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Psychotropic Medications and Direct-to-Consumer Advertising: Informative or Irresponsible?

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ABSTRACT

In 1997 the FDA relaxed restrictions on the practice of direct-to-consumer pharmaceutical advertising (DTCA). The subsequent increase in advertisements aimed at potential patients had a significant impact on rates of drug prescription. This paper gives a brief history of visual representations of mental illness used by DTCA and examines ethical concerns raised by DTCA, specifically for psychotropic medications. Issues discussed include overestimation of symptoms and over-prescription of unnecessary drugs, modification of social perception and the perpetuation of stigma, and exploitation of vulnerable potential patient groups.

Key words: Direct-to-consumer advertising; psychotropic medication; mental illness imagery; physician-patient relationship; medicalization; stigma.

In 1997 the FDA relaxed guidelines which regulated pharmaceutical marketing directed at the general public (Wilkes, Bell, & Kravitz, 2000). Pharmaceutical companies responded to this opportunity immediately; by 1999 mass media advertising accounted for 27% of their promotional spending. The explosion of direct-to-consumer advertising (DTCA) had considerable impact on pharmaceutical consumption. From 1997 to 1999 prescription of the 25 most heavily advertised medications increased by 34.2%, compared to 5.1% for all other drugs (NIHCM, 2000). Among the most heavily advertised and best-selling of these medications were psychotropic drugs (Lenhardt, 2005). In 1999 sales of anti-depressants were $8.6 billion, more than any other prescription drug class (NIHCM, 2000).

Direct-to-consumer advertising raises significant ethical concerns, including but not limited to overestimation of symptoms and over-prescription of drugs, modification of social perception and the perpetuation of stigma, and fabrication of potential patient groups. Despite such issues the FDA does not require that advertisements be approved before they are circulated, although it monitors them once they are in print. Between 1997 and 2005 ten warning letters were sent to pharmaceutical companies regarding misleading advertisements. No disciplinary action was taken in any of these cases (Lacasse & Leo, 2005; Wolfe, 2002). This paper gives some historical background of how imagery is used in direct-to-consumer advertisements for psychotropic medications, and examines ethical concerns arising from this practice.

Using imagery to sell sickness

The use of images in the representation of mental illness long predates the modern pharmaceutical industry. In 1801 Philippe Pinel, considered by some to be the father of modern psychiatry, published a classification of diseases which included detailed illustrations of people suffering from several types of mental illness, or "madness," before and after recovery. By the mid-nineteenth century photography was being used in the place of illustrations as a diagnostic aid, a notable example of which is Jean-Martin Charcot's collection of photographic studies of hysteria. As the 20th century progressed images began to occupy a less important place in the diagnosis of mental illness. The first Diagnostic and Statistical Manual of Mental Disorders, published in 1952, contained no pictures. By the end of the twentieth century brain scans had replaced clinical illustrations and photographs as the pervading visual representations of mental illness directed at physicians (Davis, 2006).

As images directed at physicians became less common, they began to appear in publications directed at the general public. Several new psychotropic medications were developed in the 1950s and became standard of care, leading to a wave of deinstitutionalization of the mentally ill. Advertisements for these drugs were directed not only at previously hospitalized patients, now treated on an outpatient basis, but at the everyday person, promising restful sleep, improved outlook, and relief from the struggles of daily life. In the aftermath of World War II these advertisements took on a new character, depicting examples of shifting back to normalcy – families reunited, men returning to work – promising aid for a society recovering from the trauma of war (Rubin, 2004).

It is unsurprising that imagery in advertisements of this period capitalized on stereotypes: beleaguered housewives, hardworking, breadwinning husbands and fathers, lonely senior citizens, all of whom could benefit from medication (Rubin, 2004). However

gender stereotypes in advertisements for psychotropic drugs continued into the second half of the twentieth century. Men were depicted in the workplace, able to lead productive, independent professional lives with the aid of medications. Women were depicted in homes and gardens, able to successfully participate in social situations because of pharmaceutical assistance (Munce et al., 2004). These advertisements suggested that relief from the normal stresses of domesticity, work, everyday life, were just a pill away (Rubin, 2004).

Before-and-after images began to dominate advertisements for psychotropic medications in the 1980s and 1990s. The potential patient, suffering from a psychiatric disorder, was depicted as tearful, isolated, and unable to get out of bed before the introduction of the proposed pharmaceutical intervention. The patient was then shown, presumably after taking the medication, returning to normal life, able to socialize with a group of friends or enjoy a favorite hobby (Munce et al., 2004). These advertisements reinforced the idea that a pill could alleviate the stresses of daily life, by extension suggesting that if a drug could "fix" the problem that the origin must be an illness (Rubin, 2004).

Also in the 80s and 90s advertisements began to emerge which minimized the role of the physician in the healing process. One such advertisement for Zyprexa, an atypical antipsychotic manufactured by Eli Lilly, shows a patient straining to reach the outstretched hand of a physician. He is only able to do so by standing on a large Z, the logo of the medication. The advertisement seems to portray the physician merely as the means to an end – the procurement of the drug which will alleviate the symptoms (Rubin, 2004).

Minimizing the role of the physicians

There is a great deal of debate regarding whether this type of advertising has a beneficial or detrimental effect on the physician-patient relationship. The Zyprexa ad described above seems to point to a smaller role for the physician in the patient's road to treatment, or a step toward bypassing meaningful interaction with a primary care physician altogether (Wolfe, 2002). However there are those who suggest that pharmaceutical ads aimed at patients do not replace communication with the physician; rather, they encourage a more informed discussion with the participants having more equal footing. The patient in this scenario is an educated consumer, armed with information about the risks, side effects, and profiling of the medication in question (Homer, 2002).

Though advertisements provide information about the symptoms of the disease, few discuss success rates of treatment, necessary duration of use, alternative treatments, or common misconceptions about the disease. The pseudo-educational character of advertisements, which are actually commercially driven, leads to confusion among patients who are presented with incomplete information intended to sway them towards a certain medication choice (Wolfe, 2002). They represent unrealistic therapeutic stages for the typical patient, minimizing adverse reactions and total failure which are well known in the use of psychotropic drugs (Munce et al., 2004). A survey of people diagnosed with depression and receiving treatment revealed ambivalence about advertisements, as well as the general impression that the information presented in them is of low quality (Bell, Taylor, & Kravitz, 2010).

Advertisements for medication play a role in encouraging discussion with a physician, leading to the potential for treatment. Depression is a prevalent chronic disease that often goes undiagnosed (Homer, 2002; Donohue & Berndt, 2004). In a survey of depression forum respondents, 40% reported that advertisements prompted a discussion with their physicians about symptoms of depression and treatment options (Bell, Taylor, & Kravitz, 2010). However, while advertisement-driven patient requests guard against initial undertreatment of major depressive disorders, advertisements that are not commercially driven can be just as effective (Kravitz et al., 2005). Studies suggest that direct-to-consumer advertising increases the number of people who are receiving antidepressants (Donohue & Berndt, 2004). What remains unclear is whether this increase in prescription is appropriate. Patient-initiated discussions about psychotropic medications prompt referral to mental health specialists, especially in the case of depression (Moran, 2003). Therefore it may be that the increase in prescription corresponds to better diagnosis and increased compliance, both as a result of advertising (Homer, 2002). Additionally, findings suggest that though DTCA for antidepressants increase probability that a person will initiate treatment after diagnosis, they seem to have little to no impact on specific drug choice (Donohue & Berndt, 2004). Though these trends are encouraging, the implications for psychiatric illnesses other than depression are alarming. A study by Kravitz et al. examined prescription trends in standardized patients with a diagnosis of adjustment disorder. Typically the treatment for adjustment disorder is psychotherapy, and there is no data which supports the use of antidepressant medication (van der Klink & van Dijk, 2003). Even so, standardized patients with a diagnosis of adjustment disorder were not only far more likely to receive a prescription for antidepressant medication if they requested it, they were likely to receive the brand-specific medication (Paxil) they mentioned in their interview. This demonstrates that in disorders for which the role of psychotropic medications is unclear or absent, the potential benefit of increased detection may be offset by the prescription of costly drugs which are likely to have little therapeutic benefit and often have negative side effects. Kravitz et al. suggests that physicians may benefit from additional training to respond to patient requests in clinically ambiguous situations (2005).

Shifting popular perceptions

Popular perception of the causes of and treatment for mental illness has changed dramatically over the last three decades. In the 1980s depression was widely understood to be a reactive condition caused by the happenings of one's life, which could be mitigated with support from loved ones and the practice of self-help techniques. By the 1990s, though little new evidence regarding the etiology of depression had actually been uncovered, the focus shifted to a largely biological explanation. Treatment strategies were dominated by pharmaceutical options (Clarke & Gawley, 2009). Antidepressant advertisements heavily promoted the serotonin hypothesis and featured computer generated images of malfunctioning synapses, demonstrating a chemical imbalance which could easily be corrected by the drug in question. This mechanism was presented as a collective science belief though a

significant body of contradictory evidence exists, none of which is addressed by the advertisements. The only clear support for the serotonin deficiency hypothesis is the efficacy of anti-depressants which work by the selective inhibition of serotonin reuptake (SSRIs). In randomized controlled trials, tricyclic antidepressants, St. John's Wort, exercise, and placebo have all been shown to be as effective as SSRIs in certain populations (Lacasse & Leo, 2005).

The mechanism presented in these advertisements also contradicts research which indicates that, while the underlying cause of depression is partially biological, there is significant contribution from environmental and psychosocial factors which cannot be corrected by medication alone. For some patient groups psychological treatments, such as cognitive behavioral therapy (CBT), are at least as effective as SSRIs in the short term and even more effective in the long term (Deacon & Baird, 2009). Not only does CBT lack the potential for drug interactions and side effects, it is also less expensive than treatment with SSRIs (Antonuccia, Thomas, and Danton, 1997; Vos et al., 2005). It is not surprising that none of this evidence is presented in pharmaceutical advertising. The purely biological focus of these advertisements contributed to the shift towards a homogenized, predominantly medicalized view of psychiatric illness. Patients who have seen such advertisements and believe their symptoms to be the product of a chemical imbalance are unlikely to respond positively to a physician's suggestion that non-pharmaceutical interventions might be better options for them (Lacasse & Leo, 2005; Deacon & Baird, 2009).

The promotion of a diseased brain model of depression may seem like a vehicle for the reduction of stigma – pointing to an underlying cause which is beyond the control of the patient decreases the likelihood that others will perceive symptoms as a failure of character, intelligence, or willpower (Deacon & Baird, 2009). In theory, the more strongly depression is perceived as a medical illness which can be controlled by pharmaceutical intervention the less a person can be blamed. Therefore a scientific explanation of depression should contribute to the view that it is an illness and not a failure of the patient's moral strength. (Payton & Thoits, 2011). However, though a medicalized understanding tends to reduce blame it also tends to elicit more prejudice towards persons suffering from psychiatric disorders. In a study by Rusch, Kanter, and Brondino, stigma reduction programs based on biomedical explanations of depression were significantly less effective than programs which explained depression as a reactive condition triggered by negative life events (2009). Biological explanations of mental illness foster an altered understanding of prognosis, based on the perception that a biological illness is less curable or controllable than one based on extrinsic factors and more likely to render a person unable to lead a normal life. This can also lead to the view that depression is less likely to respond to treatment and more likely to require intensive long term professional help (Deacon & Baird, 2009).

Even pharmaceutical advertisements which promote medicalization maintain a separation between psychiatric and non-psychiatric illness. Advertisements for psychotropic medications tend to contain less text and less specific information about the medication than ads for other types of drugs, and use more negative imagery with fewer portrayals of everyday situations (Foster, 2010). They inflate risk and lead to exaggerated perceptions of prevalence (Park & Grow, 2008). The misleading quality of these advertisements contributes to false impressions of mental illness.

Who is actually ill?

Because the ultimate goal of pharmaceutical advertising is to sell a product, it is unsurprising that advertisers are willing to exploit the emotions of the potential client to compel them to seek their product. (Wolfe, 2002). In doing so, advertisers for psychotropic medications have attempted to blur the line between normal and pathological discomforts associated with daily life in order to encourage the need for pharmaceutical intervention (Rubin, 2004). These efforts create a market in healthy individuals by suggesting that drugs are necessary to help them cope with their struggles (Lenhardt, 2005). Those who are persuaded seek – and are often successful in obtaining – prescription medications for relatively minor symptoms for which there is no clearly defined indication (Kravitz et al., 2005).

An October 2001 advertisement for the antidepressant Paxil provides an extreme example of the effort to manipulate the emotions of a potential pharmaceutical consumer. The advertisement depicts a woman on a crowded New York City street appearing overwhelmed and anxious. Above her head floats the caption, "Millions suffer from chronic anxiety." This suggests that the woman's anxiety is based in pathology. Based on the timing and the location of the target audience, it is likely that a person's ability to relate to the woman in the advertisement stemmed from an appropriate response to distressing life events – such as the recent attack on the World Trade Center (Lenhardt, 2005). Providing consumers with such specific and relatable symptoms inflates their estimates of the prevalence of mental illness. The perception that it is so widespread leads to the logical conclusion that they may be experiencing symptoms of a disease rather than healthy responses to stressful situations (Park & Grow, 2008).

This potential for manipulation exists for common diagnoses but is especially alarming in cases in which advertisements are used to promote and expand entirely new disease categories. Quoted in the journal Advertising Age, Paxil's product director Barry Brand admits that "…every marketer's dream is to find an unidentified or unknown market and develop it. That's what we were able to do with social anxiety disorder" (Rubin, 2004). Prior to the 1999 FDA approval of Paxil for the treatment of SAD the disorder was considered rare and received minimal attention. Shortly after receiving approval GlaxoSmithKline launched a "public awareness" campaign, containing no mention of either the drug or the pharmaceutical company, which portrayed men and women appearing uncomfortable and distressed in everyday situations. These pictures told stories about people cheated out of success in work, social gatherings, education, and romance by their own anxiety. The generic and familiar nature of the images challenged the viewer to question whether they were any different. Captions such as "Imagine being allergic to people" indicated that the symptoms are fairly severe, even though the scenes depicted no intense action or emotion. Paxil's subsequent ad campaign presented the "good news" that a chemical imbalance could be to blame for social anxiety, and that medication could help. This message reached an audience that had already been primed for consumption (Davis, 2006).

Conclusion

The practice of marketing psychotropic medications to potential patients raises significant ethical concerns. Direct-to-consumer advertising has a detrimental effect on the interaction between physicians and patients. Proponents claim that it is a vehicle for informing consumers, putting them on more equal ground with the physician. In reality, the information provided in advertisements is incomplete and often inadequate for making treatment decisions. Patient requests put pressure on physicians to prescribe drugs which may not be therapeutically beneficial or for which the risks outweigh the benefits. This is especially true in cases where there is no clearly defined role for pharmaceutical intervention of any kind.

Because of the size of the audience they reach, advertisements are also a major vehicle of social misconceptions regarding mental illness. Advertisements tend to promote a biological model of psychiatric illness and ignore the contributions of environmental and psychosocial factors, leading to altered perception of prognosis. The medicalized view they espouse undermines the potential for success using non-pharmaceutical treatment options. It also colors popular perception of people with mental illness as unable to lead normal or healthy lives without intensive long-term professional help.

Some campaigns go so far as to promote new illness categories in an attempt to carve out new niches of consumers. They suggest that anyone could be suffering from a psychiatric disorder and that medication is the answer. While for some this may be true, these advertisements exploit people dealing with everyday life events and experiencing healthy reactions and suggest to them that what they are feeling may be pathological.

Direct-to-consumer pharmaceutical advertising poses a threat to the effective diagnosis and treatment of psychiatric disorders. Though it is unlikely that new restrictions will be placed on the practice there are measures that can be taken to mitigate its negative effects. Physicians not trained in psychiatry may benefit from additional training in the management of disorders where drugs are unlikely to confer significant benefit. This may ease conversations with patients whose visits are motivated by information they received in advertisements. Mental health advocacy groups can counteract misinformation and fill gaps in knowledge about psychiatric illness and treatment. Most importantly, the FDA can do more to remove misleading or incomplete advertisements from circulation. Direct-to-consumer pharmaceutical advertising is inescapable. More must be done to lessen its capacity for harm.

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