7 Uptake and the Biomedical Subject

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INTRODUCTION

Recent health information campaigns draw on the ideological power of genres as a means of imposing subjectivities and subsequently disposing individuals toward biomedical interventions into their lives[1]. Asking readers "Are you depressed?", an online depression screening quiz hosted by iVillage.com offers a medicalized genre—the quiz is touted as "developed by the National Mental Health Association"—as an appropriate response to its query. By responding, readers not only *take* a quiz, they *take up* a genre and *take on* an identity that has been readied for diagnosis. Freadman (1994) has viewed such discrete generic activities as "shots" within a socially and textually constructed "game" (p. 44). She uses the term "uptake" to name "the bidirectional relation that holds between" genres (2002, p. 40), and she goes on to describe the ideological functions of that relation as occuring when genres are taken up, or translated, across boundaries (p. 43). On the iVillage site, the symptoms checklist, a diagnostic genre developed for use in research and clinical settings, crosses into a new social space, namely, the privacy of a reader's home or office, and this crossing redefines private life as clinical experience. The symptoms quiz, a list of multiple choice questions, produces a "return shot" from the reader: the "answers." In turn, the answers impel further action (visiting a doctor's office), and thus the textual chain provides an important map of the subject's transition from *reader* to *patient*. Such a textual analysis ironically elides the physical bodies and subjective actors that are the objects of medical interventions. Therefore, a reanimation of uptake with the individuals who ultimately perform it appears both necessary and timely.

The close of the twentieth century brought patients and physicians unprecedented access to information about health and illness. From online patient support groups to direct-to-consumer advertising, from memoirs to Hollywood movies, depression itself became a key character in the US health narrative. Its ubiquity may be attributed to any number of contemporary factors: the discovery of a new class of "wonder drugs," the selective serotonin reuptake inhibitors such as Prozac®, which was approved for use in the US in 1987; the relaxing of direct-to-consumer advertising restrictions by the US Food and Drug Administration in 1997; and the growth and popularity of online health reference services, such as WebMD®. Each of these factors continues to generate its own

systems of genres, and each contributes to the discursive construction of the illness. For example, pharmaceutical development and subsequent advertising encourages the medicalization of sadness and social disconnection; information delivery services create statistical portraits of the illness, informing us that each year, 14.8 million American adults experience a major depressive disorder, and that women are more likely to be depressed than men (NIMH, 2006). The current experience of depression is thus highly rhetorical in that it responds to these circulating discursive constructions, and it becomes visible through the patterns of the illness's expression. Individuals make use of these patterns as they come to inhabit healthy and ill subjectivities, taking on dispositions and subjective orientations as they take up the available genres and discourses[2].

Despite this potential to shape individual subjectivities, genre scholars have attended to uptake primarily as a necessary heuristic for understanding the ways texts and genres cohere within systems of social activity. The concept of uptake has made visible a bidirectional temporal/textual relation between, for example, a writing prompt and a student's essay in first-year composition[3]. Yet to the extent that uptake is a relation that attests to ideological processes, it needs complication not only in terms of the textual and generic chains it can help us apprehend, but also in its rhetorical preparation of the *subjects* who enact and receive utterances. Via the processes of uptake, these subjects become available for other kinds of interventions—subjective, even somatic ones. Outside of the courtroom, where the fates of subjects and their bodies are determined first rhetorically (in a sentence) and then materially (in an incarceration or an execution)[4], the medical context perhaps most dramatically illustrates the high stakes for the relations among genres, texts, and subjects[5]. Within medical encounters, embodied rhetorical moves become particularly urgent and consequential, and the roles individuals assume as they negotiate their medical-rhetorical contexts—in addition to the roles of texts and genres within those contexts—provide clues to the construction of biomedical subjects. In the following analysis, I examine a web of texts constituting the discourse of depression as mental illness in the United States, and I argue for a reanimation of uptake with individual subjectivities at the center of theoretical consideration.

REDEFINING UPTAKE

As Freadman (2002) articulates it, "uptake" is the linkage between *and* the process of linking genres within and across systems of social action. In her analysis, uptake naturalizes the connection of two (or more) generic texts in order to create a coherent sequence of activity[6]. Outside the courtroom, in which the state is officially sanctioned to dispose of bodies and subjects according to generic

codes, the rituals of medicine display the crucial role uptake plays in translating textual phenomena (words and genres) into physical outcomes (pharmaceuticals and procedures). Language manifests itself within the body via a series of intergeneric translations: a consultation interprets patient *talk* as a series of *symptoms*; a diagnosis responds to *symptoms* with a *prescription*; a pharmacist transforms a *prescription* into a *medication*; and a patient ingests the *medication* in accordance with the *directives* on the bottle, thereby incorporating into the body a material response to an initial, purely rhetorical locution. In each of these translations, a process legitimizes the connections between genres; both context (the office, laboratory, and pharmacy) and convention (the textual forms of professional legitimacy and the social rituals of prescribing), for example, must sanction the doctor's ability to write a prescription, and the pharmacist's to fill it. Freadman's articulation of uptake draws our attention to this process, which, in the medical example, socially legitimizes and individually compels the taking of drugs.

There is, however, more to a series of medical encounters than the forward march of textual signification that ultimately acts upon a patient's (passive) body. Within these medical encounters, the subject rhetorically positions herself[7]—via the mechanisms of uptake—within a specific social activity, and in the process complicates the discursive scene. The value of uptake in promoting smooth travels within the semiotic landscape of health and illness seems clear: without a doctor's uptake of *symptoms* as evidence for a *diagnosis*, a patient is unrecognizable within the medical system and unable to receive treatment. But, before deciding to visit a doctor's office, the individual must first take up experiences themselves as potential symptoms. Before the biomedical system can impose control or deliver treatment through medication, the patient must first acquire the habits of mind that comprehend experiences as symptoms, and then take up the genres of medical interaction which lead, ultimately, to the doctor's office and the pharmacist's counter. These preliminary activities operate on the boundaries of social systems; they provide evidence of individual struggles for discursive agency; they offer insight into the workings of social and discursive power.

In most scholarship on uptake, analysis focuses on sequences of texts at the expense of attending to individual, embodied subjectivities. While Freadman herself uses the legal world to display physical punishment effected via a series of instances of uptake, the body of the punished subject becomes a mere artifact, and its death one more sign available for uptake within political and cultural debate over capital punishment. In Freadman's articulation, each genre in a sequence is an uptake of a previous genre, and each uptake depends upon what she calls "memory" to make the sequence intelligible and consequential (2002, p. 42). By drawing attention to the interstices between genres, Fread-

man's theory of uptake has itself been taken up by scholars seeking to name a process that authorizes genres (Bawarshi, 2003), that precludes generic recognition (Roberts & Sarangi, 2003), or that opens a space for the performance of identity (Kill, 2006). In each of these uses of uptake, however, attention is focused on the social and interactional consequences of individual acts, without full consideration of the subjectivities constituted through the processes of uptake. If we are to account for the power, particularly the intimate, embodied power, of uptake, we must redefine uptake not as the relation between two (or more) genres, but as the disposition of subjects that results from that relation. Genres as social actions are powerful only when they direct or forestall human interaction.

In theories of performativity, what passes for identity is enacted through symbolic displays—whether writing, dress, speech, or other semiotic means[8]. The emphasis in such theories is often on how the performance creates the conditions for its recognition in the future by citing past performances. Such citations are certainly not individual innovations; they rely on their previous contexts for their present authority. In her analysis of the discourse of femininity and individuals' practices in relation to it, Dorothy Smith (1990) argues for women as "secret agents," performing beyond the public scene of discourse. Smith writes of "the subject-in-discourse [who is] is denied agency," but also of "another subject who is here speaking in her capacity as a knowledgeable practitioner of the discourse of femininity" (pp. 192-193). In other words, agency is available through a skillful articulation of circulating discourses, and agency need not—indeed cannot—be directed toward liberation from discourse *per se.* Instead, agency derives from the choices of citation made available to and taken up by individual subjects. Processes of uptake similarly cite previous genres, discourses, and situations to act within new scenes; agents represent themselves within the genres and discourses that are most likely to be recognized. Drawing on historical records, Solomon (2001) documents such adaptive behavior among seventeenth-century melancholics:

> Two-thirds of the aristocrats who came to [a physician] complained of melancholy humors; and these men and women were well informed, speaking not simply of waves of sadness but complaining quite specifically on the basis of the scientific knowledge and fashion of the time. One such patient was "desirous to have something to avoid the fumes arising from the spleen." (p. 300)

For these patients, the "scientific knowledge and fashion of the time" provided the language that made them recognizable to their physician. Their reproduction

of that language enabled them to receive treatment, but it also signaled their incorporation into a social discourse that associated melancholy with "great depth, soulfulness, complexity, and even genius" (p. 300). Their performances, Solomon suggests, were motivated by the desire to embody a poetic sensibility, rather than by the experience of illness. Such discursive manipulation represents active agency on the part of the patients (they secure a doctor's uptake of their performance *as* melancholy, and they receive the treatments that they seek), but it also represents their submission to a fashionable identity which had them ingesting concoctions that included "lapis lazuli, hellebore, cloves, [and] licorice powder . . . dissolved in white wine" (p. 300). The ability to model locutions on past genres and discourses provides evidence for the processes of uptake, processes that entail subjective dispositions and naturalize additional rhetorical and material responses.

To account for these processes of uptake, I expand Dorothy Smith's concept of the "secret agent" who uses discourses for her own pleasure (as the seventeenth-century melancholic aristocrats also seem to have done) to encompass the "double agent" in Bawarshi's (2003) characterization of the student writer as "both an agent *of* his or her desires and actions and an agent *on behalf* of already existing desires and actions" (p. 50). This more expansive notion of agency works within circulating discourses (a patient must describe his pain in familiar ways) but that also has the ability to achieve individual ends (the patient secures the intervention that he seeks). Yet in these achievements, individuals produce personal dispositions that have significant physical consequences. Thus, the problem of uptake is the problem of what is *taken on* when an individual *takes up* particular genres and discourses.

To write or speak within a system of social activity is also to assume a variety of habits and dispositions that are commonplace to that system. This may be partly a conscious act, but it may also be the inevitable consequence of being recognized within the system. As Schryer (2002) notes:

> Each genre . . . has a different trajectory, a different potential for producing world views and representing human agency. In my view all genres operate in this fashion. They function as discourse formations or constellations of strategies that instantiate a "commonsense" understanding of time and space that can affect their writers or readers. We can become habituated to these constellations of resources and fail to see the possibilities for the constraints on human action that they enact. (p. 85)

This is the power inherent in choices of genre: to position subjects and to allow them to inhabit (only) particular social roles. To the extent that scholars have in-

vestigated the generic positioning of subjects, they have largely considered the selection and maintenance of group membership through the acquisition of genre knowledge (e.g., Schryer, 1994). Bazerman's (1988) analysis of the development of research genres and the organization of the personal (and, increasingly, public) interactions of those who came to view themselves as *scientists*, however, clearly demonstrates the stakes for individuals and communities. Confronted with the realities of scientific practice, scientists perceive a "situation and available alternatives and in their choices make and remake social structure[s]" (p. 129). Nevertheless, the thrust of Bazerman's analysis is toward the construction of *science*, and, though that necessarily also includes the construction of *scientists*, individual subjectivities beyond that of the professional scientist are not his primary concern. In the contemporary medical context of depression, individuals choose from alternatives that confer not social standing as Bazerman's scientists hope to achieve, but medical recognition and subsequently the regulation of their lived experiences. Such selections—by non-members of a professional community, with the purpose not of joining but of interacting with the professional community—draw attention to the discursive and bodily consequences of uptake.

FORMS OF UPTAKE

Uptake—redefined as the disposition(s) assumed through the use of genres—encompasses the effects of those generic choices upon individuals. Making uptake visible, however, requires a means of marking and referring to the textual traces of the process. In the following analysis, I distinguish between two kinds of activities, though I do not mean to imply that they operate separately. Rather, this division allows me to focus attention on distinct textual phenomena that illuminate the subjectivities available and contestable within processes of uptake. First, "generic uptake" describes the subject's selection and translation of forms of discourse (and the impositions of power those forms imply) into new speech situations. Drawing on the textual and rhetorical patterns of other genres, generic uptake, to borrow Austin's (1975) terms, makes "nonserious" use of the speech acts that the genres are meant to perform (p. 122). Yet these nonserious uses are not, therefore, powerless (as Austinian speech-act theory would predict, given their violation of the felicity conditions for their performance). Rather, they can have very serious consequences because the forms are not empty of social dispositions when they are taken up[9]. Generic uptake can be used to exert power across institutional and social boundaries. In Freadman (2002), just such a "nonserious" use of courtroom genres allows a politician to cast a dissenting judge in the role of state's witness, thereby "confirming the disempowerment of one jurisdiction [the court] and the power of the other [the government]" (p. 47). Thus, generic uptake involves the selection and translation of typified forms (e.g., testimony) and social roles (e.g., prosecutor, witness) into new discursive

situations, thereby potentially restricting future uptake and the participants' possible subjectivities[10]. Instances of generic uptake focus our analytic attention on the organization of bodies and the persons they materially ground within a social scene.

"Discursive uptake" is a second kind of textual representation of the processes of uptake, where key phrases, rather than patterns of social organization or discursive form, are taken up in new situations[11]. Here again, the object selected must be recontextualized within its new speech situation. But, unlike those of generic uptake, the dispositional effects of discursive uptake are more individual than collective. Where generic uptake focuses attention on social organizations and roles available to multiple participants, discursive uptake provides clues to the positioning of the individual subject[12]. Political catch phrases do this extremely economically: a speaker need only use the single phrase "pro-choice" to find herself read as a particular kind of political subject. More importantly, her subjectivity is shaped by entailments within the larger "pro-choice" discourse when she takes up this single phrase. In this way, discursive uptake necessitates the assumption of particular attitudes and dispositions. In medical contexts, many of these dispositions are physical as well as rhetorical. In both forms of uptake, textual performances negotiate previous, current, and future utterances through the related practices of citation, articulation, and entailment. In generic uptake, these practices draw forward previous forms and social organizations that work to secure future roles and responses available to interlocutors. In discursive uptake, these practices draw forward previous key phrases and dispositions that work to position individuals within recognizable social systems.

As they encounter the discourse of depression, individuals use both forms of uptake as performative and interpretive acts. They draw on influential texts such as Kramer's (1997) reissued *Listening to Prozac,* which calls attention to the pharmaceutical treatments that modulate the experiences of individuals. That the revised edition of this text appears a mere four years after the original attests to the pubic appetite for such attention. Kramer's (1993) description of a "cosmetic psychopharmacology" that seemed to allow individuals to alter their *selves* in addition to treating their illnesses catalyzed a wide range of responses (p. xvi). Such responses include personal stories of depression (Casey, 2001), scholarly collections that debate the cultural repercussions of antidepressants (Elliott & Chambers, 2004), memoirs (Wurtzel, 1994; Danquah, 1998; J. Smith 1999), and monographs that analyze the psychiatric (Metzl, 2003) and pharmaceutical (Healy, 2004) communities. Many of these texts circulate without meriting much rhetorical analysis. Where such analysis has been directed, scholars have attended to the power of master documents such as the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) to organize the social scene of therapy (McCarthy, 1990; Berkenkotter, 2001). While some studies consider the content

and contexts of discursive repetitions (Ferrara, 1994; Ravotas & Berkenkotter, 1998; Berkenkotter & Ravotas, 2001, 2002) within therapeutic relationships, none have attended specifically to the paths that lead to such therapeutic interactions. Within the larger social discourse of depression—represented by the myriad texts listed above—individuals select and translate genres and terms that help them make sense of their own experiences. Within these selections and translations, they encounter and assume new subjectivities that ready them for medical intervention.

Textual traces of these processes include what I have defined as generic and discursive uptake. In the discourse of depression, a common generic form is the symptoms list, which defines the boundaries of the illness by enumerating the number of discrete symptoms that sufferers must experience to qualify for diagnosis. Generic uptake of this symptoms list, therefore, organizes social actors around the diagnostic moment. In addition, the biological shift in psychiatry has given rise to a biomedical discourse that further defines depression as a "chemical imbalance." Discursive uptake of this catch phrase shapes individual dispositions toward biomedical treatment models and responses to the illness. In the following examples, these processes operate in concert to shape the depressed subject and her future responses to the illness. Traces of uptake within a variety of texts reveal the positioning of the depressed subject as a result of complex interactions among texts, genres, scenes, and individuals.

GENERIC UPTAKE OF THE SYMPTOMS LIST FOR DEPRESSION

According to the DSM, a "Major Depressive Disorder is characterized by one or more Major Depressive Episodes (i.e., at least 2 weeks of depressed mood or loss of interest accompanied by at least four additional symptoms of depression)" (APA, 2000, p. 345). First published in 1952, the DSM has rapidly become the governing document for psychiatric diagnoses in the US, and, therefore, it has come to regulate diverse systems of activity, from scientific research to health insurance reimbursement. The third edition of the DSM, published in 1980, contained the first sets of symptoms that were intended to classify distinct disorders[13]. These symptoms, in the form of a short checklist, were taken up from research instruments (e.g., Beck et al., 1961; Center, 1971), and they have subsequently been taken up in self-assessment tools (e.g., "The Zung Assessment Tool" available online at www.Prozac.com). In the current DSM-IV (2000), the symptoms for depression include:

- depressed mood
- diminished interest/pleasure in activities

- significant weight loss or gain
- insomnia or hypersomnia
- psychomotor agitation or retardation
- fatigue or loss of energy
- feelings of worthlessness or excessive guilt
- diminished ability to think or concentrate
- recurrent thoughts of death or suicidal ideation (p. 356)

Originating from contexts of empirical research and acquiring medical authority through its reproduction in the DSM, the symptoms list positions expertise in the interpretive act of "scoring" the quiz or checklist. Users of the genre have either experience of the symptoms (patients) or knowledge of the meaning of combinations of those symptoms (researchers/doctors). By completing a questionnaire or checklist, an individual literally submits the form and herself to a medical interpretation. Via the genre, personal experience becomes the property of diagnostic readings, and the ability to interpret such experiences moves outside of the individual's purview.

Examining texts that display generic uptake of the symptoms list for depression, we can see the social roles of users being manipulated and redefined. One of the most productive sites of such uptake is the direct-to-consumer pharmaceutical advertisement in the US. A 2001 Zoloft® advertisement transforms the symptoms list into a series of second-person imperatives:

- 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.

In this case, the diagnostic outcome is tied to an apparently authoritative reader who is encouraged to accept diagnostic certainty—she *knows* when things "just don't feel right." Nevertheless, her masquerade is revealed by the advertisement's subsequent reinstatement of traditional medical authority: "[o]nly your doctor can diagnose depression." The campaign's tagline—"When you know more about what's wrong, you can help make it right"—places the reader in the grammatical subject position, suggesting a repositioning of the actors in typical diagnostic settings. The reader (who "knows") and the pharmaceutical manufacturer (who provides information) assume more active and assertive roles, but those roles travel only as far as the doctor's office, where the reader is commanded

to "Talk to your doctor about ZOLOFT." Even the empowered consumer has limited options for responding to the disorder. The generic uptake in this advertisement instantiates the social organization of acts of diagnosis, and even though the reader is encouraged to play the role of her own doctor initially, she is reinstated as the recipient of medical authority within the larger context of the advertisement. Serial acts of generic uptake accomplish this medicalization of experience: first, the DSM takes up the genre of the symptoms list from the clinical research community; then, the advertisement takes up the genre and translates it into a persuasive appeal; and, finally, the reader takes up the genre and the implicit subjectivity of an empowered *consumer* whose knowledge prepares her to submit herself to medical intervention.

In her memoir, *Undercurrents*, Martha Manning (1995) discusses her own struggle to accept a diagnosis of depression. A psychologist herself, she turns to the familiar genre of the symptoms list to persuade herself that what she is feeling *cannot* be depression:

> I pull out my manual and flip to the section on major depression. I want a second opinion. I do this in those quizzes in women's magazines with the little tests that will answer questions like, "Are you keeping your man satisfied in bed?" or "what does your closet say about your personality." I love those stupid quizzes. I fill them out, add up my score, and then quickly turn to the section that gives me my rating. If I don't like the results, I automatically turn back to the test and take it over. I change answers that were only marginally true, or ones that I've rationalized aren't really true at all, trying to get my score into a more acceptable range. I do that now. But as I work my way down the list, there are no marginal answers, not a single area in which I can "massage the data." . . . I am rattled for the rest of the day. (p. 73)

In her description, Manning seeks "a second opinion" from the genre contained within her diagnostic manual, and she initially assumes that she has control over her performance within that genre, likening it to "those stupid quizzes" in women's magazines[14]. Here, Manning performs a generic uptake that attempts to reconcile two genres that appear similar in their positioning of herself as a respondent. The diagnostic symptoms list, however, resists the revisions Manning customarily performs on the more frivolous personality quizzes. In her admission of being "rattled" by her inability to "massage the data" in her response to the symptoms list, Manning demonstrates her awareness of a received identity, a suddenly medicalized persona that has been entailed by her uptake

of the symptoms list. Thus, generic uptake positions social actors (Manning as a respondent, the text as a representative of medical authority) and they entail particular subjectivities (in this case an uncomfortable reception of a patient identity for Manning).

Beyond published examples of generic uptake, the implications of taking on the subjectivities encoded in the symptoms list are clearly visible in the talk of women experiencing mild to moderate symptoms of depression. In 2002, I conducted two semi-structured group interviews with university students to capture some of this talk about mental health and illness. The subjects in my study were recruited via a flyer that mimicked the symptoms list (e.g., Are you feeling blue?), and to qualify, they had to complete a diagnostic survey (I used the CES-D [Center, 1971]) and score within a range that would classify them as "sub-clinical." As such, these women represent the "worried well," a group that scholars argue is particularly affected by biomedical discourses (Eade & Bradshaw, 1995, p. 61). In the conversations excerpted here, I highlight moments of discussion about completing the study materials. For the women in my interviews, the questionnaire was at first troubling, but quickly became an important determiner of their health status. In one group, I invited the women to "tell me a little bit about [their] reaction[s]" to the study screening materials[15]. The answers below occur within roughly five minutes of conversation:

> Stephanie: I wanted to check between the boxes. Like, okay, last week this happened. Oh that's not quite the same as 3 or 4; it was kind of 2 and 3. I probably tried, but I've kind of forced them into categories for simplicity's sake.

Here, Stephanie refers to the choices available on the CES-D, which require respondents to indicate how often in the past week they have experienced various symptoms of depression. A few turns later, Jennifer responds to my initial question, and Mei and Stephanie elaborate on their experiences of completing the study materials:

> Jennifer: Yeah, I don't really remember. The only thing I remember, um, filling that out is, "Oh, am I going to be picked for this study?" ((laughs)) . . . .
>
> Mei: Well I just I guess it was just nice . . . . 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)) . . . .

> Stephanie: It was kind of a convenient compartmentalizing experience. "Oh, yes, this is what this is. Oh, wow, other people feel—[this]. This is so validating."

For Stephanie, the experience of completing the CES-D was "a convenient compartmentalizing experience" that allowed her to validate her feelings; she assumes the categories on the form represent others' experiences. Significantly, however, she first describes how her uptake of the CES-D was not immediately validating: she "wanted to check between the boxes." In these few minutes of conversation, Stephanie's self-presentation moves quickly from that of an individual whose experiences are *not* congruent with the genre to one whose experiences are validated and recognizable within the genre. Mei, too, finds the genre comforting, and implies that the genre itself helped her to identify symptoms that she "might not have written" had I asked simply for a narrative. For Stephanie and Mei, and indeed for others I spoke with, the genre is viewed as a tool for producing a particular identity, first as someone qualified for my study (as Jennifer suggests above), and also, often, as someone who is depressed.

The women's reception of an identity contained within the CES-D, namely, the identity of a depressed person, is striking because none of the women in my study technically qualified for a clinical diagnosis of depression. The power of the genre to help Mei recognize her symptoms and to validate Stephanie's experiences implies that the generic uptake helps translate experiences into symptoms, and therefore helps move individual bodies into the biomedical system. Despite all of my precautions—explaining that this was a study only of the language of depression, selecting only women who were not clinically depressed—several of my participants seemed to expect medical intervention or outcomes, a byproduct, I believe, of their generic uptake of my screening materials. The practice of generic uptake entails interacting with and through a form that encodes particular identities; once the form has been accepted, the medicalized identity necessarily follows.

DISCURSIVE UPTAKE OF THE BIOMEDICAL MODEL

Discursive uptake draws upon the stock phrases and dispositions of specific communities. For example, the biomedical discourse on depression is best represented by the current popularity of "brain chemistry" as source and possible cure for mental disorders. In this discourse, depression is a treatable "imbalance" of chemicals, essentially a mechanical problem that requires (most often) a pharmaceutical intervention. Poet Chase Twichell (2001), writing about her experiences with depression, relies heavily on the biomedical discourse of mechanics and brain chemistry. She writes:

> The biochemical chain reaction that results [in depression] is extremely complicated, much of it still hypothetical. What is known is that certain neurotransmitters (especially serotonin and norepinephrine) do not work properly, causing a disruption in the flow of information between nerve cells. It's like a game of telephone; the message gets lost as it travels, eventually affecting cellular metabolism, hormone balance, and the circadian system, the clock that determines cycles of rest and activity. (p. 23)

In Twichell's description, qualities of the biomedical discourse include the use of chemical names, for example, "serotonin" and "norepinephrine," and the reliance on mechanical and systemic metaphors. Twichell uses the images of a chain reaction, information flow, a game of telephone, and the notion that a clock regulates bodily activity to describe the mechanisms of depression. Importantly, she notes that what is wrong is that something "do[es] not work properly." This idea of *working* is key to the mechanical metaphor that sits at the root of the biomedical discourse; if something does not work, the solution is to fix or replace the faulty mechanism[16]. Thus, discursive uptake regulates dispositions—here Twichell understands her own depression as a malfunctioning system in need of repair—and enables particular responses to material realities. The biomedical discourse influences the research, treatment, and ideological models for depression.

Pharmaceutical companies are, obviously, very invested in this biomedical discourse; they are uniquely positioned to offer solutions to these mechanical problems. Advertisements for many antidepressants use the idea of levels of serotonin in their explanations of depression. In the words of one Prozac ad, "When you're clinically depressed, one thing that can happen is the level of serotonin (a chemical in your body) may drop." Similarly, in a Zoloft advertisement, the text asserts, "While the cause is unknown, depression may be related to an imbalance of naturally occurring chemicals in the brain." In both cases, the pharmaceutical companies are very careful to use mitigating language such as the modals *can* and *may.* Nevertheless, these markers of uncertainty do not detract from the power of the biomedical discourse. Implicit in such talk of "levels" and "balances" is the assurance that there is an optimal level, a "fill line," for serotonin or other neurotransmitters[17]. New York writer and teacher Joshua Wolf Shenk (2001) describes the reliance on the mechanical models of depression as a means of lessening uncertainties and "provok[ing] the least fear of the unknown." He writes:

> Phrases like "running out of gas," "neurotransmitter deficits," "biochemical malfunctions," and "biological brain disease" are terribly common, and are favored by well-intentioned activists who seek parity between emotional and somatic illnesses. Pharmaceutical companies also like machine imagery, since they manufacture the oils, coolants, and fuels that are supposed to make us run without knocks or stalls. This language not only reflects, but constructs our reality. (p. 247)

Here, Shenk recognizes the power of discursive uptake to "construct our reality." In this discourse, depression is essentially a mechanical problem—an imbalance of chemicals—and, as such, it is easily resolved with pharmaceuticals that rebalance the system. Individuals who take up the biomedical discourse, often through citation of the catch-phrase "chemical imbalance," ready themselves for such pharmaceutical interventions. The simplicity of a mechanical metaphor holds explanatory power for such individuals, and leads them to discount other possible causes of and responses to depression. Such reliance produces subjectivities that are then doubly vulnerable to a common pharmaceutical "poop-out" phenomenon. Lauren Slater (1998) describes the betrayal: "As fast as Prozac had once, like a sexy firefighter, doused the flames of pain, the flames now flared back up, angrier than ever, and my potent pill could do nothing to quell the conflagration" (p. 116). Having come to rely on the "sexy firefighter"—a gendering of cure as telling as the gendering of the disease itself—Slater cannot reconcile her returned symptoms with her original conceptual framework. She writes, "Prozac never again made me as well as it once had" (p. 127).

The conceptual value of the biomedical explanation is clear to the women in my interviews. The women remember pharmaceutical advertisements as key disseminators of this information:

Paige: Zoloft has a commercial with the little guy who bounces around and—

Claire: Yeah, and explains the, you know, chemical imbalance. How it works—

KE: What do you think of that commercial?

Claire: It made sense to me for some reason.

KE: The diagram, or the little guy?

Claire: The diagram. I was like, "Okay there's not really anything going on in my mind that I should be this depressed about. You know . . . I have it going really well right now, so why do I feel sad? Maybe it's a chemical imbalance."

Here, the key feature, for Claire at least, is the explanation of the "chemical imbalance, how it works." This discursive uptake serves an important function for Claire's self-identity. She signals her acceptance of this concept in her final turn, saying, "I have it going really well right now . . . Maybe it's a chemical imbalance." In this example, Claire has taken up the phrase "chemical imbalance" and actively applied it to herself. She is uncritical of the advertisement ("It made sense to me for some reason"), and seems to be particularly persuaded by the diagram—which offers a "dramatization" of neurotransmitters with and without Zoloft—that organizes her understanding of her own emotions. In this case, her discursive uptake disposes Claire to see her experiences as the result of her own faulty brain chemistry.

Similarly, in other moments, the discursive uptake of a biomedical discourse might be seen as readying the women's bodies for medical intervention. When I asked the women (after several mentions of the phrase) how they might know if they had a "chemical imbalance," they were quick to disavow any ability to diagnose themselves, but they seemed to assume that the imbalance was nevertheless specifically quantifiable:

KE: So, how would you know if you had a chemical imbalance?
Mei: I don't know how to diagnose it ((laughs)). I don't know, I mean aren't there tests they could do? Or I mean? I'm sure 'cause ((pause)) actually yeah, I don't know.

In this excerpt, Mei performs the subject position that may well have been entailed by her generic uptake of the symptoms list (see above): she disavows an ability to "diagnose it" and questions whether "they" could do tests to confirm a "chemical imbalance." In this moment, she is a patient, and the third-person pronoun indicates a medical authority; Mei is no longer validated by the genres and discourses of depression, she is subjecting herself to a medical model. Further, the notion that there should be "tests" that could confirm an imbalance demonstrates the entailments of her discursive uptake. She has not simply taken up the catch-phrase, she has also taken on the implied mechanical model of depression as well. Ultimately, this uptake seeks the translation of her body into the medical system via diagnostic tests and eventual pharmaceutical intervention. This desire for a precise diagnosis is echoed by patients in sociologist David

Karp's (1996) *Speaking of Sadness*. One man's diagnosis "became clear to him after 'they gave me a blood test and said, "You're depressed." And I believed them.'" Karp's informant experiences a series of hospitalizations following this conversion, and Karp describes the moment as "the beginning of his licit drug therapy" (p. 84). The discursive uptake of the biomedical model for depression clearly has consequences that play out within and upon patients' bodies.

CONCLUSION: THE CONSEQUENCES OF UPTAKE

In the preceding examples, generic and discursive uptake provide evidence for the shaping of individual dispositions toward experiences that come to constitute the mental illness depression. Scholars are quite good at identifying the power of discourse to structure lived experience, so my analysis of discursive uptake should be relatively familiar. However, the consequences of generic uptake seem less well understood, and, further, the interactions *between* generic and discursive uptake—such as the yoking of the genre of the symptoms list to the biomedical explanation for depression in the Zoloft advertisement—have not been adequately theorized among medical rhetoricians. In the discourse of depression, generic and discursive uptake operate in a wide variety of textual locations, requiring that we attend to social scenes more diverse and dispersed than traditional therapeutic settings. News reporting, popular self-help literature, and, even more ephemeral, word-of-mouth practices provide the environment for individual uptake, by which I mean the disposition of the self in relation to biomedical realities.

Generic uptake of the symptoms list for depression has become so commonplace that it begins to resemble discursive uptake. In a 1999 interview with *Newsweek* magazine, US Second Lady Tipper Gore talks candidly about her depression, which began after her son was injured in an accident:

> I think I can say this in generic terms: one's mind plays tricks with oneself. It's a very insidious kind of disease because you don't know you have it and you think . . . that the world would be better off without you. That is very serious . . . . There are a number of signs and symptoms of depression [including gaining weight, changes in sleep habits, lack of energy and feelings of low self-esteem]; if you read down the list and two to four of those apply to you for more than two weeks, you should see a mental-health professional. That's what I did. I know so much about this—I have a master's degree, I was going into family counseling—so in a way, I quickly knew. I looked it up and went, OK, this time I'm calling my friend not as a friend but professionally. (Rosenberg, 1999, p. 51)

Here, Gore describes depression "in generic terms," by which she means terms applicable to everyone, but by which her text also implies the diagnostic genre itself. "There are a number of signs and symptoms of depression," Gore relates, but the specific symptoms must be inserted by *Newsweek* itself. The habits and social organizations of the genre, however, are preserved in Gore's description: "if . . . two to four of those [symptoms] apply to you for more than two weeks, you should see a mental-health professional." Here, Gore positions the expertise outside of herself and, importantly, outside of her readers as well. The reduction of the genre to a mere reference implies a thorough acceptance of its entailments, not only of a patient subjectivity, but also of dispositions toward one's body and experiences. These include a reliance on quantifiable symptoms ("two to four") and rapid diagnostic decisions ("I quickly knew"). As a news story, Gore's description of her depression is a performance that anticipates its own citation and repetition by its readers; it expects uptake.

In one of my group interviews, Claire, a graduate student, describes a recent visit to the campus health center:

> Claire: I went to Campus Health and talked to a woman in there. She asked me questions, and I told her my symptoms, which are all on the list, and ((pause)) she didn't, you know, say "You're depressed," she said it sounded that way and recommended counseling and medication.

In this excerpt, and at the time of the interview itself, Claire seems unsure of how to respond to her visit. She is both antagonistic toward the "woman in there," who, presumably, has at least some medical training, though I suspect was not a physician or psychologist, and also anxious to conform to the diagnostic scene, which compels her to describe her "symptoms" rather than to provide "answers" to the questions she is asked. Claire has already translated her experiences into symptoms, and has determined for herself that those symptoms are "all on the list." She seems frustrated that the health professional does not offer explicit diagnosis, and she remains ambivalent about whether she will take up the recommended therapeutic response. This generic uptake, I believe, mirrors Mei's assumption that there are "tests" that can determine whether an individual has a "chemical imbalance." In both cases, the women have already adopted subjectivities that position them as patients with limited responsibilities and options. They have done so at least in part through processes of generic and discursive uptake within the circulating discourse of depression. Yet their hesitation and self-doubt shows them to be at least partially aware of the restrictions encoded within instances of uptake: the women in my study held open the possibility of

"going that route," by which they meant taking antidepressants, but they were not yet willing to assume a biomedical subjectivity completely. Acting as double agents within the discourse of depression, these women inhabit complicated subjectivities and authorities in relation to their own bodies and selves. They are both acting as their own agents, claiming the power to choose the pharmaceutical "route" or not, depending on their own definitions of health and illness, and they are also acting as agents of the biomedical discourse, relinquishing their rights to the diagnostic interpretation of their experiences.

For genre studies, then, the complementary dynamics of generic and discursive uptake reveal much about the formation of subjectivities in relation to professional communities and larger social networks[18]. Because the dispositions entailed by instances of uptake shape the future performances of individuals for themselves (Gore identifies herself as depressed and seeks therapy) and for others (the Second Lady demonstrates the responsibility of depressed women), attention to uptake promises to yield a clearer understanding of how *experiences* become *symptoms* and how *individuals* become *patients*. Moving beyond the textual performances occasioned by generic production, attention to uptake allows us to follow individuals through their interactions with multiple genre systems. As individuals navigate the many systems to which they belong and with which they must interact, they inevitably take up both the positions implied by generic coordination and the dispositions implied by discursive construction. Beyond exploring the textual connections within such systems, attention to the dynamics of uptake illuminates the formation of subjectivities in and through genres, and thus explicates the complex relationships individuals cultivate with biomedical and other powerful institutions.

NOTES

[1] I wish to express my gratitude to the participants in my research interviews for their willingness to share their experiences. I also very gratefully acknowledge the generous and thoughtful commentary on earlier drafts of this essay, provided by Kurt Koenigsberger and by the editors of this volume, particularly Charles Bazerman. This work additionally benefited from the comments of participants in the 4th International Symposium on Genre Studies, my travel to which was funded, in part, through the auspices of the Foreign Travel Grant program of the Baker-Nord Center for the Humanities, Case Western Reserve University.

[2] Segal (2007) makes a similar claim for the power of conventional narratives to constrain the potential subjectivities available to breast cancer survivors.

[3] This classroom application of uptake is given fullest description by Bawarshi (2003, pp. 135-141).

[4] Freadman (1999) provides a detailed account of the circulation and uptake of legal and cultural genres in relation to the case of Ronald Ryan, whose execu-

tion in 1967 marks the last imposition of capital punishment in Australia.

[5] For a more broadly rhetorical analysis of healthcare genres and interactions, see Segal (2005).

[6] Miller (1994) argues for a notion of genre that accounts for it as "social action." Freadman's work suggests that such action occurs *only* when a particular genre secures its own uptake. In Freadman's conception, it is genre itself that has agency and accomplishes social action, and individual subjects are relegated to a role in which they produce texts that are recognizable (i.e., can secure uptake) within appropriate generic systems. I am arguing that subjective agency ought to be returned to individuals in relation to "social action"—not only do speaking subjects' acts of textual production have significant effects within social systems, but also upon the shapes and trajectories of their own and others' individual subjectivities.

[7] The use of the feminine pronoun here is intentional—depression is commonly believed to be a "woman's disease" and many of the texts that encourage self-diagnosis and treatment target women in the US.

[8] See, for example, Butler's (1990) description of gender as a performance. In addition, Butler (1997) argues that the performative act is recognized less through individual intention than through successful "*repetition or citation of a prior and authoritative set of practices*" (p. 51). This definition emphasizes the role of citation within successful performative acts, and it parallels Freadman's (2002) sense of uptake as a process that derives legitimacy from gesturing backwards to previous utterances before enabling future texts (p. 42).

[9] This analysis is drawn in large part from Freadman (2002).

[10] In processes of translation, generic uptake opens the possibility for revision of forms and subjectivities. Thieme (2006) argues that, within journalistic responses to women's suffrage in Canada, the genre of direct political action (militancy) is cited (Freadman's "selection") in various ways, but that it is also redefined (Freadman's "translation") as unnecessary and unfeminine within the Canadian context. In my terms, the journalistic responses perform the generic uptake that shapes material realities and gendered identities for suffragists in Canada.

[11] Theories of intertextuality (Foucault, 1972; Kristeva, 1980; Worton & Still, 1990; Fairclough, 1992), and heteroglossia (Bakhtin, 1986) are important foundations for my concept of "discursive uptake." In addition, Wells (2003) provides a provocative discussion of repetition and interdisciplinary translation of both discourse and genre.

[12] Something like discursive uptake is the process that Bawarshi (2006) identifies in his response to a special issue of *College English* on language diversity. Reading essays by leading scholars on World Englishes, Bawarshi notes that student discursive choices—what I would call their discursive uptake—can often

seem dissonant or insincere to instructors within school-sponsored activities. Bawarshi calls for closer attention to such moments of uptake for what they can tell us about students' and instructors' attitudes and ideologies.

[13] Critiques of the DSM, including its history and authorship, add additional insight to this analysis (see Kirk & Kutchins, 1992; Kutchins & Kirk, 1997; Reynolds, Mair & Fisher, 1992).

[14] I have argued elsewhere that the overlap of diagnostic and personality quizzes is an important generic blend that specifically targets women (Emmons, 2007).

[15] I have changed names and identifying details to protect the privacy of the women who participated in my study. In addition, I have edited the excerpts for clarity, primarily by deleting false-starts and adding some punctuation; deletions of more than a single word and all additions are enclosed in square brackets.

[16] The mechanical metaphors for depression are often explicitly gendered, and this further complicates their discursive uptake. For example, in *Women and Depression*, Rosenthal (2000) explains that the "system of brain chemistry exchange is like a washing machine" (p. 157).

[17] In a telling critique of the biomedical model of serotonin imbalance, Lacasse and Leo (2005) write, "The take-home message for consumers viewing SSRI advertisements is probably that SSRIs work by normalizing neurotransmitters that have gone awry. This was a hopeful notion 30 years ago, but is not an accurate reflection of present-day scientific evidence" (p. 1214).

[18] Gender plays an important role in these processes, as I have noted above. See also Bazerman (1999) for an investigation of the gendered roles made available through the new genres.

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