“Pretty, Pills, and Perspective: The Not-so Charmed Medicalization of Women’s Mental Health”

by

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This thesis was prepared under the direction of the candidate's thesis advisor, Dr. William R. McConnell, Department of Sociology, and has been approved by all members of the supervisory committee. It was submitted to the faculty of the Dorothy F. Schmidt College of Arts and Letters and was accepted in partial fulfillment of the requirements for the degree of Master of Arts.

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Abstract

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Using content analysis and in-depth interviews, this study finds variation in perspective of mental health in 1) how it is framed on social media platforms by mental health treatment advertisements and 2) how woman perceive their own mental health struggles, how they sought and maintain treatment, and how the culture of social media influences this perspective. To investigate this topic, this study is separated into two phases: Phase One is a content analysis of 25 mental health treatment advertisements for depression and/or anxiety on Facebook and Instagram with three questions in mind: 1. How do advertisements on social media frame depression and anxiety? 2. What are the solutions proposed? And 3. How are women represented in these advertisements? Phase Two consists of 14 in-depth interviews with three questions in mind: 1. How do women understand their mental health problems? 2. How do social media advertisements affect

women seeking mental health treatment? And 3. How does social media affect current course of mental health treatment? Social media advertisements do medicalize women's perspective of mental health and can best be understood in three terms: communication, convenience, and confidence, through an interplay of medicalization and gender framing. Women give meaning to their mental health through their experience in past and current life circumstances and the culture of social media has shifted understanding and engagement with this dynamic.

Dedication

This manuscript is dedicated to the women I have counseled, mentored, and called ‘friend’ over the years. Thank you for allowing me to be a part of your journey. I also dedicate this work to my family and friends, the ones who have believed in me and the passion I have for advocacy, writing, and mental health.

“Pretty, Pills, and Perspective: The Not-so Charmed Medicalization of Women’s Mental Health”

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Introduction

There has been significant prior research investigating pharmaceutical companies, women's mental health, and social media platforms independently. However, little research has been done to explore how women's mental health is presented on social media platforms or how it is interpreted and utilized by women experiencing mental health issues; for example, depression and anxiety. Recent statistics illustrate a significant increase in social media usage and mental health treatment, especially for women. According to recent data collected, approximately 233 million people (82%) over the age of 12 in the United States utilized social media platforms in 2021; which is an outstanding increase since 2008 at only 10% of the US population (edisonresearch.com). And according to data collected by National Institute of Mental Health (NIMH) the following statistics are substantial: 22.8% overall of all US adults (57.8 million) experienced mental illness in 2021, with females rating higher at 27.2% than males at 18.1%; 21 million adults experienced Major Depressive Disorder (MDD), with females rating higher at 10.5% than males at 6.2% (nimh.nih.gov). Another source, the National Center for Health Statistics (NCHS) gives statistics and comparison for adults who accessed mental health treatment, took medication for their mental health, or received some sort of talk therapy for their mental health according to interview survey taken in 2020; 20.3 % of adults accessed mental health treatment, 16.5% received medication management, and 10.1% received talk therapy from a mental health professional (cdc.gov). With the United States being one of two developed countries that has direct to

consumer (DTC) advertising, how do pharmaceutical advertisements frame depression and anxiety to women on social media platforms? And how do women perceive these advertisements and their own mental health experience?

Social media is impacting our economy, networking, resources, and culture (Amedie, 2015). Social media has become a primary platform for product marketing. Direct-to-consumer advertising (DTCA) of pharmaceuticals continues to grow, more specifically addressed in this study, marketing of psychotropic medications for mental illness, like depression and anxiety. Over two decades ago the Food and Drug Administration (FDA) established new guidelines and policy allowing for commercials on TV (Payton & Thoits, 2011:56). The pharmaceutical industry continues to transform. "Sales of pharmaceutical products in 2003 amounted to just over $466 billion, more than the Gross National Product (GNP) of many developing countries, and the consumption of prescribed medicines in advanced industrial societies is increasing" (IMS Health, 2004a). Now as previously mentioned, significant research has been conducted on pharmaceutical companies and this study is not after 'the big bad wolf.' With significant increase in not only social media usage and access to mental health treatment, I analyzed how DTC advertising is framed to women, what is interpreted and understood by women experiencing mental health issues? From a social constructionist standpoint, how does medicalization play a part? Social construction theory states that we create and reinforce meaning to items, situations, behaviors, (i.e.: mental health and gender) through social interaction (Aneshensel, et al., 2013; Berger & Luckmann, 1966). Ridgeway (2011) argues that our primary frame in doing this as we identify ourselves and others is through gender. Conrad's theory of medicalization (1992, 2007) indicates that social problems

and issues are rapidly being defined and treated as medical problems, with medical professionals and institutions taking on responsibility for addressing them, is social media expanding on this dynamic or transforming it?

My study consisted of two objectives in collecting and analyzing data to answer these questions thoroughly. In Phase One, I collected twenty-five advertisements for mental health treatment for depression and anxiety from the two most utilized social media platforms: Facebook and Instagram. Analysis of data collected consisted of answering three pertinent questions: 1. How do advertisements on social media frame depression and anxiety? 2. What are the solutions proposed in these advertisements? And 3. How are women represented in the advertisements collected? In Phase Two of my study, I conducted fourteen in-depth interviews with women who have been diagnosed with depression and/or anxiety within the last three years. Analysis of data collected was conducted via *atlas.ti* software and coding techniques described by Deterding and Waters (2021). Although there is an interview guide (see Appendix) there were three pertinent questions at the forefront of this research: 1. How do women understand their personal mental health issues? 2. How did these women initially come to mental health treatment and did pharmaceutical advertisements influence that process? And 3. What influence does social media have on how these women think about and manage their mental health issues? Before addressing the findings of my research, it is necessary to acknowledge what prior research has established, that is the entirety of the first chapter. Next the methods of my research will be addressed in chapter two. Chapters three through five will discuss the findings of the data collected in my study. This thesis concludes with a significant discussion of what has been found and what future research can explore.

According to the data I have collected, women's mental health is indeed being marketed on social media platforms. I argue that such advertisements on social media have significant impact on women through direct-to-consumer advertising. Culture, consumption, and comparison are the doorway to marketing women's mental health. This becomes even more relevant in reviewing the interviews conducted, as women discuss their personal journey of defining, seeking treatment, and maintaining their mental health. Results of my analysis illustrate that communication, convenience, and confidence are key components overall in how these women define their mental health, seek treatment, and maintain their mental health currently, as will be discussed in chapters four and five.

Chapter One: Background

Introduction

In this chapter, we will explore extensive research that has been established of the pharmaceutical industry, medicalization, the social construction of mental health, psychiatry, social media, and the intersect of gender and mental health. Specifically, we will look at how pharmaceuticals began marketing through direct-to-consumer (DTC) advertising, the transformation of deviance to mental health concepts through medicalization and psychiatry, and how the culture of social media has implications for this process present day. We will also examine the role of gender in the definition, diagnosis, treatment, and representation of mental health in considering mental health as a social construct. Finally, we will establish the significance of this present study in understanding the current gaps in established literature.

I. Pharmaceutical Industry

Sociological studies have not fully investigated the complexity of how authority is obtained and how the living world changes intimidate administrative control (Fox, 2006). Fox investigates the assurance of technological control by utilizing a case study of the dynamic between the consumer and the pharmaceutical industry. The pharmaceutical industry holds significant control of information in the culture of technology, traditional ideas are being confronted, and new alliances are being formed. Fox utilizes qualitative methods to uncover new forms of administrative control. In conclusion, administrative

control is a transformative process of consistent disintegration and regeneration. “For consumers in a global economy without barriers to trade across borders, the internet offers both an information resource that may challenge established knowledge frameworks that support professional power” (Gandy, 2003:14), and technology removes restriction of geographies (Baym, 1995). Misdeeds of marketing have significant consequences for everyone involved. An image created and not properly maintained without consideration of its entire impact will cause the integrity to be questioned in decisions being made. In an attempt to keep things in order, public and private entities have tried to arrange formal guidelines embedded with ethical and legal standards. These guidelines administer further complexity in complicated matters of pharmaceutical advertising (Mulinari, 2016). Restrictive access to everything that takes place inside pharmaceutical companies make genuine research difficult; the narrative is controlled by those in charge. However, there are times when concealed documentation surfaces, exposing unfavored strategies.” In 2012, Eli Lilly and Pfizer both agreed to pay substantial amounts to settle charges of improper payments that their offshore subsidiaries made to foreign officials to win business in Eastern Europe, Brazil, and China” (Mulinari, 2016:151). Strategy of pharmaceutical companies extends to protect their interest and goals. Viewed from this perspective, it’s in each company’s best interest to abide by rules and guidelines. As previously explained, an image of honesty and integrity needs to be created and maintained by everyone involved in the process. There has to be trust established for a product to continue being sold. This is not just those involved within said companies, but also those on the outside, all the way down the line to consumers (Mulinari, 2016). Mulinari (2016) considers all of this with strong

implications for refinement as findings illustrate significant misconduct in marketing tactics.

Marketing strategies include developing disorders and diseases while connecting the remedy of medication, this is the new norm (Conrad, 2007; Marshall, 2004). Three sociological issues are raised in these findings: developing disorders out of human difficulties, redefining normalcy in medical terminology, and then isolating issues to individuals while actively dismissing environmental and social factors involved (Conrad, 2007:71). This is important to understand in my study as there has not been enough research investigating the social context of mental health disorders in the culture of social media platforms. This produces alarming concern and questions about administrative control of pharmaceutical advertisement in aspects of consumers' perspective in education and consumption of medications. So, what does the patient (consumer) experience in all of this? How are individuals with mental illness affected or influenced by such advertising? It is important to consider that we are not simply analyzing psychotropic medication being marketed, but the broader context of its connection with social media platforms and its perpetuated traditional gender roles and stereotypes in an idealized portrayal of these medications to women experiencing depression and anxiety. The presence of mental health treatment advertisements is not indicative of the quality or effectiveness of advertised services, but its presence is indicative modern society and the medicalization of mental health.

II. Medicalization

"In order to sell a drug, you first must 'sell' a disorder "(Lane, 2007:104). Prior research tells us that the impact of medicine and medical terminology has grown

exponentially since the introduction of the first psychotropic drug in the early 1950s, chlorpromazine, an antipsychotic. “Medicalization describes a process by which non-medical problems become defined and treated as medical problems, usually in terms of illness and disorders” (Conrad, 2007:4). Sociologists have studied medicalization since the late 1960s, with initial focus being medicalization of deviance. Deviance being behavior against societal norms established (Pitts, 1968; Conrad, 1975, 2007). Which Conrad states, “Medicalization of deviance includes alcoholism, mental disorders, opiate addiction, sexual and gender differences, dysfunction, disabilities, and abuse” (Conrad, 2007:6). That is a broad umbrella of ‘disorderly’ that have transformed into disorders. The medicalization of labeling human problems with medical terminology has soared with leaps and bounds. And it is with such labeling that social factors or structures are overlooked. As you will see in the data of interviews collected, these women each received their diagnosis for depression and/or anxiety in the past three years; yet, not one woman mentioned the impact or influence of Covid-19 pandemic. Not to argue that Covid-19 pandemic was the cause of any mental health diagnosis, but considering the isolation, loss of resources, change of relational interaction, and the stress of contact or contagions, one would think it would be mentioned in passing at least. Medicalization emphasizes individualization, that the source of the problem medicalized is within the individual. And the solution is external, most likely on the market. Esposito and Perez (2014) conducted significant research on the commodification of mental health, meaning mental health has become a commodity that is bought and sold for profit. They argue that this commodification is supported and nurtured through medicalization, changing the focus to profit over care. “Transition from disorder to disease and proliferation of such

diseases is equally likely a function of cultural, economic, and political processes" (Aneshensel, C.S. et al., 2013:26). Media plays a larger role than acknowledged in where attention is given and for what is given for, which will be addressed later. "When persons do not live up to unspoken cultural norms, they can view their subjective experiences as a situated knowledge that provides a window on self-interested systems of power and privilege" (Aneshensel, C.S. et al., 2013:29). And what happens when medicalized mental health issues are not afforded? Several women in my study share the struggle of not being able to afford professional mental health care, whether that be medication management or talk therapy. Thus, individualizing a problem to be remedied. This reinforces disabilities being treated as detriments, deficits, individual afflictions, and shortcomings. The social, cultural, economic, and political factors sustaining such harmful definitions will remain intact and unchallenged (Aneshensel, C.S. et al., 2013:30), invoking the sociological requirement of "translating private troubles into public issues" (Mills, 1959).

III. Social Construction of Mental Health

People give meaning to their existence primarily to their surroundings and relationships, as you will see illustrated in the data collected. In this when giving meaning to their personal mental illness, definition is subjected to what others say or imply. Culture influences individual experience and perspective; this changes in each society. Social construction gives meaning, sociology gives a voice to the translation of that meaning and what is understood (Aneshensel, C.S. et al., 2013). Esposito & Perez (2014) sought to uncover the dogmatic pressures driving medicalization with its corresponding consequences thus establishing mental health concepts are social constructs (2014:415).

Social constructs are being shaped by governmental control or economic persuasion of agenda which results in commodification of medicine, including the field of mental health. “Market rationality evaluates the merit of all actions according to what is deemed as valuable, acceptable, or desirable by ‘the market’ which should be the organizing principle of all political, social, and economic decisions” (Giroux 2008:2; Esposito & Perez, 2007: 418). To refrain from black and white thinking on this matter and completing putting blame on capitalism or market rationale, it is important to consider that consumerism is embedded in the language, perspective, and decisions made when women are not only experiencing mental health issues, but also seeking treatment. We live in a society where making money to pay the bills is not only a priority, but a detrimental determinant of emotional distress. And when you add that to the isolating factors of individualization of medicalizing mental health constructs and the influence of constant comparison of self with others on a social media platform, the dire ‘need’ for mental health treatment becomes one of desperation as you will understand when we uncover mental health advertisements in correlation to the interviews conducted.

When healthcare is commodified, patients are treated as customers. The conception of health, self, and normalcy are defined based on commercial appeal (Esposito & Perez, 2014). Health in regards to wellbeing, the self being that in competition of the one marketed in commercials or highlight reels of both strangers and acquaintances, and normalcy is determined by power dynamics involved in the process. “The pharmaceutical industry has controlled the script concerning mental health examples, compromising the claimed neutrality of scientific research in constructing a specific social reality manipulated on the predisposition of market pressures” (Esposito &

Perez, 2014:420). With the market rationalized in each aspect of normality, this conception breeds dysfunction in considering what is acceptable and common practice in the structure of society (Larner, 1997, 2000). And in current society, with the expansion and influence of the internet and social media, the ideal of normality emphasizes the social image at the sacrifice of social interaction. It has become more important to publicly post on social media platforms than to engage socially. Rather than exposing the web of systematic influence and social relations that shape individuals' perspective and decisions, human agency is assumed as coincidental personal choices and private ambitions. The market is framed as an expectation of human nature (James, 1991:263). Anything that deviates from this systematic order is labeled as deviant and dysfunctional (Esposito & Perez, 2014:421). Controlling beliefs and values of society are reinforced through the medicalization process, thus reiterating social inequalities and injustices to be individualized (Lupton, 1997; Esposito & Perez, 2014). Psychiatry is centrally responsible (and liable) for understanding and treating contested conditions that "limbo" between deviant behavior and medical pathology (Whooley, 2015).

IV. Psychiatry

Psychiatry plays a key role in setting in place the definition of mental disorder through diagnosis (Rose, 2019:10). Standardizing diagnosis was the route in which psychiatry would achieve credibility as a medical science. (Whooley, 2015). Psychiatry does not just understand and treat, it also defines and sets boundaries. Such boundaries have transitioned, transformed, and categorized by the DSM, APA, WHO, and ICD, through which the psychiatrization of normal variations in the human condition are listed, itemized, and become tangible codes through which billing takes place. When

understanding psychiatrization, think of the medicalization process, but psychiatry being the dominant. One has to have a diagnosis code from DSM and/or ICD in order to be reimbursed for the costs of treatment. Anyone who has or does work in the medical or clinical field understand the significance of diagnostic codes. Doctors, psychiatrists, psychologists, insurance companies, or pharmacies do not get payment without that unique code. “Each diagnosis is merely a hypothesis for the clinician and it is a psychological, social, cultural, economic, political reality for doctors, patients, families, bureaucrats and many others” (Rose, 2019:75). By diagnosis, a term is issued to a complaint (Rose, 2019:73); as a social phenomenon it has gained several ramifications for professionals and policy makers. Psychiatry, a heterogeneous field, with many different and often incompatible conceptions of mental disorder that are accompanied with many different treatment practices and interventions (Rose, 2019:5). Diagnostic practice is of great importance, psychotherapy has decreased significantly and medication management has increased (Rose, 2019).

Diagnostic systems have become an apparatus for stability (Aneshensel et. Al, 2013:43). This has become a process of medicalization as well. Several women verbalized the ‘relief’ they experienced once they received a diagnosis, even when that diagnosis was not explained to them. From this phenomenon, diagnosis becomes the doorway. Doctors are referred to as the gatekeepers when discussing medicalization and there are many different players that are central to medicalization. This categorical system of classification defined by lists of observed or verbalized symptoms became the ‘building blocks’ for scientific research of mental disorders (Whooley, 2015). This classification system provided reliability. The diagnostic and statistical manual of mental

disorders (DSM-5) was published by the American psychiatric association in 2013. "The increase in the number of diagnoses in the DSM-III from 106 in the original 1952 edition to nearly 300 disorders in the DSM-IV, which was published in 1994" (Conrad, 2007:118).

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) by the American Psychiatric Association (APA) there are eight different types of depressive disorders with five to eight sub-categories for each; Each of which are expanded upon in description over a span of 43 pages for diagnostic criteria (DSM-5; 2013: xvii, 155-88) And this is for diagnosing depression alone. Anxiety is categorized among twelve different disorders, with five to eight sub-categories and 44 pages of identifying factors for diagnostic criteria (DSM-5; 2013:xviii, 189-233). Both including but not limited to prevalence, risk and prognosis factors, differential diagnosis, and comorbidity. In reference to depression, "The common feature of all these disorders is the presence of a sad, empty, or irritable mood, accompanied by somatic and cognitive changes that significantly affect the individual's capacity to function. What differs among them are issues of duration, timing, and presumed etiology. It is characterized by discrete episodes of at least two weeks' duration involving clear-cut changes in affect, cognition, and neurovegetative functions and inter-episode remissions" (DSM-5; 2013:155). Each disorder has a list of symptomatology and diagnostic criteria that requires a minimum of five (or more) symptoms present during the same 2-week period and represents a change from previous functioning (DSM-5; 2013:156). This is significant as we analyze the advertisements for mental health treatments on social media platforms. Highlights of changes from DSM-IV to DSM-5 include but are not limited to communication disorders,

sexual dysfunctions, gender dysphoria, disruptive, impulse control, and conduct disorders, substance-related and addictive disorders, and cultural disorders (DSM-5, 2013:809-816). “Thomas Insel, when he was director of NIMH, stated unequivocally that mental disorders are biological disorders involving brain circuits that implicate specific domains of cognition, emotion, and behavior” (Rose, 2019:11). The source and dynamic of mental disorders are deficient to clearly recognize and comprehend. “Contemporary understanding of mental illness as a result of ‘chemical imbalance’ has been shown to be over simplistic, misleading, and perhaps outright wrong” (Healy, 1997; Kirsch, 2010; Whooley, 2015). Lacking biomarkers and tests, the majority of DSM-recognized mental disorders are determined by expert consensus, in other words trusted and respected individuals with the proper credentials, which is highly susceptible to the influence of social factors, outside interests, and internet-based politicking. “Psychiatrists want to convince themselves and others that troubled individuals need their chemical interventions just as badly as someone with diabetes needs insulin” (Aneshensel et. Al, 2013:27). And where that is a bold statement to digest, one has to consider its authenticity when mental health issues are medicalized to an individual, meaning the problem, when discussed in diagnosis and treatment possibilities, is to be managed within. There are only so many options available if the problem is within the individual struggling with depression or anxiety.

VI. Patients are Consumers

Biotechnology and the pharmaceutical industry have become major players in medicalization (Conrad, 2007). And this is evident and illustrated in my content analysis of pharmaceutical presentation on social media, as established history of pharmaceutical

advertising and marketing: first to doctors, then direct-to-consumer (DTC) advertising and its amplification. The medical system not only has changed, but continues to transform. Patients are consumers of healthcare. In fact, in my professional experience, we no longer called individuals ‘patients’ they are ‘clients’. Consumers have a major impact in a market-driven society. “Examples of this include but are not limited to cosmetic surgery, adult ADHD, hGH therapy, and the rise in pharmaceutical advertisements” (Conrad, 2007:138). Every part of the body is now medicalized, as a project, and medicine is the vehicle for improvement subject to market forces (Payton & Thoits, 2011; Conrad, 2007), which will be further illustrated in the solutions proposed by mental health advertisements collected.

Talboy, A. et al, (2016) conducted a qualitative assessment of how patients choose mental health treatment, concluding with three major themes: the influence of social factors in making medical decisions, perspective of science and different medications, and the price and access of medication. Over 60 million US residents search for health information online to inform their medical decisions, with more than 70% of them influenced by this information. 1 in 3 who accesses the internet will self-diagnose without ever seeing a medical professional (Talboy, A. et al, 2016). Consider how much that has increased since 2016, given not only the statistics of social media engagement and mental health treatment accessed, but consider for a moment everything that has taken place in society. Presentation of data and influence is central to prescribing and consuming psychopharmaceuticals (Horowitz, 1999; Conrad, 2007; Rose, 2019). “The drugs don’t do nothing, although how they do what they do is not fully understood. They are not specific to some underlying molecular mechanisms of the disorder, their therapeutic

capacities are limited, and what they do to thought, emotion, and desire, is shaped by expectations, beliefs, and interactional and social settings and is not inherent in the drug themselves. The hypothesis that underpinned them have proven partial at best, misleading at worse, and the drug development pathway arising from them has run into the sand" (Rose, 2019:128). It is often rationalized that it really doesn't matter what exactly they do if they are helping the individual struggling, but as interviews were conducted for this study, the trial and error process of medication management of symptoms can be overwhelming in itself and scary.

Deciding to take psychotropic medication is complicated. "Human distress encompasses an enormous array of hues, intensities, and responses dependent upon the intersections of our multiple social locations'' (Aneshensel, C.S. et al., 2013:37). Unlike other medications, psychotropic pills are developed and consumed with sole intent to alter how people think, feel, and perceive themselves and the world around them (Aneshensel, C.S. et al., 2013). Sociological research examines DSM as a social phenomenon. Diagnostic practice is of great importance, psychotherapy has decreased significantly and medication management has increased (Rose, 2019). These medications are controversial when addressing cognition and challenge the essence of being human (Aneshensel, C.S. et al., 2013:35). "Action is forged by the actor out of what he perceives, interprets, and judges, from his "standpoint" (Aneshensel, C.S. et al., 2013:24). Mental illness is illustrated as a dynamic of individual experience and a result of social and environmental influence. This requires consideration of all social experiences including how they are perceived and expected, resulting in consequences that can make life severely complex.

VII. The Culture of Social Media

In "Towards A Sociological Understanding of Social Media: Theorizing Twitter", Murthy (2012) provides Goffman's interactionist work to establish a selected literature review and insight for sociologists highlighting existing sociological theory in analyzing Twitter towards theoretical innovations. Murthy (2012) also provides another significant aspect to consider the power of social media to normalize consumption. From this stance, social media users are individualized and solely determine what generates in their feed (Murthy, 2012). Extending Goffman's (1981) work, Murthy provides the following set of tools to sociologically understand social media: ritualization, framework, and embedding (Goffman, 1981) "constructing 'synthetic situations' which are entirely constituted by on-screen projections" (Murthy, 2012; Cetina, 2009:65).

Nowadays social media platforms upsell the social aspect by promoting more communication, validating individual presence, and motivating a constant comparison of daily life (Healy, 2017). Using the term 'latently public', Healy (2017) discusses the opportunities and challenges social media creates for individuals. This leads to a propensity to associate many academic fields to promote what they believe they are doing and how it can be established. This reiterates the social construction of social media sites and its influence on users (Healy, 2017). Social media platforms warrant communication while instigating attention to and comparison between social connections; this instigation produces an image of success to gauge among peers (Healy, 2017). Some studies have illustrated a significant relationship with social media and negative mental health outcomes (Berryman, et al., 2017; Sheldon, et al., 2019) While other studies have found opposing results that evidence a positive dynamic with mental health outcomes (Amedie,

2015). With the widespread adoption of social network sites (SNS) such as Facebook, Instagram, and Snapchat, a dependency has been discussed, viewed, and termed as an addiction (Sheldon, et al., 2019).

According to prior research, addiction to social media or SNS is related to several mental health problems and includes the following symptoms: salience, mood change, tolerance, withdrawal symptoms, conflict, and relapse (Sheldon, et al., 2019). Several studies across different disciplines evidence a significant relationship with social media and mental health (Andermann, 2010; Payton & Thoits, 2011, Amedie, 2015). "Rosen, Cheever, and Carrier (2012) coined the term 'iDisorder' to describe the negative relationship between technology use and psychological problems" (Sheldon, et al, 2019:9). Past studies have concluded findings with addictive symptoms to internet use (e.g., Griffiths, 2005; Hormones, Kearns, and Alix Timko, 2014). Fear of missing out (FOMO) is another term coined in studying a relationship of addictive symptomatology with social media (Sheldon & Sykes, 2018) with respect to Facebook, Instagram, and Snapchat use. 'Selfitis' another coined term (APA, 2014) "defines the obsessive-compulsive desire to take photos of one's self and post them on social media as a way to make up for lack of self-esteem" (Kaur & Vig, 2016; Sheldon et al., 2019:13) with suggestions for further research on every aspect of social media with the correlation of influence on individuals.

The current study does not investigate the relationship between mental health and social media use. The aforementioned research provides supportive evidence of the social construction of disorders, more specifically with SNS, and the significant interaction between SNS with depression and anxiety disorders. In sociological psychology models,

the development of mental disorders is primarily dependent on cultural influence (Anshensel, C.S. et al., 2013). Can this cultural context be that of social media platforms? Sociological psychology aims their studies at how social factors influence variance and characteristics of psychiatric symptoms (Horwitz, 1999:63). I argue it is through this notion that mental health disorders such as depression and anxiety are socially constructed AND embedded, reproduced, and marketed through the culture of social media platforms (SNS). The goal of research in this study has been to investigate how aspects of the broader social, cultural, and historical context shape not only the types of mental disorders that individuals develop, but also the treatment that is sought and the avenues in which they are obtained and maintained, more specifically social media platforms such as Facebook and Instagram. And in turn, how social, cultural, and gender aspects shape women's interpretation of experience and process of seeking and maintaining treatment.

VIII. Mental Health and Gender

One of the primary frameworks that we identify not only ourselves but others and our interactions with others is through gender (Ridgeway, 2011). Prior research has been conducted in an attempt to de-stigmatize mental health through medicalization, however limited findings concluded this not to be the case (Payton & Thoits, 2011); Their findings result in a still present stigma of mental health. Other research has established an interaction between gender and informal social control in everyday life through societal reactions, deviance, and conformity. How is this represented and interpreted on social media? Several studies have mapped the intersection of gender and mental health (Bacigalupe & Martin, 2021; Andermann, 2010; Simon, 2020; Bradbury, 2019; Lee, et.al,

2020). And other research has concluded gender inequalities in the diagnosis and prescription of psychotropic drugs (Bacigalupe & Martin, 2021). Bacigalupe & Martin (2021) investigated the possibility of gender inequalities in the diagnosis of depression/anxiety and in psychotropic consumption. Findings illustrated that medicalization of mental health is occurring among women and suggested further research is needed in understanding how this takes place (Bacigalupe & Martin, 2021). I argue that such underlying mechanisms are exposed in the analyzed advertisements on social media platforms and in-depth interviews with individuals diagnosed with mental health disorders. To understand the "gender" dynamic of mental health from a sociological standpoint, one has to consider how it is identified, defined, regarded, and treated. Much research takes a scientific approach in navigating definitions, but there is also significant evidence supporting the relationship between biomedical and environment (Lee, et. Al, 2020; Horwitz, 1999; Rosenfield, 1999). Studies have shown that gender is an influential component of attitude toward mental health. (Lee, et. Al, 2020; Horwitz, 1999; Rosenfield, 1999). "Research suggests that definitions of masculinity and femininity have psychological consequences for men and women by producing gender differences in major risk factors, which, according to stress process and other theories, included differences in the stressors men and women experience, their coping strategies, social relationships, and personal resources and vulnerabilities'' (Anshensel, C.S. et al., 2013:278). Significant literature supports this argument. Denise Russell (1993) in "Women, Madness, and Medicine" conducted an historical analysis of how society views women with mental health issues. Her research navigates the gender biases that consistently influence perspective, definition, diagnosis, and treatment of

women throughout history. Her work provides a salient viewpoint on the dynamic medicalization of women's mental health and the pattern of societal biases and prejudice that result in substantial consequences for women's mental health and personal wellbeing. Three examples provided that are significant to this current study is 1. gender bias that has led to medicalizing women's emotional states against what is considered societal norm, such as depression and anxiety, which further stigmatizes women with mental health issues; 2. the medicalization of women's sexuality which is easily pathologized and marketed; and 3. patriarchal attitudes that often dictate the perception of women's mental health as a threat or commodity (Russell, 2003). I argue that gender has a significant impact in presentation and perspective not only mental health, but its representation, stigma, manifestation, and treatment (Rosenfield, 1999); My research explores such concepts and attitude towards mental health that greatly affect perspective and manipulation of such through institutions and interactions, in reference to 1. Collected and analyzed mental health treatment advertisements on social media platforms and 2. The social interaction and gendered perceptions and experiences of the women interviewed.

Prior research has established a correlation with psychological problems and social media (Sheldon et al., 2019; Amedie, 2015; Rose et. Al, 2010), also a correlation with social media and gender as framing for marketing (Bivens & Haimson, 2016; Rose, 2012); There has also been research exploring the dynamics of gender and mental health (Anderman, 2010; Bradbury, 2019; Villatoro et.al, 2018; Simon, 2020; Lee et. Al, 2020; Bicaigalupe & Martin, 2021); Yet to my understanding, there has not been research

studying the case of where these intersect and are implicitly used in the culture of social media.

Dr. Jonathan Metzel (2003) explored the cultural impact and generational influence of the psychotropic medication Prozac. His work illustrated how Prozac is marketed and idealized in media as a “miracle cure” for depression and other mental health problems that correlated with the politics and culture of the times. The marketing of this medication significantly influenced the way people thought and think about mental health and treatment. I would bet every single person reading this article now has at least heard of Prozac and has a personal opinion of it. Dr. Metzl argues that the expansion of Prozac’s use and other psychotropic medications has led to a specified “culture” for mental health medication. In this culture, mental health issues are simply a biological problem within an individual that can be easily solved with medication. This type of approach, Metzyl suggests, takes a blind-eye to the social and psychological factors that are included in mental health issues and often results in over-medicating the ‘problem’ and person. This approach becomes dismissive to alternative forms of mental health treatment. Metzl conducts interviews with patients and professionals, offering a critical analysis of the pharmaceutical industry’s marketing transformations, calling attention to gender stereotypes, as well as a nuanced perspective on the benefits and limitations of psychotropic medications like Prozac. Metzl suggests a more holistic approach to treating mental health issues that give significance and recognition to the social, cultural, and psychological factors in play. Metzl emphasizes the importance of patient-centered care and more communication between providers and patients. My study takes a similar approach utilizing the medicalization theory and gender framing to analyze and

understand the advertisements collected and interviews conducted from a social construtionit standpoint to consider how these are framed, viewed, and understood. The emphasis of my study is understanding that experience is the prioritized credential considered. The advertisements analyzed provided an understanding to how depression and anxiety is framed on social media platforms; however, it is the data collected from the women's interviews that illuminate the understanding and perspective of experience of not only such advertisements, but the experience of depression and anxiety, seeking treatment, and the process of trial and error for these women interviewed that make it all make sense.

Conclusion

Extensive ground has been covered in each of these topics; however, the purpose of this study is to analyze and understand how from a social constructionist standpoint that medicalization transforms mental health concepts for women on and through social media platforms. How does current literature translate to current social media platforms and women's perspective of mental health concepts such as depression and anxiety? And how do women understand these concepts not only on social media platforms but in their own experience of seeking treatment and managing their mental health? In the next chapter, we will establish methodology for both phases of this study, including limitations of sampling for analyzing selected advertisements and conducting interviews with women diagnosed with depression and anxiety.

Chapter Two: Method

I. Phase One: Content Analysis

In Phase one, I analyzed advertisements for mental health treatment for depression and anxiety on Facebook and Instagram platforms to address three pertinent questions: 1. How do advertisements on social media frame depression and anxiety? 2. What are the solutions proposed in advertisements on social media for depression and anxiety? And 3. How are women represented in advertisements on social media for depression and anxiety treatment? Approximately 25 advertisements were collected and analyzed in a content analysis. From the sample collected, two primary approaches were taken in marketing mental health: *problem-focused* (28%) and *solution-focused* (72%). Personalization has become the determining factor for an individual (specifically woman in this study) to diagnose themselves as the underlying tone is a question.

Metzl (2003) provides two terms in describing marketing advertisements for psychotropic medication that I will utilize in this study: personalization and overgeneralization. Personalization is to be understood in two ways: 1. The advertisements are designed to meet an individual's needs and/or desires and 2. From an understanding of how medicalization individualizes, personalization is the process of an individual making the problem or solution advertised personal with the understanding 'it is their issue to resolve'. Overgeneralization in common areas of life such as sleep, work, and mood, allow for a woman to grasp and personalize. Overgeneralization simply means

to make the issue at hand so vague, it becomes low hanging fruit, easily obtained (Metzl, 2003). The targeted demographic is young women with diversity and middle-aged white women. A pattern of framing depression (60%) or anxiety (40%) as a 'symptom' was common, with no description or diagnostic criteria. Psychotropic medication was the most common treatment offered in the sample collected (65%). The image of a beautiful, smiling woman was the ideal advertisement display with each solution proposed.

My approach proceeded in several stages. To collect advertisements, I created a new 'pseudo account' for both Facebook and Instagram (one account accesses both platforms). This pseudo account was created solely for this research, given a pseudo name, unidentified gender, age 27, and a snapshot of CW Mills "Sociological Imagination" cover as the profile picture. *

I followed four specific hashtags: #depression, #depressionhelp, #anxiety, #anxietyhelp. (1) Following each hashtag sequentially generated ads on both platforms. (2) Each ad generated was screenshot or screen-recorded and saved in its entirety. For generated ads that offered live links, a screen recording (video)was taken of the process of clicking the link: 'learn more' and following to the site. (3) I only followed the link to the extent of its advertisement and did not proceed further beyond the point of requested personal information. (4) A log was created of the order of each ad generated. (5) In order to generate additional ads on the platform considering this account did not have any followers or friends list, I then engaged each ad with a 'like'. 'Liking' signified enough engagement that produced further ads in the newsfeed that commenting on posts was not necessary for this study in the collection of 25 ads. In a span of two weeks, 25 ads were generated and collected, given one hour of scroll time for each platform every other day.

I originally attempted to check platforms every day, but I received duplicate advertisements and found every other day to be more useful to obtain new advertisements. (6) The ads were coded by number in the order in which they were received.

An initial database was set up and indexed by broad codes (Figure 1) The initial codes included: Source, date collected, full text of ad (prior to 'learn more' links), image description on ad, disorders mentioned, symptoms mentioned, treatments advertised, additional treatments advertised (if ad offered more than one treatment), potential gendered content, and external links for 'learn more'.

My analysis proceeded as follows. First, I entered information from ads into the initial code database. Each ad was then read through entirely to seek patterns by comparing the conceptualization of phenomena formed in my background literature with open suspicion of possible patterns and mechanisms in social media content pertaining to mental health stereotypes and gender norms (Riffe, et al., 1998). During this process, notes were taken, and memos created to allow for organization, easier retrieval, and development of ideas and concepts (Deterding and Waters, 2021). After reading through the spreadsheet a second time, highlighted similarities between the advertisements, the following revised codes were created: *problems, solutions, gender, ease of access, privacy, and cost.* Disorders and symptoms mentioned were comprised to *problems*; Treatments advertised comprised *solutions*; deciphering between male/female gendered content comprised *gender*, and the emphasis of simplicity in access, affordability, and privacy created new codes too emphatic not to ignore; thus, *ease of access*, *privacy, and cost* were comprised. The results will be discussed in the next chapter.

II. Phase Two: Interviews

In Phase Two, I conducted in-depth interviews with fourteen women who met criteria for this study: above the age of 18 years old (age range: 21-35; average age: 27), managing their depression and/or anxiety at outpatient (stable) level of care, and have received diagnoses in the past three years for depression and/or anxiety. Eleven of the fourteen women are diagnosed with both depression and anxiety, two are diagnosed with depression only, and one diagnosed with anxiety only. Interviews were conducted primarily in person (10/14) in Port St Lucie, Stuart, and Boca Raton, Florida, or via Zoom video-conferencing (4/14). Women were recruited via distributed flyers (see appendix). Difficulty was met in obtaining more than the selected interviews in an adequate time frame because although I obtained written formal consent from an outpatient mental health treatment facility, after three attempts of inquiry, I was informed they did not post flyers in their waiting room or lounge area. It was rationalized due to forgetfulness and busyness. So flyers were handed out in person and then flyers given at end of interview to share with acquaintances of interest. There was also difficulty in securing interviews as there was no monetary incentive to do interviews and the present participants explained a hesitancy and fear of speaking about mental health issues due to expected judgment or affiliated stigma. This is significant to consider in reviewing results as fear of stigma and discrimination is prevalent. Interviews were audibly recorded and deleted after transcription.

Several things to consider in understanding this sample that will contribute to understanding my results. Most of my women are in their early twenties, the average age statistically 27, however this is only due to two women being in their thirties. This is

relevant as to current statistics for both social media usage and mental health diagnoses.

In a recent study, the target demographic for social media usage is highest among 18–25-year-old adults (edisonresearch.com). And the highest prevalence for diagnosed mental illness (33.7%) of adults in the US are 18-25 years old, compared to 26-49 years old (28.1%), and over 50 years old (15%) (nimh.nih.gov). And although race is not measured or analyzed in this study, majority of my sample are white women. These limitations are significant to consider not only as limitation not to generalize to all women, but without intention the younger generation of women in this sample are appropriate in discussion with the target demographic in the sample of advertisements analyzed.

Data analysis employed coding techniques described by Deterding and Waters (2021). A primary list of themes was originally organized from literature background. An interview guide (see Appendix) was edited and reviewed by IRB, and thus provided a broad list of codes for analysis: location, work, family, relationships, beliefs, values, definition of: mental health, depression, and anxiety, causes, first response to MH, encourage/discourage professional help, social media, culture, medication, manage mental health, and what doesn't work for mental health. The second time through coding, focus was given to one research question at a time. The three pertinent questions for phase two were: 1. How do women understand their personal mental health issues? 2. How did these women initially come to mental health treatment and did pharmaceutical advertisements influence that process? And 3. What influence does social media have on how these women think about and manage their mental health issues? Chapter four is solely dedicated to question 1. How do women understand their personal mental health

issues? This allowed me to focus in on their personal perspective of mental health in chapter four, defined by medical or social terms, or both, and causes of mental health which provided the following codes: *beliefs, medical, social, childhood, trauma, environment, culture, and important relationships*. This provided the findings for chapter four.

The third cycle of coding focused on: *gender, social media, social media image, advertisements, choices, internet, online MH forums,* and *social media engagement* which answer questions 2 and 3: 2. How did these women initially come to mental health treatment and did pharmaceutical advertisements influence that process? And 3. What influence does social media have on how these women think about and manage their mental health issues? These findings will be discussed in chapter five.

Conclusion

With a clear understanding of how data was collected and analyzed for both phases of this study, we will begin discussing the results of analysis to better understand how women's mental health is marketed on social media and in turn how the selected women of this study understand their personal mental health and the culture influence of social media advertisements in seeking and maintaining treatment in managing their mental health. The selected women of this study should provide insightful evidence to better understand the selected sample of advertisements and offer considerable feedback of their own perspective of defining and framing depression and anxiety for young women. Chapter six will discuss the correlation between these two phases, but first we will explain the results of content analysis in the next chapter.

Chapter 3: Marketing Mental health Treatment to Women

Introduction

In Phase one, I analyzed advertisements for mental health treatment for depression and anxiety on Facebook and Instagram platforms to address three pertinent questions: 1. How do advertisements on social media frame depression and anxiety? 2. What are the solutions proposed in advertisements on social media for depression and anxiety? And 3. How are women represented in advertisements on social media for depression and anxiety treatment? From a social constructionist standpoint, I wanted to understand how mental health concepts are distributed and marketed to women who struggle with depression and anxiety. Medicalization with the utilization of gender framing attract the attention and consideration of these women through personalization and overgeneralization.

Results

Approximately 25 advertisements were collected and analyzed in a content analysis. From the sample collected, I propose two primary approaches were taken in marketing mental health: *problem-focused* (28%) and *solution-focused* (72%). This is somewhat similar to the description Metzl described in the advertisements he analyzed, with a slight difference. First, Metzl does argue that pharmaceutical advertisements are ‘unique’ because of the extensive history in representing women. Prior research has

established that women seek mental health treatment more than men; However, in "Prozac on the Couch" Metzyl argues that in addition to this, psychoanalytic history with these miracle medications, women have always been the promotional representation. And this is where gender stereotypes are embedded (Metzl, 2003:127). Metzl (2003) suggested a 'physician-viewer' in the specific advertisements he analyzed, meaning that the viewer was taking the place of the doctor in the image displayed (Metzl, 2003:145). A story is given with an image of a woman, and the viewer is invited to read different dialogues of whatever woman is described. "The more an advertisement can persuade a physician-viewer to think of quotidian assumptions as pathological, the more the product in question is prescribed, bought and sold" (Metzl, 2003:148). This is where personalization comes into play. The viewer of the advertisement personalizes the content in how treatment should be resolved. The advertisements analyzed in my study expand on this idea to transform slight differently. With the modern power of knowledge with the internet, and the immediate access offered by a smart phone, the doctor is almost dismissed in these advertisements. Almost being a key-component in this dynamic. The terminology of medical providers is utilized and some images portray a doctor, but the phone is the new prescriber. This is where *ease of access* is extremely significant. As described in the previous chapter, personalization has become the determining factor for an individual (specifically woman in this study) to diagnose themselves as the underlying tone is a question. Overgeneralization in common areas of life such as sleep, work, and mood, allow for a woman to grasp and personalize. The targeted demographic is young women with diversity and middle-aged white women. A pattern of framing depression (60%) or anxiety (40%) as a 'symptom' was common, with no description or diagnostic

criteria. Psychotropic medication was the most common treatment offered in the sample collected (65%). The image of a beautiful, smiling woman was the ideal advertisement display with each solution proposed.

I. How do advertisements on social media frame depression and anxiety?

From the sample collected, there are two primary marketing approaches to framing depression and anxiety. The first approach is problem-focused, a strategy of questioning an individual with a checklist of symptoms or struggles to solidify there is a problem. This is where the ad seeks to gravitate to the woman personally and in turn, the woman personalizes the image and key words given. Medicalization is a core element in this process. The terminology is vague enough to personalize, but medical enough for the woman to question her mental health issues as a medical disorder. This problem has a name and it's a disorder, insert depression or anxiety here. This may sound familiar, as this is the process by which professional psychiatrists diagnose their patients. However, with advertisements the 'professional psychiatrist' is not present, and it is a sample platter of symptoms or situations and the individual (consumer) reading the ad is the patient and the diagnostic determinant. The other approach is solution-focused, as if speaking to an individual who already 'knows' the problem and the advertisement is an easier way to obtain the solution (treatment) as discussed in the following section.

Problem-focused Approach

The minority of ads taken in my sample (28%) were problem-focused on their approach to framing depression and anxiety. "Life is hard" (See Figure 2) With the image of a woman distressed with her hands over her face. In order to sell a drug, you first have

to “sell” a disorder (Lane, 2007:104). We cannot negate the reality that advertisements’ fundamental purpose is to sell. And the fundamental feature in a problem-focused approach is stress. “Just don’t feel yourself” (overgeneralization) is a quote used in an advertisement for depression and anxiety medication (see figure 3 and 4) that included “Get support through breakups, job change, moving cities, and more” (personalization) to describe the need for depression and anxiety medication. The image in figure 3 and 4 are simply a glass of water and a pill bottle, because that is all you need. The issue at hand here is not that depression and anxiety do not or cannot include such symptoms or situations, but they are not sufficient alone to diagnose depression or anxiety.

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) by the American Psychiatric Association (APA) there are eight different types of depressive disorders with five to eight sub-categories for each; Each of which are expanded upon in description over a span of 43 pages for diagnostic criteria (DSM-5; 2013: xvii, 155-88) And this is for diagnosing depression alone. Anxiety is categorized among twelve different disorders, with five to eight sub-categories and 44 pages of identifying factors for diagnostic criteria (DSM-5; 2013:xviii, 189-233). Both including but not limited to prevalence, risk and prognosis factors, differential diagnosis, and comorbidity. In reference to depression, “The common feature of all these disorders is the presence of a sad, empty, or irritable mood, accompanied by somatic and cognitive changes that significantly affect the individual’s capacity to function. What differs among them are issues of duration, timing, and presumed etiology. It is characterized by discrete episodes of at least two weeks’ duration involving clear-cut changes in affect, cognition, and neurovegetative functions and inter-episode remissions” (DSM-5; 2013:155). Each

disorder has a list of symptomatology and diagnostic criteria that requires a minimum of five (or more) symptoms present during the same 2-week period and represents a change from previous functioning (DSM-5; 2013:156). So how does an advertisement cover all of this in a single advertisement?

In analyzing the collection of advertisements for treatment for depression and anxiety, the underlying tone is propositioned as a question. For an individual to self-evaluate and diagnose, different symptoms, moods, and circumstances are mentioned. Tangible issues are presented related to everyday life in three common areas: sleep, work, and mood. Similar to the illness to treatment narrative described by Metzl, we are shifting further now to convenience (Metzl, 2003:152). Unlike the DSM-5, there are no clear-cut categories or lists of symptoms. It's a mixture of questions and options of mood or situations that range from a bad day at work to harmful behaviors. Overgeneralization in presentation allows an individual to grasp and personalize. Consider the biological approach to 'specific gender tensions' and we have witnessed the process of medicalization (Metzl, 2003:157). This perspective is highly relevant to the sociological perspective of gender and mental health in relation to women. From a sociological approach these advertisments are seen as shaped by broader social, political, and economic structures. As the commodification of women's mental health issues perpetuate gender stereotypes and stigma. One simple example, women are encouraged to view their emotions and mental health struggles as something innately 'wrong' within them that can be 'fixed' through consumerism, rather than addressing the underlying societal issues at play, as their contributing factors are not represented in advertisements. Personalization has become the determining factor for an individual to diagnose themselves while

viewing these advertisements. The symptoms mentioned were scattered among different advertisements and vague in dialogue (see figure 4: Equation 1). Other symptoms mentioned only once in different ads included: inability to wake up on time, irritability, panic attacks, performance anxiety, impulsive behavior, isolation, self-harm behaviors, and suicidal thoughts. Something to note, a pattern of framing depression (60%) or anxiety (40%) as a symptom was common, with no description or diagnostic criteria.

More than half (56%) of the sample describes depression and anxiety together, there is no concise separation of the two, other than a single word contrast: "or" in depression 'or' anxiety, yet the descriptors in advertisement do not solidify which disorder they are describing. 20% of ads primarily mention depression, 16% of ads only mention anxiety, while the remaining 8% do not mention either disorder or symptomatology. Instead, psychiatrists, nurse practitioners, and therapists are the keywords utilized in the description, for example: "Finding psychiatric care can be hard. Headway makes it easy. We'll match you with a mental health professional who takes your insurance and meets your needs…" The social construct of the assumed prestige and hierarchy of doctors and psychiatrists provides the trustworthy credibility without the hassle, which is the service emphasized.

In reviewing the description of advertisements, depression is correlated with motivation (or lack thereof) and anxiety is correlated with production (or lack thereof). "Burnout and stress are on the rise" with anxiety medication in image. "If you're feeling depressed, anxious, or just not like yourself, we can help… sleep, mood, depression — they're all related. Get a personalized treatment plan to help you reset" followed by the link: "Get started" to start a demographic assessment. Both advertisements are

advertising psychotropic medication management for depression and anxiety (see figure 3 and 4). A bottle of medication and a glass of water is all you need to solve this problem.

II. What are the solutions proposed in advertisements for depression and anxiety on social media?

Solution-focused Approach

Most ads (72%) were solution-focused on their approach to framing depression and anxiety. Instead of presenting a specific problem to be addressed, the emphasis is on the actions to take. You are the patient and your phone is the doctor. Figure 4 is an example of this, disorders are mentioned but the advertisement insinuates that you already know what's wrong and this will provide a faster and easier solution. The solution-focused approach implies that the real problem is not depression or anxiety, it's the hassle or inconvenience of having to go to a doctor and/or pharmacy or having to leave your house at all for any kind of treatment. The solutions provided in the sample collected were varied treatments, which will be expanded upon, and ease of access, including privacy, and cost. Ease of access is the new emphatic tool.

Most advertisements were for some form of medication management, 20 out of 25 advertisements (80%). Out of those twenty ads for medication treatment, fifteen of them were completely available online and/or at home (75%) with "messaging care support team" as a common terminology utilized, which will be further discussed in a later section. 12% advertised talk therapy, whether counseling or Cognitive-Behavioral therapy (CBT), 4% advertised Transcranial Magnetic Stimulation (TMS), and 4% advertised inpatient treatment offering a higher level of care.

Psychotropic medications were the common advertisement recognized in the sample collected from social media. Of the twenty advertisements for medication, 65% of ads were for psychotropic medication. Primarily oral medication, as there is five common among the sample obtained: fluoxetine, sertraline, buspirone, citalopram, and venlafaxine were listed in 25% of medication advertisements by name, three ads (15%) were designated solely for specific medications: Latuda and Spravato and SeroLastin. One advertisement (5%) was for “research medication” not specifying any name or labels. Esposito & Perez describe a market solution for lifes troubles (2014:421) and then provide an understanding of medication management advertisements that offer the ability of an individual to “chemically modify themselves” to adjust or conform to market requirements (2014:425).

Ketamine treatment advertisements included 25% and included: infusion (20%) and oral (5%). The oral Ketamine advertisement emphasized ‘from the comfort of your own home’ which will be discussed further in later sections. Holistic medication and supplements 4% as only one advertisement offered a ‘natural approach to ease stress and mood. Hormonal-Replacement Therapy (HRT) 4% (one advertisement) discussed stress, energy, and mood to be directly correlated with a woman’s hormones changing in later years of life.

Therapy was primarily mentioned to support medication management. Overall, talk therapy is mentioned without corresponding medication in 12% of the entire sample. However, it is mentioned to support medication management in three of the twenty advertisements. More common among medication management is “unlimited messaging support” (online text) at 38.5% and telepsychiatry at 15.4% noting that there is a

significant difference between the two. Messaging support involves an online text board, in which an individual would post a concern or question, with 24–48-hour turnaround time for a returned message from support staff. Telepsychiatry would involve a scheduled audio or video call with a psychiatrist.

Transcranial Magnetic Stimulation (TMS) was advertised in two different ways, solely as an alternative for medication management (4% of the entire sample) and with medication management, noting in both ‘‘treatment-resistant depression’’. However, in the advertisement for TMS alone it is advertised “beat depression without meds” with a patient commentary “I felt trapped in my own mind” (ad 19, not pictured), introducing TMS as a ‘med-free treatment that works” While the other advertisement emphasizes treatment-resistant depression and states “standard care included medications” (ad 10, not pictured).

Inpatient treatment (ad 22, not pictured) offering a higher level of care with step-down programs: RES (residential) which includes 24-hour monitoring in treatment facility; PHP (partial-hospitalization) is supervision instead of 24-hour monitoring. Residents live in a structured house and go to treatment facility daily; IOP (intensive outpatient) includes attending group and individual therapy at treatment facility three to five times weekly, and virtual IOP includes virtual attendance of individual and group therapy a designated number of times each week. Emphasis was given to locations all over the United States.

Ease of access emphasizes the problem as being the hassle of having to deal with finding a doctor/psychiatrist, going to a doctor/psychiatrist, dealing with insurance companies, or the hassle of going to pharmacy. Most ads in this sample provided at-home

treatment or delivery (60%). Language is pertinent to express ease of access. Statements such as “days not weeks” “free online access” “no waiting rooms, just treatment” are just a few. “Convenient, affordable, and easily accessible” (see figure 5, ad 15) is the precise statement to reiterate the message given in advertisements emphasizing ease of access.

Several advertisements use a table to illustrate the simplicity and rapid results without leaving “the comfort of your own home.” (See Figure 6 and 7)

The appeal of convenience and rapid simplicity for results is highly appealing to an individual who is struggling with mental health concerns. Just the same as a tired, hungry person ordering food delivery. But is food delivery and psychotropic medication even in the same class? It is now. One advertisement removed the inconvenience of even having a video-call for telepsychiatry (see figure 7), they offer text messaging with providers on an app for convenience and anonymity. For an individual struggling, the image offered is an answer to everything they need, in one click. Looking at the same figures above, the emphasis of privacy and cost are included to promote how convenient, affordable, and accessible mental health treatment is. Inpatient treatment is considered a higher level of care, but not quite the institutions imagined in mental health asylums. It is voluntary admission, which will be further discussed by experience in the interviews conducted in chapter five.

III. How are women represented in advertisements for depression and anxiety treatment on social media?

Most advertisements direct their marketing to women, 21 out of the 25 (84%) advertisements. Prior research has established that gender is fundamental to status

inequality, which is dependent upon positional inequalities reiterated in shared cultural beliefs of our society, also known as stereotypes, which are the guidelines by which we play. Rosenfield (1999) suggests gender is a subliminal frame that works in the background of almost any aspect of manipulation in marketing as it is easily disguised to target mental health. Esposito and Perez (2014) denote the commodification of mental health to women as gender is fundamental to status inequality. This is dependent upon positional inequalities reiterated in shared cultural beliefs of our society, also known as stereotypes, which are the guidelines by which advertisements can implicitly strategize. It is engrained in individuals from a young age. First to sex-categorize and then in socializing, gender rules are unspoken but reinforced. Social media has become the virtual playground in a constant loop of advertisements and comparisons. In "The Dark Side of Social Media: Psychological, Managerial, and Societal Perspectives by Sheldon, et al (2019) they argue that social media can reinforce and amplify social inequalities and power struggles. It isn't just the advertisement at play, it is the placement on social media platforms influencing an individual's perspective. Social media enables discrimination, bullying, stereotypes, and in this creates an echo chamber the reiterates existing beliefs and biases.

It is easy to take a biased approach in analyzing the content of these advertisements as I am a woman who interacts with mental health every day, professionally, academically, and personally. ** The primary message given is that women need treatment for depression and anxiety. This is explicit in the focal point of women, but also implicit in the absence of a male presence. Of the ten advertisements that included a male presence, six of them were a written review alone, five including

images. Of those five images, the majority male presence was that as a male provider (doctor or clinician) and the two advertisements that depicted a male seeking treatment, one was a veteran advertising TMS therapy (ad 10) and the other was male seeking medication management for insomnia, not depression and/or anxiety. The implications in this are crucial and reinforce gendered stereotypes and stigmas. From these advertisements alone it can be assumed that men do not struggle with depression and/or anxiety; and if they do, they have extreme reason as being a veteran of war, which was depicted in the extensive scarring on his face and arms, to prove 'how much a man has to endure before he experiences depression.' The one advertisement that was collected that was entirely directed to male audience and included a male image was for ketamine treatment from home (ad 23, not pictured).

Minor diversity of women ranged in ethnicity in some advertisements, but primarily white women. Of the 21 advertisements featuring women, 17 of them were featuring white women (81%). And the diversity only appeared when featuring young women. Diversity varied between ethnicity and culture. The age range was young to middle-aged women, 50% for each, as one advertisement included both young and middle-aged women. All the advertisements feature attractive women happy and/or laughing, great smiles, outside in the sunshine or relaxing at home. To give an illustration of these descriptions I have included six images from the advertisements collected. (see figure 8). Figure 8 is a collection of six different advertisements picturing women in their variation collected, but all with the overall message of beauty, happiness, and tranquility. Marketing with the underlying message: "with the specified treatment you can be happy like these women."

“Empirical evidence supports gender as a primary frame to the categorization of people as defined in relation to self and others through a system of social practices” (Ridgeway, 2011:9). A lot of assumptions can be made about these images and with marketing, that’s the goal. These women look happy, and they are attractive, but not so attractive that it appears unobtainable. The message implied to women: “These women are just like you, but they are happy. They aren’t stressed out. They are enjoying life. And so can you!” The advertisement isn’t for beauty, but it’s implied. Comfort and class could also be assumed, depending on the individual who is viewing this advertisement. And all of this is yours with little effort, from the comfort of your own home, at a cost you can afford.

Bacigalupe & Martin (2021) utilized an intersectional approach to consider assessing gender inequalities in the diagnosis of depression/anxiety and in psychotropic consumption. Findings showed that the medicalization of mental health is occurring among women. Their research also stated that the further investigation of the mechanisms underlying these results was crucial to reduce the medicalization of women’s mental health. Studies have shown that gender is an influential component of attitude toward mental health. (Lee, et. Al, 2020; Horwitz, 1999; Rosenfield, 1999). Prior research suggests that although minimal significant difference exists in terms of the number of males or females who experience mental illness, females are more likely to access support (Bradbury, 2019; Mental Health Foundation, 2016).

Conclusion

Women’s mental health is indeed being marketed on social media platforms. I argue that such advertisements on social media have more of an impact on women than

direct-to-consumer advertising on television for three apparent reasons. One, the influence and access to social media is not only growing, but it is as close as a pocket, purse, or in hand. Considering an advertisement every four posts on a feed is significant, how fast do you scroll? Second, the culture of social media is a constant loop of highlight reels that an individual is consuming and comparing. This study does not focus on the correlation of mental health and social media, but the relationship is significant in considering the mental health advertisements in the loop of friends' highlight reels. Several studies have implicated a significant dynamic between depression, anxiety, and social media platforms. Lastly, overgeneralization in presentation of mental health treatment advertisements allows an individual to grasp and personalize in moments of frustration or situational overwhelm. Phones have become more than an accessory, with the click of a button, they are an escape from any given moment with the access to anything, literally of the entire world. With the help of these advertisements and ease of access, your phone is now replacing the inconvenience of an actual doctor. Social media apps are one click away, and so are quick, easily obtained, affordable opportunities to be beautifully stress-free and happy, just click here.

On one hand, social media can provide a 'sense' of community and support for individuals who may feel isolated, lonely, or marginalized. Social media is a marketing tool to give the sense of similarity and community when in fact it isolates and causes a constant comparison (Sheldon, et al; 2019), which is not beneficial to an individual struggling mentally, as you will see described in the interviews conducted in the following chapters. With the marketing incentives of social media, the familiarity of seeing 'friends' posts and highlight reels; social media can be used to spread

misinformation and propaganda in enabling the manipulation of public opinion (Sheldon, et al; 2019). The design of social media is to incentivize certain behaviors, for example the creation of viral content or the cultivation of a ‘following.’ This is important to consider in evaluating and analyzing not only mental health advertisements on social media, but also the impact on perspective for women dealing with depression and anxiety.

I would like to introduce three terms in understanding the current social construction of medicalizing women's mental health in this study: communication, convenience, and confidence.

Communication is crucial to consider the implications of medicalizing women's mental health as it sculpts the way mental health concepts are defined, understood, diagnosed, and treated. mental health advertisements such as pharmaceutical companies (as they were the majority in this analysis) can target women in advertising, which in turn can pressure women to seek medication management for their mental health struggles. This results to the over-prescription of medication and underestimation of other non-pharmaceutical interventions (Rose, 2018; Metzyl, 2003). Marketing can take the assumed virtue of medical professionals such as doctors and psychiatrists and facilitate a correlation between women and the mental health treatment advertised through communication. Language is not only the dialogue portrayed in text, but communicated through the images portrayed, in the culture trending on social media. Communication is also highlighted as a feature in these advertisements in emphasizing a reliable presence of professionals who care about mental health struggles. And lastly, communication

between individuals offline carry a message beyond the 30-60 second interval of advertisement displayed.

Convenience contributes to medicalizing women's mental health in a substantial way through ease of access advertised in this sample. In modern society, people are overwhelmed with stress and 'hustle' is a trending mindset. This leads to individuals (women in this study) seeking quick remedies and fast solutions to their mental health struggles. This emphatic need for convenience can lead women to gravitate towards a 'quick fix' advertised in this sample rather than engaging in traditional roles of scheduling in-person doctor appointments or counseling, or even implied in this sample time-consuming trips to the pharmacy. Medicalizing women's mental health can be beneficial for medical professionals as well, medication management is a lot less time consuming and provides more time to see more patients. The convenience advertised in this sample overlooks the time constraining factors that would be considered in lifestyle adjustments, ongoing therapy, or changing broader social factors that can contribute to mental health issues (Rose, 2018).

Finally, confidence plays a significant role in the medicalization of women's mental health in these advertisements. There is a significant confidence in the medical profession that is marketed through these advertisements and the efficacy of medication management that is communicated on and offline through ample amount of confidence our society puts in the medical field. There is an illustrated confidence of medicalizing women's mental health supported in these advertisements that is reinforced by the platform in which it is displayed. Confidence is an implied factor of social media platforms, and this notion is supported by the images displayed. The women in these

advertisements are confident, peaceful, and happy. Confidence is an easy attribute to market and has been a source of marketing since marketing first began. Murthy (2012) provides significant research of understanding the power of social media in normalizing confidence in consumption by investigating the individualistic tools of social media and the embedded social factors involved when analyzing Twitter.

In providing a foundation for communication, convenience, and confidence in understanding the medicalization of women's mental health in advertisements on social media platforms, I would like to take this terminology into the next two empirical chapters involving the conducted interviews of this study by not only analyzing data with current literature, but also in comparison with the findings of this chapter.

Chapter Four: How Do Women Understand Their Personal Mental Health Issues?

Introduction

When these interviews began there was a set of ideas that I had in what I may hear or should look for. The conducted interviews brought a significant amount of insight and brought me back to a statement I had wrote in my proposal in "giving voice' to individuals who experience mental health challenges. There has been a lot of attention and awareness brought to mental health, whether that be in advertisements or research on pharmaceuticals or new avenues of treatment. It was not until I started these interviews that the results of the previous chapter illuminated. These interviews provided light in the content analysis portion of this study. I argue that the best education and awareness comes from those that are living through the topic being discussed. As the experiences and perspectives are discussed, I challenge the notion of the term 'disorder' as a negative connotation to the struggles that humans experience, more specifically women in this study. This chapter will investigate how women define their mental health and what they believe is the cause of mental health issues in considering biological and social factors in the social construction of mental health concepts.

Results

To introduce and illustrate the nature and social construction of mental disorders, there was not one specific reason given during the interview process. These women understand their mental health through the lens of their personal experience. These women give meaning to their existence primarily to their surroundings and relationships,

as you will see illustrated in the data collected. In this when giving meaning to their personal mental illness, definition is subjected to what others say or imply. Culture influences individual experience and perspective; this changes in each society. Social construction gives meaning, sociology gives a voice to the translation of that meaning and what is understood (Aneshensel, C.S. et al., 2013). When asking them to define mental health, depression, and anxiety, the language used to communicate how they comprehend their struggles is evident to background information obtained in the beginning of the interview, more specifically family, education, career, and most significantly important relationships. For example, when asked what mental health means in general, Monica, who is 31 years old, recently married with three children, and a clinical therapist stated: um just like. How you like- how you live, how do I put this? Um, how you function and the effect that chemical imbalances have on you.

Another woman, Liz, who is 26 years old, primarily worked in customer service and hospitality explained it as: where my head is at, if I'm in a bad spot. I get anxious all the time.

Both women struggle with anxiety, however the language used to explain it illustrates their personal lives and perspective. Monica works with others' mental health in her daily routine, utilizing terminology that is not common and she utilized 'you' statements and had difficulty personalizing her responses unless it was describing her family or important relationships. Liz may interact with others that struggle with mental health, but her understanding is personal and unique to her own, not from a professional capacity. There were five women that are currently in university studying psychology and sociology and described mental health with language illustrating their personal

encounters and education. It is important to understand that every single response given was correct, as it was evident to their own environment and experience. The data collected reiterates the process of medicalization in understanding the social and cultural stressors that are described as medical problems. Conrad (2013) discusses a range of medicalization, whereas something may be viewed as a ‘problem’ but not necessarily an illness or disability (Conrad, 2013:198). Shared personal experience illustrated in this chapter is where the ‘range’ is emphatic, and in the previous example of Monica and Liz, language is its determinant influenced by social factors such as career and significant relationships.

How do women understand their personal mental health issues?

To understand depression and anxiety from the perspective of personal experience, personal feelings and circumstances are given to describe depression and anxiety. Katrina is 25 years old, single and currently a store manger in Illinois who was visiting a friend in Florida (that she refers to as family) during the time of interviews being conducted. She was emphatic on important relationships to her. She described the causes as:

> **Katrina**: I think this depends on the individual, but for me, a mixture of genetics and life experiences probably helped cultivate my depression. I am told its genetics, but I definitely know that the environment I grew up in or have lived in have a major impact on my mental health. That’s why I am very deliberate in who I choose to surround myself with, and keep in mind the environments that I’m required to be in, like my work environment. I can’t just not go to work, but I am mindful of myself and how it affects me and my mental health or perspective. It sounds so easy talking about it, but it’s usually me having some kind of mental break down or emotional meltdown to take some time to evaluate my circumstances and environment.

This is illustrative to the range of medicalization that Conrad describes. It is understood from a biological standpoint from what 'she was told' and from a perspective of social factors in her experience. Katrina explains that her environment is crucial to her mental health. She understands the influence of social factors such as work or relationships, but pinpoints isolation as her biggest tale-tell sign of depressive symptoms.

Brandi, a 24-year-old admissions counselor for an online university, struggles with her significant relationships. Her family is her 'most important relationship' however there is turmoil because her family does not like her partner. Brandi describes her family as always being 'career-oriented' and she explained that: emotions actually make me anxious. I'm not sure how to express myself intimately, so I don't. Brandi explained that she struggles with anxiety and it was meeting a past boyfriend that made her think something was wrong inside because he would ask questions attempting to get to know her personally and she was too anxious to talk about her parents or growing up. At that time, she stated, she brushed it off and kept conversations '*topical*.' She shared that she realized if she *was ever going to get close to anyone she would have to work on this*. Brandi understood her anxiety in the context of personal relationships and the symptoms biologically:

> **Brandi:** I think mental health problems arise from a variety of sources and for a variety of reasons. For me, I do not think any single thing can be identified as the "culprit," but rather, the course of my life led me to a place where my brain and body work in a particular way.

When interviewing Angela, 26-year-old with a background in education and administration, explained the cause of mental health struggles as society and how it is structured. Angela, originally from Brazil, with close family connections moved to the

US at the age of 12 years old. The cultural difference was influential in her understanding of depression and anxiety. This is how she explained the cause of mental health issues:

> **Angela**: Society. I mean like how society is structured around us, it's awful you know. We wake up. We must go to work. We don't really have any time for ourselves. We need to make money because you need to get this-you need to buy this. Everything is structured to make us like little robots but that's not how we function. So yeah, you know, health care you got to worry about this, you got to worry about that. If you have kids, you must worry about them. It is a cycle of worrying. I feel like that's how society is structured.

It was understood that to make it in society, she needed to manage her mental health. And although she understood the cause of her mental health issues as societal factors, it was up to her individually to adapt to those factors as will later be discussed in her seeking treatment and maintaining her mental health. This is illustrative to medicalization explained by Conrad (2007, 2013) and also the commodification of mental health discussed by Esposito and Perez (2014).

And then there are women who only see their mental health struggles through personal experience and significant trauma. Emma is 35 years old, a single mother who listed a vicarious employment history, and '*needs to stay busy*.' She explained that: relationships are how I have defined my whole life. I guess I didn't realize it or I realized it more when I had my son. She described depression as feeling lonely, isolated, and no one cares about me. And understood the cause of her mental health issues as 'anything that made her a prisoner in her own mind.'

> **Emma**: I think it's a lot of things, trauma, relationships, expectations, fear, **** growing up and maturing causes mental health problems, anything that makes you a prisoner in your own mind. I was abused growing up and for some f***** up reason I thought it was normal, like everyone gets the **** beat out of them for nothing. But I always wondered what I did wrong, why it kept happening, then I believed something was wrong with me.

> So, I apologized for everything, definitely a people pleaser. Thinking about it makes me sick. But yeah, f***** up s*** happened, and I didn't know what to do about it. So, I just learned how to bury it all and pretend it never happened. But I thought about it all the time, I just had to make sure others didn't know that. I guess that's how the anxiety started. Living in constant panic, fear, sadness, confusion.

Emma gave feeling words and metaphors, with no association to medical terminology. She described the abuse she endured as being taught to her as normal. This started during developmental years and '*staying busy*' was how she learned how to not think about it. The responsibility of having her son was when she first thought to seek professional mental health treatment, which will be further discussed in the next chapter. Horwitz (2013) gives four sociological explanations of mental disorder: Etiological (biological, not culturally dependent), Sociological Psychology (culturally dependent, individual object of explanation), Social response (socially caused an explained), and Social Constructive (social explanation and cultural dependent) (Aneshensel, et al; 2013:96). From a social constructive perspective, these women have learned how to explain their mental health issues through the language and culture of their environment. I am going to provide several examples from the interviews conducted that differentiate between social factors and biological predisposition in understanding the causes of mental health issues with depression and anxiety.

Social Factors

> **Freya**: I think I grew up too fast, many adult issues at a very young age and I feel that being raised in a secular sort of environment was not conducive to healing through these issues I—I was allowed to fend for myself to find God on my own time which I am thankful for. I'm thankful for my journey and I'm not blaming my parents at all for how I was raised; no one's perfect, there is generational trauma in every generation and every family in some way shape or form for me having some more knowledge but it has given me the power perhaps to fend

> off my demons while using drugs and alcohol or perhaps keep me from staying in my addictions as long. I dealt with addiction for over 15 years almost 20 years. I started very early so it's hard for me to pinpoint which one really came first whether it was trauma or addiction because I did start with both so young.

Freya identifies the cause of her depression and anxiety to life course experience in how she was raised and the environment she was brought up in. Freya explained that trauma and addiction were taught to her as 'normal' from a young age. She goes on to explain that, at the time, she did not understand it as 'trauma' or 'addiction' but rather the lifestyle and environment in which she grew up. It wasn't until adulthood and her personal journey of recovery and seeking professional mental health treatment did the terminology integrate into her understanding.

> **Jessica**: yes I would say, I would say, I think the reason I feel it's not just one thing, is because I can't just pinpoint it to one thing for myself. I feel it is a combination of my peers, growing up, my home life, my genetic predisposition, and how I talk to myself. I think ultimately, it really is how I talk to myself and how I treat myself. I feel when you tend to be harder on yourself, you find that you're in situations mentally where you're don't know how to baby yourself, you don't know how to be like "it's OK, people make mistakes. Things happen. You're not supposed to be perfect. You're learning." Things I would tell a friend or a family member that I'm not choosing to tell myself; because I'm either A. caught in that cycle or B. so far past it, I'm not seeing it for what it is. It's like being in the eye of the hurricane.

When interviewing Jessica, she explained how she came to understand her mental health issues through relational interaction and conversation. It was the physical manifestations of anxiety that led her to seek professional help, which started in the emergency room before she ever interacted with mental health professionals. She thought she was having a heart attack and it was explained to her as a panic attack originating in her mind and manifesting in chest pains, racing heartbeat, sweaty palms, and dizziness. Jessica has worked in hospitality as a server and bartender her entire career, she describes

herself as a people-person. She primarily describes her mental health issues in relational terms – with herself and with others. Similar description given by Liz, a 27-year-old single woman who has previous experience with telemarketing, but currently cleans houses, and is expecting her first child in five months. Depression is "a dark hole. Heaviness, not wanting to be alive, not wanting to do anything, feeling like I'm alone and don't have anyone who cares." She goes on to explain emphatically that mental health issues would not exist if people were kind to each other.

> **Liz**: Um, yeah. People suck. I got bullied in school because we were poor, so I hated going to school, which sucks because I used to love school. Kids would rather be popular than be kind. If people were nicer, I don't think mental health problems would exist.

Interviewing Pamela was emotional and inspiring. She is 27 years old, an assistant manager in the hospitality industry. She is recently divorced and just lost her 2-year old son to a sudden death. Many would describe Pamela's experience as trauma and grief. It was explained to her as major depression as she experienced a lot of what she describes prior to the divorce and death of her son.

> **Pamela**: yea, like getting divorced at a young age, getting married at a young age, getting pregnant at a young age, and losing my son at a young age. I'm trying to understand why that happened and I must grow through it without wanting to. I've been through all of it. I've been through childhood trauma, divorced parents, my sister being physically abusive and mentally abusive, growing up having a mentally abusive husband, and at some point, probably becoming his abuser as well, because I had to protect myself. Trying to be a good mother and then losing your child in the middle of it. It all just sets the tone for the future, like everything else will be okay, but just not this. I would never be OK with that. I've been through all of it and I'm a human. You know, like I'm alive. I didn't self-destruct like maybe most people would have. I tried to take all these bad situations and just gruesome moments, and try to make something good out of it, because I have control of that. I don't have control of anything else that happens to me, nothing at all

> so I must roll with the punches, just look calm on top and totally crazy underneath.

What Pamela was experiencing was explained to her in medical terminology, but she understands it as life experiences, the situations, and circumstances that she has encountered in her life course, how they affect her, and how she responds to it all to take care of herself and "to keep being able to show up for her family, friends, and responsibilities."

Biological Factors

The next few examples are of women who understand their mental health issues in medical terminology and an etiological explanation. It is interesting to note that each of these women have an academic background, whereas the previous examples given did not. This is not highlighted in a discriminatory manor; but rather to emphasize the influential difference in cultural and education in understanding the social construction of mental health concepts in explaining how medicalization is embedded in our society.

> **Monica**: I think its chemical imbalances in your brain. I do think like environmental factors have an effect on things um but I'm kind of on the side of -I believe that you're born with them, or they are developing in your brain while you develop.

Monica (as previously stated) is a clinical therapist in mental health treatment.

> **Natalie**: um I think it was for me um, probably a gene where I was kind of susceptible to it and then my environment like bit by bit made it worse and then it just became this, depression and anxiety run in my family. So, we don't really talk about those things, so I guess you kind of have to pick up signs, but as far as I know I haven't talked to them about it.

Natalie is 25 years old and a recent graduate as she received her Master of Arts degree. With limited work experience to being that of her first job as a teenager was a brief exposure to working in fast food, her primary cultural influence is her family and education. This will be further explored in the next chapter as we look at seeking mental health treatment and managing

mental health. Pay attention the next example, Phoebe, 24-year-old college graduate as they explain it "as they accept it" with little understanding of biologically what is going on. It is more accepted than understood. Conrad (2007) and Rose (2019) both touch on this in their work to explain medicalization of mental health issues and the terminology that is passed around in psychiatry and clinical arenas but not scientifically sound, as they are lacking biomarkers in the brain to designate mental health disorders in their classification of symptomatology. Out of the fourteen interviews conducted, this was the only one understood from an entirely etiological view point.

> **Phoebe**: The first counselor that I saw we kind of went through everything. We talked about my family history, we talked about my life, if I had any trauma, and I don't really have anything that would be outstanding or abnormal. We kind of just concluded that I probably just have an imbalance of like serotonin levels or something in my brain. It's just like, I don't know, like some people it's just natural. Some things-some people just have depression and anxiety, and it can't really be explained. So that's just how I kind of accept it. I didn't have like a crazy childhood or any significant problems. I mean I guess I would say that it might be hereditary, because I don't know, my families have a lot of problems. I don't know, we concluded that it wasn't any like external factors; so, I would just say that it's just something that just happened to me.

Combination of Social and Biological Factors

The majority of interviews articulated a combination of factors; however, only those with an academic background and/or medical experience understood their own mental health in terms of a biological predisposition, and they used the same key phrases: genetic predisposition, chemical imbalance, biological factors, or hereditary. And this is not to dismiss or advance one understanding from the others; it is simply to highlight how broader social and cultural factors play a significant role in definition, understanding and perspective.

> **Rebekah**: I mean so many things: environmental factors, biological factors, um crises, um life stuff. I feel like there's more ways to lose your mental health than to get it back.

Rebekah is 28-year-old graduate student and mental health professional. She explains that it wasn't until she gained a sense of mental health or clarity that she understood her mental health issues. Rachel, also a graduate student understands her experience through social factors and her symptoms through a biological understanding.

> **Rachel**: I think what caused my own is definitely a trauma that I've gone through in my life and in my previous romantic relationship has definitely contributed to a lot of it. Um, but I think in general, society causes a lot of it because there's a lot of expectations and people compare themselves and you know to what societies expectations are, even those societies expectations aren't necessarily um like reality, so I think that that comparison causes people to have anxiety and depression.

In attempting to explain how women understand their personal mental health problems it is evident that they do not have a specific definition or answer, but in the process of describing their lives, they have an adequate sense of self awareness and reflection. These responses could have easily been categorized and described statistically or by symptomatology as in the DSM- 5 or any previous version. But is with great argument to gain insight and understanding directly from the verbalized explanation. Psychiatry misses the mark with this present day (Rose, 2019). Research has dug so deep into trying to prove it is a brain disorder that the individual struggling is dismissed into a check list of symptoms. Difficulty in life has been coded as a mental disorder (Conrad, 2007; Rose, 2019). Whether it be their childhood, past experiences, current life circumstances, or a series of trial and error in navigating their own journey, their responses are dependent on relationships, circumstances, and choices.

When asked "when they first thought they thought something was wrong" each woman designated emerging adulthood and their tale tell signs were evident in their interactions with others. Even though they encountered struggles at home, school, or in their relationships, they did not seek professional help for their mental health until recent years. Both discouragement and encouragement for professional help in seeking relief came from their important relationships. Most of the discouragement to seek professional help was verbalized to be parents' negative opinion of medication management due to their own opinion or experience.

> **Rachel**: um I'm still going to say an example of a choice that I made that my relationships didn't effect was my decision to go on anxiety medication because my family was not 100% like on board with it and I still decided like this is my body I guess to make their decisions for my body whether they agree with me or not and if it doesn't work then I can always decide to not like continue taking the medication and something that you know that I did use my families input for is probably you know like I bounce a lot of ideas off of them as far as like career or school or work so sometimes I use my relationships as like a sounding board and if they agree with me on something then I'm more likely to go through with it or if they disagree with something then I may be as likely to go through with it but maybe I'll think through a decision more.

Every single experience articulated of receiving encouragement to seek professional help in navigating a solution was received from significant relationships in peer group.

As we proceed into discussing perspective and experience in these chapters, keep in mind two things: 1. This is not to negate any understanding of any mental illness. And 2. This data is designated to depression and anxiety and is not circumventing all mental illness or disorders. Depression and anxiety are significantly correlated, as evident in the advertisements from phase one of this study and the interviews in phase two, most of the

time they are considered a package deal. Although both designated to mental capacity, depression is described as a personal failing and anxiety is contributed to productivity. Some say depression is an identity of failure, whereas anxiety is a fear of failure. Both causing impairment to the extent of not being able to engage in daily activities or a slow disconnect from normal routine. However, the negative emotion and overwhelm is not only a social factor in analyzing where 'self' went wrong in relationships, or grief in loss, or not being able to accomplish everything expected on a daily agenda, or traumatic events that have broken a woman's wellbeing or perception of life. All very significant events, circumstances, and reasons. Women not knowing how to cope with life and recognizing how unprepared they are or exactly how hard life is. This isn't a matter of fever or infection, this isn't a medical calamity or illness. There is no clear description for either, being overwhelmed could be symptoms of depression and anxiety. However, sadness and loss are primarily delineated to depression. Anxiety is primarily connected to fear, whether that be fear of rejection, fear of failure, or fear of loss. Here are two different examples of response when asked to define depression and anxiety. To clarify, first response given by each woman is defining depression, second response is indicated by prompt in defining anxiety:

> **Jessica**: back to the ladder in the hole, and forgetting how to climb out of it, and feeling like some days there's people looking over at you in the hole. They're trying to help and feeling like other days people are throwing rocks down it. I'm still constantly trying to climb up the ladder regardless of whether people are there or not. I feel that is the goal to realize that you need to rely on yourself. You can rely on yourself. I think in the last six months I've learned that more than anything. Between work, and friends, and family, in my living situation, and things of that nature. I feel isolation, even though it feels good, it's not good. My mom always taught me treat yourself like a baby. I would always laugh. I'd be like, oh that's crazy. We're not even going to do this talk, and she's not wrong. What would little Jessica

want? Would she be proud of what you've done? Would she say that's bad or good? Would you give little Jessica sugar at 4:00 in the morning? Probably not. The little things like that.

JW: So, what does it mean to you personally?

Jessica: depression, I mean it's like I'm failing.

JW: how would you define anxiety?

Jessica: just like a constant nervousness, always feeling like you're late. Always feeling like you're behind. I grew up a late bloomer, so I just feel I'm always behind. Umm and also, like you know, going into, I don't know if it if it's anxiety specifically, or if it's just how I'm built; but when I go into another room, I can feel, and I don't know what I'm picking up on sometimes. If people are feeling good or bad. I can just feel multiple energies or moods at once. I think that also triggers my anxiety a lot, is being around multiple people in a room, and not knowing them, but being able to almost feel them. It's just very overwhelming.

And Emma for the second example in this comparison of defining depression and anxiety:

Emma: My feelings are going to eat me alive.

JW: Can you elaborate?

Emma: I feel lonely, isolated, like no one cares about me. I have no energy; I don't want to do anything or go anywhere. I drink more, like not for fun, but by myself to drown out my existence. I'm emotional but apathetic all at the same time. Like I don't care about life so much that everything sets me off or makes me cry. It's like I'm at war with myself. Like taking a shower can be a huge ordeal, even though I know it's going to help me, I fight with myself in my mind on not doing it, then just spiral down the rabbit hole.

JW: how would you define anxiety?

Emma: Umm, without saying feeling anxious. I guess my mind and insides racing, panic, a sense of impending doom, suspicion like my thoughts are exposed and everyone thinks I'm a fraud. I get that it, being more concerned with whatever others might be thinking that it physically is consuming me. Sweaty palms, racing heart, chest pain, I feel like I can't breathe, oh my god its awful

The similarities verbalized among these women can be translated to almost any person reading this to some extent whether personally, or within personal relations. The

description of experiences given are socially contingent. They develop and change with social interaction and circumstances. The limited terminology given to describe these experiences medically was either A. describing physical manifestations like sweaty palms or racing heart and chest pain, or B. a popular term of ‘chemical imbalance’ that has become familiarized with medicalization but cannot adequately be defined to any specific biomarkers in the brain and has yet to suffice a universal explanation. Views that symptoms are a result of brain disorders are accepted and legitimized by the language utilized by those with credentials in the medical field, which becomes a topic of discussion for culture and society, not the actual location of disease or disorder in the brain. Whether discussed and explained in social terms or medical terms, it is the individual’s perspective that validates the reliability. The next chapter will illuminate further understanding of women navigating mental health treatment, pharmaceuticals, and how the culture of social media has significant influence.

Conclusion

As illustrated, interviews evidence that these women primarily understand their mental health struggles through social factors but do not dismiss biological factors all together. Significant literature supports this as previously established, Conrad’s research (2007, 1992) suggests a significant yet complex dynamic among social, cultural, and biological factors in not only the development of disorders but also in treatment of such. Conrad provides significant recognition to the legitimacy of biological factors that contribute to mental health issues but ultimately focuses on medication management being the go-to for treatment of mental health issues, which is relevant and evident in the previous chapter as medication management was the majority of advertisements

analyzed; and suggests that better attention be given to the social and cultural factors at play (Conrad, 2007). Rose (2019) also provides significant research supporting the need to evaluate and consider social and cultural factors when discussing and diagnosing mental health disorders without forgetting the relevancy of biological factors. Mental health issues is a complex arena that is defined, diagnosed, and treated by a multitude of variables. I believe the findings of this study support previous research in how we as a society construct collectively and individually an understanding of the medicalization of mental health issues such as depression and anxiety, for women through communication, convenience, and confidence.

Communication is crucial to consider the implications of medicalizing women's mental health as it sculpts the way mental health concepts are defined, understood, diagnosed, and treated. In comparison with the previous chapter of content analysis, communication is a key element for the women interviewed and how they understand their mental health issues. The dynamic of communication in learning an understanding what is going on with them, the communication that takes place in considering mental health treatment, and the communication of medical and clinical professionals that provide a language to not only help them understand and navigate their experience, but also to validate their experience; this is seen in both communication with significant relationships and medical professionals which will further be explored in the next chapter. In this context, communication provides a sense of validity and reliability. Communication becomes the avenue in which social factors, cultural influence, and environmental stressors are medicalized and individualized within each woman interviewed, as it is communicated as a personal responsibility to address and maintain.

Convenience is best understood in this chapter as the acceptance of what is communicate to them, primary example with Phoebe. As they did not quite understand the chemical imbalance going on, but accepted it. In evaluating the responses of this chapter, there is nothing convenient about the struggles they have experienced. However, as we will see at a greater velocity in the next chapter, the need to make life more manageable and convenient to the societal expectations that are described in this chapter, medicalizing human struggle provides the best approach for doing this. This leads to individuals (women in this study) seeking quick remedies and fast solutions to their mental health struggles, which we evaluated and discussed in the previous chapter. And lastly, the emphatic need to not be an inconvenience is evident in the interviews conducted. The women identified a significant amount of their struggle by recognizing how it affects their relationships and careers. With significant evidence highlighting social factors I the attribution of mental health issues, it is only through medicalizing human struggle that the responsibility for solution is individualized and then commodified as illustrated in the previous chapter (Rose, 2019; Esposito & Perez, 2013; Conrad, 2007).

The confidence illustrated in the responses of this chapter are two-fold. On one side, there is a relevancy and confidence in these women being able to communicate with me directly the cause of their mental health issues and how the define what is going on with them. Whether it was social or biological factors, or a combination of both, there was no hesitancy in their communicating with me exactly what has caused them to struggle and the extent of why. In comparing the responses of how women understand their personal mental health issues and what they believe cause them with the marketed

advertisements from the previous chapter, it could be understood that mental health issues are the misplacement or disparity of confidence. With this understanding, it is easy to understand how mental health treatment advertisements present a smiling, peaceful, confident women to market their product (Metzl, 2003; Russell, 1993). In the next chapter, we will divulge this further in exploring how women seek mental health treatment, the role of social media advertisements, and their understanding of it all.

Chapter Five: Social Image in Seeking Mental Health Treatment

Introduction

Previous work has established women struggle more than men from internalizing disorders -negative emotions turned against self-such as depression and anxiety (C.S. Aneshensel, et al; 2013:277). To understand the "gender" dynamic of mental health from a sociological standpoint, one must consider how it is identified, defined, regarded, and treated. And for the purpose of this study, I wanted to know how women seek mental health treatment and how did advertisements and social media influence this process? What influence social media use has on women's current mental health care, in how they think and manage their mental health issues? I believe the findings will invoke purposeful discussion and further sociological research. In this chapter there are two main questions: 1. How do social media and pharmaceutical advertisements influence the women interviewed as they sought mental health treatment? And 2. How does social media affect current course of treatment?

I. How does social media and pharmaceutical advertisements influence women seeking mental health treatment?

In reviewing the data collected, the primary starting point for women in seeking professional mental health treatment circulated between two factors: 1. conversation among important relationships. For example:

> **Monica:** yeah, I would talk to close family and friends.
>
> JW: Does that help you?
>
> **Monica:** yes, because like I said before you feel like you're not living in a shell. I'm like holding all of this emotion in and you feel like you're just like open and it lifts the weight off your shoulder; so, relief maybe.

and 2. search engines on the internet; For example:

> **Rebekah**: I'll do a Google search and then I'll like the first page that comes up you know I'll usually hit like a third of those links. A lot of the times it's WebMD or Mayo Clinic or sometimes it's like -I'm embarrassed to say- it's like Reddit and Quora- you know, I'm getting my medical advice from Joe-13 or whatever (laughing) and then YouTube. I use YouTube to find videos.

Each woman identified it to be their personal choice to seek professional help but those decisions were influenced by significant relationships, self-reflection, and 'scrolling' on social media that led to research on the internet. To better illustrate this, here are examples from Katrina and Brandi of how significant relationships and internet search affected the choice to seek mental health treatment:

> **Katrina**: I used Google to find all kinds of answers about myself until I started treatment. It was all very confusing, because there was so much information in one place. It was actually that overwhelming confusion that pushed me to seek professional help. It was almost a catch-22 because the more I researched different sites or quizzes, the worst I felt, like I was doomed. But it was that doomed feeling that pushed me to seek help.

And then Brandi,

> JW: When you first started seeking professional care, did you ever use the internet to research or understand what was going on with you?
>
> **Brandi:** Yes- all the time! I looked for answers to questions online regarding my relationship, anxiety, and all kinds of other things.
>
> JW: What kinds of things?

> **Brandi**: Statements like “does anxiety go away” “symptoms of anxiety” “what do I do if I’m anxious” and then ridiculous things like “how can I know if I can trust my boyfriend” The internet has quizzes for everything nowadays.
>
> JW: Did you use search engines or WebMD to look up your problems? What was that like?
>
> **Brandi**: I usually used a search engine, I google statements or questions. I took quizzes, watched little clips of people talking about it. Information overload is anxiety inducing in itself and it almost gave me conflicting information.

Each woman described in their own experience a significant amount of time in self-reflection with a desire to ‘fix’ the issue on their own somehow. That time of self-reflection included a considerable amount of isolation with their own thoughts and phone with access to an infinite amount of information. Women describe their important relationships as ‘sounding boards’ for the decisions they made in seeking mental health treatment.

> JW: was there anything that did encourage you to seek help?
>
> **Natalie**: yeah, my friends. they were just like you probably are depressed and encouraged me to seek help - talk to someone like it's really bothering you.

It is interesting to note that in every single interview, contact made to others on social media about their mental health was through direct messaging and not public posts. This will be further discussed later in this chapter. Fear of judgment or negative feedback was entirely the reason for not sharing publicly on social media any personal mental health struggles.

> **Katrina:** A few times I reached out using social media to close friends. Direct messaging, not like a status post, I didn’t cry wolf! But they would help me in the short term, but in the long-term, I needed something more.
>
> JW: Can you elaborate?
>
> **Katrina:** Sure. Short-term meaning, I felt better in the moment sharing my thoughts with someone and having them validate my

> thoughts. But the next day, or later that day when it was just me, everything I was going through inside was still with me, and then I would contemplate everything I had looked up on Google, it was exhausting in my mind.

Throughout the interviews there is a common picture being illustrated of significant commentary and information being consumed by these women who then internalize and start seeking professional help. This reiterates the research conducted by Esposito & Perez (2104) that suggests the solution to mental health issues is consumerism. The problem is identified and isolated within the individual and the solution is understood as external and tangible, whether that be of medication, therapy, or other treatment modalities marketed. Each woman described using internet search engines and remember seeing advertisements on social media for mental health treatment; however, the commentary on utilizing the actual links provided on social media was interesting. Each interview described a negative perspective and commentary of social media advertisements for mental health treatment.

> **Phoebe**: I have strong opinions about why I don't like those ads. I don't like seeing ads for mental health. Oh well I know I've got- I've been getting a lot of ads recently. I just remembered of one of those talking apps, that you get and like it's like a you know like when you swipe on like your Instagram stories and then like you'll swipe between people and then you get an ad. so like I've been getting one of those like a lot recently and it's like a girl saying like "you know like I was so lonely and like now I have this app and I could talk to a licensed therapist and stuff" and I just scroll by it. Because I don't like that. I feel like it's predatory. I feel like --I feel like these apps make it seem like that they're going to solve people's problems. I don't know, I just feel like it's insidious. I feel like, I don't know how to explain it, I don't like it.

And even with a negative perception of mental health treatment advertisements, these ads are still influencing decisions being made about mental health treatment. In

describing her experience with seeking mental health treatment, Liz explains that although she didn't have a good feeling about the ad, it became her ultimate solution.

> **Liz:** I don't know, I found out I miscarried. I was in bed all the time. It was bad, I had dreads in my hair from laying there so long. And there was this thing on Instagram, that was for women with depression. So, I looked up symptoms of depression, and I had it. I guess I've always known. But I took the quiz, and it said I had major depression. After I did that, it was probably another month before I went to the ER.
>
> JW: why did you go to the ER?
>
> **Liz:** don't judge me, I thought the thing on Instagram was a scam. And I don't have insurance, so I went to the ER. They said they couldn't give me anything because I didn't already have a prescription. So, they told me about a clinic that helps people who don't have insurance. But they had a wait list for two months before I could get in. So, I went back to Instagram and got the website. It seemed too easy, I felt like I was doing something wrong.

Rebekah explained that although she doesn't agree with mental health advertisements for medication, she obtained her therapist through an advertisement that she saw on social media. Instead of clicking the link on Facebook, she stated she remembered the name from one of the advertisements and looked it up on the internet:

> **Rebekah**: you know uhm there was a point in time where I was looking for a therapist right when Betterhelp or I think it's better help started taking off. It was like online therapy so I was looking for an online therapist through that. It ended up being so expensive that I abandoned ship and then more recently it has turned into such a craze. There's so many people doing that [that] I'm skeptical of it because it doesn't-- it doesn't seem like it's like 100% authentic help. It feels very much like—like-- it's being advertised to me, it's not something I'm seeking out, and it's not personalized.

So, in understanding that these advertisements for mental health treatment, whether medication management or talk therapy, are receiving negative feedback and commentary during the interview process, they ultimately still affect influence the decisions being made for professional mental health treatment. So, why the negative

attitude towards these advertisements? There are two conclusions I gather from these interviews: First, during the interview process, women explained that these advertisements were unsolicited. Meaning that although they utilized the internet for research and information on depression and anxiety with alternative remedies and solutions, they emphasize that they weren't looking for this information on social media. In fact, it was repeatedly reiterated that effort was made to NOT bring personal mental health issues to social media platforms.

> **Rachel**: but I just feel like it's something that I would much rather have a conversation with someone about rather than you know just posting all over my Instagram "I'm depressed and I have anxiety" (uncomfortable laughter) you know and I think that also probably is attributed to like the snapshots right of social media that should really only saying the high point of people life but uhm I mean I'm very open but I just prefer to connect with people about my mental health in person as opposed to online via social media.

There is an image to be maintained on social media and mental health issues were to be kept private from this domain. Every single woman interviewed describes how they do not post or mention their mental health struggles online in fear of negative comments, feedback, or judgment. Secondly, the image of women portrayed in advertisements for mental health is unrealistic. As illustrated in the following example,

> **Pamela:** I'll be scrolling and I'll find like a medication ad and then you start reading the ad, like "if you're feeling like this then this is for you", or like a lot of commercials which tend to all have women feeling that. Like when I used to watch like a lot of TV, I would see a woman in her kitchen zoning out washing dishes and her child is running up to her pulling on her and the dad is kind of oblivious and then after she takes her medication she's like playing soccer and now everything is great -that kind of thing; so it's just kind of you know and I read it, like there would be a girl-- like a worldwide kind of post where anyone could comment on it, and I saw a comment where a man said "you just use this for attention" yeah dude, I totally want attention on mental health, you know, like I totally want to be the ringleader of that, or just say "just get over yourself "or "just

> stop feeling those feelings and just grow up" type of thing or "everyone wants to be baby when they go through things in life." These are comments that are given. I've read that but like sometimes I get angry and I'd like fire back and like school them on it.

Cecelia Ridgeway (2011) examined how gender 'shapes' our social interactions and expectations in a variety of settings in her book 'Framed by Gender', which can easily be applied and understood in the cultural of social media. In this comprehensive analysis, Ridgeway argues that gender is a central organizing principle of our social world; one that influences the way we view and evaluate others. This analysis may not specifically focus on mental health, the concepts and issues it addresses are significant in comprehending the complex ways in which gender and social inequality are intertwined and impact mental health through social interactions and social media platforms. Social media has a significant and complex relationship with gender ideology and mental health concepts. This is understood in how it is consumed and utilized, the messages given and received. This is illustrated in reinforcement of gender norms, for example, a woman being 'too emotional' or 'overly concerned with her appearance or the image portrayed on social media platforms. This creates pressures to conform to expected or assumed ideals, leading to exacerbate anxiety, depression, or other mental distress (Ridgeway, 2011).

II. How does social media affect current course of treatment?

Significant controversy arose in discussing current course of treatment in managing mental health and how social media plays a part. Esposito & Perez (2014) argue that the image of social reality normalizes the medicalization of human life; this is further understood in the image of social media and the expectation prescribed by its

platform. The ideal of success and happiness marketed in advertisements, reiterated through comparison of post images of 'friends' is that a healthy individual is one of 'material, wealth, and prestige" (Esposito & Perez, 2014). I propose in this section a synthetic version of three areas: 1. Social interaction, 2. Emotional management, and 3. Consequences of image as women navigate through 'trial and error' what does and does not work for them in managing their mental health. The term synthetic I draw from Murthy (2012) who analyzed twitter to better understand the individualistic power of that social media platform in analyzing the underlying mechanisms at work she described as 'constructing synthetic versions' which solely were constituted by onscreen projections (Murthy, 2012). When understanding synthetic in what is illustrated here, consider a false façade or possibly a chemical remedy when referring to medication management; this best illustrates the commodification of mental health and its image on social media platforms.

Social Interactions

In the interviews conducted, when women discussed their support or managing their mental health, a realization of lacking real communication was significant. Jessica shared how she doesn't realize how much connecting with people in real life helps until she starts talking and then compares this with engagement on social media:

> **Jessica**: I don't post much but if I do it is motivational, it depends on what you're posting and what you're looking to receive. If you're posting with negative intent, you are going to receive that. I feel like if you're posting with encouragement I feel like that's the audience you're going to attract. I mean maybe I'm old school but I just feel like somebody sending me a like or heart over social media is not going to feel the same as somebody hugging me.

Emotional Management

Several women described their journey with medication management and the process of trial and error" This is where the determination of whether or not medication was suitable or 'working' was comparing how they felt prior to the medication in comparison to the side effects from the psychotropic medication, symptom management. Tabitha explains the process over a 2-year period:

> **Tabitha**:I have a therapist and I am on med management. It's been a journey for sure. A lot of trial and error, dose changes and medication changes to get it right, I am on Prozac, well fluoxetine, I take 40mg at night and 20 mg in the morning. I was taking another medication for night terrors I started having, but it didn't work. That was a scary trip that I thought I wasn't going to make it back from. My skin was burning, I had nightmares, the night terrors didn't go away. I was sleep walking. It was an out of body experience for sure. But the fluoxetine works I guess, it mellows me out. I don't want to party anymore and it helps me complete my day-to-day routine, But I have been on Effexor, Lexapro, Zoloft and now Fluoxetine, it's the one that has been most consistent. I can't remember the name of the medication for night terrors. The Effexor dried me out, the worst cotton mouth I have ever had. I wasn't on it long enough to notice any other problems with it. Lexapro made me dizzy. I was disoriented, and I was on the lowest dose.

Consequences of Image

The majority of women describe either detaching from social media to better their mental health or limiting their engagement to maintain their mental health, as there is an image of positivity and encouragement expected or assumed and a negative connotation associated with needing help with mental health issues. Rebekah describes this image projected as "I am the helper" and not "I need help" when explaining why she does not post about her personal mental health on social media. "I try to keep my social media appearance very clean." Brandi explains this image portrayed as:

> **Brandi**: Even though it is supposed to be my newsfeed, it is my representation to the world literally, so I must maintain that and the access I allow of that to other people.

> Monica describes “I think being a woman you are more- like it’s judged online and joked about that women are crazy, so it’s like almost assumed that all women have anxiety or all women are neurotic, I think it’s very hidden with men and very prevalent with women. That’s why I don’t engage or post about mental health on social media, I’m scared of people’s reactions. I’m sensitive. So, I post pictures of my family or funny memes.”

Sheldon, et al (2019) argues that social media can be a ‘double-edged sword for individuals who struggle with mental health issues, especially women. There is a synthetic sense of community and connection that is experienced differently for individuals; yet it can be a source to find information or resources related to mental health as demonstrated in this study. Gender stereotypes for women vary across cultures and time periods, but some common examples remain intact that impact mental and emotional wellbeing (Sheldon, et al; 2019; Ridgeway, 2011). Women are emotional and irrational; this stereotype suggests women are more likely to be motivated by emotion rather than reasoning or logic. Women are weak and delicate or lesser than’, a stereotype emphasizing women as ‘needy’ and another reiterated in this study, women are obsessed with their appearance, as this is where their confidence truly is; This stereotype suggests that women’s primary efforts and concern are in their appearance or their ‘image’, which has been illustrated above, and in previous chapters. Gender and mental health concepts are both intertwined and social constructs that are influenced by cultural norms and expectations, and these have been amplified on social media platforms and marketed through mental health advertisements.

Conclusion

It is through social interactions and structures that these women understand and explain their mental health issues and wellbeing. It is the same familiar stigma associated

with gender and mental health that keep most women silent or hesitant to share their struggles and experience. Stigma being a negative connotation or discrimination against a certain group of people, in this case women with depression and/or anxiety. Pescosolido (1992) provides significant research in regards to public stigma of mental illness that extends on previously established research by Goffman. I believe there is an expected and projected stigma when it comes to mental illness as described by Pescosolido. Pescolido completes a broader - spanned out- perspective of stigma that is embedded in public eye through three main areas: stereotypes, prejudice, and discrimination. (Pescosolido, 1992). The responses in this chapter correlate with the previous chapters in slowly exposing what I believe is an expected and embedded stigma. These women describe a fear of rejection or negative feedback and the 'need' to display a certain image online to keep social graces per se. According to Goffman, stigma is and will always be the social process, initiation, and affiliation that individuals experience if they are 'different' or 'deviant' from that which is structured as 'normal' but more so from the individual perspective of those labeled as such, and not just those who have breached the labeling or categorizing as mental illness that is articulated by Pescosolido, which I personally believe has a tremendous effort by medicalization and making 'different' medical (Pescosolido, 1992). In the next chapter, we will further discuss the benefits and limitations of findings, with anticipation of future research expansion.

Several studies have implicated a significant dynamic between depression, anxiety, and social media platforms. This is illustrated in this study through personalization and overgeneralization in mental health advertisements and evident in the responses given by the women in their interviews. It is projected and understood on

social media, even in the nature of the platform. This illustrates how these women grasp and personalize in moments of frustration or situational overwhelm the content displayed. And although there is negative commentary of how they view them, there is something to be said in the very fact that they can recall them and have an opinion about them; Negative feedback is still feedback. And does stigma have a role in the negative opposition to these advertisements and their placement on social media platforms? This would be significant questions to further explore in future research. Phones have become more than an accessory, with the click of a button, they are an escape from any given moment with the access to anything, literally of the entire world. With the help of these advertisements and ease of access, your phone is now replacing the inconvenience of an actual doctor. Social media apps are one click away, and so are quick, easily obtained, affordable opportunities to be beautifully stress-free and happy, just click here. On one hand, social media can provide a 'sense' of community and support for individuals who may feel isolated, lonely, or marginalized. Social media is a marketing tool to give the sense of similarity and community when in fact it isolates and causes a constant comparison (Sheldon, et al; 2019), which is not beneficial to an individual struggling mentally, as you will see described in the interviews conducted in the following chapters. With the marketing incentives of social media, the familiarity of seeing 'friends' posts and highlight reels; social media can be used to spread misinformation and propaganda in enabling the manipulation of public opinion (Sheldon, et al; 2019). The design of social media is to incentivize certain behaviors, for example the creation of viral content or the cultivation of a 'following.' This is important to consider in evaluating and analyzing not

only mental health advertisements on social media, but also the impact on perspective for women dealing with depression and anxiety.

To understand the medicalization of women's mental health in discussing the responses given in this chapter, I would like to consider it in terms previously established in prior chapters: communication, convenience, and confidence with how they correlate to concepts discussed in this chapter: social interactions, emotional management, and consequences of image. I believe this dynamic is how to best understand from a social constructionist standpoint how these women's mental health issues are medicalized and marketed on social media platforms.

In chapter four, "How do women understand their personal mental health experience?" The similarities verbalized among the women can be translated to almost any person reading this to some extent whether personally, or within personal relations. The description of experiences given are socially contingent. They develop and change with social interaction and circumstances. The limited terminology given to describe these experiences medically was either A. describing physical manifestations like sweaty palms or racing heart and chest pain, or B. a popular term of 'chemical imbalance' that has become familiarized with medicalization but cannot adequately be defined to any specific biomarkers in the brain and has yet to suffice a universal explanation. Views that symptoms are a result of brain disorders are accepted and legitimized by the language utilized by those with credentials in the medical field, which becomes a topic of discussion for culture and society, not the actual location of disease or disorder in the brain. Whether discussed and explained in social terms or medical terms, it is the individual's perspective that validates the reliability. This significant representation of

how communication solidifies medicalizing women's mental health issues is transported to social media platforms and it is an amplified and modified version of social interactions. Social media provides a 'sense' of community, but yet the communication that takes place on social media platforms is filtered and stifled. As established in the responses these women provided, they cannot authentically communicate what is going on with them to their online community. The only time this is taking place is through seldom direct messaging or with people in real life. The role of communication is in the content consumed in scrolling. And not to say that all content and everything is negative when it comes to social media. The fact that individuals can connect with friends, family, or strangers all over the globe is an amazing thought to consider. And while medicalization is transforming the perspective of mental health issues, it is evident in how these women respond that stigma is still very present on social media platforms. Gender biases and stereotypes are still present and embedded in this virtual social interaction and is highlighted in the communication that takes place, by both what is shared and the hesitation or constraint to not share.

Thee discussion in this chapter on emotional management is significant when considering convenience in the discussion of medicalizing women's mental health. More specifically, the convenience of medication management that is marketed in chapter three and then the experience of trial and error in symptom management mentioned in this chapter reiterate that not everything is as convenient as believed to be. Tabitha shared a process over a two-year period, that at the time of interview was not completed elated with the results. Exchanging one struggle for another is a matter of what is more convenient to the schedule of tasks or responsibilities expected of the women sharing

their experience. Some of these women described management of themselves and when asked to elaborate, it was to make sure there was no significant sign of emotion when in public or social settings.

And lastly, confidence has been established in prior chapters in terms of reliability when it comes to medical professionals, a personal wherewithal of the causes of their mental health struggles and what they know to be depression and anxiety in their personal experience, and the representation given that the very presence of mental health struggles is the misplacement or disparity of confidence at all. With this chapter, in discussing the consequence of image, there are two points I gather in discussing the medicalization of women's mental health issues in this study. First, the confidence these women have in sharing their experience, what their understanding of it all is and how it makes sense to them personally, and what they know works for them and doesn't work for them when it comes to their mental health. Secondly, there is an expected confidence when engaging on social media platforms in fear of negative consequences if anything less is displayed. These women described having to maintain this image of "being the helper' and not being able to display anything that may project the idea "I need help." And where highlight reels of great memories and pictures with friends and family are absolutely amazing and not negated in this study, the fact that not one woman I interviewed expressed any possibility of being able to voice a need for help or a position of vulnerability only reiterates the stigma in real life situations. Social media may be a synthetic world of social interaction as many women reiterated 'it's not real' the consequences of consumption and social interaction of still very real and have implications that follow them offline.

With that in mind, the next chapter will take into consideration the benefits and limitations of this study with recommendations for future research as the dynamic between social media and women's mental health continues to transform and expand.

Chapter Six: Discussion and Conclusion

Introduction

This study utilized both content analysis and in-depth interviews with 14 women diagnosed with depression and/or anxiety, in an attempt to better understand the variation in perspective of mental health in 1) how it is framed on social media platforms by mental health treatment advertisements and 2) how these women perceive their own mental health struggles, how they sought and maintain treatment, and how the culture of social media influences this perspective. By investigating such a broad topic this study is separated into two phases: Phase One is a content analysis of 25 mental health treatment advertisements for depression and/or anxiety on Facebook and Instagram with three questions in mind: 1. How do advertisements on social media frame depression and anxiety? 2. What are the solutions proposed? And 3. How are women represented in these advertisements? Phase Two consisted of 14 in-depth interviews with three questions in mind: 1. How do women understand their mental health problems? 2. How do social media advertisements affect women seeking mental health treatment? And 3. How does social media affect current course of mental health treatment? Findings from both content analysis and interviews suggest that such advertisements on social media do impact women's perspective and can best be described in three terms: communication, convenience, and confidence, through an interplay of medicalization and gender framing.

Women give meaning to their mental health through their experience in past and current life circumstances and the culture of social media has shifted understanding and engagement with this dynamic to a synthetic version of life and interaction, meaning there is an expected image on display, not only with mental health advertisements but in the personal assumption and expectation of the women interviewed in this study. Medicalization in the process of commodifying mental health concepts as advertisements utilize societal norms and gender stereotypes to market their different treatment options to women on social media platforms. One of the first frames that we identify not only ourselves but others and our interactions with others is through gender (Ridgeway, 2011). Prior research has been conducted in an attempt to de-stigmatize mental health through medicalization, however limited findings concluded this not to be the case (Payton & Thoits, 2011). Their findings suggest there is still a barrier of stigma when discussing describing and treating mental illness. Other research has established an interaction between gender and informal social control in everyday life through societal reactions, deviance, and conformity. This is illustrated in both phases of this study. However, the term 'control' is replaced with consumed, as it is a society governed by consumption and every aspect of human life is commodified, including but not limited to mental health (Conrad, 2007; Esposito & Perez, 2014).

As we proceed into discussing perspective and experience from these chapters, keep in mind two things: 1. This is not to negate any understanding of any mental illness. And 2. This data is designated to depression and anxiety and is not encompassing all mental illness or disorders. In reviewing the data of this study, depression and anxiety are significantly correlated, as evident in the advertisements from phase one of this study and

the interviews in phase two. Although both refer to mental capacity, depression is described as a personal failing and anxiety is attributed to productivity, performance, or presentation. Some say depression is an identity of failure, whereas anxiety is a fear of failure. And there is an evident influence of social factors such as significant relationships, the culture of education and career, and experience in interactions and circumstances that reiterate not only the social construction of mental health concepts, but the medicalization of mental health issues and how they are marketed or interpreted on social media platforms.

Communication

It is illustrated and understood through the entirety of this study the importance of communication and its implications. Language is significant in both what and how terminology is utilized. What is communicated and by whom that determines what is or isn't as the transformation of mental health concepts have changed from discriminatory deviance of norms to mental health disorders through the process of medicalization (Rose, 2019). For example, the illustrated evidence in chapter three with the assumption of credibility and reliability in referencing medical doctors and psychiatrists; in chapter four with these women describe their mental health issues in accepting what they were told through phrases such as 'chemical imbalance' (Rose, 2019). Then there is the communication between social structures and social interactions that illuminate how mental health is commodified through market rationale, which has been demonstrated in all three empirical chapters. However, the previous chapter helps illustrate this not only through medicalization in these women and how they sought treatment for their mental health; but with the culture of social media and the influence of social media

advertisements. Although these women gave negative commentary towards mental health advertisements on social media platforms, they still referenced these sites in their own internet search. And lastly, the communication of perspective and understanding of individuals with mental health issues such as depression and anxiety that illustrate the influence of culture and social factors, going back to chapter three and the correlation with academic backgrounds or clinical careers influenced how they described the causes of their mental health issues.

Convenience

Mental health has changed drastically over the past fifty years in how it has been defined, understood, and treated. Access to treatment has tremendously transformed with DTC advertising, and more recently this DTC advertising on the internet and social media platforms. Ease of Access is understood as treatment in the palm of your hand, that is, your phone is slowly replacing the traditional doctor's office and pharmacy, where the convenience "from the comfort of your home" slowly becomes the new norm as illustrated in chapter three. This offers the confidentiality of privacy, and comfort of minimal effort in the descriptions of certain mental health advertisements, but this can also have negative consequences in misdiagnosis over overmedicating an individual. The transition from patient to consumer became more influential over the past few years. Yet, not one woman interviewed mentioned anything about social and environmental factors like Covid-19 in expressing their experience with seeking and obtaining mental health treatment. There is acknowledgement of excessive isolation but is understood as a personal failure not a societal stressor or contributor. And I can't help but question how social media influences their understanding and perspective. Present day on social media

platforms, Covid-19 is discussed in humor and gratitude of the pandemic being over. Although this study is not investigating the implications and effects of Covid-19, I was surprised that it wasn't mentioned. Social media is a platform that markets individualistic consumerism so it is understandable that when these women describe their experience, the responsibility is individualized (Esposito & Perez, 2013).

Confidence

There are two types of confidence understood in discussing the findings of this study. One being the personal experience of women who feel that they are maintaining their mental health in positive ways in describing the extensive journey of 'trial and error' in understanding what does and does not work for their personal mental health. And then there is a false or expected confidence as described in the last chapter, in a false image expected on social media platforms. This is both in the 'sense' of community and connection provided by social media platforms or the unrealistic image of 'happy and healthy' generated by a society and platform designed and governed by consumerism. Social media platforms warrant communication while instigating attention to and comparison between social connections; this instigation produces an image of success to gauge among peers (Healy, 2017). Some studies have illustrated a significant relationship with social media and negative mental health outcomes (Berryman, et al., 2017; Sheldon, et al., 2019) While other studies have found opposing results that evidence a positive dynamic with mental health outcomes (Amedie, 2015). This study reiterates previously established stereotypes and stigma associated with gender and mental health. However, the benefits of this study outweigh the limitations, as even the limitations allow for future research to explore and expand.

Limitations

Considering the broad range of topics discussed and data analyzed, it would benefit to have more individuals included to be able to fully explore every aspect of such a broad dynamic. While it was extremely beneficial that I began my interviews while I was conducting content analysis, establishing a coding system and having a team to explore the data I believe would benefit substantially. I would suggest future research to expand on these findings by reviewing the methods of both the content analysis and in-depth interviews with employment of revision based on acknowledged limitations. For example, it was not until analyzing the interviews, that more specified questions of inquiry came to mind. So, given the findings of this study, future research should engage more questions on culture and gender normativism, ask questions specifically about stereotypes and stigma, or other social factors that contribute to mental health perspective and experience.

For example, this study discusses gender framing, stereotypes, and biases but with limitation. It would be interesting to frame future research with these areas as the primary lens instead of medicalization. It is only hinted to and suggested in the advertisements and interviews, but the data is there. And with more individuals expanding on this topic, I believe more interviews can be conducted with the idea of follow-up interviews with individuals as to reexamine and re-evaluate any changes, difference, or revelations.

Another limitation that can be adjusted in future research is the lack of specificity in demographic questions that include race, status, and social class, to explore further dynamics and influence of discrimination and poverty. Socioeconomic status was a contributing factor in this study, but I did not want to discuss my results based on

assumption as questions of this nature were not implored. And with given specificity to these areas, approaching the data from social causation standpoint would produce insightful evidence. A recent study by Haltigan, et al. (2023) investigated social media platforms such as Tik Tok in determining the mechanisms by which social may influence and cultivate the development of psychopathology and examined the potential role of social contagion (Hatigan, et al., 2023). The newly concept 'psychosomatic social contagion' refers to process by which individuals emotional and psychological states are influenced by others' emotional and psychological states in their social network, and for this study social media networks. Future research could implore different interview questions to gauge content analysis with in- depth interviews, in explore how different attitudes, beliefs, behaviors, or emotions are spread and reinforced through social media platforms.

Suggestions for Future Research

With the social media advertisements, this study found an immense amount of different treatment modalities offered. Future research may want to limit to certain treatment options offered to explore more in-depth the influence and outcomes of specific treatments. The comparison of two social media platforms was beneficial to this study, given the feedback from the interviews conducted I suggest future research explore Tiktok's platform as it is expanding quickly and was mentioned by the majority of women interviewed.

I believe taking the dynamics offered in this study at a more concentrated level would offer more underlying mechanisms of social construction and influence. However, the findings of this research have shown beneficial in understanding the influence of the

culture of not only social media but marketing as well, as stereotypes and stigma connect these two and impact women who experience mental health struggles. I would like to see future research explore the same dynamics with men, as this is something not researched or discussed enough. Future research could benefit in expanding on this study in the concentration of stigma and the commodification of mental through medicalization by challenging the notion of whether stigma only appears to be lessening because it is more talked about on social media platforms in the form of advertisements for treatment? This could also be tailored in the interview questions, as the questions of this study did not expose underlying mechanisms that are suggested in not only the advertisements discussed in chapter three, but the interview responses in chapter five.

I also believe future research could expand on this study with examining the political process and economic structures associated with social media and mental health advertisements, as this study is more concentrated on medicalization through social interaction and the social construction of mental health concepts navigated through personal perspective and experience. Overall, there is extensive amount of possibility in expanding on this research and learning from the perspectives given in this study to further education and awareness of mental health in general.

Figure 1

Source
Date Collected
Full text of ad (prior to ‘learn more’ link)
Image description of ad
Disorders mentioned
Symptoms mentioned
Treatment(s) advertised
Potential gendered content
External links for ‘learn more’ clicks

Figure 1:Initial Data Spreadsheet for Advertisements.

Figure 2

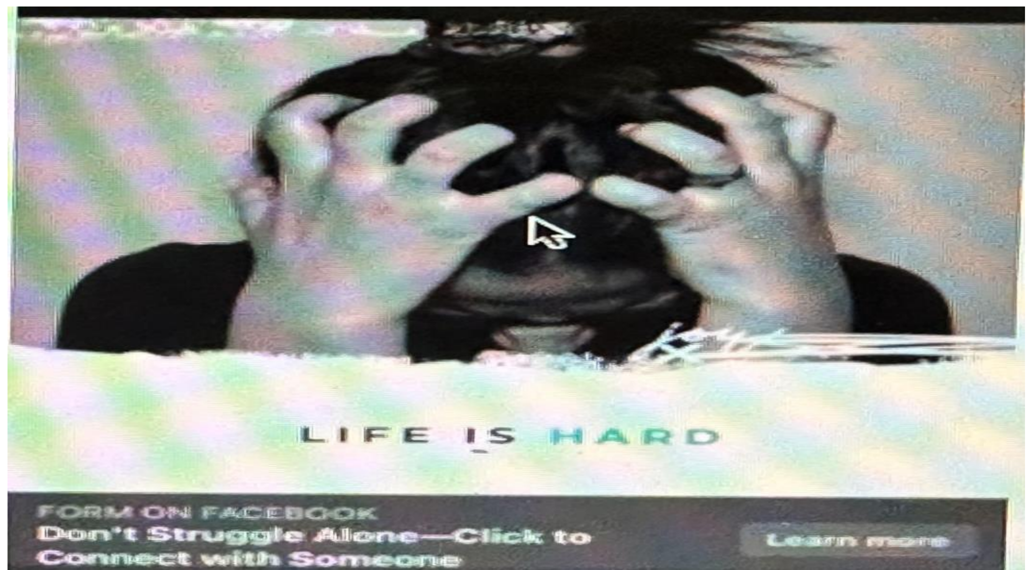

Figure 2: With the image of a woman distressed with her hands over her face.
Illustration of overgeneralization and personalization.

Figure 3

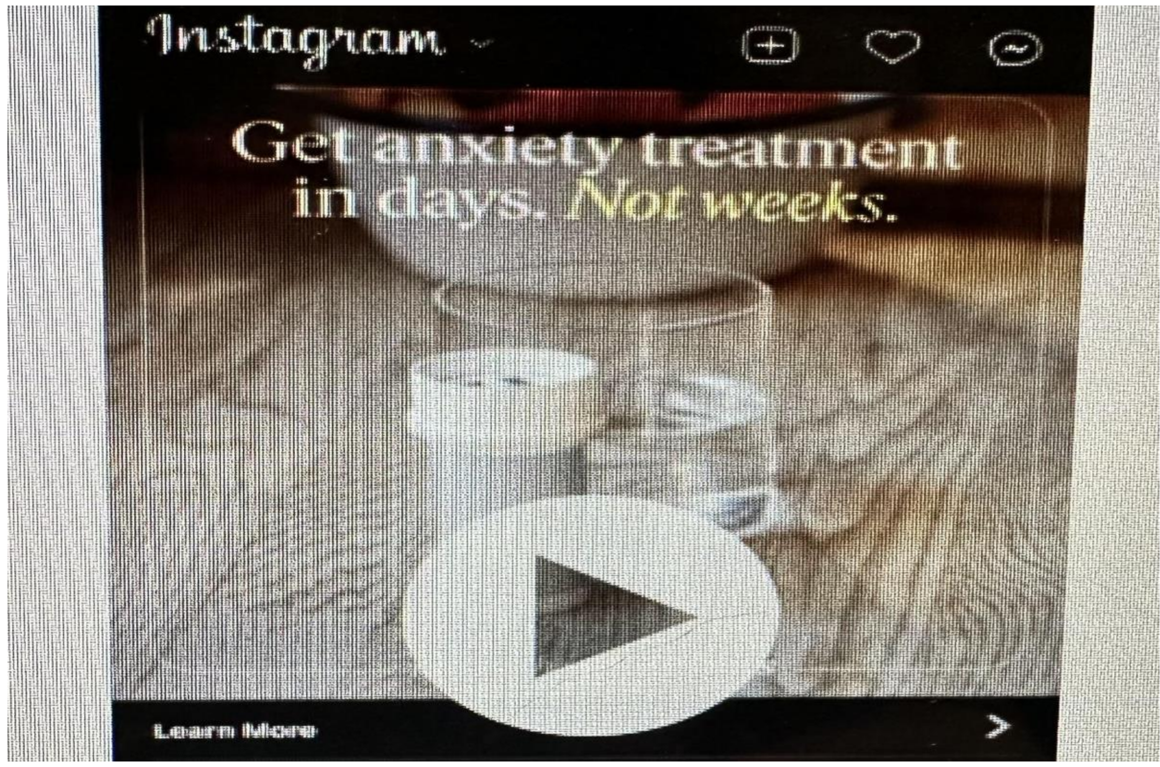

Figure 3: First image from advertisement 3: psychotropic medication advertised on Instagram.

Figure 4

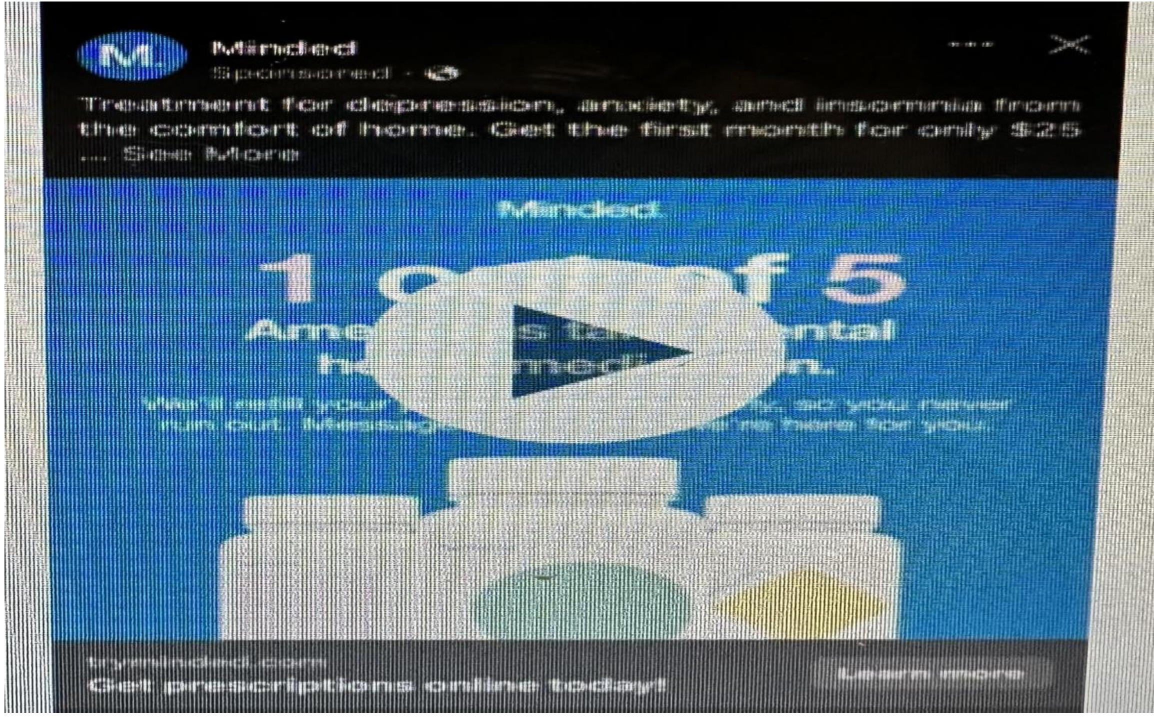

Figure 4: first image for advertisement 4, psychotropic medication advertised on Instagram.

Figure 5

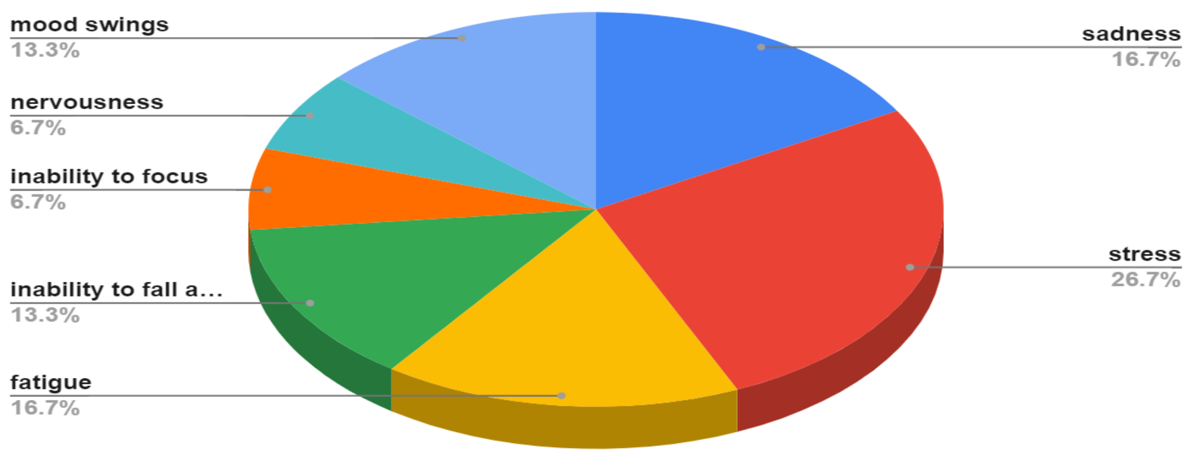

Figure 5: Statistical analysis of overall symptoms mentioned in advertisements collected.

Figure 6

Figure 6: Language is pertinent to express ease of access, emphasizing convenience, affordability, and accessibility.

Figure 7

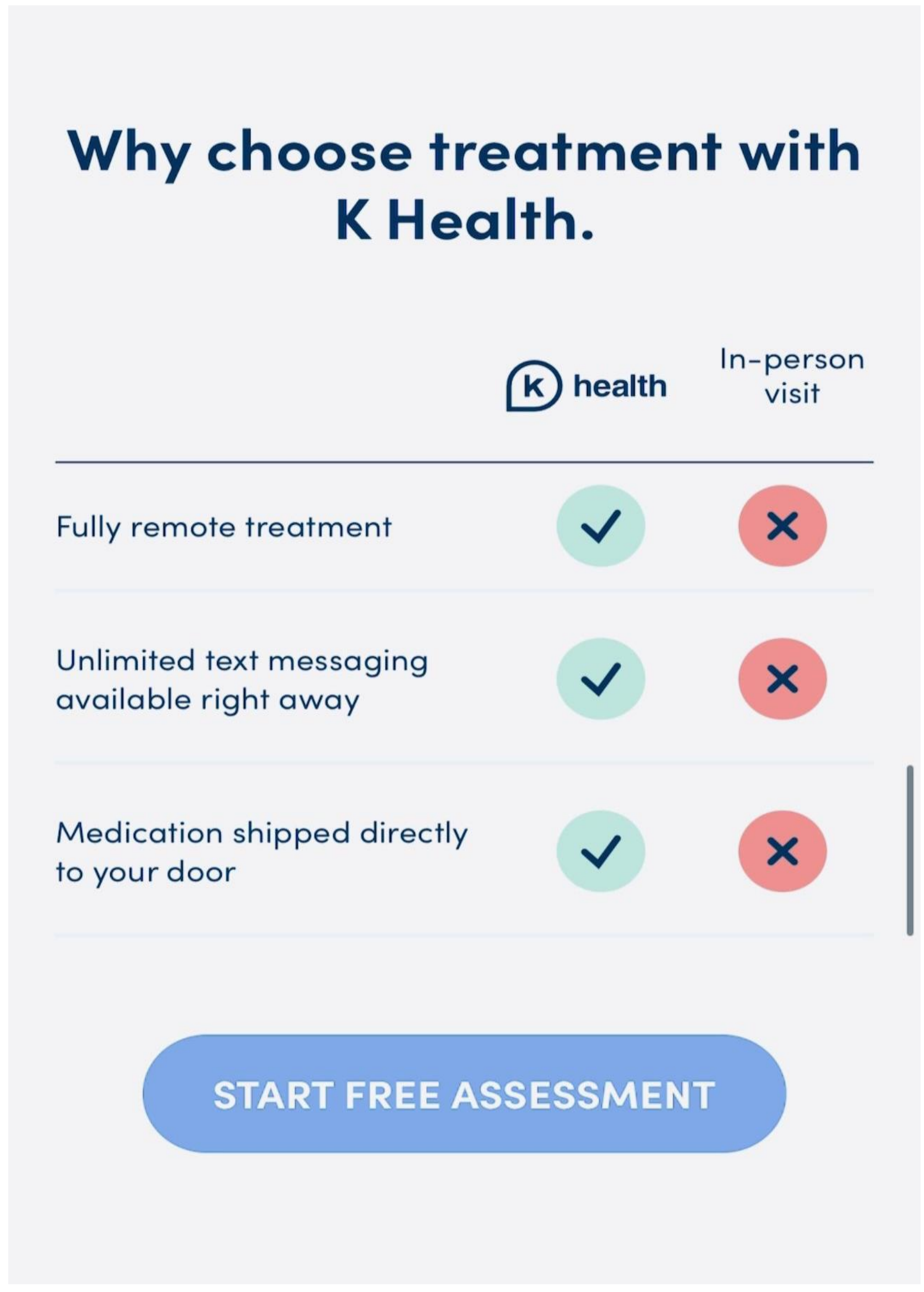

Figure 7: screenshot of tables from advertisements to illustrate the simplicity and rapid results without leaving "the comfort of your own home."

Figure 8

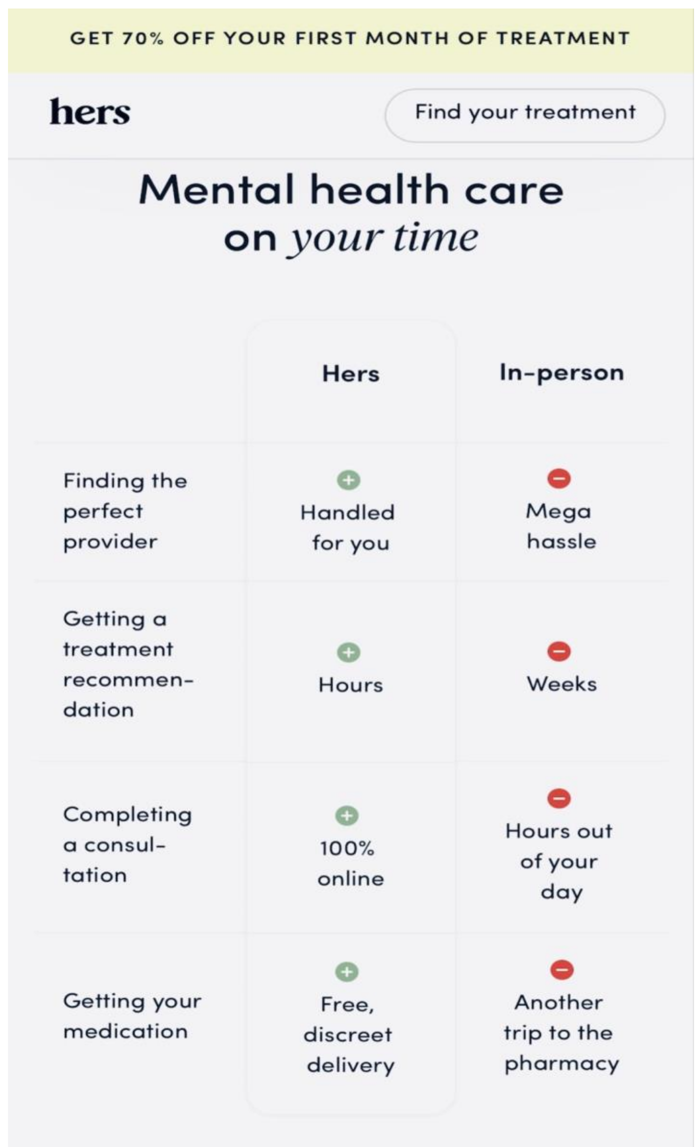

Figure 8: screenshot of tables from advertisements to illustrate the simplicity and rapid results without leaving "the comfort of your own home."

Figure 9

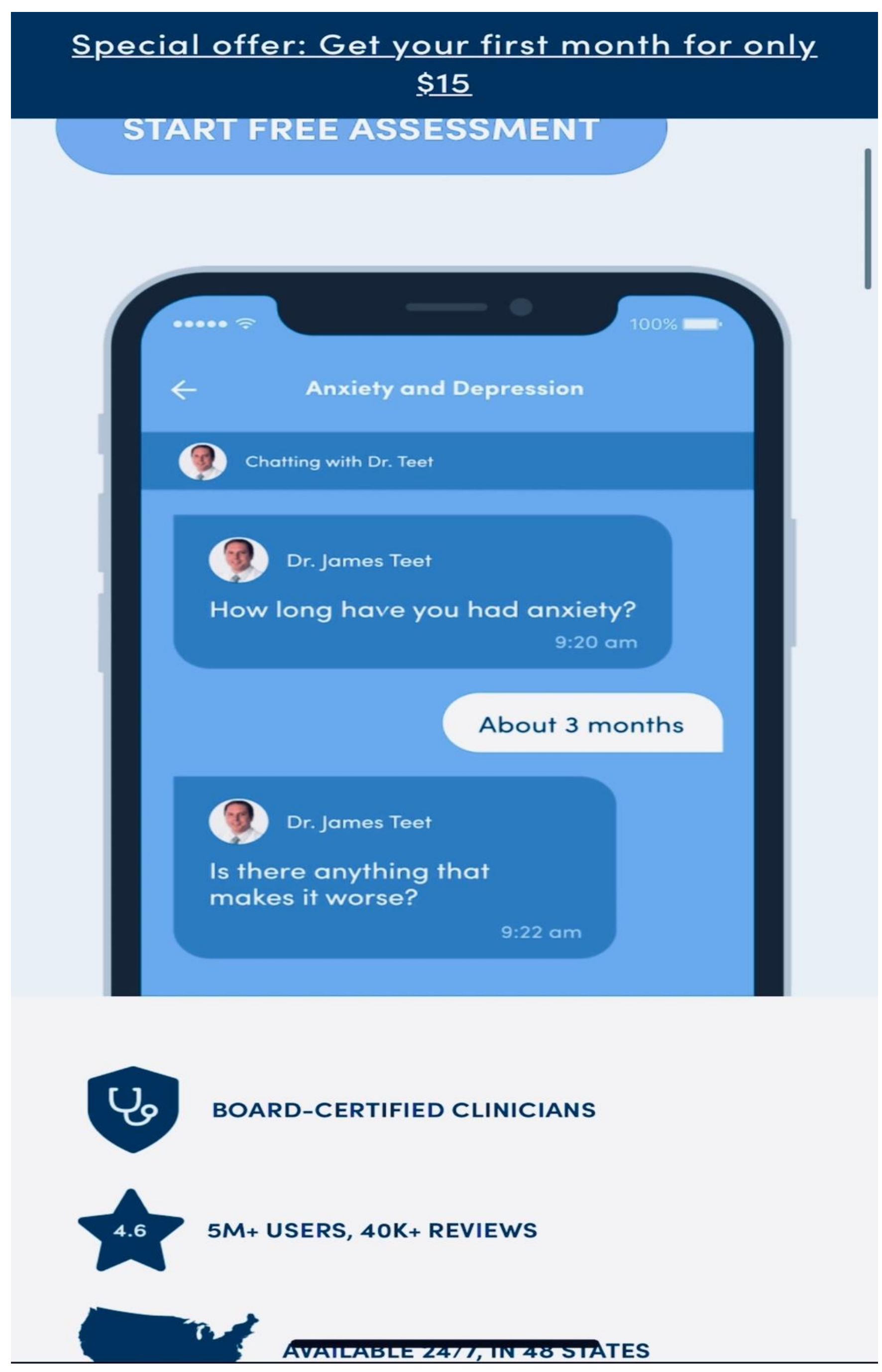

Figure 9: Ease of access screenshot of advertisement to text with doctor.

Figure 10

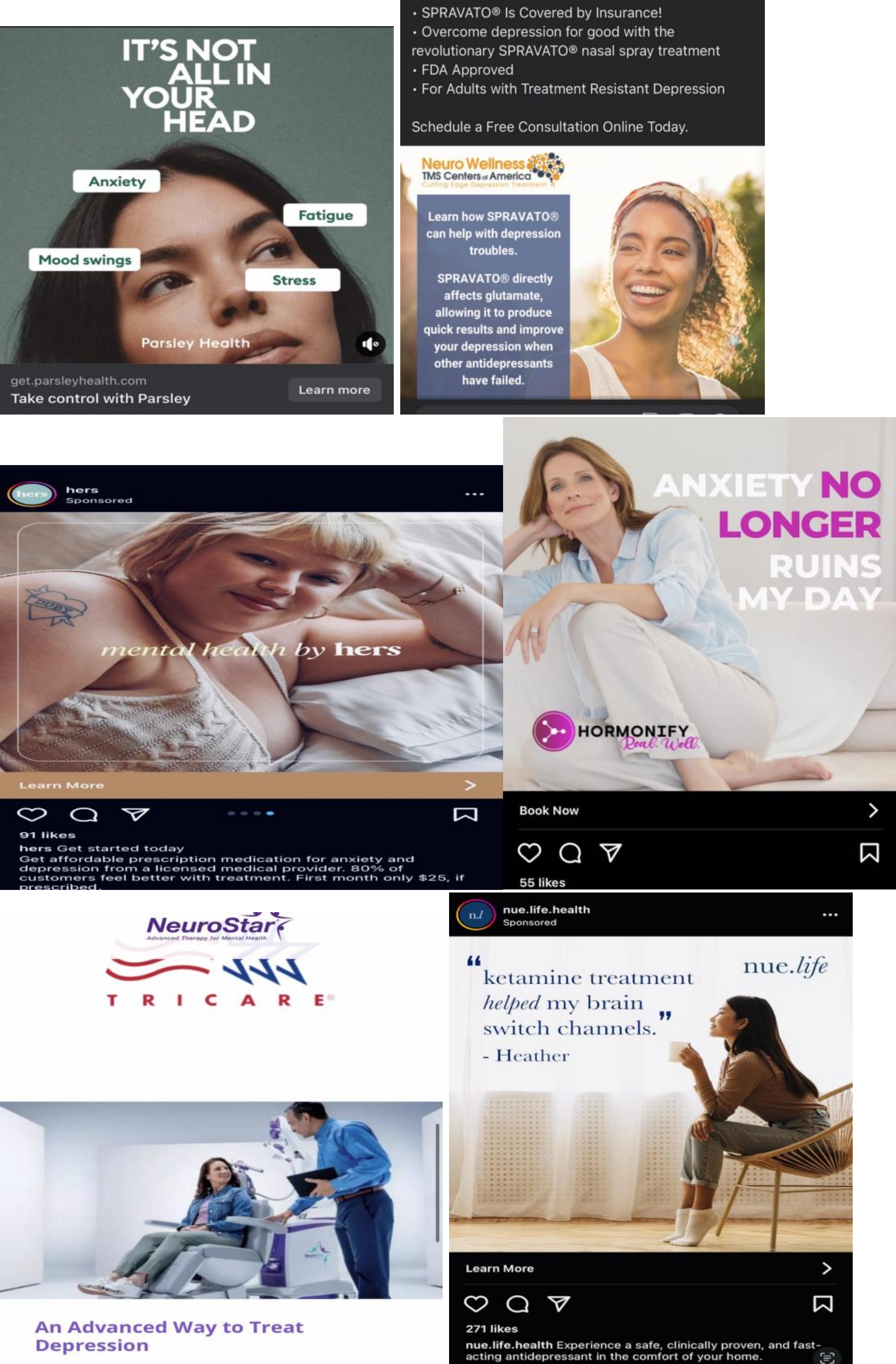

Figure 10: Overall illustrations of women depicted in advertisements for mental health treatment.

Appendix

Appendix A: Demographic Questionnaire

1. What is your age?____

2. Where do you live? (city, state only)___________________________________

3. What is your gender?____

4. Sexual Orientation____

5. What mental health diagnoses have you received from a medical professional, whether currently or in the past? When was each diagnosis first received?

Appendix B: Phase 1 Content Analysis Coding Sheet (with example)

Ad #	**Source**	**Date collected**	**Full text of ad**	**Describe images on ad**	**Disorders mentioned**	**Symptoms mentioned**	**Treatments advertised**	**Additional treatments mentioned**	**Potential gendered content**	**External links or other resources included**	**Community engagement (# likes/comments)**	**Research engagement (liked/comment)**
Sample1												

Sample 1: Source: Instagram; date collected: 05/31/22; (Screen recorded: 3 minutes 36 seconds)
Full context of ad: "Medication for depression, anxiety, and insomnia from the comfort of home. Get the first month for only $25. Monthly video appointments, personalized treatment plan, unlimited messaging with your care team, appointments available within days, affordable without insurance."
Description: video ad included young adult male, setting of living room, phone in hand, casual clothing. Link: tryminded.com Pink and blue lettering, white background. Then a picture of a young woman sleeping comfortably. "Get sleep medication prescribed online" Then picture of smiling psychiatrist, young woman "Elizabeth Corvino Lead Psychiatric Nurse Practitioner 'sleep is so important for your mental and physical health. Let our team of experts personalize a plan for you. We'll help you find the medication that works for you. Vistaril(hydroxyzine), Ambien(zolpidem), Lunesta(eszopiclone),Desyrel(trazodone) see frequently prescribed medications-arrow pointing. Then an image of a small pink and blue heart 'We prescribe responsibly' in bold letters. 'Our expert psychiatry providers will work with you to find the right treatment plan. They can only consider treatment with controlled medication for individuals with proof of prior prescription in their state Prescription Monitoring Program. Small print: Minded does not prescribe controlled medications in every state we operate. Bold print: Insomnia is more than a bad night's sleep. Find how we can help if you're experiencing: Color tabs listing symptoms: Hours spent lying awake-yellow, Inability to fall asleep or wake up on time-pink, Trouble concentrating and increased worrying-yellow, irritability, grogginess, and fatigue- green, feelings of anxiety and depression-pink. Bold print: Why you should switch to Minded: table of comparison with minded and in-person psychiatrist: No trip to doctor or psychiatrist required, affordable without insurance: 65/month versus $300 a visit, video appointment within days, sleep medication prescribed and refilled online, monthly video appointments and medication

adjustments, and unlimited messaging with your care team. Bold print: Only $25 for your first month of personalized care with Minded(regularly $65). GET STARTED-link, In pink: 85% of Minded members feel better after 8 weeks. In blue: Life-changing results from real members. “Minded helped me take back my life and also saved me $200 per appointment with my previous provider.” Image of male smiling, ‘Tegan, 25 Bedford, Tx; “During an extremely stressful time in my life, Minded was there to help get me on a more appropriate medication for my condition. Very grateful for Minded!” Image of woman smiling, ‘Crystal, 34 Schaumburg, IL; “It’s only been two weeks since my appointment with Minded, but my anxiety is already less of an issue. I can’t wait to see where I will be in a few months with further treatment.” Image of young woman smiling, Melina, 22 Santa Ana, CA. Bold capital letters: HOW IT WORKS: 1. Discuss your treatment plan, complete a free online assessment to see if Minded is right for you. Then, video chat with your psychiatry provider to determine medication appropriate. 2. Get your prescriptions filled monthly. We’ll deliver your prescriptions or send them to the pharmacy of your choice and refill them regularly so you never run out. 3. Chat with your care team anytime. Message us if you have questions about your medication or want to make changes to your treatment. We’re here for you every step of the way. Insignia of : WSJ AW Alley Watch, CNN, Tech Crunch, Forbes. Sign up today and get your first month for only $25!(Regularly $65/month). Image of three prescription bottles, no logos only colors, and two of the three bottles have medication names in small print at top: Pink color: Sertraline, bottom of bottle:Minded; Blue bottle: bupropion- top, MInded-bottom, yellow bottle has no name, in back ground.GET STARTED: button(link) Minded. Logo right corner: www.tryminded.com legitscripts.com 10/07/21 Approved; Get the latest from Minded, enter your email: (arrow). Logos for Instagram, Twitter, and Facebook. Comment box: small print: If you’re in emotional distress, contact the National Suicide Prevention Hotline at 1-800-273-8255 to connect with a counselor immediately, or text HOME to 741-741 for the Crisis Text Line, Phone emoji: if you’re having a medical or mental emergency, call 911 or go to your local ER hospital.
Disorders mentioned: depression, anxiety, insomnia.
Symptoms mentioned: inability to fall asleep, inability to wake up on time, inability to concentrate, increased worrying, irritability, grogginess, fatigue, feelings of anxiety or depression, stress.
Treatments advertised: medication management
Additional treatment mentioned: messaging care support team
Potential gendered content: color patterns with pink and blue. Male interview referenced, emphasized regaining control of life, both males first in video then in written testimonial referenced regaining control. Male in written testimonial referenced regaining control and money saved. Woman testimonials referenced getting help with adjusting medication, looking forward to progress in treatment, grateful for help.
External links: tryminded.com legitscripts.com
Community engagement: 2,649 views. Does not show number of likes or comments.
Research engagement: WSJ, AW Alley Watch, CNN, Tech Crunch, Forbes logos included in advertisement insinuating support.

Appendix C: Phase 2 Interview Guide

What I Want to Know: To Keep in Mind

1. How do patients understand their personal mental health problems? To what extent do they think about the causes, symptoms, and consequences of their mental health problems in medical terms or personal/social terms?
2. How did patients initially come to mental health treatment and how did pharmaceutical advertisements and social media influence that process?
3. How is social media use related to patients' current mental health care? What influence does social media have on how patients' think about and manage their mental health issues?

Background Information

1. Where did you grow up?
2. Where have you lived?
3. What jobs have you had?
4. What do you do for a living now?
5. Are there any beliefs or values that you consider important?

Relationships & Support

1. Who is family to you?
2. What relationships are important to you?
3. Do you think your relationships affect your life and choices?

Personal Perception of Mental Health

1. What does mental health, in general, mean to you? When you think of the term 'mental health' what comes to mind?
2. *[For patients with Depression –related diagnosis/history]* How would you define depression? What does depression mean to you personally?
3. *[For patients with Anxiety-related diagnosis/history]* How would you define anxiety? What does Anxiety mean to you personally?
4. What would you say causes people to have mental health problems? Do you have an opinion about what caused your own mental health problem(s)?

Initial Path to Treatment & Diagnosis

1. When did you first think that you might have a mental health problem? What made you think that something might be wrong? What did you do about it at that time?
2. When did you first seek professional mental health treatment?
    1. How long did it take you to seek professional help for the first time?
    2. Was there anything that discouraged you from seeking professional help for the first time? (e.g., feelings, thoughts, people, situations)
    3. Where did you first go for help and what happened?

4. Did you receive a diagnosis at that time? What was the diagnosis? How did they explain what was going on with you?

3. Do you remember talking to friends or family about your mental health when you first started professional care? What was their reaction?
4. When you first started professional care, did you ever use the internet to research or understand what was going on with you?
    1. Did you use search engines or WebMD to look up your problems? What was that like?
    2. Did you ever ask others for help or advice on social media? What was that like?

Current Treatment Experience

1. How do you manage your mental health problems right now?

a. Do you currently see any mental health professionals? Who and how often?

b. Do you take any medications [for depression/anxiety]? Which kinds?

c. Thinking about your day-to-day life, what do you do personally to maintain your mental health?

2. What do you feel works for you when it comes to managing your mental health problems? What have you tried that doesn't work for you?

3. Have you ever changed medications for your mental health problems? What led to the change? Have you ever wanted to change or stop taking your current medications?

4. Do you talk about your mental health or treatment with anyone in-person or online? How do they react? Is talking to other people about your mental health helpful for you?

Social Media Use

1. Are you on social media such as Facebook or Instagram? How much time do you spend on sites like this during a typical day?
2. Do you read or participate on any online forums related to mental health?
3. Do you ever post online about your mental health? Why or Why not? What kinds of things do you post?
4. Have you seen posts or ads on social media for depression/anxiety? Can you describe any of these ads? Have online ads ever influenced decisions you've made about your mental health treatment?

Concluding Questions

1. Are there any questions you have about what we have discussed?
2. Are there any revelations or ideas you have had during this time?

Appendix D: ***Written Informed Consent***

I am asking you to participate in a research study titled "*Is Mental Health Being Marketed on Social Media?"* I will describe this study to you and answer any of your questions. This study is being led by Jennifer Wilson, Sociology Department at Florida Atlantic University. The **Faculty Advisor for this study is** William McConnell, PhD, at Florida Atlantic University.

What the study is about

The goal of research in this study is to investigate how aspects of the broader social and cultural context shape not only the types of mental disorders that individuals develop, but also the treatment that is sought and the avenues in which they are obtained, more specifically social media platforms in this study. And in turn, how social, cultural, and gender aspects shape patients' interpretation of experience of mental health treatment.

What we will ask you to do I will ask you to answer a series of questions about yourself and your personal experience with your mental health.

Risks and discomforts I do not anticipate any risks from participating in this research. A Pseudo name will be used and transcriptions will be shredded upon completion of study. Contact information will be provided at the end of the interview if there are any follow up questions or concerns.

Benefits The most important benefit of this study will be to give voice to individuals who experience depression and anxiety. This will provide further insight to not only research but recommendations for treatment utilization, societal education and awareness, and insight to actual experience will provide solutions for change in social interaction and societal stigma.

Compensation for participation This study is completely voluntary and offers no compensation for participation.

Audio/Video Recording Recordings will be deleted once transcription is complete.

Please sign below if you are willing to have this interview recorded audibly. You may still participate in this study if you are not willing to have the interview recorded.

c I do not want to have this interview recorded.

c I am willing to have this interview recorded:

Signed: ____

Date: ____

Privacy/Confidentiality/Data Security

- Pseudo name will be utilized
- This consent form will be kept by the researcher for five years and stored in a locked cabinet.

Sharing De-identified Data Collected in this Research De-identified data from this study may be shared with the research community at large to advance science and health. We will remove or code any personal information that could identify you before files are shared with other researchers to ensure that, by current scientific standards and known methods, no one will be able to identify you from the information we share. Despite these measures, we cannot guarantee anonymity of your personal data.

Taking part is voluntary. Participation in this study is completely voluntary. You may refuse to participate before the study begins, discontinue at any point during the interview, or skip any questions that make you uncomfortable, with no penalty to you.

Follow up studies May we contact you again to request your participation in a follow up study? Yes/No

If you have questions: The main researcher conducting this study is Jennifer Wilson, a graduate student at Florida Atlantic University. Please ask any questions you have now. If you have questions later, you may contact Jennifer Wilson at jenniferwils2019@fau.edu. If you have any questions or concerns regarding your rights as a subject in this study, you may contact the Institutional Review Board (IRB) for Human Participants at 607-255-5138 or access their website at http://www.irb.cornell.edu. You may also report your concerns or complaints anonymously through Ethicspoint online at www.hotline.cornell.edu or by calling toll free at 1-866-293-3077. Ethicspoint is an independent organization that serves as a liaison between the University and the person bringing the complaint so that anonymity can be ensured. **A copy of this form and your written demographic survey is available to you at the close of this interview.**

Statement of Consent

I have read the above information, and have received answers to any questions I asked. I consent to take part in the study.

Your Signature____
Date____________ Your Name (printed)____

Signature of person obtaining consent_____________________________

Date

This consent form will be kept by the researcher for five years beyond the end of the study.

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