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An independent academic psychologist, based in England, who has written extensively on different areas of psychology with an emphasis on the critical stance towards traditional ideas.

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1. RETURN TO: MENTAL ILLNESS, THE PHARMACEUTICAL INDUSTRY AND THE AGE OF LUDICROUSNESS [1]

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1.1. ABSTRACT

Psychotropic drugs are marketed in the same way as any consumer product. Advertising is used to increase the market for this product.

This article focuses upon a number of areas where pharmaceutical companies are active in increasing their market:

i) The expansion of sufferer numbers;
ii) Marketing the drugs;
iii) Evaluating the efficacy of the drugs;
iv) Influence on psychiatry.

This article presents a critical stance to these types of behaviour including a content analysis of the adverts for psychotropic drugs in the "British Journal of Psychiatry" in 2003.

It is proposed that drug development and production would be better off in the hands of not-for-profit organisations.

[1] Originally: Psychology Miscellany 1, 3-38, September 2007.

1.2. INTRODUCTION

Pharmaceutical companies began as offshoots of chemical companies, but, by the beginning of the 21st century, were highly profitable large companies on their own, making higher profits than most comparable companies in other industries (Moncrieff 2003). For example, the anti-depressant "Zoloft" had sales of $3 billion in 2004 in the USA for Pfizer (Lacasse and Leo 2005), and "Prozac" sales of $2.2 billion per year for Eli Lilly in the 1990s (Brewer 1999).

Moncrieff (2006) noted succinctly that: "Despite the fact that objective measures showed that health is improving, people in the Western world are taking more prescription drugs than ever before" (p301), and many of these drugs for mental disorders. For example, in the UK, anti-depressant prescriptions have increased over 200% in the 1990s (National Institute of Clinical Excellence 2004).

Pharmaceutical companies support biological models of mental illness, and fund research and campaign in this area, including, disturbingly, research into things like "compulsive buying disorder" (Moncrieff 2006) [2]. But the biological basis of mental disorders is not absolutely confirmed, certainly not in the simple sense of single neurochemical imbalance causing a problem (eg: lack of serotonin and depression) [3]. But the advertisements by pharmaceutical companies suggests that this is the case. In other words, there is a gap between the advertising claims and the scientific literature.

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[2] Serious academic papers have discussed this "condition" as "Impulse Control Disorder Not Otherwise Specified" in DSM-IV (APA 2000) (eg: review by Bullock and Koran 2003).

In "consumer capitalism" where individuals are encouraged to buy more, it is interesting that such a behaviour should be pathological. Compulsive buyers are the perfect consumers. The only problem is that they buy more than they can afford and ultimately fail to pay their debts. Apart from this issue, why would any company have a problem with such behaviour?

Companies would be more interested in pathologising the opposite - "compulsive non-buying behaviour". Individuals who are compelled to think carefully before they buy anything.

McElroy et al (1994) proposed criteria for "compulsive buying disorder", which I have adapted for "compulsive non-buying disorder":

- Preoccupation with thinking carefully before buying, such that advertisers find senseless
- Frequent buying of things that individuals can easily afford including cheaper or non-branded versions
- Buying behaviour that causes marked distress for companies.

[3] For example, the group, "Questioning Unreliable Diagnosis of Schizophrenia" (QUDOS) emphasised that "the controversial condition, known as 'schizophrenia' is not analogous to physical illness, like a broken leg or ruptured appendix. ..Consequently, the diagnosis may have to be based largely on doctor's subjective interpretation of symptoms. Sometimes they can make little more than an informed judgement" (quoted in Baker 2000).

Moncrieff (2006) linked this situation with the growth of "neoliberalism" (appendix 1A). Market forces are viewed as the correct way to control everything, even the health service, and the consequent profits for private companies as normal. "Therefore the guilt that would normally arise from excessive consumption or profiteering is suppressed" (Moncrieff 2006 p301).

I prefer to use the term "consumer capitalism". This requires that companies make more profits each year (Brewer 2001a). Pharmaceutical companies are under such pressure from "opportunistic investors seeking new products and profits - not patients seeking new diagnosis and treatments" (Moynihan and Cassels 2005), and so they must sell more drugs each year [4]. One way is to increase their market by expanding the categories of mental disorders (and thus the consumers).

But pharmaceutical companies are also aided by the nature of "consumer capitalism" and modern society. In order to sell more products generally, it is necessary to have the demand, and this can be "created" by advertising which leaves individuals as always unsatisfied.

Individuals feel unsatisfied in a society that tells them that they should be happy all the time, and if not, there must be something wrong. Furthermore, this "something wrong" has a biological cause within the individual, and the consumption of drugs can resolve it.

Feelings of insecurity are key. Insecure individuals, in the sense of unhappy consumers or fearful voters, are easier to control and manipulate, and thus to sell (unnecessary) products to.

The focus of the problem is upon the individual rather than society. There is nothing wrong with society, the problem is you. "If people are permanently preoccupied with their mental health, they are less able to challenge social conditions and to fight for alternative values" (Moncrieff 2006 p302).

However, Moncrieff (2006) did see a positive side to modern society in that "[C]onsumer participation has

[4] Brewer (2001) listed different ways to sell more products used by companies:

- Differentiate products eg: produce different colours of the same product
- Increase buying by encouraging purchase of more than one
- Link products to status
- Link products to changing fashions
- Continuous updating with new versions
- Link product with normality and absence means abnormality
- Change consumption group eg: skin care products for men.

democratised services, increased access to information and challenged the hegemony of professionals" (p302).

This article focuses upon a number of areas where pharmaceutical companies are active in increasing their market:

i) The expansion of sufferer numbers;
ii) Marketing the drugs;
iii) Evaluating the efficacy of the drugs;
iv) Influence on psychiatry.

Then follows a content analysis of adverts for psychotropic drugs in the "British Journal of Psychiatry" in 2003.

1.3. THE EXPANSION OF SUFFERER NUMBERS

One way to increase the sale of a product is to expand the number of potential customers. In the case of psychotropic drugs, this means more people suffering from a particular mental disorder. This can involve diagnosing more people using the current categories of diagnosis and/or expanding the categories of diagnosis.

Woloshin and Schwartz (2006) noted the problem: "Sick people stand to benefit from treatment, but healthy people may only get hurt: they get labelled 'sick', may become anxious about their condition, and, if they are treated, may experience side effects that overwhelm any potential benefits".

Take bipolar disorder as an example. The term first appeared in DSM-III (APA 1980) as a replacement for "classic manic-depression". Subsequently, variations have been added included "bipolar disorder not otherwise specified" and "cyclothymia", each with slightly different symptoms and symptom clusters. While in the twenty years from 1980, the estimated prevalence of bipolar disorder has risen from 0.1% of the population to 5% (Healy 2006a).

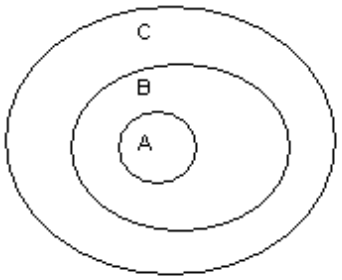
This increase may in part be due to better diagnosis and increased public awareness, but a lot of it has to be because the categories of illness have expanded. The increase in bipolar disorders from one person in one thousand to one in twenty would mean in the USA, for example, (assuming a population of 200 million adults) an increase from 200 000 sufferers to ten million in less than a quarter of the century. It seems unlikely that so

many sufferers would have gone unnoticed (appendix 1B).

I want to propose that the increase in diagnosis of mental disorders can be conceptualised as three circles (figure 1.1). Category A is the hardcore of individuals who undoubtedly are suffering from psychological problems of some kind, which can be called a particular mental disorder label. In fact, their suffering is so obvious that it does not need a professional to notice it.

Category B are individuals who struggle with life in different ways from time to time, and if the category of mental disorders is expanded, they are quickly included as suffering. Category C is the larger group of people who do not have a "real" problem, but category expansion soon includes them as mentally ill.

Category C individuals will be encouraged to see certain behaviours as abnormal and needing treatment (eg: feeling unhappy for no apparent reason from time to time).



A = "hardcore" sufferers
B = "strugglers with life"
C = no "real" problem

Figure 1.1 - Three circles to conceptualise the expansion of categories of mental disorders.

We can use a simple example of defining depression as number of days in the week feeling unhappy. Category A covers individuals who feel unhappy for six or seven days in a week. Then the definition is changed to include those feeling unhappy for four or five days a week (category B), or further to two or three days a week (category C). So the market for psychotropic drugs has been expanded because the definition of mental illness has changed, and the definition of normality shrunk. In the example above, a time could come where unhappiness on

one day a week is defined as depression. It becomes impossible to be unhappy without being abnormal. Behind this increase is subjective (flexible) criteria for mental disorders [5] [6].

Another way to increase the market for a psychotropic drug is to reduce the age of onset of a disorder and treatment. Healy (2006a) observed the "surge" of diagnosis of paediatric bipolar disorder in the USA, including a diagnosis of a two-year-old in Texas.

The book that fuelled this growth, "The Bipolar Child" (Papolos and Papolos 2000), even recommended overactivity in the womb as a possible symptom of paediatric bipolar disorder.

Let's be cynical: diagnose them in the womb and drug them from birth onwards. This may sound silly, but it is often hard to satirise such ideas because of the "age of ludicrousness" that we live in [7]. "Zyprexa" and risperidol (anti-psychotics) are being given to pre-schoolers in the USA (Healy 2006a).

1.3.1. The Role of the Media

The media also plays a role in the expansion of the number of sufferers (appendix 1C). Woloshin and Schwartz (2006) used the example of the growth of the sleep disorder, restless legs syndrome, since an awareness campaign in 2001 by GlaxoSmithKline. By 2005, roprinirole had been approved in the USA for its treatment. Restless legs syndrome is an urge to move the legs when laying down as in bed due to an unpleasant feeling in the legs.

Between November 2003 and November 2005, Woloshin

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[5] This has happened, I feel (Brewer 2003), with the introduction of "minor depressive disorder" in DSM-IV.

[6] The definitions of health and disease are also changing with pre-state of diseases, like pre-diabetes, which could develop into the full disease. So, to be cynical, it is not possible to say that "I am healthy", rather "I am in a temporary state of undisease".

[7] It seems to me that the desire to sell anything and everything, and as much as possible within "consumer capitalism" produces situations that are ludicrous. Selling makes everything else unimportant.

For example, the withdrawal from sale of a toy pole-dancing kit for safety reasons (BBC Radio 4 News 27/10/06), but no concern over the message it gives to young girls playing with it. Thus it is that pornography has become a lucrative business, and opportunity for fame for, mostly, women.

While Monbiot (2006) noted the example in late 2006 in London of "statutes of canine 'heroes' from the second world war being unveiled while the deaths of Iraqi civilians go unrecorded".

Linnett (2000) listed examples of, for him, "unhealthy" behaviour in the UK including campaigns against illegal drugs while those with the most powerful consequences (alcohol and nicotine) are freely available, and the number of injuries and deaths from car accidents while fast cars are presented as glamorous and car crashes as entertainment.

and Schwartz found thirty-three "major newspaper" articles about the condition. Analysis of the articles produced three themes:

i) Exaggeration of the prevalence of the condition - This is done through the uncritical acceptance of broad definitions of the condition (97% of articles).

ii) Encouraging more diagnosis - Nearly half (45%) of the articles referred to under-diagnosis by doctors and under-recognition by patients. No articles suggested the possibility of overdiagnosis.

iii) Suggesting that treatment is always the answer - For example, half the stories (15 articles) referred to roprinirole, including, in many cases (34%), the use of "miracle language" to describe its benefits, and only one-third (29%) of these mentioned side effects.

Only one article was critical of the disease definition, and no articles reported sufferers who were not bothered by the symptoms. About one-fifth of articles quoted the "Restless Legs Foundation" (a "non-profit" organisation funded in part by GlaxoSmithKline).

Woloshin and Schwartz were pessimistic for patients reading and journalists writing the stories as "there is no obvious way to distinguish information from infomercial".

1.4. MARKETING THE DRUGS

Pharmaceutical companies, like any private company, spend large amounts of money on marketing their products. In the USA, pharmaceutical companies can advertise directly to consumers (known as direct-to-consumer advertising; DCTCA) (appendix 1D), and the average American can see nine such adverts per day (Moncrieff 2006).

But there is a difference between a general information campaign and the excessive lifestyle advertising (common to consumer products) that many pharmaceutical companies are involved in.

Applbaum (2006) noted three assumptions of the "free market" that underpin this type of lifestyle advertising:

i) The assumption that individuals have limitless and insatiable needs and wants.

Thus marketing is required to help individuals to know what to purchase to attempt to fulfil these needs and wants.

Marketing also focuses upon what individuals lack. Sahlins (1996) observed a positive correlation between the subjective experience of lack and the objective wealth of a society. In other words, the richer people become, the more aware they are of what they don't have. This is a ridiculous situation, and it must have been manufactured (by advertising).

ii) The "free market" allows individuals to choose how to fulfil their needs, and in the process to construct an identity or lifestyle for themselves.

This manifests itself as "lifestyle advertising" where a product is marketed as part of a particular aspirational lifestyle. So it is with "lifestyle drugs". This is the idea that certain psychotropic drugs are necessary for a particular lifestyle rather than used to help individuals overcome certain problems. The best example is the marketing of the anti-depressant "Prozac" (Brewer 1999).

Allied to this process is the move from "patients" to "consumers" [8]. If individuals are consumers, then why do they need to seek a doctor's advice? Consumers know what is best for themselves. As noted by the New York Times of young New Yorkers in their 20s and 30s: "confident in their abilities and often sceptical of psychiatrist's expertise, they choose to rely on their own research and each other's experience in treating problems like depression" (quoted in Applbaum 2006 p0446).

This process only works if consumers are familiar with the products, which is where DTCA comes in. "But this choice is an illusion. For in our pursuit of a new-utopian promise of perfect health, we have, without realising it, given corporate marketers free reign to take control.." (Applbaum 2006 p0447).

Lexchin (2006) proposed that "Viagra" (sildenafil citrate) is a perfect example of market expansion by Pfizer. "Viagra" was transformed from "a effective product for erectile dysfunction (ED) due to medical problems...into a drug that 'normal' men can use to

[8] This fits with ideas of patient involvement/engagement, empowerment and autonomy in care, satisfaction, shared decision-making, and personalised care (Irvine et al 2021).

enhance their ability to achieve an erection and to maintain it (in a 'harder' state) for a longer period of time" (p0429).

For Lexchin (2006), "Viagra" is part of the emerging availability of medication to treat "what until recently have been regarded as the natural results of ageing", like baldness. So ageing is now being presented as abnormal, or the failure to do what has always been done. But this is not that extreme in a society focused on youth (and physical appearance). Ageing is only acceptable if individuals can continue to do (or look) the same as when younger.

Returning to "Viagra", it is a drug with a limited market if only for men with ED due to diabetes or prostate surgery, so its marketing is required to expand the demand. This has been done in a number of ways (Lexchin 2006):

a) Redefinition of prevalence of ED.

Claims were made by Pfizer that over half of men over forty has erection problems. Studies have shown that this figure may be correct for men over seventy, but for those younger men, it is much less (eg Blanker et al 2001 in Holland; Laumann et al 1999 in the USA).

Gaining high figures for erection problems is not helped by using self-rated questionnaires with terms like "minimally impotent" or "moderately impotent" [9]. Anyway, the Dutch study, mentioned above, found that a number of older men were sexually active without erections anyway.

b) Marketing "Viagra" as the choice of treatment.

Sexual problems may arise from non-physical causes like stress, and techniques of stress reduction would be the preferred treatment. In many cases, erection problems are temporary when stress-related, but Pfizer still recommended "Viagra": "Even if erection problems happen only once in a while, VIAGRA can help" (Pfizer website quoted in Lexchin 2006 p0431).

Potts and Tiefer (2006) observed: "The discovery and promotion of sildenafil citrate (Viagra) for the treatment of erectile difficulties affecting men has augmented the already substantial influence of the

[9] Brewer (2007) described the general problems with studying sexual behaviour using structured questionnaires.

medical model of sex. Whereas critical examination of the escalating biomedicalisation [10] of sexuality since the advent of Viagra is available, less attention has been paid to the ways in which Viagra and other sexuo-pharmaceuticals are interacting with and modifying the cultural landscape of sexual experience" (p267). This change has been given the term "Viagra culture" (Potts and Tiefer 2006).

c) Marketing "Viagra" to all men as a "lifestyle drug".

Direct consumer marketing of "Viagra" occurs in the USA, varying from television advertisements with an ageing former politician to the use of a baseball player as a spokesman. Pfizer spent over $300 million on this type of advertising between 1999 and 2001 (Lexchin 2006).

Not surprisingly, and despite Pfizer's denial, more younger men (18-45 years) are using "Viagra", and most without erection problems (Lexchin 2006). The use of "Viagra" is becoming for some men part of normal sexual behaviour.

The focus on drugs for enhancement of the natural rather than for curing the ill is an expanded market for the pharmaceutical companies [11]. But it does mean that vast amounts of effort is placed on developing such drugs for the rich world, and the drugs to cure the ills of the poor world are despised. There is more money in drugs to improve the life of rich people ("cosmetic pharmacology") than to save the poor from malaria, for example.

As with any market for products, competitors arrived for sildenafil in the form of vardenafil (brand name "Levitra") and tadalafil (brand name "Cialis"). The producers of Viagra, Pfizer, are thus under pressure to increase advertising and marketing for their "market leader" to maintain this position. This involved DTCA in the USA to all men for their "on and off days", and the supporting of campaigns about impotence education in other countries where DTCA is not permitted (Rubin and Wylie 2009).

[10] Biomedicalisation refers to the "increasingly complex, multi-sited, multi-directional processes of medicalisation that today are being both extended and reconstituted through the emergent social forms and practices of a highly and increasingly technoscientific biomedicine" (Clarke et al 2003 quoted in Grace et al 2006).

[11] The use of drugs, aimed at specific mental disorders, by healthy individuals have far-reaching implications including side effects, and the pressure in the future for everybody to take them (Brewer 2007).

iii) The "free market" means competition among drug companies, and this is assumed to be best to produce innovation.

But where competition (and profit) dominates, each of the players must have their own version of the product. So, for example, one pharmaceutical company produces a new type of anti-depressant based on different neurochemistry, then the competitors will soon have their version on the market. This is not innovation as much as making sure that competitors do not steal a march.

1.4.1. "Disease Mongering"

It is a thin line between public awareness campaigns and "disease mongering" (Moynihan and Cassels 2005). "Disease mongering" is aided by non-specific symptoms which vary from everyday experiences to profound suffering. Along this continuum, what is normal is reduced and what is abnormal is expanded.

Payer (1992) defined "disease mongering" as "trying to convince essentially well people that they are sick or slightly sick people that they are very ill". Payer listed ten strategies involved including "Taking a normal function and implying that there's something wrong with it and it should be treated" (p88), and "Taking a common symptom that could mean anything and making it sound as if it is a sign of a serious disease" (p98) [12].

Tiefer (2006) called "the creation and promotion" of "female sexual dysfunction" (FSD) a "textbook case of disease mongering". With FSD, the process is aided by "greatly inflated public expectations about sexual function and the importance of sex to personal and real satisfaction" (Tiefer 2006 p0436).

Tiefer drew the time line for the promotion of FSD from a pharmaceutical industry-sponsored conference in May 1997, and including:

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[12] Payer (1992) listed ten strategies of "disease-mongering":

1. Suggesting normal function as something wrong
2. Imputing suffering that is not there
3. Defining as many people as possible as suffering from the disease
4. Defining the condition as having a biological basis
5. Use of advertising to support these ideas
6. Presenting the issues as supportive of above
7. Selective use of statistics to highlight the benefits of treatment
8. Using "end point" that benefits the publicity of the treatment
9. "Promoting technology as risk-free magic" (Payer 1992 p98 quoted in Tiefer 2006)
10. Common symptoms as signs of serious disease

- Stories by medical journalists from 1998 onwards;

- Academic articles and the establishment of a high prevalence: eg: 43% of US women in a study (Laumann et al 1999) in the "Journal of the American Medical Association";

- Advertising campaign by pharmaceutical companies.

Healy (2006a) , commenting on an awareness campaign about bipolar disorder, noted that "Adverts that encourage 'mood watching' risk transforming variations from an emotional even keel into potential indicators of latent or actual bipolar disorder" (p0441).

Healy (2006a) was particularly interested in how pharmaceutical companies have developed their products as "mood stabilisers". This term rarely appeared in the academic literature before 1995, and then there was a massive increase to the peak in 2003 (Healy 2006a). The increase in the number of articles is partly because of the lack of academic psychiatric consensus about the term, but "this lack of consensus did not get in the way of the message that patients with bipolar disorder needed to be detected and once detected needed mood stabilisers..(Healy 2006a p0442).

The drugs used as mood stabilisers were not necessarily created for that purpose [13]. These are drugs that had other functions (eg: anti-convulsants), and added mood stabilising to their repertoire. Having a new market for a drug is one part of the strategy, the other is to expand the number of sufferers from a particular disorder and the length of treatment time. For example, patient support materials for "Zyprexa" recommended long-term use with bipolar disorder (Healy 2006a):

> The use of 'mood stabilisers' as a long term maintenance treatment for bipolar disorder is based more on wishful thinking than on a solid theoretical or empirical basis. There is good evidence that these drugs threaten the health and lives of adults taking them - who knows what lies in store for the growing number of young children given these complex agents? Only the health of drug companies' profit margins appears assured (Healy 2006b p41).

[13] Many psychotropic drugs originally had different functions: eg: chlorpromazine (early anti-psychotic) was developed as an anaesthetic in surgery in the 1940s, and also to control itching and nausea (Brewer 2002).

Direct-to-consumer advertising of psychotropic drugs in the USA is not always about directly encouraging the viewer to buy the product because many of the drugs are only available through psychiatrists and doctors, it is about the indirect influence of emphasising the biochemical basis of mental disorders: for example, the lack of serotonin and depression.

In terms of evidence, the link between serotonin and depression is not established (Lacasse and Leo 2005): "Contemporary neuroscience research has failed to confirm any serotonergic lesion in any mental disorder, and has in fact provided significant counterevidence to the explanation of a simple neurotransmitter deficiency" (p1212).

Yet the advertising of selective serotonin reuptake inhibitor (SSRI) antidepressants by different pharmaceutical companies tends to mention serotonin, for example:

> Celexa helps to restore the brain's chemical balance by increasing the supply of a chemical messenger in the brain called serotonin. Although the brain chemistry of depression is not fully understood, there does exist a growing body of evidence to support the view that people with depression have an imbalance of the brain's neurotransmitters (Forest Pharmaceuticals website quoted in Lacasse and Leo 2005).

This above statement is vague enough to avoid completely saying that lack of serotonin causes depression, but, to the non-expert, it is inferred. If the serotonin hypothesis for depression is wrong, what do pharmaceutical companies do with their highly profitable SSRIs?

In the "age of ludicrousness", it would be wrong to assume that advertisements have to be true (in the factual sense). Take the example of Nike and their claims of corporate social responsibility. In 2002, the Californian Supreme Court ruled that companies did not have the right to lie after Nike were sued over a misleading public relations campaign. This case moved to the US Supreme Court, where a number of multi-nationals, including Nike, argued "that if a company's claims on human rights, environmental and social issues are legally required to be true, then companies won't continue to make statements on these matters" (CorporateWatch 2007 p31). Here we are in a situation where large companies

are arguing against having to tell the truth. Remember that in "consumer capitalism", selling is what matters beyond anything else.

Returning to the advertising of anti-depressants, in the USA, the Federal Drug Administration monitors advertising of drugs, and sends out warning letters to those companies that break the "Code of Federal Regulations". Lacasse and Leo (2005) noted that one defence for pharmaceutical companies is the need to provide simple information for individuals with low reading age. Simple information is provided for what is a complex issue. But if this is the case, why have DCTA? Because DCTA is a very powerful marketing tool.

1.5. EVALUATING THE EFFICACY OF DRUGS

Many studies of the efficacy of psychotropic drugs are designed, conducted, and supported by pharmaceutical companies. But are these studies "essentially self serving to market their products" (Chiu and Jeste 2006)?

The ideal is non-industry funded studies which show improvement rates on treatment compared to no treatment. However, even such studies do not automatically give "true" efficacy of the drugs studied, particularly in conditions where individuals do not get better, and the treatment is only to slow decline as in dementia. Criteria of worth may be used like cost effectiveness as in the National Institute of Clinical Excellence's decision not to recommend prescription of memantine (cholinesterase inhibitor) for dementia sufferers (Chiu and Jeste 2006). The cost effectiveness calculations were based upon the concept of quality-adjusted life years (QALYs) [14] [15]. This is a prediction of "good quality" years

[14] Quality-adjusted life years (QALYs) are "health state descriptors" - ie: the "levels of functioning in different aspects of health. A patient who has difficulties with mobility but no pain is in a different health state than a patient who has no difficulties with mobility but has frequent pain. A patient with severe depression is in a different health state than a patient who struggles with substance abuse. By specifying the levels of physical, psychological, cognitive, social or other kinds of functioning, any number of health states can be defined. These can also be used to describe the outcomes of different interventions. For this reason, health states are also called health outcomes" (Bognar 2015 p45).

Health states are evaluated by asking individuals to place a value on good health or poorer health. The choices are converted into numbers, and this is taken as the health-related quality of life. A QALY is "a combination of the health-related quality of life associated with health outcomes and the time spent with those health outcomes" (Bognar 2015 p46). It is also possible to calculate a health-adjusted life expectancy (HALE).

[15] This is similar to the concept of disability adjusted life years (DALYs) used by the WHO. It is the life expectancy minus the loss of years through the physical or mental illness.

ahead for those receiving treatment versus those not. It is not the same as number of years of life left.

For example, two individuals aged sixty who have dementia will both live for ten years. The individual given treatment has five QALYs (ie: 5 "good" years), and the other without treatment only two. Drugs for other conditions will increase the lifespan which is also measured by QALY. The concept is not without its critics and problems (table 1.1).

- i) Measurement - eg: the original sample determines the scores allocated. It has been found that "the general population considers many health outcomes worse than health professionals do, who in turn consider them worse than patients who live with those outcomes" (Bognar 2015 p50).

- ii) Health resource allocation - Cost-effectiveness analysis will be used to set healthcare priorities, and returning to full health is always favoured. "Some patient groups, including people living with disabilities and chronic health conditions, may have a limited capacity to benefit compared with those who can be returned to full health. Thus, their treatment will be given lower priority. They will be unfairly discriminated against" (Bognar 2015 p51).

- iii) Social and moral value - eg: age-weighting function means that a disease or injury is considered worse for an individual in their 20s than for an infant or an adult of retirement age.

Table 1.1 - Three ethical issues with QALYs and DALYs.

It is one thing to question the motivation of studies of drug efficacy, but another to have limited evidence at all. Healy (2006a) argued, for example, that there is little evidence for psychotropic drugs, other than lithium, benefiting in bipolar disorder. Furthermore, any benefits must be weighed against the harms of certain drugs, particular antipsychotics with their side effects.

If treatments are working, then individuals should show less of the disorder: "the index condition should disappear, as general paralysis of the insane disappeared after the introduction of penicillin" (Harris et al 2005 p423).

Harris et al (2005) analysed the records of psychiatric hospital admissions (15-65 years) in North Wales in the 1890s (Denbigh Asylum 1/1/1890 - 31/12/1899) and the 1990s (Hergest Unit 1/4/96 - 31/3/97 and 1/3/99 - 28/2/00) using contemporary diagnostic criteria. They

noted an average of four admissions every ten years with manic-depression in the pre-psychotropic drug 1890s, and this had increased to 6.3 admissions by the 1990s for bipolar disorder, despite the arrival of modern medications. This is an increase from sixteen patients per million population resident per day in hospital in the 1890s to 24 in acute service beds in the 1990s. "This is not ordinarily what happens when treatments 'work', but quite often is what happens when treatments have effects" (ie: side effects) (Healy 2006a p0443) [16].

Overall, the results of studies can be presented in such a way that the benefits are "exaggerated": not publishing negative results, the use of multiple outcome measures, multiple publication of positive findings, and exclusion of certain patients from analysis (Moncrieff 2003) [17].

Not publishing undesirable findings is the simplest strategy for pharmaceutical companies. Kirsch et al (2002 quoted in Lacasse and Leo 2005), after gaining access to unpublished clinical trials in the USA, found that 57% of these pharmaceutical company-funded trials had no statistically significant difference between an anti-depressant and a placebo.

Lexchin et al (2003) reported a literature review of medical clinical trials funded by pharmaceutical companies or through other sources. The researchers found thirty studies to include, and drew from them three conclusions:

a) Research funded by drug companies was less likely to be published than other funded research. There have been cases of companies attempting to block publication of unfavourable results: eg: HIV-1 vaccine "Remune" was found to be no better than a placebo, and the producers, Immune Response Corp did not want the results published (McCarthy 2000);

b) Research funded by drug companies was over four times more likely to find results favourable to the sponsors. One reason suggested by the authors was that drug company-funded trials are more likely to appear in symposium minutes which are not necessarily peer-reviewed as academic journals;

[16] Brewer (2002) highlighted the normality, from the viewpoint of psychiatrists and doctors, of unpleasant side effects with antipsychotics, like chlorpromazine.

[17] There are other issues with academic publishing including editor self-publishing (appendix 1E).

c) But there was no difference in the quality of study design and methodology depending on funding.

1.6. INFLUENCE ON PSYCHIATRY

Pharmaceutical companies are not able to expand their markets without the "collusion" of psychiatry. From the funding of research to the expansion of definitions of sickness, Moncrieff (2003) asked very simply: "Is psychiatry for sale"? Such a situation must be a conflict of interests.

A number of the influences of pharmaceutical companies upon psychiatry have been discussed earlier as general influences, but Moncrieff (2003) included the following:

i) "Hospitality".

Varying from small gifts, like mugs and pens, to funding conferences and delegates. For example, Torrey (2002 quoted in Moncrieff 2003) estimated that $10 million was spent by the pharmaceutical industry on promotion and delegates' fees at the 7th World Congress of Biological Psychiatry in 2001.

Through the processes of social influence, individuals are persuaded by others. Advertising in general would not exist if it did not have influence. At its simplest, it may only be that a psychiatrist recalls a particular drug to mind when prescribing for a particular condition because of an advert on the pen they are using. Advertising does not guarantee that this is the best drug, only the drug with the most advertising. Such it is with all products.

ii) Sponsorship of research.

It has been estimated that 70% of research into drug treatments is funded directly by pharmaceutical companies or indirectly through "independent" research organisations (Moncrieff 2003). It would be wrong to say that such trials are directly fixed, but it is possible to design the study in a certain direction. For example, in the inclusion of "responsive" patients (eg: milder versions of the condition), short-term studies only, or the criteria for improvement.

Many academics involved in administering the research have contacts with pharmaceutical companies as

consultants, for example.

iii) Setting the research agenda.

This includes getting medical "opinion leaders" to raise issues or act as "product champions" (Moncrieff 2003). Furthermore, advertising revenue from pharmaceutical companies is an important part of the income of academic journals. Does it allow them to be impartial?

In the USA, patient groups can be funded or even set up by pharmaceutical companies, and be no more than public relations firms rather than independent consumer groups: “Post Traumatic Stress Disorder Alliance” or “Social Anxiety Disorder Coalition” (Moncrieff 2003). This has been called "astro-turfing" - "the formation by drug companies public relations professionals of fake grass roots advocacy groups, often featuring celebrities..." (Fitzpatrick 2005).

iv) Regulators.

Influence on regulators including lobbying law-makers about licenses for products and length of approval times for drugs. For example, the US pharmaceutical industry paid $1.1 million towards George. W. Bush's presidential campaign funds, and an estimated $230 million of all aspects of the 2001 elections, much through the "Citizens for Better Medicine" (Charatan 2001).

Gosden and Beder (2001) described how pharmaceutical companies have "manufactured highly effective advocacy coalitions that incorporate front groups in order to set the policy agenda for mental health" in the USA and Australia.

An example from another industry: if Burger King reported that a "Whopper" was nutritious, few would belief it. But if the "American Council on Science and Health" (and their panel of experts) said this, people would listen (even if the organisation was a front group) (Megalli and Friedman 1991). A well-known public relations advisor said: "Put your words in someone else's mouth" (quoted in Gosden and Beder 2001).

In the USA, the “National Alliance for the Mentally Ill” (NAMI) is accused of being one such organisation. It

is reported as receiving nearly $12 million from eighteen pharmaceutical companies in the 1990s (Silverstein 1999).

Silverstein (1999) gained access to internal documents from NAMI that showed donations from pharmaceutical companies, Eli Lilly, Janssen, Novartis and Pfizer among others between 1996 and mid-1999 (totalling over half of their funding). An executive from Eli Lilly was working at the NAMI (for free) to aid in the "Campaign to End Discrimination".

Other activist groups for "psychiatric survivors" believed that NAMI too often "parrot the line of the drug companies in saying that drugs are the essential thing" (Support Coalition International quoted in Silverstein 1999).

The overall aim of the pharmaceutical companies is agenda-setting, particularly if public opinion takes on board the ideas promoted. Gosden and Beder used the example of setting the agenda with the introduction of new, more expensive drugs for schizophrenia in the 1990s. The key was the introduction of the idea of a pre-psychotic phase of schizophrenia which required drugs as prevention. In other words, before individuals had shown symptoms of schizophrenia (but were classed as high risk of it), they would be given drugs as preventative treatment.

The campaign of pharmaceutical companies involved funding and directing support groups for relatives of schizophrenia sufferers, and influencing psychiatry to promote the "science". This policy also required involuntary treatment (ie: forced, or as NAMI called it, "assisted treatment"). This was achieved by associating schizophrenia with violence (Gosden and Beder 2001).

Legge (2002) was scathing of this idea:

> The "dangerous mental patient" is in fact nothing more than a social stereotype. It fulfils the same role that the "lazy, ignorant negro" did in the southern states of the USA or that the "sly, dishonest jew" did in nazi Germany. It is a piece of politically motivated bigotry (p9).

v) Promotion of biological psychiatry.

There are few psychiatrists who have not accepted that mental illness can be treated as physical illness. If mental illness is physical illness of the brain, then the only answer is drug treatment. "Drugs so dominate

psychiatric practice that it is not easy to develop alternative forms of treatment, even though some research suggests that patients with severe mental disorders may do well without them" (Moncrieff 2003).

vi) Expansion and creation of mental disorders.

This includes the expansion of the categories like "depression", the "creation" of others like social phobia, and the pathologising of childhood with labels like "attention-deficit-hyperactivity-disorder" (ADHD).

This can be seen in the number of versions of bipolar disorder in DSM-IV-TR (APA 2000). Here are some of the distinctions for bipolar I disorder. Bipolar I disorder is recurrent mania with episodes of depression, and bipolar II disorder refers to recurrent major depression with episodes of mania:

- Bipolar I disorder, single mania episode (code 296.0x)
- Bipolar I disorder, most recent episode hypomanic (296.40)
- Bipolar I disorder, most recent episode manic (296.4)
- Bipolar I disorder, most recent episode mixed (296.6)
- Bipolar I disorder, most recent episode depressed (296.5x)
- Bipolar I disorder, most recent episode unspecified (296.7)

There is also cyclothymic disorder (301.13) and bipolar disorder not otherwise specified (296.80). For bipolar II disorder there are numerous categories of distinction as well. Is this increase in categories because psychiatrists are better at diagnosing mental disorders, or is it a question of making it harder to not suffer from a disorder? With drugs looking for markets, I suggest the latter. Thus it becomes statistically abnormal to not have a mental disorder diagnosis.

The categories were further “refined” in DSM-5 (APA 2013). I counted seventeen codes related to “versions” of bipolar disorder I, including the severity (mild, moderate, and severe), and current or most recent episode (mania or depression).

vii) Neglect of adverse effects of drugs.

Szalavitz (2005) raised the question of why, when there are campaigns to discourage amphetamine use because of the harmful effects, amphetamine-based drugs (eg: "Ritalin") are being increasingly prescribed for ADHD, including twenty million prescriptions per month for amphetamines and related drugs in 2001 in the USA. She concluded: "if doctors were prescribing cocaine, heroin or ecstasy to children, you'd want to be sure they knew what they were doing" (p39).

Brewer (2002) noted that the "acceptability and normality of side effects can be seen in the drug company's official data sheets for pharmacists. The official data sheet for 'Largactil' preparations [anti-psychotic] lists twenty-one possible side effects, varying from nasal stuffiness to neuroleptic malignant syndrome" (p17).

The most serious side effects of antipsychotics are known as extrapyramidal side effects (EPSE) (table 1.2), which include parkinsonism, dystonia, akathisia, and tardive dyskinesia. These side effects may not be reversible even after cessation of the drugs.

Parkinsonism • This includes reduced facial expression, general muscular rigidity, monotonous speech, tremors, and uncontrollable shaking of the limbs, and excessive salivation
Dystonia • Including unco-ordinated movements, forced opening of the mouth, tongue protrusions, and swallowing difficulties
Akasthisia • Including inability to sit still, shifting weight from foot to foot when standing, and inability to keep legs still
Tardive dyskinesia • Has up to twenty-five different symptoms including movements and grimaces of the mouth, and tics and mannerisms

Table 1.2 - Details of extrapyramidal side effects.

Lieberman et al (1994; reported in Cunningham Owens

1996) recorded the side effects reported by at least ten per cent of patients taking clozapine (atypical antipsychotic drug). These included anergia (lethargy), drowsiness, hypersalivation (excess saliva and dribbling), dizziness and nausea, and weight gain and loss.

1.7. REFLECTIONS SO FAR

It is wrong to say that psychotropic drugs do not help anyone. For the hardcore group of sufferers, drugs may be the only treatment. But expanding the market to give nearly everybody such drugs devalues their benefits when really needed.

The behaviour of expanding their market by pharmaceutical companies is the normal behaviour of "consumer capitalism". However, with something as important as health, it is better to place it in the hands of public organisations rather than profit-driven private companies. Drug research and manufacture by public organisations (not-for-profit) would mean that drugs that were actually needed would be produced, and all of humanity could benefit from medical inventions that clearly are better to have than not have.

There are other alternatives to the current system including the idea of "ethical pharmaceuticals". These are drugs modelled on expensive medicines which are cheaper to manufacture (Boseley 2006). It is early days with this idea, and I am sure that there will be legal challenges from pharmaceutical companies under the pretext of "intellectual property". There is too much money at stake for them. Meanwhile people around the world suffer.

From a different point of view, Fitzpatrick's (2005) advice was to challenge the processes of medicalisation including redrawing the boundaries between health and disease.

1.8. ADVERTISING OF PSYCHOTROPIC DRUGS: A CONTENT ANALYSIS

Introduction

Advertisements by pharmaceutical companies in major psychiatric journals are a prominent feature. For example, in issues in 2002, the "American Journal of

Psychiatry" had over thirty pages of adverts in 200 pages, and the "British Journal of Psychiatry", up to sixteen of 100 pages (Moncrieff 2003).

As early as 1894, questions were being asked in the "Journal of the American Medical Association" about the presence of adverts for "medical" products (Villaneuva et al 2003). Now it is accepted that advertising of this kind is normal practice, but the questions are about the accuracy of the claims made in these adverts.

Advertisers in medical journals are backing up their claims by reference to specific studies. But do the studies quoted support the promotional claims? Villaneuve et al (2003) investigated this question in relation to adverts for antihypertensive and lipid-lowering drugs in six Spanish medical journals in 1997. They found that the referenced study did not support the promotional claim of the drug in 44.1% of the adverts.

The authors were pragmatic in their conclusion: "..some of the claims could be correct, although they are not supported by the accompanying bibliographical reference, whereas others could be incorrect, yet supported by papers of poor methodological quality or reference to parts of the papers that did not allow us to draw a conclusion as to their truthfulness".

Methodology

Content analysis is a form of indirect observation that focuses upon analysing media messages and communications. It can be used to collect quantitative and qualitative data. The analysis involves looking for patterns or underlying meanings in the media messages.

Taking the "British Journal of Psychiatry" for 2003, in twelve issues, there were fifteen different psychotropic drugs advertised on full (or double) pages, and one advert for a pharmaceutical company (which is not included in the analysis). Six of the products had two different adverts in the year, and one had three versions. The adverts usually appeared more than once giving 105 separate adverts in total. Table 1.3 provides details of the products and number of occasions appeared. Two drugs were advertised in all twelve issues, but not with the same advert.

Table 1.4 shows the distribution of adverts in the "British Journal of Psychiatry" across the year. The most adverts appeared in March, and the least in August and

December.

The focus of this research was upon the pictures and large text rather than the text containing technical details including references of studies, which covered up to half the page.

Findings

The content analysis of the adverts from the "British Journal of Psychiatry" 2003 produced a number of themes:

1. Change
    a) From hell to heaven
    b) Back to normal (and better)
2. Building on social representations
3. “Scientific claims” vs “Advertisers’ claims”
4. Same drug, different conditions and campaigns
5. Side effects
6. Choice of images
7. Speed of treatment
8. Special products
9. Wrong message?
10. Controlling nature

1. Change

The whole point of taking the drugs are to change the individual, but the adverts portrayed the dramatic nature of that change in two ways:

a) From hell to heaven

The adverts presented the extremes of the negative of the mental disorder, and the positive after taking the drugs. For example, the advert for "Risperdal" (Ad 4). There is a drawing of a collapsing or disintegrating castle with a man on top on one side of the double page, and the other, an intact castle with a man standing at the open door appearing to invite in a woman followed by a man. The emphasis is upon the extremes.

b) Back to normal (and better)

Just as important is the change from abnormal behaviour to normal in the "Seroquel" adverts. In one (Ad 9a), a black woman is smiling slightly sitting on a bus

PRODUCT	COMPANY	MENTAL DISORDER IN ADVERTISEMENT	APPEARANCE IN "BRITISH JOURNAL OF PSYCHIATRY"
1a. Cipralex (Escitalopram)	Lundbeck	Depression	7/Jan-July
1b. Cipralex			5/Aug-Dec
2a. Efexor XL (Venlafaxine)	Wyeth	Generalised Anxiety Disorder	10/Jan-Oct
2b. Efexor XL			2/Nov-Dec
3. Concerta XL (Methylphenidate)	Janssen-Cilas	Attention-Deficit-Hyperactivity Disorder	6/Jan-June
4. Risperdal (Risperidone)	Janssen-Cilas	Schizophrenia	11/not Aug
5a. Seroxat (Paroxetine)	GlaxoSmithKline	Anxiety	4/Jan-April
5b. Seroxat			1/June
6a. Reminyl (Galantamine Hydrobromide)	Janssen-Cilas	Alzheimers	4/Feb-May
6b. Reminyl			1/June
7a. Depakote (Valproate)	Sanofi-Synthelabo	Bipolar disorder	5/Feb-June
7b. Depakote			1/Nov
8. Solian (Amisulpride)	Sanofi-Synthelabo	Schizophrenia	5/Feb-June
9a. Seroquel (Quetiapina)	AstraZeneca	Schizophrenia	5/Feb-June
9b. Seroquel			5/Feb-May, July
9c. Seroquel			2/Oct-Nov
10a. Exelon (Rivastigamine)	Novartis	Alzheimers	3/Feb, April-May
10b. Exelon			2/June, Oct

11. Zispin (Mirtazapine)	Organon	Depression	5/Jan, March, Aug, Oct-Nov
12. Aricept (Donepezil Hydrochloride)	Pfizer	Alzheimers	9/Feb-July, Sept-Nov
13a. Ebixa (Memantine)	Lundbeck	Alzheimers	2/March, May
13b. Ebixa			1/July
14. Viagra (Sildenafil Citrate)	Pfizer	Erectile dysfunction	3/March-April, Sept
15. Zyprexa (Olanzapine)	Lilly	Schizophrenia	6/May-July, Sept-Nov

Table 1.3 - Advertisements for psychotropic drugs in "British Journal of Psychiatry" in 2003 (total = 105).

MONTH	NUMBER OF ADVERTISEMENTS
January	6
February	12
March	14
April	13
May	13
June	13
July	6
August	3
September	6
October	8
November	8
December	3
	TOTAL = 105

Table 1.4 - Distribution of advertisements over the year.

looking out of the window. She is thinking "someone just sat next to me". The byline for the advert is "Lets you see the person, not the schizophrenia".

In the next "Seroquel" advert (Ad 9b), a couple in a cafe are being served with coffees, and she is thinking (it is assumed): "I didn't spill a drop". The male waiter is smiling at her. The heterosexual couple are faced away but they look attractive and fashionably dressed. The same headline as Ad 9a is used. The emphasis is on the

benefits of social acceptance when a person is normal.

The third "Seroquel" advert (Ad 9c) features a young male chef in a kitchen watched by two smiling male colleagues. The byline is "Back to life, back to reality". Smiling in all cases is the social reward for being normal.

Other adverts suggest that the individual will change to become better than normal. With "Cipralex" (Ad 1a), a youngish, physically attractive [18], woman is smiling in the rain in the middle of a marathon. She is saying: "New Cipralex, I CAN", and the byline reads: "So start prescribing New Cipralex for all your patients who would have received Cipramil and help them rediscover what they can do". You may not have been able to run a marathon before the drug, but you can now.

2. Building on Social Representations

Advertising generally links to social representations (SR)(Moscovici 1984)). These are shared meanings within a group or society. SR are generated as part of communication, and act as a short-hand in making sense of the social world. An obvious example in food advertising is the picture of the countryside to suggest the product is natural and healthy (despite the reality that it was made in a factory).

The adverts in the "British Journal of Psychiatry" did similar things. It saves time in getting the message over because the viewer will already know certain things which can be used. The advert for "Viagra" has a close up of an older heterosexual couple kissing, and the byline "Speaks for itself". Interestingly the Pfizer logo is as large as the product name. There is no need for an explanation because this product has become a "cultural icon" (partly through previous adverts).

3. "Scientific claims" vs "Advertisers' claims

Most of the adverts made claims about the product, but some of the claims were backed up with references to studies (7 products). Others (8 products) made the "inflated claims" of advertising generally: eg: "Before

[18] Being physically attractive when normal is important because mentally ill can't be physically attractive. There are definitely no images of physically attractive women with mental ill, or physically unattractive women without it. So do these drugs make someone beautiful as well as deal with any psychological problems?

Aricept, it [Alzheimer's disease] didn't have a realistic treatment" (Ad 12); "helping move lives forward" ("Zyprexa"; Ad 15); or "works in a way other anti-depressants can't" ("Zispin"; Ad 11).

Table 1.5 lists the main claims and whether references to studies were made.

PRODUCT	CLAIMS IN ADVERT	REFERENCE TO STUDIES
1a. Cipralex	Superior efficacy; early symptom relief; greater response rate	2
1b	Works as early as week 1	1 (same as above)
2a. Efexor	Relief from anxiety that won't go away; the first anti-depressant licensed for general anxiety disorder	0
2b	Helping patients with depression and general anxiety get their lives back	0
3. Concerta	One morning dose provides 12 hour improvement in attention and behaviour throughout day; minimises peak-trough plasma fluctuations associated with methylphenidate tds; well tolerated	1
4. Risperdal	Hard hitting efficacy; low risk of relapse; long-term management of schizophrenia	0
5a. Seroxat	Tough on anxiety symptoms	0
5b	Depression doesn't live here anymore	0
6a. Reminyl	Postpones behavioural symptoms	0
6b	Slows reduction in cognitive functioning for up to 4 years	1
7a. Depakote	Proven across spectrum of today's bipolar patients; proven effective in classic mania; proven effective even when lithium fails; proven effective in bipolar rapid cycling; proven effective in mixed mania	5

7b	Get acute mania under control fast	1 (as above)
8. Solian	Relieves symptoms that can make everyday living difficult for patients with schizophrenia; well-tolerated; low incidence of EPS and other side effects	6
9a/9b/9c. Seroquel	None	0
10a/10b/10c. Exelon	Robust efficacy across all 3 key domains in Alzheimer's; inhibition of both AChE and BuChE	4
11. Zispin	Works in a way other antidepressants can't	0
12. Aricept	Before Aricept, it didn't have a realistic treatment	0
13a/13b. Ebixa	Benefits in global response, activities of daily living and cognition	2
14. Viagra	None	0
15. Zyprexa	Helping move lives forward	0

Table 1.5 - Claims made in advertisements and number of scientific studies quoted to support them.

I focused upon the studies quoted by one product, "Depakote" for bipolar disorder:

- Claim: "Proven effective in classic mania"

The study quoted to support this claim is Bowden et al (1994). This is a comparison of divalproex (Depakote), lithium, and a placebo. There were improvements of greater than 50% in 25% of the placebo group, 48% of the divalproex group, and 49% of the lithium group. The divalproex group improved significantly more than the placebo group.

The study has two problems:

a) Not comparable groups - there were more extreme sufferers in the divalproex group. This could mean that more individuals improved that the study found;

b) Treatment was terminated in 30% of the divalproex group, 33% of the lithium group and 51% in the placebo group due to lack of efficacy.

- Claim: "Proven effective even when lithium fails" and "Get acute mania under control fast"

In the quoted Pope et al (1991) study, there was a 54% decrease in mania ratings with valproate [19] ("Depakote") compared to 5% with the placebo. There were benefits for the treatment within one to four days. But this study only used 36 patients in total over 21 days.

- Claim: "Proven effective in mixed mania"

Swann et al (1997) is quoted to support this claim. They compared divalproex to lithium to placebo among 179 hospitalised patients with acute manic episodes. The conclusion was that "Although their overall efficacy in acute mania is similar, lithium and divalproex may be most effective in clinically and biologically distinct groups of patients" (p37).

These three studies quoted in the advert are a few years old, and are not as definite as the claims of the adverts. For example, Bowden et al found a significance level of 0.04 which is only below the normally accepted level of p = 0.05 in psychology, but it is not significant using the more stringent p = 0.001.

Concerning the age of the studies, if the drugs are so good, there must be more recent and larger (better) studies to quote. It is probably assumed that few people will actually check the references. The inclusion of references covers any legal challenge to the advertisers' claims.

4. Same Drug, Different Conditions and Campaigns

For example, "Efexor" is advertised as the "first anti-depressant licensed for Generalised Anxiety Disorder", and later as good for anxiety and depression. Does this mean that these two conditions have the same neurochemical origins, or is this drug so good that it works in two ways? Probably both are being claimed

[19] Divalproex sodium is comprised of sodium valproate and valporic acid. Depakote is a brand name for the drug. Valproate was originally designed as an anti-convulsant in the 1960s (Harris et al 2003).

indirectly.

Many drugs were originally produced for different reasons. Mood stabilisers are a good example. At one time bipolar disorder was treated with lithium during the mania, and antidepressants in the other part of the cycle.

Valproate and valpromide were syntesised in France to combat epilepsy, but were observed to have calming effects. Thus their use as mood stabilisers (Harris et al 2003).

5. Side Effects

The experience of unpleasant side effects is part of taking psychotropic drugs, but there is little reference in the adverts. Two adverts claim to be "well tolerated" (Ad 3 - "Concerta" and Ad 8 - "Solian") with studies referenced to support this.

Bazire (2005) compared the different anti-depressants on seven relative side effects using four ratings (marked effect, moderate effect, mild effect, and little or minimal effect). Many of the older anti-depressants (eg: tricyclics) had marked effects, but the newer drugs (eg: SSRIs) were not without their problems (table 1.6).

TYPE OF ANTI-DEPRESSANT	MARKED EFFECT	MODERATE EFFECT	MILD EFFECT	LITTLE OR MINIMAL EFFECT
Tricylics (out of 70)*	16	35	16	3
Selective Serotonin Reuptake Inhibitor (SSRI) (42)	3	8	3	28
Monoamine Oxidase Inhibitor (MAOI) (21)	1	7	8	5
Others (70)	3	13	21	29 (4 unknown)
TOTALS (203)	23 (11.33%)	63 (31.03%)	48 (23.65%)	65 (32.02%) (unknown 1.97%)

(* Score calculated by 10 anti-depressants x 7 categories)

Table 1.6 - Number of ratings of side effects of anti-depressants (Bazire 2005).

6. Choice of Images

Women appear in adverts for antidepressants (Ad 1a and Ad 1b), while black women are featured in Ad 8 and Ad 9a (anti-psychotics). Did the advertisers mean to suggest that only women get anxiety and depression? What about showing images of black women in relation to schizophrenia?

There are differences in the prevalence of different mental disorders between genders, and ethnic groups (eg: Shaw et al 1999; study in Central Manchester) (table 1.7).

	AFRO-CARIBBEAN			WHITE		
	MALE	FEMALE	TOTAL	MALE	FEMALE	TOTAL
Depression						
	4	19	13	7	11	9
Anxiety						
	0	5	3	7	10	9

(After Shaw et al 1999)

Table 1.7 - Percentages of sample showing anxiety or depression based on ethnicity and gender.

Whether these differences in rates of mental disorders are "real" is open to question. Brewer (2004) addressed the three possible reasons for figures on ethnic differences:

a) The differences are real because there are biological differences between ethnic groups;

b) The different rates between ethnic groups are caused by social differences;

c) The figures are distortions and there are no real differences.

7. Speed of Treatment

The quickness of the treatment is mentioned in Ad 1b ("Cipralex works as early as week one") and 7b ("Get acute mania under control fast"). This is compared to the

claim of longer-lasting in Ad 4: "Concerta" is presented as covering both - "One morning dose provides 12 hour improvement..". What more could be desired from a drug - it works immediately and lasts a long time?

8. Special Products

Two of the products were presented as special - Ad 2a ("Efexor": "first antidepressant licensed for Generalised Anxiety Disorder"), and Ad 13a ("Ebixa": "first licensed therapy for moderately severe to severe stages of the disease", Alzheimer's).

Common terms used in advertising generally include "the only" and "no other". These create their products as different to the rest (when in reality most products of the same type are very similar). For most mental disorders, there are a number of competing drugs available. Advertisers must make their product stand out from the crowd.

9. Wrong Message?

One of the "Seroxat" adverts (Ad 5a) shows a gazelle being chased by a cheetah, and next to the gazelle are written the words, "on edge, butterflies, pounding heart". These are the symptoms of anxiety being highlighted. But in the case of the gazelle, it is an appropriate situation to have such physiological changes. Is the advert suggesting the normal physiological response to danger and stress is inappropriate here? I am not sure that the advert is conveying the desired message which I assume is that the problem is having these symptoms in inappropriate situations.

10. Controlling Nature

In advert 6a ("Reminyl": "Just because Gordon has been diagnosed with Alzheimer's doesn't mean he has to suffer from it"), the diagnosis of Alzheimer's disease is nature which the drug is able to fight. The ability of modern humans to control nature.

"Depakote" (Ad 7b) also talks about putting an undesirable behaviour (mania) "under control". The fallibility and weakness of the flesh can be overcome with these products.

1.9. CONCLUSIONS

Psychotropic drugs are advertised more or less in the same way as any other product in consumer society. They have become products like any other foodstuff or consumer good. So advertising is part of the normal company behaviour with their products, and it is about pushing those products to the head of the queue in the consumer's mind.

It is not that the adverts are lying about their products, they, like all advertising, are just not telling the truth. And one of the truths is that most products are very similar, and never do what is claimed, in particular make life perfect. Because this is what advertising today is selling, beyond the product, it is the perfect life etc.

Psychotropic drugs can help individuals suffering from mental disorders who need such help. They have a special place for this reason, and to treat them as products belittles them. But this is what happens when private companies own products. I feel that there would be a lot more benefit from drug development and production being undertaken by not-for-profit organisations.

1.10. APPENDIX 1A - NEOLIBERALISM

"Neoliberalism is a value system in which the economic has replaced the intellectual and political and in which the competitive, rational individual predominates over the collective. Within this framework higher education has been instrumentalised as a source of skills supply, with universities located as servants of the 'knowledge economy' and learning replaced by a concern with 'outcomes'... Competitive markets have been put in place between and within institutions, and teaching and student support budgets are often diverted into marketing... This has eroded institutional and intellectual autonomy, shaping management preoccupations with league table positions and quality assurance and the personal aggrandisement behaviours of some academics... In the marketised higher education sector students have been positioned as consumers, which evidences itself in an obsession with degree classifications often to the detriment of learning..." (Phipps and Young 2015 p306).

For neoliberalism "the human is fundamentally economic rather than social in basis" (Gane 2014 p1095). Thus it seeks "to apply economic analysis to a series of

objects, to domains of knowledge or conduct which were not market forms of behaviour or conduct... to marriages, the education of children, and criminality, for example" (Foucault 2008 quoted in Gane 2014). However, Gane (2014) gives a warning: "Neoliberalism is a complex and multi-faceted project and it would be a mistake to reduce it to a single epistemological position or commitment" (p1102).

Gilbert (2013) stated that neoliberalism "advocates a programme of deliberate intervention by government in order to encourage particular types of entrepreneurial, competitive and commercial behaviour in its citizens, ultimately arguing for the management of populations with the aim of cultivating the type of individualistic, competitive, acquisitive and entrepreneurial behaviour which the liberal tradition has historically assumed to be the natural condition of civilised humanity, undistorted by government intervention" (p9). Classical liberalism believes that "left to their own devices, humans will naturally tend to behave in the desired fashion", while neoliberalism feels that humans "must be compelled to do so by a benign but frequently directive state" (Gilbert 2013 p9).

1.11. APPENDIX 1B - SHYNESS: NORMAL OR ABNORMAL?

Chronic shyness is a fear of negative evaluation which causes emotional distress and inhibits an individual's life (Al Razek et al 2006). Buss (1985) distinguished between fearful shy individuals who are afraid of novelty, and self-conscious shy individuals who have an excessive focus on public aspects of the self.

Al Razak et al (2006) preferred to distinguish between a normal (physiological) shyness and the abnormal (pathological) type which overlaps with social phobia [20], and avoidant personality disorder (table 1.8).

Half of the population experience shyness, but only just over 10% are disable by it (Henderson 2004). While in a US study, 40% of individuals self reported as being chronically shy, 40% as previously but no longer, 15% as shy in some situations, and 5% never shy (Zimbardo et al 1974).

[20] Social phobia first appeared in DSM-III in 1980, and defined as "a marked and persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others. The individual fears that he or she will act in a way (or show anxiety symptoms) that will be humiliating or embarrassing" (APA 1994 p416 quoted in Scott 2006 p135).

- Avoidant personality disorder is a "pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation" (APA 1994). DSM-IV diagnoses it based on four or more symptoms from the following seven:

- Avoids interpersonal contact
- Unwilling to form relationships
- Restraint within intimate relationships
- Preoccupation with being criticised or rejected
- Inhibited in new interpersonal situations
- Views self as inferior to others
- Risk adverse

Table 1.8 - Criteria of avoidant personality disorder.

Al Razak et al (2006) investigated shyness among 76 Egyptian medical students and 76 Saudi Arabian college students all aged between 18-23 years. The volunteers completed the Shyness Scale, Fear of Negative Evaluation Scale, Social Phobia Scale, and the Diagnostic Checklist of Personality Disorders (all Arabic versions).

Fifteen percent of the sample were classed as showing pathological shyness with it more common among women. Shyness Scale scores were significantly positively correlated with Social Phobia Scale and Fear of Negative Evaluation Scale scores.

The line between normal shyness and pathological shyness or diagnosis with social phobia and avoidant personality disorder has a lot to say about how behaviour in a society is defined as normal or abnormal.

Scott (2006) argued that there was a medicalisation of shyness into social phobia, and this allowed for the use of medications, like SSRI anti-depressants, with it. She believed that shyness is seen as "a failure to achieve certain cultural values, such as assertiveness, self-expression and loquacious vocality". For her, shyness lies on the "contested boundaries" between physical health, mental illness, and social deviance:

> On the one hand, this is a relatively normal experience: many of us can identify with episodic feelings of shyness that arise in certain types of situations. On the other hand, some people identify so strongly with the "shy" label that they feel constantly anxious, lonely and frustrated, and understand shyness to be a chronic and debilitating condition that interferes with their everyday lives" (Scott 2006 p133).

The increasing number of self-help books, websites, and therapies present shyness as "a new social problem, of apparently epidemic proportion". The reticence associated with shyness is seen as a barrier to a "successful life", which is, thus, a "neglect of social responsibilities". "As a reflection of changing social values, therefore, the medicalisation of shyness suggests that bashful modesty and reserve are no longer so acceptable and that to succeed we must be vocal, assertive and capable of gregariously participating in social life" (Scott 2006 p134).

The distinction between normal and abnormal can be viewed in different ways:

1. Deviation from the social or statistical norm is abnormal.

Either social or statistical criteria are seen as the norm, and the absence of these is abnormal. For example, a certain amount of social interaction without fear is normal, and individuals who cannot do this are abnormal. Statistical criteria uses the majority, for example, as the norm.

Problems with deviation from social norm:

i) Depends on what society decides is normal, not necessarily what is a problem for an individual. For example, in Nazi Germany norms were established by the government that encouraged hatred and mistreatment of Jews, Romany people, and those with disabilities. In particular, these groups had to wear distinctive clothing and the norm for Germans was to spit at them (Brewer 2001b).

ii) It can be a means of social control for those individuals who do not conform. Conversely, there may be individuals who conform but are suffering from a problem (eg: "conforming neurotics"). Part of the problem is a fear of rejection, and so they adapt their behaviour to fit in perfectly (Brewer 2001b).

iii) Definitions will vary between cultures, societies, and historical periods, so no universal criteria. For example, in Victorian England (nineteenth century), women wore between six to eight undergarments to make sure that every part of their body was covered,

except the face. In particular, the female leg was seen as highly arousing for men, such that even table legs were covered, and the word "limb" was used instead of "leg" in polite company (Brewer 2001b).

Problems with deviation from statistical norm:

i) How to establish statistical norm - for example, by absolute majority or standard deviations from norm using the normal distribution (table 1.9).

ii) A behaviour may be statistically normal, but not desirable. For example, a majority of people will suffer from some form of depression at some stage in their lives. It is usually felt that depression is not a desirable or normal state of affairs. Controversially, it has been suggested that over half of the USA population have experienced abuse of some kind as a child. Again this may be statistically normal, but not desirable.

iii) No universal criteria as definitions will vary between cultures, societies, and historical periods.

2. Presence of symptoms

The diagnosis of mental illness is based upon the presence of certain symptoms seen as maladaptive. It does not matter how may people have the symptoms, their presence is enough for a diagnosis of abnormal (mentally disordered). For example, refusal to meet people through fear of embarrassment while desperate to interact socially is a symptom.

- By far the most common statistical technique is the normal distribution. This is a statistical concept which is able to establish the scores of a majority of people on a particular test. It is most often used for intelligence. Any IQ test will have a mean score (usually standardised to 100), and a standard deviation (which shows how the scores cluster around the mean).

- It has been statistically established that certain percentages of the population can be found at certain scores (standard deviations). Statistically 95% of the population will score between -2 and +2 standard deviations of the mean. This is classed as the normal range. Using an IQ test with a standard deviation of 15, this would make the normal range vary from 70 (-2 standard deviations) to 130 (+2). Therefore anybody with an IQ outside that range is classed as abnormal.

- There are problems, though. Firstly, IQ tests vary on their standard deviations. For example, the Stanford-Binet test has a standard deviation of 16, while for the Wechsler Adult Intelligence Scale (WAIS), it is 15. Another test may have a standard deviation of 10. In each case, there will be a different range that is classed as the normal range.

TEST	A	B	C
MEAN	100	100	100
STANDARD DEVIATION	20	15	10
-2 TO +2 RANGE	60-140	70-130	80-120

- Secondly, the decision to establish the normal range as -2 to +2 standard deviations is a subjective one. It could quite easily be -1 to +1 standard deviations (which covers approximately 68% of the population), or -3 to +3 standard deviations (98% of population approximately) (Brewer 2001b).

Table 1.9 - Normal distribution of scores and establishing normality.

Problems with presence or not of symptoms:

i) Who decides that certain symptoms are abnormal? The answer is the medical profession, and especially psychiatrists, who view mental illness as the same as physical illness in the body. This is the medicalisation of behaviour.

ii) Do the presence of certain symptoms mean an underlying mental disorder exists? There is much debate about the reliability and validity of classification systems, like DSM-IV, that use symptoms to diagnose mental disorders.

iii) Gives power to the groups in society who do the diagnosing. This also allows for what is seen as abnormal to expand and what is normal to be reduced. For example, in figure 1.2, using the high and low emotions, new categories of mental disorder have limited the room for normal behaviour - major depressive disorder, mild depressive disorder, and minor depressive disorder.

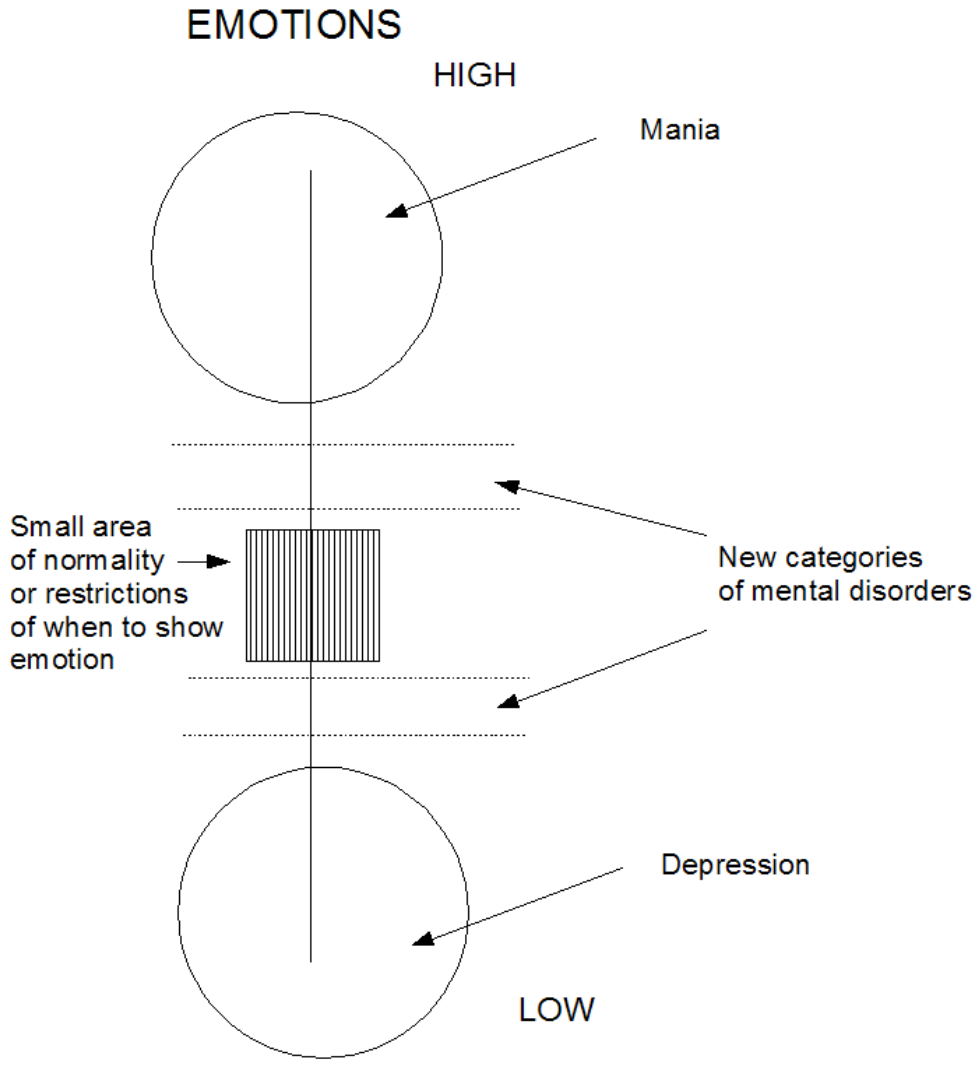

Figure 1.2 - How expanding categories of mental disorders for high and low emotions reduces the room for normal behaviour.

1.12. APPENDIX 1C - THE CREATION OF BODY DISSATISFACTION AMONG WOMEN

The continual presentation of images of thin women in the Western media has produced a situation where most women are dissatisfied with their bodies. Rodin et al (1984) called this, "normative discontent".

This is worrying because body dissatisfaction is linked to the development of eating disorders. While,

from a feminist viewpoint, the focus upon the body "can steal resources (eg: time, attention, monetary resources) from other issues and activities that might empower women, rather than making them feel inadequate" (Engeln-Maddox 2005).

The myriad of media images of thin women (between 10-20% below expected weight; Wiseman et al 1992) links such physiques to physical attractiveness. This is internalised as social rewards for physical attractiveness among women, emphasised in society, and manifest as body dissatisfaction. Social comparison plays a role as individuals evaluate themselves in relation to others. Media figures are ideals and possess "expertise", and thus become models for comparison. "Because few women can meet the beauty standards created by this ideal, dissatisfaction with one's own appearance is a likely outcome of this comparison process" (Engeln-Maddox 2005).

Studies using different methods have shown the link between exposure to idealised media images of thin women and body dissatisfaction.

i) Correlational studies - eg: Harrison and Cantor (1997).

232 female and 190 male undergraduates in communication courses at the University of Wisconsin-Madison, USA were asked to complete surveys about their media exposure, and attitudes towards eating and dieting. These were the two variables for the correlation.

- Media exposure - eg: number of hours of television watched; frequency of viewing certain popular television shows with thin bodies (eg: "Melrose Place") and heavy bodies (eg: "Roseanne").

- Attitudes towards eating and dieting - eg: "Am preoccupied with desire to be thinner", "I think my hips are too big", "I have gone on eating binges where I felt that I could not stop".

For women, media exposure was significantly correlated with disordered eating for magazines read per week, but not for overall television viewing. There was not a correlation between type of television show (eg: thin bodies) and disordered eating. But overall television viewing did correlate with body dissatisfaction.

For men, media exposure correlated with positive

attitudes towards perceived personal thinness and dieting, and with a favourable attitude towards it for women.

ii) Quasi-experiments - eg: Becker et al (2002).

Becker et al looked at the effect on Fijian adolescent females of the arrival of television to the Nadroga province of Fuji [21]. Data were collected from two separate groups in 1995 (soon after television arrived) and 1998 using the EAT-26 questionnaire (Garner 1982) (in English - the language of education - and the local Fijian dialect). Scores above twenty are treated as a sign of an eating disorder.

In the 1998 sample significantly more adolescents had an EAT-26 score greater than twenty (29.2% vs 12.7%), and reported self-induced vomiting to control weight (11.3% vs 0%) than in 1995.

Table 1.10 summarises the limitations of this study, and table 1.11 outlines controls that a "true" experiment would have. However, performing such a controlled experiment is very difficult in social situations.

- 1. As a quasi-experiment variables were not manipulated by the researchers and full randomisation to groups did not take place. Thus it is necessary to be cautious about cause and effect compared to a laboratory experiment.
- 2. No baseline before television arrived. Quasi-experiments tend to be opportunist studies that make use of a social event - in this case, the arrival of television to parts of Fiji.
- 3. No details about samples before 1995, and some of these individuals may have had disordered eating before television arrived.
- 4. Eating disordered behaviour was based on self-reports and not clinical diagnosis by psychiatrists.
- 5. Small sample sizes (n = 63 in 1995, n = 65 in 1998).
- 6. No investigation of other social variables than television that could explain increase in eating disordered behaviour.

Table 1.10 - Limitations of Becker et al (2003) study.

[21] See map at http://tinyurl.com/yeqw94m.

- Baseline measure of behaviour - before television arrived.
- Details of participants at baseline - eg: how many already showed eating disordered behaviour.
- Random allocation into two samples.
- Measurement of other relevant social variables during the study.
- Ideally, interview same individuals at two points in time (ie: longitudinal study).

Table 1.11 - Controls needed for experiment rather than quasi-experiment.

iii) Experiments - Groesz et al's (2002) meta-analysis of twenty-five experiments that manipulated the images presented found that body image was significantly more negative after viewing thin models compared to average size models, plus size models, or inanimate objects.

1.13. APPENDIX 1D - FOR AND AGAINST DTCA

ARGUMENTS FOR	ARGUMENTS AGAINST
1. Encourages patients to seek beneficial treatments. 2. Aids in patient education about health and illness. 3. Pharmaceutical companies can reach people unaware of problems. 4. Part of patient empowerment. 5. Many medical professionals are not able to keep up with all the latest developments. 6. Pharmaceutical companies as competitive companies should be allowed to market their products unimpeded.	1. Advertising is not for education but profit, and so not presenting all the options. 2. Advertising focuses upon products that companies want to sell (eg: new, expensive) not necessarily the best. 3. Devalues the role and expertise of medical professionals. 4. Individuals with mental disorders may not be able to decide for themselves which drug to take. 5. Increased demand for drugs will lead to increased costs to the NHS if drugs are free or subsidised. 6. Concerns about the social construction of mental disorders to increase the market for products.

Table 1.12 - Main arguments for and against DTCA of psychotropic medications.

Table 1.12 summarises the main arguments for and against DTCA.

Adams and Harder (2018) examined direct-to-consumer advertising (DCTA) in the USA for prescription drugs aimed at overweight and obese individuals. One hundred and twenty advertisements aired on television between 1997 and 2015 were analysed for messages about the "healthy lifestyle".

The authors found two forms of healthy lifestyle presented through:

i) "Drug compliance ads" - The use of the advertised drug is key to health management. "In terms of disease aetiology, these advertisements focus on the non-preventable origins of the condition and on how the efforts on the part of the patients to manage the condition without the use of drugs are partially to wholly ineffective. Frequently, advertisements explicitly or implicitly convey the message that genetic factors are the underlying cause of the focal health problem. This enables drug compliance advertisements to either ignore or downplay the role of healthy behaviours not involving drug use, such as diet and exercise, in prevention or disease management" (Adams and Harder 2018 p443).

For example, an advertisement for a cholesterol-reducing drug showed sport-playing older adults with the caption: "High cholesterol is a tougher opponent than you think... for millions of adults with high cholesterol, diet and exercise aren't always enough" (p443).

ii) "Complementary drug use ads" - A healthy lifestyle is the combination of diet and exercise, and the advertised drug.

For example, a weight-loss drug advertisement showed unhealthy foods, and included the voiceover saying: "Eat right, stay active. But if that's not enough, ask your doctor about adding [drug name]" (p444).

Adams and Harder (2018) concluded that both forms of DTCA "regard drug use as a type of healthy behaviour" (p446). They continued: "By presenting drug use as a type of behavioural solution, DTCA draws on the dominant public health discourse concerning the importance of adopting and maintaining healthy behaviours. By defining drug use as a healthy behaviour, DTCA appears less like profiteering through corporate-based interests and more like a legitimate, non-biased source of health information. In other words, it somewhat resembles public health promotion, the goal of which is to prevent

and manage disease" (Adams and Harder 2018 p446).

1.14. APPENDIX 1E - SELF-PUBLISHING EDITORS

Editors of academic journals are rarely professional editors, and they continue to be active academics who perform additional duties on top of this work. Sometimes editors publish their own findings in the journals they edit (ie: "self-publishing"). There is "the possibility that the editors' submissions are treated favourably, which may be considered as 'an abuse of the scientific publishing system' [Abdel-Baset et al 2019]" (Liu et al 2023 p353).

Liu et al (2023) analysed a dataset including the publication records of 20 000 editors, and found that "12% publish at least one-fifth, and 6% publish at least one-third, of their papers in the journal they edit. Editors-in-chief tend to self-publish at a higher rate. Finally, compared with women, men have a higher increase in the rate at which they publish in a journal soon after becoming its editor" (p353).

The researchers commented on their research: "Naturally, these findings raise the question: How much self-publication should be considered too much? Of course, there are perfectly innocuous explanations of why editors self-publish. Some may conduct research in a niche field with only a few alternative journals to publish in; others may be established scientists who self-publish their best works to boost the reputation of a young journal. Still, if there is anything that can be learned from recent scandals involving editors [eg: Van Noorden 2020], it is that the power enjoyed by editors can be exploited. For instance, consider those editors-in-chief who self-publish at high rates, despite being responsible for overseeing the review process of every submission, including their own. To an external observer, it may not be entirely clear how such articles are handled to circumvent the apparent conflict of interest" (Liu et al 2023 p359).

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2. TWO EXAMPLES WHERE GIVING A GIFT HAS A NEGATIVE IMPACT

2.1. Gift-giving and selfishness
2.2. Apology gift
2.3. References

2.1. GIFT-GIVING AND SELFISHNESS

Generally, gift giving is described as "the cement of social relationships" (Kornter and Vollebergh 1997 quoted in Polman and Lu 2022). But there are negative aspects to the practice including "a hidden cost in the form of furnishing gift givers with moral capital — feelings of goodwill — which can be subsequently spent on lapses of respectful and considerate behaviour toward their gift recipients" (Polman and Lu 2022 p1). Such behaviour is an example of "moral licensing, whereby after establishing oneself as kind or moral, people subsequently relax their behaviour by taking 'more liberties' and letting their behaviour slip a little south of appropriate" (Polman and Lu 2022 pp1-2).

The research on the psychology of gift-giving has unearthed two relevant variables - egocentrism, and warm glow. The former involves the giver focusing more on their thoughts and feelings than the recipient, while the latter is akin to a "helper's high" (Luks 1988) (the giver or helper feeling good after their behaviour) (Polman and Lu 2022).

So, it is not a large step to the idea that "buying someone a gift serves as a preamble to less-than-virtuous behaviour against a gift recipient" (p2), which is what Polman and Lu (2022) investigated in their three studies.

Study 1

This study investigated whether giving a gift to a romantic partner influences perceptions of infidelity. The six hundred and twenty-six participants recruited from Amazon Mechanical Turk (mTurk) were asked to imagine having a romantic partner before rating which behaviours they perceived as infidelity. Half the behaviours were linked to buying a gift (eg: "You're out buying your girlfriend a romantic present, and while gift shopping you receive an email from another woman. You respond to the email and agree to have dinner with her"; p3), and

half not (eg: "You receive a text from another woman and reply with a flirtatious message"; p4). The non-gift scenarios were rated as infidelity significantly more than the gift-based scenarios. The researchers concluded that "imagining giving a gift to a partner appeared to loosen participants' moral standards, such that participants viewed potentially dubious interpersonal behaviours as less bad — that is, less likely to be considered cheating on their partner" (Polman and Lu 2022 p4).

Study 2

This study involved 606 US undergraduates imagining giving a birthday gift to a friend (or not), and arranging to meet later. However, the meeting is not possible, and the participants were asked to write an email to the friend explaining the cancellation. The politeness of the email was scored. Emails in the gift condition were significantly less polite than in the control condition. But participants' self-rating of the politeness did not vary. "In sum, after giving a gift to their friend, givers behaved less warmly: they sent their friend a less positive message when cancelling plans and did not recognise their lax behaviour" (Polman and Lu 2022 p5).

Study 3

In this study 268 pairs of friends were randomly assigned to the gift or control condition. In the gift condition, one of the pair was given $10 to buy a gift for the friend, while in the control condition it was $10 to spend on themselves. Seven days later participants were given two pro-self/pro-social dilemmas. For example, Polman and Lu (2022) explained, "we asked participants to imagine that they received a $300 speeding ticket while taking a road trip with their friend. In the scenario, the friend was driving while the participant was taking a nap. We asked participants whether they would split the $300 speeding ticket with their friend and how much they would pay" (p5). Significantly more participants in the gift condition chose a pro-self option than in the control condition.

Overall, the studies showed that "giving someone a gift can provide people with a license to be more self-

serving in their relationship with the recipient. Giving a gift may thus not always be a win–win situation and may even have negative consequences for people's romantic and platonic relationships" (Polman and Lu 2022 p6).

Table 2.1 summarises the key methodological issues with the studies.

STUDY	POSITIVE	NEGATIVE
1	* Large sample * Range of adults (US?) * Like a repeated design as each participant rated both gift and non-gift scenarios	* MTurk users only * Use of imaginary scenarios * Online study
2	* Large sample * Write an email rather than using rating scale * Coding of emails by independent research assistants * Self-ratings of politeness also measured	* US undergraduates in one class at one university * Use of imaginary scenarios * Average of two coders used for final politeness scale * No details of ethnicity etc of sample
3	* Real-life study * Independent groups design	* Two dilemmas only * No details about participants
Overall	* Control * Wide range of participants	* Limited situations, mostly imaginary scenarios * Samples not that diverse

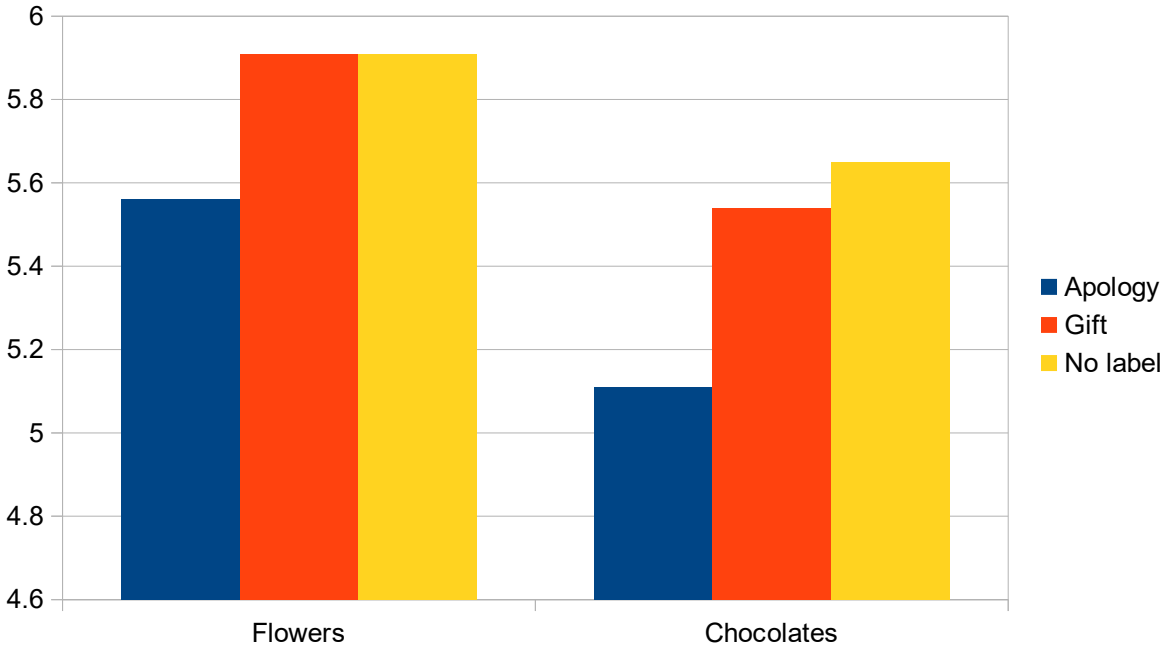
Table 2.1 - Key methodological issues with the three studies by Polman and Lu (2022).

2.2. APOLOGY GIFT

Products given as gifts as a way of apologising has increased in recent years with items like flowers, jewellery, and chocolates manufactured with apology labels. De Hooge and Straeter (2023) argued that "due to the specific context in which apology gifts are usually given, namely after transgressions where givers have hurt recipients, apology gifts act more as transgression reminders. Consequently, consumers evaluate apology gifts as less positive compared to 'regular' gifts or products.

When recipients receive apology gifts following transgressions, they prefer to decline or regift the gifts, and the receipt of apology gifts can negatively affect their relationship evaluation. Finally, we reveal that this effect occurs because apology gifts act as transgression reminders, and because apology gifts insinuate that givers misunderstand recipients' emotions" (p1).

These researchers provided evidence with six experimental studies. In the first study, 300 British participants were recruited to imagine receiving a bouquet of flowers labelled "I'm sorry" (Apology condition) or "For you" (Gift condition), or no label (Control condition). Participants were asked to rate the flowers on a seven-point scale. The rating was significantly lower in the Apology condition compared to the other two conditions. A version of the study (Study 1b) used a box of chocolates with three hundred more British participants, and found the same ratings (figure 2.1).



(Data from table 1 De Hooge and Straeter 2023)

Figure 2.1 - Mean rating of product (out of seven) based on label.

Study 2 compared a gift as a "thank you" or as an apology with 114 European undergraduates. They completed

a questionnaire online and received a gift of thanks, or the computer crashed during their questionnaire and they received the gift as an apology. The outcome measure was acceptance or rejection of the gift (a "mind teaser game"). In the Apology condition 44% of participants accepted the gift compared to 78% in the other condition.

Study 3 investigated the regifting of a gift with 294 students. Participants read a scenario about a planned outing with "Alex", who did not turn up. In one version of the story, Alex had forgotten and subsequently gives a gift of apology (Apology-gift condition), or Alex was hospitalised by an accident (Sadness-gift condition). In the control condition the outing occurs and a gift is given later (Neutral-gift condition). The intention to regift the gift (a DVD) was significantly higher in the Apology-gift condition (figure 2.2).

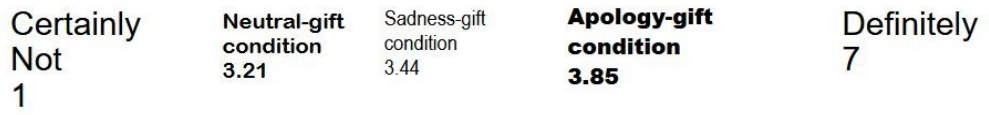


Figure 2.2 - "Would you consider using Alex's DVD as a regift for somebody else?" (mean scores).

Study 4 involved 297 MTurk workers allocated to one of four conditions. Participants were asked to recall a recent event when they were angry with a friend. Then told to imagine an Apology-gift, Spoken-apology, or No-apology. The control condition was recalling a neutral event. The outcome measure was rating the relationship after the imagined gift. Participants in the Apology-gift condition rated the relationship as significantly lower.

In the final study the reason for the apology gift (flowers) was investigated with 400 online participants. The gift was rated as a reminder of the transgression with the highest score (table 2.2).

De Hooge and Straeter (2023) concluded that the findings "shed light on how presenting products in a gift-giving context or with a special motive, such as to apologise for transgressions, can have negative consequences for product evaluations and for

- "These flowers will remind me of something negative" (4.69 vs 1.77)
- "These flowers compensate for the described event" (2.91 vs 3.09)
- "A material gift, such as the flowers, shows me that the giver misunderstands my feelings" (4.19 vs 1.51)
- "Accepting the flowers oblige me to repay the favour" (1.92 vs 2.71)

(Mean scores: apology-gift vs spontaneous gift (control) conditions out of 7)

(Data from table 4 De Hooge and Straeter 2023)

Table 2.2 - Examples of measures used in Study 5 by De Hooge and Straeter (2023).

relationships. Apparently, presumably good intentions, such as making a costly apology, can tarnish recipients' views of products and relationships" (p6).

Evaluation of methodology:

i) The use of hypothetical scenarios or imagined situations, which removed the context of everyday interactions (eg: giver and recipient identities; nature of relationship; aspects of the gift) (-). Other variables or mediators that are relevant were not included or controlled (eg: emotional vs material damage; material vs experiential gift) (-).

ii) A wide range of participants recruited - British adults, European students, and mTurk workers (+), and a large number (over 1700) (+). But biased towards online and/or students (-), and only volunteers (+/-).

iii) Outcome measures based on mostly seven-point Likert scales (-), but these are common to such research (+).

iv) Experimental method (+) with independent groups (or between-participants) design (+/-).

2.3. REFERENCES

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