumer materials mute them."

I asked where the idea for Beethoven and Van Gogh came from.

> From reading Kay Jamison's book on genius manic depressives, Schumann, Van Gogh, Poe. Then we had another author (I guess he was a jealous academic) ask us why not use his book, which is on military leaders and manic depression, so they did one with Napoleon, with quotes from [military heroes] but they couldn't use Stalin and Hitler. They issued these for three years—they were wonderful!

Later, Jack Levy, medical director of an advertising agency, explained the general principle behind the effort: borrowed interest. Inside the mailing tube with the calendar would be a paragraph on the famous figure and then a full Lithium-P sell: "An example of borrowed interest would be using Cal Ripkin in an ad for a beta blocker. Cal doesn't take the drug, but we borrow his long duration and hope it sticks to the drug."

From her perspective as a production manager, Katherine Holmes talked about how ads are tailored to patients who belong to different populations. Katherine illustrated how pharmaceutical advertisers share general cultural notions about particular mental conditions and funnel them back into materials designed to promote relationships between drugs and populations of patients.

> The same drugs are used, but the populations are very different. Schizophrenia tends to be downwardly mobile. I mean when people get it, they could be from any background. But once you get it, you could end up homeless, with no job—people just cannot function. So the average schizophrenic will end up either in a hospital or without a job somewhere living on minimum wage. I mean there are a few, rare cases of people that are teachers, but it's not your average. Whereas with manic depression—those are creative people who are successful, and you wouldn't even know that they [were taking medication or had] the disease. So it's a very high-functioning group of people, which I think makes it even harder to treat them because they are smart, they are creative, and they don't like to take their medication. When they are on the high part of it they create, they produce, they do things, wonderful things. And it's just when they are in the depressive part that things are really bad.
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> The main "beam" [focus] of the creative for our drug was very artistic—the idea was [to move the patient] from chaos to control. Those aren't the words we used, but the ad would show a page with just a scribble on it and then it would turn into musical notes. And so the idea was that your mind goes from being confused and everything, to kind of understanding, and then up to creative.

Katherine went on to explain how these advertising materials build on the widespread cultural connection between manic depression and creativity.

> A lot of the stuff that the advocacy organizations do is around arts—they have art shows. I think there's definitely an understanding that it is a creative person who might have that disorder. I don't think the agency exactly views the disorder as a good thing. Maybe it's more that we should realize it's just OK. Like with depression it's totally open: Mike Wallace is on Zoloft [for depression] and that's not at the level of being abnormal. Depression does have a very dark side, but I think manic depression still really has that other side to it. I'd use the word "crazy" but . . . you know, it's high energy, things are happening.

In devising ads for drugs used to treat manic depression, advertising designers take for granted cultural associations between manic depression and creative energy. The drugs they design for this condition must promise neither too much dampening, which would lead to loss of creativity, nor too little, which would leave the patient's chaotic thinking intact.

The Rationality of Consumers

Between 1998 and 2001, when I was doing fieldwork on the pharmaceutical industry, it was undergoing some important changes that bore on its ability to build relationships with consumers. First, DTC advertising had begun in earnest in 1997. Draft promotional guidelines from the FDA's Division of Drug Marketing, Advertising and Communications (DDMAC) in August of that year permitted pharmaceutical companies to advertise the benefits of prescription drugs by brand as long as they also made clear the product's most important negative effects.[3] The marketing and advertising budgets of the pharmaceuticals subsequently increased through 2000, adding fuel to critics' claims that high prescription drug costs resulted from pharmaceutical advertising.[4]

Second, new FDA guidelines now allowed products to be directly linked to brand names. Early in my research, Sam Giosa, a physician who works as medical director for an advertising agency, explained to me,

> Previously, the FDA legislated that the pharmaceutical companies could use ads to show the drug name or the condition it treated, but they could never link the two. If they did, they had to present the entire product information statement. This would take so much time on TV and cost so much that the companies didn't want to do it. They could link them in print, but they had to include the whole product fine print about side effects, etc. Now there is a trial period where they are allowed to link the two, if they make a "major statement" at the end, so the public won't be misled.[5]

In part because of DTC advertising, the market for psychotropic drugs grew rapidly. In the United States, sales reached $2.5 billion in 1990, $6.6 billion in 1995, about $7.6 billion in 1996, and then over $15 billion in 1999.[6] Academic studies documented that the proportion of visits to a doctor in which a psychotropic medication was prescribed increased from 5.1 percent to 6.5 percent between 1985 and 1994, an increase that can be accounted for by the three new Selective Serotonin Reuptake Inhibitors (SSRIs): fluoxetine in 1988, sertraline in 1991, and paroxetine in 1992.[7]

DTC ads are intended to tap into consumers' emotions, but what happens when the consumer's emotions are disordered? Can a manic-depressive person, say, be a good consumer? On the one hand, we might think that people labeled "irrational" by virtue of mental illness would be considered ripe targets for these ads. Since irrationality is often defined as emotions getting beyond the control of reason, "irrational" people might seem especially susceptible to advertising's emotional appeal.[8] On the other hand, however, the point of the ads is to get the consumer to consume: to decide he needs the drug, to seek a doctor who will prescribe it, and so on. "Irrational" people might not seem reliable in following through all the way to the act of consumption. When I asked my pharmaceutical interlocutors about this puzzle, they were as confounded as I was.

Katherine Holmes: It's something that I think all the drugs that have indications for mental illness have to consider, especially the antidepressants. Depression is more common and the patients are generally more functioning than, let's say, a schizophrenic or a bipolar. The patients, it's hard to reach them, since they are not really necessarily aware of what they are doing, they are not going to respond to . . . [Her voice trails off.] Prozac is trying to do direct-to-consumer [marketing] for their drug, and Zoloft is considering it. It doesn't seem like they've really been that successful. So it's more like public relations than it is like direct advertising to these people because I think . . . it's just . . . [hesitating] because of their illness they're not necessarily . . . they're not going to respond and go ask their doctor for the medication.

Emily Martin: Is that partly an issue of noncompliance? (When patients do not take drugs a doctor has prescribed for them?)
Katherine Holmes: Right, I used to work on that issue, too. Yeah, a lot of this is much more educating the doctors and the caregivers, the families around these people, than it is the person, because these people sometimes really cannot . . . it's not even . . . like if you presented them with a 1-800 number? [Shrugs.]

Jason Marshall, who worked as a sales rep at the beginning of his career in marketing, talks about the difficulties of advertising to patients for Drug S, used for schizophrenia and bipolar disorder.

Emily Martin: Did the company do any DTC advertising?
Jason Marshall: No, there was no DTC for Drug S. I'm just taking a guess about why that was, but first of all it's not a huge market. Psychiatric disorders in general and especially schizophrenia can't be more than a couple million patients. Most of the DTC advertising you see is for physical disorders, which are very common, so it's easy, you know, if you are doing Propicea, because 20 percent of the audience could experience baldness. To advertise directly to people with psychosis . . . [He trailed off with a dubious expression.]

Or you *can* specifically target people with schizophrenia, but that's probably not a good way to advertise something . . . and I'll be willing to bet that as much as doctors are upset about direct-to-consumer advertising with products for asthma and hypertension, they'll be *very* upset with us if we tried to influence a patient with a psychiatric disorder.

Jane Fuller has worked on a number of ad campaigns for psychotropic drugs and so I asked her whether advertising for psychotropic drugs is ever directed to patients who are deemed mentally ill. She thought that doing so would be contradictory because such patients might not have enough self-awareness to act on their own behalf by seeking the drug. But she thought that if a patient took the drug and began to feel better, he or she would "engage," and might begin to complain about weight gain or sexual side effects. With increased awareness, such a patient might be able to behave like a good con-

sumer, that is, behave rationally, and actively seek out the best drug on the market.

The advent of DTC advertising has brought the uneasy and volatile status of the mentally ill directly into the advertising process. A patient who is not regarded as functioning rationally enough to be an appropriate target for a drug ad might still be able to "feel better" with the aid of the drug. Earlier in this chapter we saw how pharmaceutical employees imagine indirect relationships with patients by reaching through the materials provided to doctors. Now we can see that forms of advertising sent directly to the mass of consumers fall short of people who are thought to be "less aware." The relationships in question are almost always one step removed from actual patients, but they live vividly in the imagination of pharmaceutical employees. People with some forms of mental illness are thought to lie outside even this imagined social landscape.

Living with Drugs

If drugs, like other commodities, are given the particular kinds of life I have just described through marketing and advertising, how do people who take the drugs make sense of this thing that now literally takes up residence inside them? Does the drug seem alive to them the way a person or a spirit would be? Does the personality advertisers intend to create for the drug take hold in their imaginations?

Before tackling these questions, we must remember that since psychotropic drugs are a commodity and, as such, carry a price, everything we say about them should be framed in political economic terms. Who can afford to buy them? Who has knowledge to use them? Who has access to physicians or others who can monitor their effects and suggest adjustments? In the United States, these basic questions are determined mostly by where one is in the hierarchy of resources. Whether one is encouraged or required to take psychotropic drugs in a welfare office, never offered the choice in a remote rural or underserved inner-city setting, given them in a one-off way by a doctor in a clinic, or carefully monitored over months or years of minute adjustment: these are more

often matters of what one can afford and what one is in a position to know than what one prefers. At the high end of the scale, a psychiatrist in New York City told me that her patients take cell phone calls during their consultations with her about their psychotropic medications. Overhearing them say proudly, "I am with my psychopharmacologist," she commented, "I feel like a Prada bag; everyone has to do this to be up to the minute."

One's standing in the hierarchy can also change over time. As health benefits run out, a job ends, savings evaporate, or the like, a person can drift down the scale. Kiki described this succinctly on a Web newsgroup: "Well—I saw my otherwise wonderful PDOC [psychiatrist] today for a reg. session to discuss meds and my symptoms, etc. In the past I would have liked to have seen her 1x week for meds and therapy, but she is not on my HMO's panel and I cannot afford $175/week—so I see her for meds ($90) and disability management about every three weeks since 4/30."[9] Kiki would prefer a therapeutic hour every week, but she can only afford fifteen minutes every three weeks.

In my many visits to support groups, the vast majority of people spoke of fifteen-minute appointments with county doctors once a month, where the doctor could do little more than just renew prescriptions. Hilary told one support group that she saw a doctor at a clinic who spent at most two minutes talking to her, and then "it is on to the next patient. She must see thousands of patients in a day; it is like you are on an assembly line." This situation is no more the choice of doctors than patients. Speakers at conferences I attended for psychiatrists and for patient support groups alike regarded these kinds of constraints on physicians' ability to treat patients as deplorable.

As we have seen, one main goal of DTC drug advertising is to invest the drug with a personality. When people talk about the experience of taking drugs, however, the drug frequently does not survive with its own intended identity intact. Rather, the drug goes in the person, and a new person results. A woman spoke out at a support group I attended.

> I am Hanna and I am manic depressive. I am a rapid cycler; I am either up or down, and I am not much in the middle, or at normal (if you want to call that normal). I realize I expected the pills to

> manage the manic depression, and now I see *I* need to manage it at all levels, including the spiritual. *I* need to learn more, to exercise more, to be active not passive. My shift in thinking is due to taking Depakote—it is like a new suit of clothes! I am a snake who has shed its skin, I am all new and shiny.

In another support group, Gail, a very thin woman in her thirties, whose long, dark hair shadowed her face, had been through four years of a lot of therapy and medications, all of which "came to nothing." Worse than that, the medications she was given made her literally sick, to the point of vomiting. She had just been to see a new doctor who started her on a new drug, Tegretol, and she was feeling hopeful. But in spite of her hopes for the drug, she stated most emphatically that her social relations with other people were more important than the drug in moderating her behavior: "I go to these groups because I have a network of friends in them. I don't want to depend too much on my fiancé to do things for me. Instead I would rather have feedback from my friends *and* my fiancé, because this would allow me to 'modulate my own behavior.'"

Gail's emphasis on her network of friends and family does not mean drugs can come and go from people's lives without perturbation. Linda said she had gone for a second opinion to another doctor, who, the support group facilitator assured her, was a very good psychopharmacologist. This doctor told Linda the medications she was taking were terrible for her. He was so certain these drugs would not deal with her anxiety that he recommended she should taper them off and start a new combination of drugs. Linda was upset by this and told the group, "I want my old personality back. I know I look terrible, and I feel I am looking worse and worse. I am really alone, I don't know whether I lost the phone numbers of the group or just couldn't bring myself to call." As she talked, several people passed her their numbers written on little slips of paper.

Marcy, a graduate student who initiated contact with me and traveled from another state in order to tell her story, described her deep dislike of switching drugs because switching changes one's identity and threatens the "magic" of the original drug.

> If I take a new drug, even a new brand name of the same drug, like a different version of the same drug, I have to reshape my entire identity, like now I am not that person who took Depakote. If I have to go and take lithium, then I have to come up with an identity that takes lithium, and that's a lot of work for me, that's something I have to get used to, and so I have an aversion to doing it. It's the work of producing a new identity, it's like integrating something new into your old identity. This is a lot of work, and for what? It takes away from the magic of the first drug. And if the first one worked for you, then it has magical properties. You can only be cured if your medicine has a power beyond being medicine, well, beyond being a drug. What makes it a medicine instead of a drug are the magical properties that I associate with it.

Marcy's notion of "magic" made the drug sound like an impersonal force, but occasionally, others spoke of specific properties of the drug that seemed to give it human-like qualities. For example, at an East Coast support group meeting, Georgia said she told her doctor she wanted to take Zoloft because (holding out her hand as if to cup the pill)

> it was like a little robin's egg, it has that blue color and it represents hope. Later the doctor added lithium. Still I was knocked down by depression every spring. Now I am on what my doctor calls an "iron-clad defense" against manic depression: two mood stabilizers, lithium and Depakote, and two antidepressants, Wellbutrin and Zoloft. My friend said, "Oh, I wish he hadn't said that, 'iron-clad defense,'" because it implies the defense could give way. It might break.

In this instance, which stands out from the usual way people spoke of their drugs, Georgia does see Zoloft as alive, like a little robin's egg filled with hope, but before long its hope fades as she finds it to be inadequate by itself to handle her needs.

Although most prescription drugs advertised directly to consumers have a rather amorphous identity in the eyes of patients, lithium, which is not advertised to patients, is granted so much consistent agency that it does have a kind of personality, albeit one with both

positive and negative sides. On the positive side, many people felt that lithium was the most "natural" of all the psychotropic drugs, explaining, "It's just a salt." Others referred to the mood-steadying effects of lithium as a boon. Sometimes people mentioned the lyrics of songs such as Sting's "Lithium Sunset," in which lithium folds "obsidian darkness" into its "yellow light."

Lithium is surrounded by ambivalence. For all that some people appreciate how it can lift depression and dampen mania, others resist it more ferociously than any other drug that psychiatrists prescribe. Widespread informal consensus labels lithium the drug that elicits far more "failure to comply" than any other. Partly this is because lithium's side effects—on the liver and thyroid—are well known. But partly it is because people are loath to have the pleasures of a rising mood taken away from them.[10] "I'd rather stand in front of a moving train than tell my psychiatrist I am manic, because I know she will make me take more lithium" was a not uncommon sentiment in my fieldwork. Kay Jamison explains that people who are not manic depressive cannot understand why there is such resistance to lithium, which promises you can "be normal": "But if you have had stars at your feet and the rings of planets through your hands, [and] are used to sleeping only four or five hours a night . . . it is a very real adjustment to blend into a three-piece-suit schedule, which, while comfortable to many, is new, restrictive, seemingly less productive, and maddeningly less intoxicating."[11] As Jamison writes, manic depression "destroys the basis of rational thought."[12] If lithium restores it, then it is highly significant that some patients who have experienced being "irrational" refuse lithium precisely because it restores rationality, despite the agonies that manic depression can produce. Lithium is seen as a kind of stern schoolmaster, enforcing the rules and stopping the fun. Like a stern schoolmaster, it cannot be escaped without detection. Patients who take lithium under the care of a physician are required to have periodic blood tests that assess the level of lithium in the blood, in part to detect possible toxic effects. If you aren't taking your lithium as prescribed, your physician will know that, without a doubt. No other psychotropic drug can be easily assessed in this way, leaving lithium as the only one patients must take or be found out.

There is another dimension to the reluctance to take lithium that has come into play recently. In my fieldwork, some people insisted that the specificity in the design of recent psychotropic drugs adds to their potency. Marcy continued to explain her aversion to lithium, but added this twist at the end.

Marcy: One of the reasons they might have given me the Depakote was that I *really* reacted to the lithium thing, like "I am not taking that, lithium is poison." I mean, it's one thing to be ingesting a controlled substance; it's another thing to take poison, and to me lithium was poison because I knew that a high enough dose of it would definitely kill me. Even now, I will never take lithium. Even though I understand that based on the dosage it might actually be safer than taking Depakote, I still would prefer the Depakote. I associate very negative things with lithium and I for some reason can't handle the idea.
Emily Martin: Does the fact that Depakote is a new drug, produced by new technology, make it more powerful in the way you think about it?
Marcy: It's not more powerful, but taking it has less stigma.
Emily Martin: Less stigma?
Marcy: Yes, less stigma and also more of this, like, specificity. It's more specific. It's tailor-made for me and my disorder, it's tailor-made for me and my disease *and only for me and my disease* and using my drug to treat some other thing takes away from—once again—the magical specificity property that it's going to uniquely help me.

Specificity was a trait many people valued in their drugs, a trait that they thought enabled the drug to produce one but not another particular mental capacity or state.[13] At a support group meeting, Nicole, a petite, fortyish woman, said that she was off for the summer from her job as a guidance counselor for the public schools. Her doctor had her taking drugs five times a day. She had the bottles all lined up on the counter with her pillbox and it was quite something to get it all straight. Because of her continuing depression, the doctor had added an additional dose of antidepressant, Effexor, at 4:00. The last drug she takes before bed is another antidepressant, Seroquel: "I like the last dose of

the day best of all, that is the Seroquel. I like the calm, drowsy feeling it gives me, and I sleep very, very well. But now I am having trouble making decisions. Before I never had this problem—like at restaurants I would always know what I wanted to eat. But now I am thinking I need some pill added to help with my decision making." Seroquel does a good job making her calm and drowsy before sleep, so it makes sense that there might be another drug to help her make decisions.

Larry, a young, nattily dressed man with a gentle southern accent, told another group that he had gone back on lithium and was "going up." "You know, now that I am taking lithium again, I am going up. Tegretol sent me down, you know." John, the group facilitator, asked if he was worried about getting too high and manic. Larry said, "I have Risperdal to take if that happens." John agreed: "If you feel mania, or have racing thoughts, you just pop a Risperdal and it brings you right down."

The Web is another place to see how people describe the qualities of drugs, and on the Web there is no disapproval, as there is in support groups, of discussing specific drugs and dosages. Postings on Web newsgroups for bipolar disorder make it immediately apparent how many people are taking complex bundles, "cocktails," of drugs that they try to adjust to ease new symptoms, side effects, or drug interactions. Here are some extracts from newsgroup postings:

On side effects:

> Well, after getting sun blisters on Trileptal and double vision as well, my doctor and I have decided to try Topamax once a day to start and a Klonopin at night. I was on Seroquel for sleep but since I had no paranoia or hallucinations, it really wasn't necessary and Klonopin can act as a secondary mood stabilizer anyway. Wish me luck all, this is my 5th cocktail, hopefully it will work. My mind is racing so much and I am so angry, I feel like I'm losing it all.[14]

On recalcitrant symptoms:

> I'm new, here's an intro.
> I have been diagnosed with bipolar for about 3 years now, before that they were just diagnosing me with mood disorder, chronic depression, anxiety, and personality disorder.

My current meds are:

Wellbutrin SR = 300 mg daily
Lorazepam = .5 2× daily
Topamax = 200 mg daily (just reduced from 400 mg daily)
Depakote = 250 mg AM
Depakote ER = 1000 mg PM
Lithium = 600 mg daily

We're currently playing with my meds again trying to get me stable once more, I'm a rapid cycler, and had a pretty quick cycle into high and then dropped out to a long lasting low that caused some problems.[15]

On side effects and recalcitrant symptoms:

From: selene
Subject: cocktail hour
dearest armchair psychopharmacologists, < i mean that as a compliment > can anyone make any recommendations for my new drug blend? i'm going in to see my pdoc. tomorrow and want to have an idea of what i'd like to try next. of course, i'll listen to her recommendation first . . . but i know we dedicate a lot of time to research around here, and consequently i value such well-read, if unofficial, input! i'm thinking about Neurontin and Effexor . . . here's my chemical resume: started Tegretol (400 mg/day) 3 weeks ago; got unusual red spots on my skin 2 weeks in, discontinued use as instructed by my doctor. also started Wellbutrin at that time—a tiny dose, only 75 mg per day. when i stopped the Tegretol, i continued on with the Wellbutrin. i have not lapsed into hypomania, and am, in fact, quite classically depressed. this is manifesting in a very physical way, more than usual—i feel ok emotionally, but have no motivation to leave the house, tidy up the place, or to do anything but the barest essentials with my time. i feel fuzzy in that i don't even know where to start, i felt much, much clearer before the Wellbutrin—i've been dulled! i have therefore stopped the Wellbutrin. if it seems as though i didn't give the Wellbutrin a fair chance, please note that i took it several years ago, with little/no result. past drugs i've given a fair chance and that haven't worked: lithium, Prozac, Norpramin, Depakote (had a

> reaction). but i suppose i can't be too choosy, since there's only Neurontin and Lamictal left.[16]

Much in these narratives resonated with my own experiences. At the time, I was taking lithium, Focalin (a form of methylphenidate, the active ingredient of Ritalin, prescribed for ADHD), and Lexapro, an SSRI. Because of my complaints about the side effects of Lexapro—emotional numbness and loss of libido—my psychiatrist convinced me to try Lamictal, an antiseizure drug that doctors had begun to use for manic depression. Depending on how I did on Lamictal, I might be able to get off the Lexapro. Graduating from lithium, Focalin, and an SSRI to lithium, Focalin, and Lamictal frightened me badly. My own prejudices were revealed: I was scared of sharing a medication with people suffering from even more stigmatized conditions than mine—epilepsy, brain damage—and I was scared of the side effects. My doctor told me with some urgency that if I broke out with a rash I should stop the medication and immediately call her. On the CVS pharmacy information sheet, I read: "Rarely, serious (sometimes fatal) skin rashes have occurred while using this medication. These rashes (e.g., Stevens-Johnson [SJ] syndrome) are more common in children . . . even after stopping this medication, it is still possible for the rash to cause permanent or life-threatening scarring along with other problems." To me this seemed a bit more dire than a "rash." On the Web I discovered that there is a foundation for SJ syndrome, and I learned (and saw horrifying pictures of) what it entails.

> Painful blistering of the skin and mucous membrane involvement.
> In many cases preceded with flu-like symptoms and high fever.
> As it evolves the skin literally sloughs off.
> Ocular involvement includes severe conjunctivitis, iritis, palpebral edema, conjunctival and corneal blisters and erosions, and corneal perforation.

In a way I was glad I didn't know what some of these things were. Wanting to be free of Lexapro, and aware that I was fortunate to have superb medical care—a caring psychiatrist, an insurance plan, and Internet access—I began taking Lamictal. Its effects were miraculous.

Some months into taking it, I credited the drug with an immense easing of symptoms of depression, anxiety, and obsessiveness, without the emotional flattening of the SSRI. That left me with just the fear of side effects, and the fact that every few weeks a strange lesion opened up on my face and bled. I was assured this was not "the rash," but no one knew what it was. The lesions embodied ambiguity: were they the result of Lamictal, my fevered imagination, or something else? In any case, I was disconcerted at having escaped one set of side effects only to struggle with another.

In my fieldwork, the strategy of combining drugs into cocktails in pursuit of fewer side effects and fewer symptoms was a commonplace topic during informal discussions among doctors. I did not have access to ongoing clinical sessions where doctors discussed and adjusted medications with patients. Although it was less than ideal for the purpose, I was able to get some hints about the ways physicians talk about managing patients on drugs through Web forums set up (by pharmaceutical companies) for doctors to raise questions about medicating their patients.[17] The pharmaceutical company that produces the drug sponsors the Web forum and it is usually company sales reps who give out passwords to doctors they hope will prescribe the drug. This is one way companies hope to foster off-label uses of their drug. One site to which I gained access through a generous person in a publications company (a pharmaceutical corporation had subcontracted the maintenance of the Web site to this company) showed me the extent to which postings from doctors were concerned about the intricate details of particular patients' overall health, the appropriateness of particular drugs, and how to meet patients' needs through elaborate combinations of drugs. For reasons of confidentiality, I call the drug that is the focus of the Web site "Drug R."

The selection of postings below illustrates a common theme: patients commonly take a great many medications at once and their doctors write to the forum for advice about how to deal with cascading side effects. This doctor describes a patient experiencing significant thirst: "I'm treating a woman in her 40's for depression and panic disorder. She may have a subtle bipolar illness. She is currently on lithium carbonate 1500 mg a day, Drug R 45 mg a day, Depakote 625 mg a day,

Klonopin 0.5 mg TID [three times a day] and Pamelor 50 mg a day. 1/27/00." Another describes a similarly complex regimen that is still not handling the patient's depression: "Male 37 years old with previous documented sexual abuse as a child, current diagnoses: DID [Disassociative Identity Disorder], ADHD, PTSD [Post-Traumatic Stress Disorder], bipolar II with refractory depression . . . current meds: lithium 1200 mg, Lamictal 200 mg, Effexor 450 mg, Drug R 45 mg, Cytomel .25 mcg, Ritalin 80 mg." When the patient recently became hypomanic, the doctor decreased his Effexor, Ritalin, and Drug R, but in three days, he again had the "most malignant depression I have ever treated." Not all postings received a response, but this one did. The consulting online doctor replied, "With this understandable and heroic combination of meds, what to do? I suggest adding another mood stabilizer (Depakote or an atypical antipsychotic Olanzapine). 5/12/2000." When drugs are causing problems, the solution is more drugs.

One doctor asks about a patient whose depression Effexor has relieved but who now experiences anxiety, insomnia, and agitation. He wonders about augmenting the Effexor with Drug R. The on-call expert replies that the combination is used more and more often in similar circumstances "with anecdotal success," but that there are no controlled studies of safety and efficacy. He suggests a conservative starting dosage of Drug R. Another doctor asks for suggestions for ways of counteracting a patient's weight gain and sexual dysfunction while on SSRIs as well as Effexor and Drug R. He has tried augmenting with Wellbutrin and Buspar, but seeks additional advice. The expert suggests a number of options: switch to a low sexual dysfunction, weight-neutral antidepressant (Wellbutrin or Serzone); try adding Viagra; try Gingko, even though there are no controlled data; try dose reduction, though you may lose therapeutic benefits; prevent the weight gain through diet and exercise, though this is easier said than done; add weight loss agents, such as Orlistat, though there are no controlled studies and it may block the absorption of the antidepressant; try weight loss agent Topamax, though it has a high incidence of CNS (central nervous system) side effects.

Another doctor asks for information regarding menstrual irregularities in her thirty-three-year-old patient taking Drug R, which has eased

her depression. In addition the doctor wonders how to handle the side effect of insomnia, which occurred when he increased the dose of Drug R to a level adequate to handle the depression. The doctor had used Ambien, to induce sleep on a temporary basis, but worries about harm from adding an atypical antidepressant with sedative properties such as trazodone to Drug R. The expert suggests several possibilities: split the total dose of Drug R with a lower dose at night; combine Drug R with trazodone, which has had no complications in his experience; even better, combine Drug R with an over-the-counter antihistamine such as Benadryl; or combine Drug R with a low dose of Zyprexa at night.

As a patient I have experienced how strategies like these are translated into written instructions. At the onset of a rapid descent into depression, with insomnia and anxiety (I had been taking lithium [450 mg] and Celexa [10 mg] at the time), my doctor wrote the additional measures I should take on a prescription pad.

1. bed at 10 p.m.
2. take Ambien at bedtime
3. try Dexedrine 5 mg in a.m.; can go to 20 mg by 5 mg increments
4. Ativan, try .25 mg in afternoon before anxiety sets in and in middle of night try .25 or .5 mg.

One week later, with not much improvement, I got another set of written instructions to *add* to the previous ones.

1. take Ativan, .5 mg 4 times a day, a.m., noon, early p.m., and late p.m.
2. take Ativan again .5 mg during middle of night
3. increase Celexa to 20 mg

Doctors and patients develop more and more elaborate combinations of drugs as they try to solve the side effects or symptoms of one by the action of another.[18] The need to take so many drugs, and to monitor their relational effects, might have the effect of diluting any sense that each drug has a particular personality. Each drug is more like a precise instrument than a living being. Gone from this picture are the complex associations possessed by old drugs like lithium. Marcy prefers "the

magical specificity property" of Depakote, but she may have to give up the "yellow light" of Sting's "Lithium Sunset."

When I started this research, perhaps seduced by the marketing literature I had read, I imagined that people would invest their drugs with personalities and form some kind of relationship with them, perhaps seeing them as encouraging companions, calming presences, or strong protectors. My expectations led me to look hard for such relationships. What I actually found was that patients personify new, high-tech drugs only weakly, and do not usually invest them with elaborate symbolic value of a person-like sort. Both doctors and patients see drugs as precision instruments that would excise suffering if they could only find the right combination. It is as if there is a dearth of appealing metaphors to capture what it is like to live with a drug inside you. Let me suggest one: when drugs lift depression or calm mania they could be seen as teachers, modeling new habits. Medications need not be seen as a management tool, a view that inevitably raises the question whether the patient or the doctor is in charge of the medication, but as something we might call "co-performers." This terminology casts them as something like agents inside the person who enable the performance of calm, of energy, of organization, or, if needed, of stability. Medications could be regarded as teachers who enable the person to experience such states. Can a precision instrument that is only slightly personified perform or teach? I think the answer is yes. A training board for a windsurfer, a walker for a stroke patient: these are among the simple but precisely engineered devices that guide and steer people as they learn new skills. Could not drugs be regarded in this light?

The accounts above are permeated with ambivalence—simultaneous and contradictory feelings of attraction and repulsion. The drugs help me, they hurt me; they ease one kind of pain and intensify another; and they take away one painful symptom but add a new one. It was to my astonishment, then, that I witnessed a display at the 2000 APA, which depicted the worry patients feel (some of which is surely legitimate) as a literal form of paranoia. This display, liberally branded with the logo of Risperdal, a major prescription antipsychotic from Janssen Pharmaceutica, was a virtual reality set-up called "Virtual Hallucinations." People stood in line reading an information card explaining what

was to come. Meanwhile, overhead, a video on continuous loop featured a man diagnosed with schizophrenia telling us that the experience we were about to have was true to life. Eventually I reached the head of the line, went to my assigned station, and put on my headphones and helmet. This gear would provide the sight and sound for me to experience a virtual world. The attendant instructed me, "When you enter the pharmacy, look around, and keep looking around to find the pharmacist." As the virtual scene unfolded, I understood that I was a patient who needed her antipsychotic medication, but my prescription had run out. So my friend, a woman, had brought me to the pharmacy to get a refill. My friend and I entered the pharmacy door. Just inside, the friend turned around and said, "I'll be back soon; you will be all right, won't you?" She then vanished rapidly out of sight into the back of the store. The virtual reality narrator directed me to look around for the pharmacist. I saw people in the aisles who seemed to be there one minute and gone the next. The sound was echoing and distorted. Objects and people sped through space in a blur. Voices came from everywhere, and sometimes specifically from the people I saw. A woman in the aisle looked at me suspiciously with a hateful expression. As I made my way to the back of the line to wait for my prescription, the virtual reality narrator provided the script of my thoughts: "The pharmacist does not want me to have the pills; he is going to do something terrible; he is going to call the insurance company and this will put me in danger. Who can tell what the consequence might be?" I felt frightened and wanted to flee. As I watched him prepare my medication, the pill bottle turned into a bottle of poison with a skull and crossbones on it. The dissonant music and disturbing special effects made this terrifying prospect the dramatic culmination of the experience.

The intended message of the display was that paranoia is a well-known symptom of some psychotic conditions and that the drugs that the virtual pharmacist was preparing can alleviate this symptom. The patient, however, could have been frightened by any number of strange things that happened in the virtual scene. What the patient feared most intensely was the pharmacist and the drugs he was preparing. This startling development echoes back to Mr. Burton's rounds, where social knowledge—repressed in rounds but erupting from a hidden place—

pushes through. The obvious message is that the patient has irrational, paranoid fears of the pharmacist. But the obvious message overlays another darker one: the reason the patient fears the pharmacist and his drugs is because the drugs are poison! The association between feelings of paranoia and schizophrenia comes right out of the DSM: what is extraordinary is that Janssen Pharmaceutica, surely despite its own interests, portrayed a prescription antipsychotic (a product they manufacture) as a bottle of poison. When even powerful pharmaceutical corporations cannot stop themselves from imagining that the psychotropic drugs they produce are poisons, we can better understand why the people in this chapter who decide to consume such drugs also regard them with ambivalence.