

# **The Birth Control Pill: Popular Discourse and Personal Experience**

by

**Shannon Vogels**

B.A. (Hons.), University of Calgary, 2009

Thesis Submitted In Partial Fulfillment of the  
Requirements for the Degree of  
Master of Arts

in the

School of Communication

Faculty of Communication, Art and Technology

© **Shannon Vogels 2013**

**SIMON FRASER UNIVERSITY**

**Spring 2013**

All rights reserved.

However, in accordance with the *Copyright Act of Canada*, this work may be reproduced, without authorization, under the conditions for "Fair Dealing." Therefore, limited reproduction of this work for the purposes of private study, research, criticism, review and news reporting is likely to be in accordance with the law, particularly if cited appropriately.

# Approval

**Name:** Shannon Vogels  
**Degree:** Master of Arts (Communication)  
**Title of Thesis:** *The Birth Control Pill:  
Popular Discourse and Personal Experience*  
**Examining Committee:** **Chair:** Shane Gunster  
Associate Professor

**Gary McCarron**  
Senior Supervisor  
Associate Professor

---

**Thea Cacchioni**  
Supervisor  
Assistant Professor  
Women's Studies  
University of Victoria

---

**Cari Miller**  
External Examiner  
Assistant Professor  
Health Sciences  
Simon Fraser University

---

**Date Defended/Approved:** January 24, 2013

## Partial Copyright Licence

The logo for Simon Fraser University (SFU) is displayed in white text on a black rectangular background.

The author, whose copyright is declared on the title page of this work, has granted to Simon Fraser University the right to lend this thesis, project or extended essay to users of the Simon Fraser University Library, and to make partial or single copies only for such users or in response to a request from the library of any other university, or other educational institution, on its own behalf or for one of its users.

The author has further granted permission to Simon Fraser University to keep or make a digital copy for use in its circulating collection (currently available to the public at the "Institutional Repository" link of the SFU Library website ([www.lib.sfu.ca](http://www.lib.sfu.ca)) at <http://summit/sfu.ca> and, without changing the content, to translate the thesis/project or extended essays, if technically possible, to any medium or format for the purpose of preservation of the digital work.

The author has further agreed that permission for multiple copying of this work for scholarly purposes may be granted by either the author or the Dean of Graduate Studies.

It is understood that copying or publication of this work for financial gain shall not be allowed without the author's written permission.

Permission for public performance, or limited permission for private scholarly use, of any multimedia materials forming part of this work, may have been granted by the author. This information may be found on the separately catalogued multimedia material and in the signed Partial Copyright Licence.

While licensing SFU to permit the above uses, the author retains copyright in the thesis, project or extended essays, including the right to change the work for subsequent purposes, including editing and publishing the work in whole or in part, and licensing other parties, as the author may desire.

The original Partial Copyright Licence attesting to these terms, and signed by this author, may be found in the original bound copy of this work, retained in the Simon Fraser University Archive.

Simon Fraser University Library  
Burnaby, British Columbia, Canada

revised Fall 2011

## Ethics Statement



The author, whose name appears on the title page of this work, has obtained, for the research described in this work, either:

- a. human research ethics approval from the Simon Fraser University Office of Research Ethics,

or

- b. advance approval of the animal care protocol from the University Animal Care Committee of Simon Fraser University;

or has conducted the research

- c. as a co-investigator, collaborator or research assistant in a research project approved in advance,

or

- d. as a member of a course approved in advance for minimal risk human research, by the Office of Research Ethics.

A copy of the approval letter has been filed at the Theses Office of the University Library at the time of submission of this thesis or project.

The original application for approval and letter of approval are filed with the relevant offices. Inquiries may be directed to those authorities.

Simon Fraser University Library  
Burnaby, British Columbia, Canada

update Spring 2010

## **Abstract**

This thesis demonstrates the transformation of the birth control pill from a contraceptive technology to a lifestyle drug by comparing its historical origins to contemporary iterations and attendant issues. Drawing from biomedicalization theory, I suggest that contraception is one of many areas of life that have become subject to medical intervention, and use the pill to illustrate how contemporary health is characterized by a shifting landscape of privatization and commodification, new sources of information and knowledge, and an emphasis on optimization of the body. First, I conducted a critical discourse analysis of popular media texts related to the birth control pill in order to highlight problematic themes that characterize dialogue surrounding the pill. Secondly, these issues were compared with the results that emerged from a series of interviews with women who have taken the pill. Through exploring both the public and private realms, I argue that the pill is an agent of both biomedicalization and of gender performativity, and articulate the ways that this important pharmaceutical development enforces hegemonic standards of femininity.

**Keywords:** biomedicalization; performativity; oral contraceptives; pharmaceutical marketing; normative femininity

## **Acknowledgements**

First and foremost, I would like to thank Gary McCarron, who has eagerly offered support since I first expressed interest in graduate studies at Simon Fraser University. Thea Cacchioni, whose expertise and perfectly timed placement at SFU have been vital to my academic development, is a wonderful influence who I am grateful to have met. My fellow graduate student friends, particularly Heidi Wudrick and Brendan Plummer, have both aided my progress and provided much needed distraction. And finally, I thank my family and friends for their love and support.

# Table of Contents

Approval.....	ii
Partial Copyright Licence .....	iii
Ethics Statement.....	iv
Abstract.....	v
Acknowledgements .....	vi
Table of Contents.....	vii
List of Acronyms.....	ix
Glossary.....	x
<b>1. Introduction: Understanding the Pill.....</b>	<b>1</b>
<b>2. Theoretical Perspectives .....</b>	<b>4</b>
2.1. Medicalization.....	5
2.1.1. Medicalization→Biomedicalization .....	6
2.1.2. Lifestyle Drugs and Optimization.....	8
2.1.3. Pharmaceutical Marketing.....	9
2.1.4. Limitations.....	10
2.2. Performativity .....	11
2.3. Conclusion .....	15
<b>3. Agents of Biomedicalization: A Historical Trajectory.....</b>	<b>16</b>
3.1. The Pill: Historical Origins.....	16
3.1.1. Backlash .....	20
3.1.2. Resisting Pharmaceuticals: The IUD.....	23
3.2. The Pill Today .....	24
3.3. Other Agents of Biomedicalization .....	25
3.3.1. Hormone Replacement Therapy .....	25
3.3.2. Sexual Pharmaceuticals.....	27
3.3.3. Gardasil .....	29
3.3.4. Menstrual Suppression .....	32
3.4. Conclusion .....	34
<b>4. The Pill in Popular Discourse .....</b>	<b>37</b>
4.1. Critical Discourse Analysis .....	37
4.2. Methodological Justification.....	38
4.3. Overview of Discourse Analysis.....	40
4.4. Lifestyle Enhancement .....	43
4.5. Normative Femininity.....	50
4.6. For Physicians.....	52
4.7. Conclusion .....	54

<b>5. Personal Experience .....</b>	<b>56</b>
5.1. Methodology.....	56
5.2. The Pill: Influences of Normalization.....	58
5.2.1. Medical Authority/ Pushing the Pill .....	58
5.2.2. The Pill as a Lifestyle Drug.....	62
5.2.3. Media Representations .....	64
5.2.4. Male Partners.....	66
5.3. Women’s Experiences: Making Meaning of the Pill.....	68
5.3.1. Not So Easy: The Down Side of the Pill .....	68
5.3.2. Risk Negotiation.....	69
5.3.3. Side Effects.....	71
5.3.4. Barriers to Access and Knowledge.....	73
5.3.5. Performativity .....	75
5.3.6. Transformation of the Body .....	77
5.4. Conclusion: Discursive Confines .....	79
<b>6. Conclusion.....</b>	<b>82</b>
<b>References.....</b>	<b>88</b>
<b>Appendices.....</b>	<b>92</b>
Appendix A. Recruitment Poster.....	93
Appendix B. Participant Demographics .....	94
Appendix C. Study Details and Interview Guide .....	95
Appendix D. Consent Form .....	96
Appendix E. Participant Questionnaire .....	98



## List of Acronyms

DSM	Diagnostic and Statistical Manual of Mental Disorders
DTC	Direct to consumer
FSD	Female sexual dysfunction
IUD	Intrauterine device
OC	Oral contraceptive
PMDD	Premenstrual dysphoric disorder
PMS	Premenstrual syndrome

## Glossary

Depo Provera	An injectable hormonal contraceptive, developed by Pfizer. Administered seasonally, the drug provides contraception and eliminates periods for three months as a time.
Gardasil	The first vaccination for HPV, developed by Merck & Co., Inc. Prevents strains of HPV that cause cervical cancer and genital warts.
Lybrel	A continuous use oral contraceptive developed by Pfizer. Taken 365 days a year, without placebo pills, so that women never experience withdrawal bleeding.
Sarafem	A drug developed by Eli Lilly, chemically identical to Prozac but used to treat symptoms of PMDD.
Seasonale/ Seasonique	A continuous use oral contraceptive, developed by Barr Pharmaceuticals. Contains only one week of placebo pills every three months, so that women experience withdrawal bleeding seasonally rather than monthly.
Yaz/ Yasmin	An oral contraceptive, developed by Bayer. Contains drospirenone, which treats symptoms of PMDD, but is also associated with increased side effects and health risks.

# 1. Introduction: Understanding the Pill

Since it was first approved in 1960, the birth control pill has remained at the forefront of the contraceptive landscape; as of 2010, it was estimated that over 100 million women worldwide used oral contraceptives (Szarewski, 2010, p. 231). The approval of the pill was met with widespread enthusiasm, as it was predicted to eliminate the risk of unwanted pregnancy, thus empowering women across the world and solving the impending crisis of overpopulation. While the social and economic benefits of reliable contraception are clear, it is equally apparent that over fifty years later, the pill has not entirely lived up to these high expectations. In her historical account of oral contraceptives in America, Elizabeth May admits, “As it turned out, the pill did not solve all the problems of the world. It did not eradicate poverty, nor did it eliminate unwanted pregnancies or guarantee happy marriages” (2010, p. 6). Of course, it has helped, and the controversial history of the pill has also provided opportunities for women to demand not only access to reliable birth control, but also the ability to make informed decisions about their reproductive health. However, there are problems with the pill—medical, political, and cultural—that this work will uncover. Put succinctly, there is evidence that to be on the pill is, for many women, less of an individual, informed, and health-ensuring decision than it is an unquestioned requisite of modern femininity. That the drug can be simply identified as “the pill” speaks to its normalized and fully entrenched position in contemporary discourse. Broadly, this work seeks to investigate and challenge the common assumption that the pill is a necessarily safe, effective, and empowering product, and to initiate a dialogue that emphasizes critical awareness and encourages informed choice.

This project is motivated by an interest in exploring and understanding personal experiences—my own and those of others—and how they correspond with broader discursive trends and popular ideologies. Foundational to this work is a critical understanding of the increasing influence of biomedicalization on how individuals consider their physical health and subjective experiences. It will be argued that the birth

control pill is a preeminent example of the emergence of a biomedical model that increasingly governs health, sexuality, and gender. This will be accomplished in several steps. First, the theoretical foundations of this work—biomedicalization and performativity—will be described and applied to the case of the birth control pill. Key to this discussion are the situation of the pill as a lifestyle drug, the increasing privatization of health, and the attending influence of pharmaceutical marketing. The relationship between the three will be illuminated first by explaining the history of the pill, and then by tracing a historical trajectory of other agents of biomedicalization. Examples of more current developments like hormone replacement therapy, Viagra, and Gardasil reveal that the biomedical model is increasingly relevant to understanding developments and trends in health, medicine and lifestyle. The examples provided all concern sexual and reproductive health specifically, and highlight the important implications that biomedicalization has for contemporary sexuality and gendered identity. Ultimately, I argue that these agents of biomedicalization all contribute to the construction of normative gender roles, and relevant discourse implies that the unmedicated individual is less successfully masculine or feminine than the pharmaceutically mediated body.

After providing an explanation of the foundational theoretical perspectives at work and then tracing the history of the birth control pill and subsequent agents of biomedicalization, the emphasis will return to the birth control pill. Specifically, I will focus on contemporary issues that differentiate current generations of the birth control pill from earlier iterations. A discourse analysis of popular texts concerning the pill will illustrate current issues and perspectives surrounding oral contraceptives. The primary focus will be on marketing materials, which are an important element of health-related discourse in a biomedical landscape, and which have demonstrated influence on the perceptions and health-related decisions of women. A selection of texts that target medical professionals will also be analysed in order to illustrate the fact that popular promotion of the pill comes from multiple directions and has many levels of influence. Highlighting trends in popular discourse will provide an understanding of the sociocultural climate in which women come to understand the birth control pill itself, and how they make health and lifestyle decisions that involve the pill. Finally, the experiences and perceptions of young women who have used the pill will be illustrated through an analysis of data collected through individual interviews. Broadly, two different themes which emerged from the

interview data will be discussed: (1) women's decision to take the pill is mediated by a number of influences that normalize and prioritize being on the pill as an imperative for modern femininity, and (2) women's experiences of the pill are in fact more complex and difficult than popular discourse surrounding the pill suggests. The goal of the interviews was to achieve an understanding of how women experience and make meaning of the pill, and how these experiences correspond with common assumptions about the pill that are reinforced by various influences such as medical professionals, popular media, peers, and male partners.

The sociocultural influences of the birth control pill have been an important area of scholarly inquiry across many disciplines over the past fifty years, and this work is preceded by that of feminist scholars like Barbara Seaman (1969), Elizabeth Watkins (1998), Andrea Tone (2001) and Abby Lippman (2004) who have critically investigated the pill and its negative consequences for women. However, this project is a unique contribution to academic investigations of the pill in that it uses ethnographic interviews in order to describe how the pill impacts women in their lived experiences, and how these personal meanings relate to popular discourse concerning oral contraceptives. Further, this work is the first to directly investigate the important relationship between biomedicalization and performativity. Biomedicalization theory argues that medical discipline is emerging in new ways that govern people's health-related decisions, and the notion of performativity suggests that individuals act out their gender through a series of gestures, often overlooked or thought of as meaningless and mundane. This work strives to draw the connections between the two, and to demonstrate that being "on the pill" is a biomedically driven decision that facilitates the performance of normative feminine identity. Ultimately, the pill is argued to perpetuate biomedical standards of femininity, and the negative implications of this phenomenon will be highlighted and challenged.

## 2. Theoretical Perspectives

This research is informed by two different theoretical perspectives: biomedicalization and performativity. Biomedicalization is a recently coined term that describes how the agents and implications of medicalization have evolved in recent years. Adele Clarke and colleagues undertook the ambitious theoretical project of reconsidering medicalization, explaining that “since around 1985, dramatic and especially technoscientific changes in the constitution, organization, and practices of contemporary biomedicine have coalesced into *biomedicalization*, the second major transformation of American medicine” (Clarke, Shim, Mamo, Fosket, and Fishman, p. 1, 2010). Because biomedicalization serves as the primary theoretical lens at work here, it is important to first understand the more established concept of medicalization. Addressing the differences between the two is particularly instructive for demonstrating the changing social role of the birth control pill. The objective here is to describe the shift from medicalization to biomedicalization in recent years, while highlighting the importance of gender in biomedical discourse and practices.

Next, a description of gender performativity will elucidate the ways in which the biomedically driven act of being “on the pill” has meaning for women and contributes to the constitution of normative femininity. Judith Butler’s work on performativity and phenomenology, in which she describes how everyday acts constitute gender identity (1988) provides a theoretical lens through which to explore how personal, individual acts (in this instance, consuming the birth control pill) illustrate and perpetuate biomedicalization in public discourse. While these two theories will be addressed separately, their intersections will be highlighted and will serve as the foundation for this project.

## 2.1. Medicalization

Medicalization theory was initially developed in the 1960s by sociologists such as Irving Zola and Peter Conrad, who describe “a process by which nonmedical problems become defined and treated as medical problems, usually in terms of illness and disorders” (Conrad, 2007, p. 4). It is important to clarify that most scholarly work on medicalization concerns itself with the consequences of *over*medicalization. In general, medicalization is characterized as professionalization of the medical field and its control over individuals, as well as the increasing role of technological interventions in the maintenance of health. Conrad in particular remains an important scholar in the field, and describes it as follows: “Medicalization studies... focus especially on the creation, promotion, and application of medical categories (and treatments or solutions) to human problems or events” (2007, p. 13). This phenomenon has been well-established, and is evidenced by a host of historical and contemporary events related to women’s reproductive health, such as the diagnosis of homosexuality, nymphomania and frigidity, and eugenic sterilization. Conrad explains the social implications of medicalization, and describes “how medicalization has transformed the normal into the pathological and how medical ideologies, interventions, and therapies have reset and controlled borders of acceptable behaviour, bodies, and states of being” (2007, p. 13). This sentiment serves as both a justification and a guide for analyzing the important implications the birth control pill has had for women; not only their reproductive bodies, but also their feminine identities are mediated by the influence of (bio)medicalization.

It is well-established that medicalization has predominantly targeted women (Cacchioni, T. and Tiefer, L., 2012; Clarke et. al., 2010; Conrad, 2007; Tiefer, 2012). Beginning with unnecessary hysterectomies to treat menstrual difficulties in the nineteenth century, medical interventions in women’s sexual and reproductive functioning have increased dramatically, bringing more and more areas of normal processes into the realm of surveillance and treatment. Indeed, all stages of women’s reproductive lives have effectively been medicalized, from menstruation to conception (not to mention contraception in the meantime), and childbirth to menopause. More and more, women’s bodies are understood as problematic, and in our current sociocultural climate in which individuals strive to be ‘better than well’ (Kramer, 1993), there is an

increased tendency to categorize natural bodily states as unhealthy, unnatural, or unmanageable, and to treat these 'problems,' usually through pharmaceutical means.

At the same time, there is a growing visibility of the negative implications of medicalization, due to the formation of activist groups and the continued attention of scholars. For instance, Mary Brown Parlee began to examine the medicalization of premenstrual syndrome (PMS) in the 1970s; this subject is particularly relevant to current discourse surrounding the pill, which is frequently promoted as a cure for PMS. Currently, Leonore Tiefer is an important figure who has brought awareness to the consequences of medicalization. Her work is particularly relevant to understanding how medicalization and gender are increasingly linked, and the implications of such linkages for men and women as individuals, as well as in relation to one another. Furthermore, she emphasizes the fact that medicalization "involves the triumph of a hegemonic medical model, nomenclature, research and teaching, and it involves the geometric expansion of medical institutions, money, and health media" (2012, p. 312). This statement clearly articulates the connection between health and industry in a biomedical model.

Although I have described medicalization as problematic phenomenon that has significant implications for individuals, I do not wish to suggest that medicalization is a universally unavoidable force that the average citizen is unable to comprehend or critique. Rather, my objective to highlight the ways in which medicalization has increasing relevance to health, sexuality, and gender identity, and to critically assess these implications. Keeping these foundational points in mind, one can understand biomedicalization as a timely and relevant extension of medicalization, and the birth control pill as an important illustration of this phenomenon.

### **2.1.1. *Medicalization* → *Biomedicalization***

Many of the well-understood characteristics of medicalization apply to biomedicalization, including the professionalization of the medical field and its control over citizens, as well as the increasing role of technological interventions in the maintenance of health. As such, it is important to keep in mind that there is no distinct boundary between the two, and they must be considered as parts of a broader



trajectory. Clarke et. al. clarify that “many of the themes we develop here are not new, but their synthesis within an argument for technoscientifically based biomedicalization is. Further, the shifts are shifts of emphasis—these trends are historical and historically *cumulative* from left to right across the table, not separate and parallel” (2010, p. 56). Thus, while developments such as the pill could also be understood as examples of medicalization, the more contemporary theory of biomedicalization properly conveys their current roles.

A number of recent transformations make biomedicalization a more apt term to describe the contemporary health landscape, especially with regards to reproductive health and standards of sexual normalcy. Several characteristics outlined by Clark et. al. are particularly relevant to understanding how the birth control pill fits into a biomedical model. Specifically, they are: privatization and commodification of knowledge and of health; the tendency of health governance to define, rather than solve, health problems; the production of multiple accessible knowledges; and customization of individual bodies (2010, p. 52-53). While medicalization focuses on illness, disease, and injury, within the biomedical model, health itself is also mediated through consumption of pharmaceutical products, self-surveillance, access to knowledge, prevention, and assessment and treatment of risk (Clarke et. al., 2010, p. 48), and each of these is relevant to a contemporary understanding of the birth control pill.

Tiefer refers to Clarke et. al.'s biomedicalization theory as “a recent and broader perspective (that) went beyond the increasing availability and popularization of medical experts, theories, and treatments to emphasize the expanding role of technoscience and commercialization in shaping the public's self-understandings and choices” (2012, p. 312-313). While I agree with her description of biomedicalization, and particularly appreciate her attention to its influence on individuals' “self-understandings”, I argue that biomedicalization theory is not a *broader* perspective than medicalization, but in fact a more *specific* one. While biomedicalization theory incorporates a number of new emphases, these more recent developments in fact help to paint a more precise picture of how medical influences intervene in individuals' daily lives. For instance, direct-to-consumer advertising, the dominance of pharmaceutical corporations, and the role of the Internet in educating patients and consumers are central to biomedicalization, and these additions refine the concept of medicalization into the more technoscientific, profit-driven

biomedicalization model. The significance of these characteristics will be made more apparent through a discussion of specific developments related to reproductive health within the current biomedicalized landscape.

### **2.1.2. Lifestyle Drugs and Optimization**

Clarke et. al. argue that a key characteristic that distinguishes biomedicalization from medicalization is the increasing role of lifestyle drugs—that is, medications or procedures that are intended to improve performance or enhance lifestyle, rather than cure a legitimate medical problem (Conrad refers to such agents as ‘cosmetic pharmacology’ (2007). Meika Loe (2001) succinctly introduces this contemporary trend, explaining how

Science, medicine, technology, gender, and sexuality are inextricably linked in contemporary time. During this time of advancing technology and unheard of pharmaceutical industry growth, especially in the realm of “lifestyle drugs,” twenty-first century America is witnessing the rise of the pharmacology of sex, where pharmaceutical companies exercise increasing authority over areas of life, such as sexuality, not previously requiring prescription drugs. (p. 98)

Clarke et. al. also describe the role of lifestyle drugs within a biomedical model, explaining that there is a “greater emphasis within biomedicalization theory on enhancements, what Rose... more broadly calls *optimization*—the increasing legitimacy of ensuring the best possible features” (2010, p. 23). This emphasis on optimization is well-demonstrated by a variety of pharmaceutical products for sexual and reproductive health, including Viagra, hormone replacement therapy, and—in ways that will be elucidated—the birth control pill.

Viagra is perhaps the clearest illustration of how optimization has become a priority in the domain of sexuality. While initially intended for (typically elderly) men experiencing erectile dysfunction, the market has expanded substantially and the drug is now considered an appropriate option for any man seeking ‘better’ sexual performance, and ‘hyper-potency’ has become a new standard of male sexuality. While stigma surrounding sexual difficulties may have at first dampened sales for Viagra, it did not take long for it to become one of the most profitable pharmaceutical developments in

history. It was widely celebrated in popular media; for instance, a lay book published on the pharmaceutical optimistically claimed, “For the first time, it is possible to restore optimal sexual function to nearly every man who desires it” (Lamm and Couzens, 1998, p. 11). This statement is problematic in that it suggests the ‘optimal function’ that Viagra provides—that is, one-hundred percent reliable, exceptional erections—was ever a natural state, and is thus an achievable standard of normative masculinity. Loe explains the social implications of such lifestyle uses of Viagra, saying, “by pushing the boundaries of erectile function, performance, and sexuality, Viagra sets new standards and constructs countless male bodies in need of repair” (2001, p. 113). The ways in which these new standards contribute to rigid gender roles for both men and women alike are clear, and are potentially counterproductive to their relationships and their self-understandings and expectations.

The social significance of Viagra is effectively stated by Barbara Marshall, who explains, “Far more than a pharmaceutical product, the little blue diamond-shaped pill has become a cultural signifier of virility, bioperfection, potentially unlimited sexual performance in a new era in sexuality” (2002, p. 132). While the connection between the pill and lifestyle enhancement has yet to be described, at this point I will suggest that the pill—often pink and in presented in an iconic dial pack—certainly bears the same symbolic weight for women as Viagra does for men.

### **2.1.3. *Pharmaceutical Marketing***

One of the characteristics that Clarke et. al. describe as fundamental to the transition from medicalization to biomedicalization is the increasing role of pharmaceuticals in a largely commodified medical industry (2010), and marketing is an undeniable component of this contemporary landscape. The role that popular marketing has played is well-evidenced by the aforementioned (and a host of other) medicalizing agents, and has multiple layers of meaning, which will be explored in depth. Briefly, the relatively recent advent of direct-to-consumer (DTC) pharmaceutical marketing has drastically changed the ways in which consumers receive their information about drugs. Whereas previously drug companies could advertise only directly to doctors, pharmaceutical advertising is now a multi-billion dollar industry (Conrad, 2007). Given

the ubiquity of DTC advertising, it is essential to understand the implications that it has on people's behaviours, attitudes, and consumption choices. Pervasive marketing combined with largely positive, uncritical popular coverage of drugs like hormone replacement therapy, for example, have contributed to an overwhelming acceptance of unsafe drugs, before their serious consequences came to light.

Not only have DTC ads become more ubiquitous, they have also become more sophisticated. Marketing of relevant products such as Viagra, Gardasil, and birth control rely on and perpetuate ideologies that are gendered and pathologizing. Mamo and Fosket use the example of Seasonale, a birth control pill that reduces monthly periods to seasonal periods; they analyze the marketing campaign for the drug to demonstrate how the product "produces feminine embodiment" (2009, p. 937), and emphasize the fact that within this new strategy, not only are women seeking contraception targeted, but potentially *all* girls and women who might desire fewer periods are hailed by the ads (p. 932). This feature is shared by the campaign for the HPV vaccine Gardasil, which dictates to *every* girl and woman within a certain age range (initially ages 9-26, but now including older women as well) that she is at risk, and should therefore choose vaccination. In these cases, there is little space offered to girls and women to contemplate their health and pharmaceutical consumption in a personal, individual way. The implications of contemporary DTC advertising strategies will be discussed at greater length, but it is important here to situate the trend within a general discussion of current issues concerning the biomedicalization of women's sexual and reproductive health.

#### **2.1.4. Limitations**

It is necessary to note that biomedicalization is not a universally accepted theory, and that some find the reconceptualization of the term unnecessary. Conrad himself refers to the work of Clarke et. al., and while overall his impression of their contribution is positive, he also suggests that it might be more appropriate to describe the transformation as "shifting engines of medicalization" (2005), such as the pharmaceutical industry, rather than to develop a new term altogether (2007, p.14). I argue, however, that the concept of biomedicalization as described by Clarke et. al. provides new emphases that can more clearly illustrate the evolving influence of medical interventions in individuals' lives, particularly given the rapid acceleration of lifestyle drugs, which will

be discussed in greater detail. Ultimately, this project will make evident the ways in which the birth control pill and its cultural influence, in contemporary North American society, can be best understood through the theoretical concept of biomedicalization.

It is important to note that, while the process of medicalization (and biomedicalization) is largely regarded critically, both in this work and among medicalization scholars in the past, this is not to say that its influence has been entirely negative. It goes without saying that there are many examples of how medical advancements have improved the health and well-being of countless individuals, and these should not be discounted. In some instances, the medicalization of a problem, such as erectile dysfunction, may help to de-stigmatize a previously taboo or embarrassing issue. However, as Conrad succinctly notes, “there are certain social consequences of medicalization irrespective of any attendant medical or social benefit” (2007, p.147). It is the social consequences that I wish to investigate here, and this is not only justified, but *necessary* in that few of them receive a considerable amount of critical analysis, particularly within popular media and among the majority of individuals affected by the implications of medicalization.

It is also important to note that individuals are not passive and helpless against biomedical institutions; as Tiefer explains, “The public is also not merely a passive player reflexively responding to the proselytizing of health experts and the media. Rather, medicalized discourse about sexuality seems to be actively sought to provide both authoritative direction and self-protective attributions” (1995, p. 28). This observation provides a logical point of departure from the discussion of the nearly omnipresent influence of biomedicalization, to the more personal ways that this influence is internalized and acted upon.

## **2.2. Performativity**

Now that a picture of biomedicalization and its implications for gender have been established, we can turn to the more specific ways in which biomedicalization theory explains how women are targeted, and how their self-understandings and identities are mediated through pharmaceutical agents, particularly the birth control pill. It is key to

acknowledge that the pill does not only have implications for women in terms of reproductive control and the freedom it entails; I argue that it has an even broader impact on women's understandings and experiences of their own femininity and sexuality. This view is consistent with the position advocated by Clarke et al. (2003), who make an argument for the considerable role that medical technologies, within a biomedical model, play in formation of identity. They say,

Medical and public conceptions reflect a conviction that the body's capacity is almost unlimited. Representatives of the biomedicalization thesis argue that biomedicalization has reconstructed the boundaries between the material body and social identity, so that medical interventions in the form of "technologies of the body" enable an enhancement of a certain type of revered notion of the self, the creation of "technoscientific identities." (p.184)

Clarke et. al explain the important ways that biomedicalization has led to the construction of technoscientific identities that are increasingly forced upon citizens, and these are key to understanding the implications of biomedicalization for women's reproductive health, particularly as demonstrated through the use of the birth control pill. They describe several ways in which biomedicalization mediates identity, saying that "technoscientific applications to bodies allow for new ways to access and perform existing (and still social) identities" (2010, p. 81). First, they can be used to attain social identities or roles that are desirable but were previously inaccessible. Secondly, biomedicalization imposes new standards of identity and performance onto people's sense of self, and lastly, technosciences establish and redefine categories of health-related identities (2010, p.81).

A significant implication of the pill as a pervasive agent of biomedicalization is that the new standards of femininity that correspond with the birth control pill can be understood as elements of feminine performativity. "One is not born, but, rather, becomes a woman" are the often quoted, enduringly relevant words of Simone de Beauvoir (1953, p. 267), and here they serve as a starting point from which to explore the birth control pill—now fully entrenched in what it means to be a woman—as an agent not only of biomedicalization, but of performativity. While the notion of performativity has been explored and applied in many contexts, here the term refers to Judith Butler's conception, which argues that gender is "an identity instituted through a stylized repetition of acts. Further, gender is instituted through the stylization of the body and,

hence, must be understood as the mundane ways in which bodily gestures, movements, and enactments of various kinds constitute the illusion of an abiding gendered self” (1998, p. 402). Here I will argue that there is a close relationship between consumption of the birth control pill and performativity; indeed, the state of being “on the pill” has become one of the more pervasive signifiers of modern, sexually liberated yet self-controlled femininity.

Butler’s succinct explanation of performativity contains two words that deserve particular attention—*mundane*, referring to the everyday and unremarkable, and *abiding*, defined as persistent and conforming. When the act of taking the birth control pill is considered in relation to these terms, important inferences can be made. The possibility that I would like to explore is that to be “on the pill” is at once mundane—certainly to many, a taken for granted fact of life—but also unquestionably constitutive of a rigid form of femininity that millions of women adopt, and for this reason it is indeed remarkable. Arguably, the pill has been considered critically over the fifty-two years it has been on the market as a contraceptive for a number of reasons, and many discussions surrounding the pill may no longer be compelling or relevant. However, given contemporary issues that have emerged in relation to the pill in recent years, there is evidence to support revisiting the pill from a critical perspective. Butler explains, “One is not simply a body, but, in some very key sense, one does one’s body and, indeed, one does one’s body differently from one’s contemporaries and from one’s embodied predecessors and successors as well” (1998, p. 404). This is important to consider, and will be increasingly evident as the shifting role of the birth control pill among contemporary North American women becomes illuminated. Through using performativity as a theoretical lens, taking the pill can be understood as a specific corporeal act that constructs gender (Butler, 1998), and the contemporary implications that the pill has for women’s material bodies and personal identities can be understood. Indeed, “the life-world of gender relations is constituted, at least partially, through the concrete and historically mediated *acts* of individuals” (Butler, 1998, p. 523), and the daily ritual of taking the pill is one such act that has both material and symbolic meaning for women, individually and within their relationships with others.

By this point, the ways in which biomedicalization and gender performativity intersect should be apparent. Further, they are both perpetuated by similar phenomena

and ideals; advertising, self-regulation and improvement, normativity, and consumerism are all integral to both biomedicalizing processes and performative acts. While these two theories work well together, they are also independently useful to help explore the personal and public domains that I argue are influenced by the birth control pill. That is, while biomedicalization theory aptly describes popular practices and discourse related to the birth control pill, the notion of performativity is more relevant to women's individual experiences. Each of these realms—the public and the private—will be explored through a specific methodology, which will be discussed in further detail. In general, this research will be inductively performed, and will synthesize results from a critical discourse analysis of popular media texts with themes that emerge from ethnographic individual interviews.

Through analyzing how the pill is situated in both the public and private realms, it is clear that it has important implications—as both a tangible pharmaceutical product, and as a symbol for a particular normative femininity—in both popular discourse surrounding femininity and sexuality, and in the subjective experiences of individual women. Judith Butler provides an especially poignant justification for the critical analysis of the daily acts, often unquestioned, that constitute gender:

Gender is not passively scripted on the body, and neither is it determined by nature, language, the symbolic, or the overwhelming history of patriarchy. Gender is what is put on, invariably, under constraint, daily and incessantly, with anxiety and pleasure, but if this continuous act is mistaken for a natural or linguistic given, power is relinquished to expand the cultural field bodily through subversive performances of various kinds. (1988, p. 415)

This serves as a justification for pursuing the birth control as a topic of critical inquiry, as an illustration of how it contributes to feminine performativity, and a motivation to draw conclusions about the consumption of the pill that will have positive implications for women.



## **2.3. Conclusion**

Thoughtful consideration of the birth control pill reveals how it contributes to such processes of self-identification and performance; a key goal is to understand the pill's role in the construction of feminine identities. Riska explores how biomedical influences contribute to the construction of identities from a critical perspective, noting that "the self is not a gender-neutral notion. Instead the construction of the enhanced body recaptures normative, heterosexual norms of femininity and masculinity and gendered expression on sex and sexuality" (2010, p.154). Through the critical lens that Riska provides, I will offer an analysis of contemporary discourse surrounding the birth control pill in order to explain how it fits into a contemporary biomedical model, and will describe the implications this has for women's reproductive health, as well as their personal experiences and expressions of feminine identity.

### **3. Agents of Biomedicalization: A Historical Trajectory**

The significance of the birth control pill as an agent of biomedicalization, in a North American context, can be best understood through tracing its history and situating it within a broader analysis of pharmaceutical developments pertaining to women's reproductive health over the past fifty years. This analysis will begin with a brief history of the pill, and will then chronologically examine similarly targeted pharmaceutical developments, including hormone replacement therapy, Viagra, Gardasil (the first human papillomavirus vaccine), and menstrual suppressing oral contraceptives. This historical overview will illustrate how the birth control pill fits in to a long and increasingly pervasive trend towards a biomedical standard of women's sexual and reproductive health, and will highlight some of the links between biomedicalization and performative femininity.

#### **3.1. The Pill: Historical Origins**

1960 marks the year that the first birth control pill, Enovid, was approved by the FDA and sold on the American market, and consequently, the year that the biomedicalization of contraception began. While similar products had previously been approved for menstrual regulation, it was not until 1960 that the hormonal pill was approved for use as a contraceptive. The road leading up to this historic occasion was tumultuous, and indeed, the decades following the approval and immediate widespread popularity of Enovid were marked by controversy. The time of Enovid's approval was characterized by anxieties surrounding unprecedented population growth and a growing dissatisfaction with traditional gender roles; women in particular were beginning to reject the seemingly inevitable role of housewife, and reproductive control was central to enabling women to pursue education and careers. The most popular birth control methods available (the diaphragm used in combination with spermicide, and the

condom) were only moderately effective with typical use, and were seen as messy and disruptive to sexual activity. They also required particularly close contact with one's own genitals, which made some feel uneasy (Watkins, 1998). It was in this climate that the birth control pill was developed and enthusiastically accepted by American women.

Unlike today, the inception of the pill was inspired by advocates for women's reproductive control, rather than by a pharmaceutical agenda. The story of the pill begins with several key characters, one of the foremost being Margaret Sanger, who for decades acted as a champion for birth control and women's reproductive health. Sanger opened the first birth control clinic in Brooklyn in 1916, despite the illegality of such an endeavour. She was a tireless advocate for reproductive choice, and was dissatisfied with the options available to women, many of which relied on male partners' control over, or least their compliance with, women's contraceptive choices. Sanger felt that it was imperative that a contraceptive be developed that was controlled exclusively by women themselves, and that was simple and undistruptive. Her drive to improve birth control options for women was fuelled by a vision of a "magic pill" of sorts, which she felt could be developed by progressive scientists. Her vision was revolutionary and her passion undeniable. However, this alone was not enough to change the state of contraception for women; it would take financial support and scientific knowledge to make her ambition a reality.

In general, drug companies in the 1950s shied away from the controversial topic of birth control. However, scientific developments being made in other areas had positive implications for birth control research. Specifically, experimentation with sex hormones at pharmaceutical companies G.D. Searle and Syntex, S.A. lead to the development of artificial progesterone that was intended for use in treating gynaecological disorders. In 1957, Searle would receive FDA approval for the patented compound that would eventually be used in Enovid (Watkins, 1998). Searle had worked with doctor Gregory Pincus since the 1940s, and sponsored his hormonal research by providing him with drugs, but it was Katherine McCormick, a wealthy colleague of Margaret Sanger's, who would ultimately provide the funds to allow Pincus' research to realize Sanger's vision of a birth control pill. Sanger had been collaborating with Pincus, exploring the feasibility of an oral contraceptive, and in 1952 she discussed with McCormick how such a project might best be funded. Both women believed firmly in the power of science and

technology, and they fully supported Pincus' research. McCormick provided generous financial support to the project, and by the mid-1950s, significant developments were underway. Eventually, Pincus—with the help of Catholic gynecologist John Rock—began clinical trials of the combination of norethynodrel and mestranol that would eventually become Enovid.

The biomedicalization of birth control is historically linked to eugenics and population control, and this problematic history is often overlooked by a generation that generally takes the pill for granted. Clinical trials for the first oral contraceptive began in 1956 in Puerto Rico; the selection of this location is significant in that it illustrates the implications of the United States' colonial rule over Puerto Rico in the beginning of the twentieth century. It also highlights the eugenicist principles upon which the development of the pill was founded. Indeed, it is important to consider the history of eugenic sterilization that occurred in the decades preceding the clinical trials for the pill. The 1937 Birth Control Bill saw the implementation of the Eugenics Board, which disproportionately promoted sterilization among Puerto Rican women. It wasn't until the 1970s that the extent to which many women were coerced into sterilization without knowing the implications came to light, and it was within this period of controversy that Puerto Rico was selected as the location of the clinical trials.

Tone explains that "Pincus had chosen Puerto Rico as the site for his experiment because he believed that clinical tests on women there could be carried out quietly. But this was a belief based on the assumptions about the indifference, docility, and ignorance of Puerto Ricans" (2001, p. 223). Indeed, Sanger made her unfavourable views of citizens of developing nations clear when she advocated for a "contraceptive to be used in poverty stricken slums, jungles, and among the most ignorant people" (quoted in Tone, 2001, p. 207). In fact, this citation reflects her long-standing opposition to reproductive freedom (necessarily equated with 'overpopulation') in Puerto Rico, which was articulated in her 1932 *Birth Control Review*. To Sanger and Pincus, Puerto Rico seemed a desirable location because of overpopulation. Moreover, because the population was generally poorly educated, Puerto Rican women would serve as a useful indicator of whether or not the daily regimen of taking the birth control would be manageable for the average woman (Watkins, 1998). Laura Briggs describes the complexity of the birth control within this climate, noting that the situation "suggests a

great deal about how compacted a symbol birth control really was, at once an argument about economics, poverty, nationality, and U.S. political and military intervention” (2002, p. 77).

Besides the problematic use of Puerto Rican women for subjects in the clinical trials, the trials were also inadequate at a methodological level (bearing in mind that ethical standards in the 1950s were much different than they are today). The number of women tested was 830—clearly an insufficient sample size to realistically determine the efficacy and risks of the pill—and some of these women participated for as little as one cycle (Tone, 2001, p. 32). Also problematic was the fact that many of the reported side effects—which included nausea, headaches, and dizziness, and were serious enough to cause many women to drop out of the study—were discounted by the physicians managing the clinical trials. Especially telling is a statement issued by John Rock that suggested the symptoms were psychosomatic; he informed a journalist, “I very much doubt that the nausea, etc. has anything to do with the tablets. We have never seen it in any of *our* patients” (quoted in Tone, 2001, p. 224 <sup>1</sup>). This once again reveals the potentially racist and classist implications of the clinical trials, and also distinctly suggests that the birth control pill was inadequately tested, ultimately at the health-related expense of many women worldwide.

Despite the apparent shortcomings of the clinical trials for Enovid, the oral contraceptive was approved by the FDA in 1960. Within five years it became the most popular method of birth control in America, with over six and a half million married women (and many more unmarried women) using the new drug (Watkins, 2001, p. 1998). This figure is particularly staggering when one considers the oppositional stance of the influential Catholic church, as well as the general attitude towards premarital sex at the time. The rapid adoption of the pill was fuelled by a number of factors, chief among which was the fact that the new contraceptive method was condoned by physicians, Planned Parenthood, and popular media. While the Catholic church remained firm in its prohibition of any methods of birth control it deemed unnatural, most other sources of information and guidance were supportive of oral contraceptives for

<sup>1</sup> Original emphasis.

married women, and it was clear that many single women's attitudes towards the pill were similarly favourable. Watkins asserts that "the country's love affair with the Pill was in many respects a quintessentially American phenomenon," pointing to statistics documenting high rates of pill use in the United States (1998, p. 239). While the number of pill users was significantly higher in the United States compared to Canada—6.5 million versus 750,000 (Tone, 1998, p. 239)—when the population of each country is considered, the rates are quite similar. In fact, documented use of the pill during the year in question (1967) is actually higher in Canada, and so evidence of the pill's success in America can easily be applied to Canadian women.

The sudden widespread use of the pill was notable for a number of reasons. It was a pivotal development because for the first time, control over contraception was placed in the hands of women themselves. It was the first contraceptive that could be utilized by women without the cooperation—or even knowledge—of their partners. Sanger insisted that this was an important requisite of a truly effective and empowering birth control measure, and the woman-controlled nature of the pill had positive implications for women's equality and opportunity. On the other hand, the pill implicated another figure in the birth control practices of women: the doctor (Tone, 2012). While previous barrier methods required some interaction with doctors and pharmacists to acquire, the pill was unique in that it required almost constant surveillance—not to mention moral approval—by a physician. Women needed to visit doctors regularly in order to refill their prescriptions, and so while the balance of power in regards to contraception shifted from male partners to women, it simultaneously shifted into the hands of medical professionals. This relocation of power effectively normalized the prevailing influence of medicalization on contraception and women's reproductive health, and the implications of this have had increasing relevance ever since.

### **3.1.1. *Backlash***

While the decade following the approval of the pill saw widespread acceptance and use of various brands of oral contraceptives, this time was not without controversy. At first, the pill was met with criticism for moral reasons, rather than for its health and biomedical implications. The moral debates precipitated by the approval of the pill were overcome easily enough, as is evidenced by the high rates of pill use among even

Catholic women. That is not to say that the moral implications of the pill were not considered; arguments still abound over whether or not the pill played a significant role in the sexual revolution of the 1960's. Some worried that the pill was instrumental in the weakening of moral standards by reducing the consequences associated with sex, particularly among unmarried women. However, many reasoned that it was a combination of social factors that contributed to the sexual revolution. Sociological research on sexual behaviours and contraceptive use might reveal a correlation between availability of the pill and premarital sex, for example, but a more holistic approach recognizes a diverse range of factors that contributed to shifts in attitudes and practices relating to sex. Changes in education, technological developments, urbanization, shifting religious outlooks, and a myriad of other factors certainly contributed to changes in gender relations, and consequently, sexual behaviours and attitudes. To what extent the pill played a role in the sexual revolution is still contested, but increasing concerns over the safety of the pill in the 1960s overshadowed this debate.

Concerns over the pill's safety escalated as people struggled to understand the long-term health implications of oral contraceptives. Because millions of healthy women were taking the pill every day, conversation about oral contraceptives, and about medical control more broadly, began to gain momentum, and Watkins explains a series of factors that turned these concerns into a widespread controversy. She says,

The combination of these three factors—poor communication within the medical community, problems of risk-benefit analysis, and difficulties in data collection—provided the framework for a controversy over the health effects of the pill that was at first slow to develop and then was resistant to resolution (1998, p. 80).

At first it was fatal instances of thromboembolism that incited concern over the safety of the pill; by August 1962 there were twenty-eight reported deaths from blood clots among Enovid users (Watkins, 1998). Questions were also being asked about the pill's potential link to cancer; some suspected that the pill might cause certain types of cancer, while others argued that pill use could actually prevent it.

While the medical community was conducting studies on the health risks of the birth control pill, media representations of the pill were generally positive, and potential

negative side effects were notably deemphasized. Typically, news and editorial content focused on the social implications of the pill, rather than health-related outcomes. However, some journalists were dedicated to critically exploring the potential risks associated with the pill; Barbara Seaman was a particularly important figure who fought against widespread use of the pill. Her 1969 work *The Doctor's Case Against the Pill* made a strong argument against the birth control pill, and remains an influential text. In fact, this important book acted as a catalyst for the birth control movement, as it prompted Senator Gaylord Nelson to hold an inquiry into the use of oral contraceptives. The Nelson hearings of 1970 were concerned with assessing the long-term safety of oral contraceptives, and ensuring the informed consent of the women taking them. While these motivations behind the inquiry were certainly admirable and had women's well-being in mind, the feminist critique of the hearings was strong because of the absence of women's voices in the dialogue. In total, only four women testified over the course of the hearings, and all were medical professionals (Tone, 1998). This surprising figure clearly demonstrates that women's voices and experiences were not valued, and that the case of the pill facilitated medical authority over women's bodies and reproductive decisions.

Despite the problematic nature of the Nelson hearings, they still served as an important and informative event for women across North America. Media coverage of the hearings was widespread, and the hearings made news on a number of major networks. It is estimated that millions of American women—up to 87 percent of women between twenty one and forty five—followed the Nelson hearings (Tone, 1998), and it is safe to assume that Canada's proximity to the United States and the availability of American stations on Canadian television meant that Canadian women were also privy to the debate taking place. The outcome of the hearings was a new regulation that stated pill manufacturers were required to include a patient information insert in every pill package, which was an important step towards informed consent for women taking the pill. While patients still see these inserts in pill packages today, and can learn about proper use and potential side effects, it is also worth considering to what extent these inserts downplayed the importance of a personalized dialogue about the birth control pill and its appropriateness for individual women. An information pamphlet can barely be said to ensure informed consent, and a lack of patient-doctor communication about birth control continues today.



### **3.1.2. *Resisting Pharmaceuticals: The IUD***

In the wake of alarm surrounding the health risks of the birth control pill, women began to seek an alternative to the medicalizing option of the pill. Generally speaking, controversy over the pill faded in the 1970s. The Nelson hearings effectively brought the possible negative side effects of the pill to women's attention, and the patient information insert seemed an adequate solution. For those who rejected the pill, either for reasons of safety or affordability, the intrauterine device (IUD) emerged as an increasingly popular birth control option, and by the mid-1970s millions of women were using the IUD (the most popular of which was the Dalkon Shield) as a contraceptive. The IUD was simpler than the pill as it required a one-time insertion that provided years of pregnancy prevention. Because the IUD was non-hormonal, many perceived the device as less medically invasive, and the negative side effects associated with oral contraceptives were eliminated. Further, the IUD presented women with the opportunity to avoid continuous medical surveillance in that it required only insertion and removal by a doctor; women could use the IUD effectively for years without further medical intervention. Hugh Davis, the inventor of the Dalkon Shield, championed the device as a safer alternative to the pill, and even wrote the introduction to Seaman's book, challenging the favoured status of the pill. However, it soon came to light that the Dalkon Shield was responsible for a number of alarming side effects that impacted an unacceptable number of women. Not only was insertion an exceptionally painful procedure, the Dalkon Shield was responsible for 200,000 cases of gynecological complications including infection and miscarriage, as well as eighteen deaths (Tone, 1998; May, 2010). Moreover, the Dalkon Shield was found to be four times more likely to cause such adverse events than any other IUD (Tone, 1998), which can be attributed to the inadequate testing of the device and the concealment of evidence of the dangers of the Dalkon Shield by Davis. It was also discovered that Davis had denied his commercial interest in the success of the product; in fact, he owned one third of the shares in the marketing company. In the wake of the controversy surrounding the pill, the Dalkon shield was perceived as a safer, more liberating alternative. Unfortunately, the story ultimately reiterates the tendency of pharmaceutical corporations to market products for women's sexual health, forsaking individuals' well-being for monetary profit.

## 3.2. The Pill Today

While focus on oral contraceptives may have died down in the latter part of the twentieth century, recent events justify directing critical attention to the pill once again. While in the United States, the debate surrounding the pill and access to contraception is unfortunately still markedly moral, in Canada, this emphasis has waned. In place of moral controversy are debates about the health-related implications of the pill. First, evidence has begun to emerge suggesting that popular birth control pills Yaz and Yasmin, produced by Bayer, present a significantly increased risk of potentially fatal thromboembolic events. The increased risks are due to the fact that these birth control formulas contain drospirenone, which is used to treat acne, as well as premenstrual dysphoric disorder (PMDD). A number of studies suggests that oral contraceptives containing the synthetic progesterone present a significantly increased risk of adverse events, and while other studies contradict this conclusion, it is clear that further studies are required (Dunn, 2011). It is particularly significant that Bayer marketed the products as providing increased benefits over other birth control pill brands because of the very ingredient that has caused significant adverse events. As of 2009, over one hundred lawsuits had been filed against Bayer related to the marketing and side effects of Yaz and Yasmin. The campaign in question has been criticized for overstating the potential lifestyle benefits of the pills, while deemphasizing the risks associated with their use. Given this recent controversy surrounding the safety of popular birth control options, it is clear that greater dialogue and patient education is necessary. Dunn advises that “when prescribing oral contraceptives, the patient’s individual risk-benefit profile should be considered, because such patients are often young, healthy, and may take the chosen pill for a long time... it seems sensible to prescribe an oral contraceptive with a well-known favourable safety profile unless there is a persistent reason to use another type” (2011, p. 1).

These recently emerging safety concerns have a great deal to do with another emerging trend in birth control—the rise of the pill as a lifestyle drug, rather than as a contraceptive. The pill has always been unique as a pharmaceutical product in that it is taken daily by women who are healthy. On one hand, this is reasonable because it is extremely effective, and for many women the health risks the pill poses are outweighed

by the benefits of reliable contraception. On the other hand, the use of the pill as a lifestyle enhancement is questionable; girls and women are known to take the pill in order to clear their skin, suppress menstruation, and even to increase their breast size. When these factors motivate women to use the pill, the superficial benefits might be less promising when compared to the safety risks (although uncommon), and the possibility of other less serious side effects, including changes in mood and loss of libido. While such side effects aren't given much attention in popular discourse about the birth control pill, depression and other changes in mood are one of the most common reasons for women discontinuing use (Oinonen and Mazmanian, 2001). A consideration of these recent issues concerning the pill is important to understand how the birth control pill reinforces the influence of biomedicalization on women's reproductive health and experiences of femininity.

### **3.3. Other Agents of Biomedicalization**

Besides early generation oral contraceptives, a number of other pharmaceutical developments related to sexual and reproductive health effectively demonstrate the increasing trend towards biomedicalization over the past several decades. This overview will briefly describe the role of several relevant pharmaceutical products within the context of biomedicalization, and will explore the implications of these agents for health and femininity.

#### **3.3.1. *Hormone Replacement Therapy***

A notable example of the negative implications of biomedicalization is hormone replacement therapy (HRT), which became an extremely common solution to problems associated with menopause for North American women. HRT was marketed and consumed as a "cure" for the effects of menopause. While many of the reasons for taking the popular estrogen drugs were for valid health concerns, the superficial benefits were equally highlighted, and many women took HRT medications to combat the effects of aging. Elizabeth Watkins explains,

The personal and cultural implications of the medicalization of aging and the dilemma of growing old in a youth-centered society presented issues

that remain unsettled and unsettling. Many of the available educational resources on menopause and aging gave equal weight to issues of health and appearance. (2007, p. 86)

In popular discourse surrounding menopause and hormone replacement therapy, women's menopausal bodies were presented as being unmanageable, burdensome, and less feminine than their younger, fertile cohorts, and HRT was situated as a universally beneficial, unquestionably safe solution to the problems of menopause and aging. The implicit assumption perpetuated by the popular discourse surrounding HRT was that the medicated body was more controlled, predictable, youthful, and feminine than the unmedicated body. While there was some critical discussion surrounding HRT and its safety, such prescriptions enjoyed varying levels of success throughout the later half of the twentieth century, and enthusiasm for the drug markedly peaked in the 1980s. Watkins explains, "The medical model of menopause and aging gained further support in the 1980s as the preventative effect of estrogen on osteoporosis received more attention and endorsement" (2007, p. 76), and popular coverage of HRT was overwhelmingly celebratory. It was in the wake of this newly rejuvenated enthusiasm that the real long-term health implications of HRT came to light.

It was not until the twenty first century that the severe negative consequences of HRT were revealed. An important 2002 report federally funded by the Women's Health Initiative revealed that the overwhelmingly popular prescription drugs were associated with a variety of negative—and even fatal—side effects such as breast cancer, heart disease, stroke, and blood clots. Most alarming about these revelations was the fact that HRT drugs had been on the market for over sixty years, and they had long been assumed by doctors—and consequently by their patients—to be a healthy, safe, and effective option, whether for treatment of serious health problems, or simply as a lifestyle enhancing measure. The report prompted many women to stop using HRT prescriptions, and today more women are cautious when it comes to taking estrogen to treat the symptoms of menopause.

The story of HRT tells us several things about popular discourse surrounding women's sexual and reproductive health. First, it clearly indicates that women's bodies are subject to a strong medicalizing influence, even in the later stages of their lives. It

tells us also that the efforts to medicalize women's bodies are often counterproductive, or even dangerous, to women's health and well-being. Furthermore, this example demonstrates the problematic ideological imperative of youth and desirability for women. HRT was situated as a solution to the problem of aging, and its initial success illustrates how vital attractiveness is to women's value in society. By mediating—or eliminating—the relationship between sexuality and aging, HRT promoted new standards of hegemonic femininity. By way of this example, it is clear that the trend towards biomedicalization is one that problematically suggests that the unmedicated female body is inferior to the medically mediated one, and this assumption produces negative consequences, both for women's health, and for the ways in which women understand and experience their bodies.

### **3.3.2. *Sexual Pharmaceuticals***

It is important to note that it is not only women's sexual bodies that have been regulated and 'enhanced' by biomedical products and regimes, and the success of Viagra and its competitors reveals that men's bodies as well are increasingly subject to this influence. The pharmaceutical invention needs no introduction, but it is worth reflecting on the ideological implications of the 'Viagrization' (Riska, 2010, p. 159) of men's health. While the term may seem novel, it is apt given the phenomenal success of the drug; by 2003, six million men were taking Viagra, with total sales of \$1.7 billion (Conrad, 2007, p. 42). Such widespread use surely has social implications for how women and men alike understand male sexuality. Riska explains, "Viagra not only is a concrete drug intervention but has also become a metaphor for a new thinking about the male body. The Viagra-enhanced body is seen as more natural and real than the natural and real body" (2010, p. 161). Much of the literature on Viagra reveals that the drug has enforced rigid standards for men in terms of (hetero)sexual success (Loe, 2001; Marshall, 2002; Potts, 2003; Riska, 2010), and the implication is that the unmedicated male body is inferior to the pharmaceutically enhanced one. These new standards clearly influence men in a direct way, but it is also important to consider how the sexualities of women are affected by this pharmaceutical phenomenon. Certainly, the (largely) female partners of male patients could also experience a change in standards of their sexual roles in correspondence with the changing capabilities and expectations

of men. This medically mediated relationship between men and women is characteristic of a biomedical model. Riska explains that “the medicalization thesis has mainly been used to show how medical knowledge of the female body and the concomitant medicalization of women’s health-related issues are part of a patriarchal control of women. In contrast, the biomedicalization thesis has highlighted the gendered character of health and illness in a way that the female body and the male body are constituted relationally” (2010, p.149).

The success of Viagra has had an even more direct implication for women’s sexual health. Because treatment of sexual difficulties turned out to be such a profitable endeavour for pharmaceutical companies, it was only a matter of time before a female equivalent was in the works. Conrad explains that “the success of Viagra and the subsequent extension of the concept of male sexual dysfunction has prompted other companies to enter and expand this market (2007, p. 43), and pharmaceutical companies soon began experimenting with a variety of techniques to improve female desire and pleasure. There are two points of significance here; first, it is problematic to assume that desire and pleasure can be quantified or measured (particularly for women, whose cues are obviously not as easy to identify as those of men). Secondly, a new drug to treat women’s sexual difficulties requires a market of women who have something to treat, and so pharmaceutical companies are also faced with the task of establishing a diagnosable problem for women that can be treated by their product. This has resulted in the creation of female sexual dysfunction (FSD) to diagnose female sexual problems. It has been well-established that FSD is a problem developed by pharmaceutical companies in order to create a perceived need for a pharmaceutical solution, and the definition of the disorder problematically labels as many as fifty percent of women as sexually “dysfunctional”.

Moynihan and Mintzes explain the emerging phenomenon in depth, and point out the extent to which pharmaceutical companies play a role in defining illness; they note that 95% of those involved in refining the definition of FSD had ties to pharmaceutical companies (2010, p. 7). The diagnostic survey developed to identify women with FSD relies on questions so broad that forty nine percent of women can be diagnosed, and despite widespread criticism of this figure, it has been widely cited in popular media. It should come as no surprise, then, that the ways in which it is defined allow such a large

percentage of women to be diagnosed as “dysfunctional”; the potential for profit is an undeniable incentive. FSD is gaining increased attention in mainstream media, and many conversations support the quest for a pharmaceutical treatment for women’s sexual problems. This contemporary issue very clearly highlights the relevance of the biomedical model. Riska explains that

The biomedicalization thesis privileges the material body as a major site of biomedical and public discourse. The focus shifted to knowledge-making practices, especially how the body is discursively constituted through biomedical knowledge and practices. The central argument is that the new technoscience and biomedical corporate enterprises influence not only how medicine is practiced but also how technoscientific discourses penetrate the public discourse. (2010, p.154)

FSD serves as a telling example, along with Gardasil and newer developments of the pill, of how in a biomedicalized model, power has shifted into the hands of corporations. Riska asks the important question of “How and by whom are new medical categories constructed that expand medical jurisdiction? Conrad argues that the “engines” behind medicalization have shifted from the medical profession to social movements and interest groups and more recently to market interests in the form of consumers and pharmaceutical companies” (2010, p. 151). Thus, the case of FSD can be understood as reinforcing the tendency of a biomedical model to be problem defining, rather than problem solving, and the implications of this on women’s experiences cannot be overlooked.

### **3.3.3. *Gardasil***

Another contemporary illustration of the tendency towards biomedicalization of women’s sexual and reproductive health is the vaccine Gardasil (and its antecedent competitor Cervarix), which prevents strains of human papillomavirus (HPV) associated with cervical cancer and genital warts. Approved in 2006, Gardasil was developed by pharmaceutical giant Merck & Co., Inc.; significantly, it is the first vaccine ever developed to prevent cancer. While this accomplishment cannot be overstated, the ways in which Gardasil has been situated in popular discourse have been problematic. There are several key elements of the discussion that explain how Gardasil has effectively

perpetuated the trend of biomedicalization—this time for adolescent, and even pre-adolescent, girls.

First, the approval and subsequent widespread vaccination of girls and women age nine to twenty four once again placed the control over women's health into the hands of doctors. Both marketing strategies and popular discourse surrounding the vaccine encouraged universal vaccination of all girls and women between these ages, and the implication was that without vaccination, girls and women would be helpless at preventing cervical cancer. What is particularly interesting about the articulation of the threat of HPV is that it is nearly unavoidable due to the pervasiveness of the virus and the ease with which it is transmitted through sexual contact; however, the sexually transmitted nature of HPV has been highlighted in a way that instills fear (to be quelled by vaccination), rather than as part of a more useful discourse that encourages a practical, de-stigmatized discussion of sexual health. For the most part, the sexually transmitted nature of the virus was glossed over, presumably to reduce stigma and ensure acceptability of vaccination. Casper and Carpenter explain the potential for controversy surrounding Gardasil and Cervarix, and suggest that

Because the HPV vaccine's target is sexually transmitted, it provokes longstanding controversies swirling around sex, gender, and women's bodies in the U.S. Not surprisingly, Merck, GSK, and pro-vaccine actors frame the issue as cancer, not HPV—taking advantage of the lag on public perception of cervical cancer as an STI and suppressing the gendered dimensions of both diseases. (2008, p. 896)

This is problematic because it positions Gardasil as the only means of protection against cervical cancer, and undermines the ability of girls and women to consider their sexual health in a more holistic and self-determining way. Polzer and Knabe describe the marketing strategies for Gardasil as problematic, because “the advertising tactics that compel young women to manage their risks for HPV and cancer through vaccination render invisible any concerns they may have about vaccination and effectively displace their meaningful involvement in decisions regarding their health” (2009, p. 869). Gardasil is presented as the sole means through which women can prevent cervical cancer, and so interaction with medical professionals is encouraged, to the point that failure to get vaccinated is taken as a failure to protect oneself adequately; this suggestion reinforces



moral imperatives for girls and women with regards to their reproductive health. Just as women are the sole bearers of responsibility for contraception, Gardasil effectively makes them responsible for the prevention of HPV.

It is important to note that widespread acceptance of Gardasil (with the exception of religious conservatives who equate protection against the consequences of sexual activity with increased promiscuity) occurred despite the fact that the vaccine has arguably been inadequately tested. The trials included 12,167 women, 6,087 of whom received the vaccine rather than a placebo (Future II Study Group, 2007). Significantly, women enrolled were between the ages of 15 and 26 (Future II Study Group, 2007); this is important to consider given that the vaccine was approved for girls as young as nine years old. Finally, clinical trials began in 2002, only four years before the 2006 approval of the vaccine. This means that the long-term safety and side effects of the vaccine are unknown, as is its efficacy beyond five years. Also of significance is the highly gendered nature of the vaccine and surrounding discourse, in that it positions women as solely responsible for striving for sexual health and dismisses men from this requisite. Universal vaccination for girls and women has been encouraged because it is the most effective means of reducing instances of cervical cancer. But if eradication of the virus were the main goal, it would be safe to assume that a gender-neutral vaccination program would accomplish this more efficiently, as men carry the virus and transmit it to women. Despite this, it was only women for whom the vaccine was initially intended, which proves that it is women's bodies that are more readily medically mediated and surveilled.

Popular attitudes surrounding sexual and reproductive health focus almost exclusively on women, and the Gardasil instance articulates this well. Jennifer Caseldine-Bracht explains, "If the goal is to protect women's health with a safe and effective vaccine, then it would follow that women be substantially more protected if men were vaccinated" (2010, p. 103). She goes on to note that "in the relatively few mainstream media articles that mention anything about administering the vaccine to men and boys, a typical response is that it protects men from ugly genital warts and might protect gay men from developing anal cancer. There is generally no comment at all regarding the fact that if men were vaccinated, then women would be protected" (p. 103). It is clear, then, that Gardasil must be considered critically, because of the lack of

informed choice for young girls being vaccinated, and for the lack of long-term information about the risks of the vaccine. While it is too soon to know the long-term implications of the vaccine, it is within reason to consider the potential of Gardasil to resemble previous pharmaceutical developments for women's sexual health that turned out to be inadequately tested and consequently detrimental to women's health and well-being.

### **3.3.4. *Menstrual Suppression***

The ways in which the pill has medicalized contraception are apparent and well-founded. More recent variations of the pill, however, suggest that the pill corresponds with a biomedicalization model in that it suggests the possibility for an enhanced, and therefore superior, female body. Brands of the pill like Seasonique, Seasonale, and Lybrel are all meant to be taken continuously in order to suppress menstruation so that it occurs only seasonally, or not at all. The rhetoric of menstrual suppression suggests that the menstruating body is less manageable, and less successfully feminine, than the unmenstruating woman, who is represented as experiencing more freedom and unfettered sexuality. While women have always taken birth control in strategic ways in order to predict or delay their periods, it is only recently that the pill has been marketed for this use, and the practice of menstrual suppression has been the focus of much discussion in popular media. Not only does the trend of menstrual suppression illustrate the biomedical ideology of optimization, I argue that it also demonstrates an element of performativity; the woman who participates in this practice is not only empowered by taking control of her fertility and her menstrual cycle, but she is also successfully feminine in that avoiding the mess of menstruation makes her 'cleaner' and sexually available any day of the month. The implication is that a woman who suppresses her menstrual cycle is more empowered, and certainly more attractive, particularly to men.

The discourse surrounding menstrual suppression is problematic; a content analysis of media coverage of women's reproductive health issues reveals that it is often one sided, sensational, inaccurate, and frequently reinforces stereotypes and taboos surrounding women's reproductive bodies (Johnston-Robledo et. al., 2006, p. 356). One study found that discussions of menstrual suppression referenced Seasonale specifically in almost every instance, although just over half mentioned that the drug had not yet

been approved by the FDA (p. 356). In general, articles supported menstrual suppression, and advocates of the practice were quoted twice as often as critics (p. 353). While there are debates surrounding the safety of menstrual suppression, most arguments tend to focus on the convenience that such products would afford women, and are based on the assumption that no woman, if given the option, would choose to experience monthly periods. The dominant assumption is that menstruation is inconvenient, messy, unnecessary, and at odds with women's sexuality and attractiveness, and many women seem to agree. Helen Loshny notes that increasingly, "menstruation is being cast in the same way as menopause, as a problem of pathology that needs to be "fixed" or "eliminated" for not just its immediate undesirable effects but also because of its disease-causing potential" (2004, p. 65).

The argument that menstruation might actually cause disease has gained popularity in recent years, first being introduced into popular discourse with the book *Is Menstruation Obsolete?* (Coutinho and Segal, 1999). The authors argue that menstruation is an unnatural and potentially dangerous process, and advocate menstrual suppression through pharmaceutical means. While there has been resistance to menstrual suppression by some women, attitudes have been changing, and studies have found an increasing number of women are open to the idea of temporarily, or even permanently, suppressing menstruation (Andrist, 2004; Glasier et al., 2003). Laura Eldridge explains women's tendency to accept such pharmaceutical interventions, saying "one reason that women have been ready to pop the pills or take the tests or undergo the procedures, both historically and currently, is that both the medical and pharmaceutical communities have tended to gloss bodily processes that are distinctly female as equivalent with illness" (2010, p. 144). Popular discourse surrounding menstruation and hormonal suppression of the process exemplify this attitude. Eldridge articulates the connections between menstruation and the pill in a way that illustrates the problematic nature of a biomedical model and its specific implications for women's reproductive health, as well as their subjective experiences of their bodies. She suggests that "both the enforced silence surrounding menstruation and the twentieth-century pressure women feel to pass as nonmenstruators have huge ramifications for choices about birth control. Just as menstrual concealment produces a fantasy of

bloodless womanhood, so hormonal birth control creates a cultural fiction of contraception without cost” (2010, p.151-152).

Recent developments of the pill, then, demonstrate the shift from medicalization to biomedicalization. Abby Lippman (who uses the term ‘neomedicalization’ to describe the phenomenon), says it “fits seamlessly in the consumer-oriented society of North America today and to current views of disease—if not ‘pre-disease’— as a “market opportunity!”— For example, this latest medicalization comes packaged as individual “choice” with the offer of multiple “options” to women. Thus, both neomedicalization and consumerism construct health as a commodity” (2004, p. 9). Menstrual suppression products are marketed to women as a means of empowerment; they offer women freedom from normal processes that are pathologized in popular discourse. The trend towards menstrual suppression through the pill corresponds with many of the characteristics of a biomedical model as identified by Clarke et. al, including: privatization and commodification of health and lifestyles; problem-defining health governance; production and dissemination of multiple knowledges; and customization and individualization of bodies. Each of these characteristics of a biomedical model are apparent through an analysis of the pill, particularly in its increasing use as a lifestyle-enhancing, commodified pharmaceutical solution to the problems of women’s supposedly problematic reproductive bodies.

### **3.4. Conclusion**

Through an examination of pharmaceutical developments targeting women’s sexual and reproductive health over the past fifty years, there is a clear indication of the increasing trend towards biomedicalization. While the birth control pill is one of the oldest of such products, it has increasing relevance in the twenty-first century. Not only has the pill effectively medicalized contraception, its increasingly common use as a lifestyle-enhancing drug demonstrates the pill’s situation in the realm of biomedicalization. Clarke et. al explain that

The extension of medical jurisdiction over health itself (in addition to illness, disease, and injury) and the commodification of health are fundamental to biomedicalization. That is, health itself and proper

management of chronic illnesses are becoming individual moral responsibilities to be fulfilled through improved access to knowledge, self-surveillance, prevention, risk assessment, the treatment of risks, and the consumption of appropriate self-help and biomedical goods and services. (2010, p. 48)

In many ways, some of these are worthy ambitions. In others, however, they are problematic in that they promote a standardized notion of what it means to be healthy, and this is achievable almost exclusively through pharmaceutical means. Such reliance on pharmaceutical goods has demonstrated not only a faith in medication that has had negative—even fatal—consequences for women, but also contributes to an ideological climate in which women are expected to accept such pharmaceutical solutions without critical consideration of their reproductive health on a more holistic or individual level.

In some ways, the biomedical model can be seen as an empowering framework through which women can gain knowledge and thus make educated choices when it comes to their reproductive health. Riska makes such a case, explaining,

Research in the 1980s suggested that women were actively involved in defining their own health, and feminist research pointed to the importance of patients' own perspectives... soon this capacity was presented within an empowerment model, which pointed to women's own capacity to "medicalize" symptoms previously not recognized as medical—for example, chronic fatigue syndrome, fibromyalgia—and gain control over their diagnosis and treatment. The empowerment version of the medicalization thesis points to the claims-making capacity of consumers, as opposed to repressive medicalization, which makes women the victims of medicine. (2010, p.153)

Such liberating potential is found particularly through processes of biomedicalization, which are characterized by the creation of, and access to, multiple knowledges about health. The democratization of information, through the Internet for example, has no doubt played a significant role in women's health decisions and experiences. However, the implications of biomedicalization must also be understood critically, as they present a number of drawbacks. In addition to the problem of enforcing (hetero)normative standards of sexuality, Loe explains the negative potential of biomedicalization on a more individual level. She says, "technology promises to be enhancing and lifesaving, while obscuring the fact that it also acts as a disciplinarian and surveillant" (2001, p.

102). The individual is taught to “know her body” to the point of self-conscious self-surveillance (Basalmo, 1996, p. 6; Foucault, 1977) and view her body as fractured, with constantly improvable, fixable parts (Loe, 2001, p. 102-103). These two perspectives will be used to explore the role of the birth control pill, as a biomedical and performative agent, within popular discourse and women’s personal experiences.

## **4. The Pill in Popular Discourse**

It is well-established that the history of pharmaceutical developments that target women's sexual and reproductive health has been heavily mediated by popular media. Texts such as direct-to-consumer advertisements, promotional materials for health care professionals, and newspaper and magazine articles have all played an important role in informing the public and shaping popular opinion about each of the agents of biomedicalization previously identified. Given the increasing dominance of the biomedical framework, which is characterized by commodification and the proliferation of new sources of knowledge (such as the Internet and advertising), such popular texts remain important sources of information for consumers, and also serve as particularly instructive illustrations of popular ideology. A critical discourse analysis of media texts concerning the birth control pill will reveal how it is situated in popular culture, and this will provide an understanding of the ways that popular discourse might influence the contraceptive practices and opinions of women. Drawing from Roland Barthes' notion of myth (1957), this analysis will reveal how the pill has maintained a mythological status in contemporary discourse, not just for the contraceptive control it offers to women, but for the punitive ways that it helps to create or enhance modern femininity.

### **4.1. Critical Discourse Analysis**

The critical discourse methodology emerged in the 1980s and has been advocated by scholars as a powerful interdisciplinary method (Hammersly, 1997, van Dijk, 1993). In general, it seeks to identify and challenge hegemonic dominance and resulting social inequalities. Hammersly identifies several objectives that characterize critical discourse analysis. Put succinctly, critical discourse analysts realize that a phenomenon must be analyzed with consideration of the broader social context; that the knowledge produced reveals pervasive ideologies that perpetuate the status quo; and that the results can help to identify ways to improve the world through the eradication of

oppression (1997, p. 238). These objectives are central to this work, which seeks to reveal and challenge the ideological implications of the birth control pill, in that it reinforces imperatives of normative femininity. van Dijk explains that “although there are many directions in the study and critique of social inequality, the way we approach these questions and dimensions is by focusing on *the role of discourse in the (re)production and challenge of dominance*”<sup>2</sup> (1993, p. 283). The dominant forces at work in the case of the birth control pill are plural; patriarchal, capitalist, and biomedical hegemonies are reproduced through the pill, and all have important implications for the formation of acceptable feminine identities.

The objective here is not to provide a comprehensive, systematic analysis of all cultural texts relevant to the birth control; instead, it is to highlight dominant themes within accessible popular texts related to Yaz and Seasonale/Seasonique. Convenience samples have been used by feminist scholars exploring similar issues in the past, and they have proven to be an effective way to highlight discursive trends and explore their implications (Kissing, 2006; Watkins, 2012). While the restricted availability of relevant texts is a methodological limitation, Hammersly argues that the value of critical discourse analysis “lies not so much in the analytic techniques it employs as in its attempt to locate discourse within a particular conception of society, and its adoption of a thoroughly ‘critical’ attitude towards that society” (1997, p. 237). Throughout this discourse analysis, it will be argued that these two particular products are important examples in the current birth control marketplace, and that discourse surrounding these two products articulates pervasive ideologies related to biomedicalization and normative femininity.

## **4.2. Methodological Justification**

There are a number of factors that motivate a discourse analysis of contemporary marketing materials for the birth control pill. While the pill can clearly be understood as an agent of biomedicalization at a theoretical level, the average individual probably does not consider their health-related choices in such an abstract way. Furthermore, while the ways in which pharmaceutical products like the pill, Viagra, and

<sup>2</sup> Emphasis author’s own.



hormone replacement therapy perpetuate biomedical ideologies and mediate people's gendered identities are well-demonstrated, it is important to understand how these ideologies are manifested in everyday, public, and popular discourse. The objective here is to understand how popular discourse surrounding the pill promotes normative femininity for women, which such discourse suggests can be achieved through pharmaceutical consumption. Todd and Fisher describe the relationship between gender and discourse, saying, that language is "the bridge between social interaction and the socially constructed self", and that it ultimately has the capacity to translate theory into practice (1998, p. 12). This demonstrates the value of analyzing popular discourse in order to address the ways in which a theory—in this case, biomedicalization—comes to life in the language of corporations, institutions, and individuals.

In recent years, the pill has received increased attention in popular media due largely to the development of new iterations of oral contraceptives, including (but not limited to) Seasonal, Seasonique, Lybrel, Yaz, and Yasmin. The former three are continuous-use oral contraceptives taken in order to reduce the occurrence of menstruation to once every three months (or not at all), and the latter contain drospirinone, and are meant to treat symptoms of premenstrual dysphoric disorder (PMDD). The emergence of new pill variations meant to perform a variety of functions beyond pregnancy prevention has resulted in increased competition between brands, and has meant a high level of visibility of the pill in mainstream culture and popular discourse. While each and every text related to the pill—whether produced by advertisers, journalists, or by pill users themselves—is worthy of attention, this discourse analysis will revolve around two particular products and emerging related issues: controversy surrounding the safety of Bayer's Yaz/Yasmin, and the phenomenon of menstrual suppression, recently commodified by Teva's Seasonale and Seasonique. Focusing on these two products in particular will be useful for understanding how current pills differ from first-generation oral contraceptives, and will highlight their status as lifestyle drugs, firmly situated in a biomedical model.

Direct to consumer advertising is a recent phenomenon that clearly reinforces biomedical ideologies. Further, it is a massive industry; it is estimated that DTC spending reached \$2.3 billion in the first 6 months of 2009 alone (Arnold, 2009, p. 8). While this figure quantifies spending in an American context, this has significance for Canadian

consumers as many American advertisements make it to Canada through the Internet, magazines, and television networks. Numerous studies have cited magazines as frequently utilized sources of information on sexuality for young women (Johnson-Robledo, 2003; Sutton et. al., 2002; Treise and Gotthoffer, 2002; Walsh-Childers et. al., 2002). Therefore, a primary focus of analysis will be recent print ads for oral contraceptives. Due to the difficulty of obtaining recent print-ads online, the units of analysis will come from a convenience sample of recent ads located online through image searches, as well as analyses of articles directed to physicians located in journal databases.

### **4.3. Overview of Discourse Analysis**

As has been established, biomedicalization is characterized by the increasing privatization and commodification of health, and the significance of the profit motive for pharmaceutical companies cannot be overstated. In addition, the relatively recent strategy of direct-to-consumer pharmaceutical advertising has important implications for biomedicalization in terms of how it is promoted and perceived within popular/public discourse. Elizabeth Watkins describes the current state of contraceptive technology by pointing out that scientific development has practically come to a halt since the 1990s (2012, p. 1462). She points to a number of reasons for the slowing down of contraceptive research, including the difficulty of obtaining FDA approval, and the “increasingly litigious nature of American society”, referring to the frequent involvement of courts in matters of restitution for side effects of pharmaceutical products (2012, p. 1463). One important implication of the stagnancy of the contraceptive landscape is that, in order to maintain profit, pharmaceutical companies must present their products in ways that seem new; this is especially true given the competition fuelled by expiring patents and generic competition (Medley-Rath and Simonds, 2010, p. 783). This means that promotional materials and popular discourse surrounding new contraceptive products have become a dominant source of information about birth control.

While the pill famously put contraceptive control into the hands of women more than it had ever had been before, whatever power was taken from women’s male sexual partners was placed into the hands of doctors, and this mediation continues today.

Conrad and Leiter describe a mediated market that facilitates medicalization, a description that aptly explains the market in which the birth control pill currently exists:

In mediated markets, corporate medical producers attempt to increase demand for their products by promoting directly to consumer and providers, with the market mediated by health insurers and managed care organizations. Consumers become the target for market expansion, with physicians largely remaining as gatekeepers prescribing treatment. While not an exact reflection of society, advertising typically illustrates popular perspectives, and works circuitously to both reflect and inform normative ideologies. (2004, p. 168)

It is important to keep in mind the mediating role of health care providers when it comes to oral contraceptives; because of this, pharmaceutical companies need to not only appeal to female consumers, but also to medical professionals (Medley-Rath and Simonds, 2010, p. 790). Through a discourse analysis of texts that target potential or current pill users and their physicians, an understanding of the ways in which popular promotional texts related to the birth control pill illustrate and inform popular understandings of the pill will be reached.

Not only have privatization and commodification become central characteristics of biomedicalization in general, they are particularly relevant to the pill; Watkins explains, “marketing decisions, rather than scientific innovations, have guided the development and positioning of next-generation contraceptive products in recent years” (2012, p. 1464). This explanation highlights the problematic nature of both Seasonale/Seasonique, and Yaz/Yasmin. The former products have recently received a great deal of attention for their seemingly revolutionary capacity to allow women to skip their periods; rhetoric surrounding these products emphasizes the freedom enjoyed by women by having only four periods a year (Lybrel does even more by allowing women to eliminate their periods entirely). While promotional discourse for these products makes this feature seem new, these pills are in fact hormonally identical to other pills on the market, and are simply taken in a longer succession, with the placebo pills that initiate withdrawal bleeding taken only seasonally, rather than monthly. Through rebranding these pills, pharmaceutical manufacturer Teva is positioned to earn increased profits from the many women who might choose Seasonale or Seasonique for menstrual suppression. It is important to note that while these pills are hormonally identical to

conventional birth control pills, these products have been officially approved and advocated for menstrual suppression, despite the fact that little is known about the long term effects of this practice. In the case of Yaz, Bayer's decision to market the pill for the treatment of PMDD has garnered critical attention because the company was found to overstate the benefits of the drug, while downplaying the increased risks associated with Yaz, which include potentially fatal blood clots and strokes. This safety issue has resulted in disciplinary action by the FDA. In both of these cases, marketing strategies played a significant role in differentiating these pills from competing brands, and these corporate decisions have had direct medical consequences for many women.

In addition to the physical implications of more recent birth control pills, relevant popular discourse also demonstrates broader ideological implications by associating normative femininity with consumption of commodities. Just as Judith Butler maintains that gender is constituted actively through a series of acts (1998), Dorothy Smith explains that women create themselves in ways mediated by markets for consumer goods: "The relations organizing this dialectic between the active and the creative subject and the market and productive organization of capital are those of a textually mediated discourse" (1990, p. 161). This is relevant to consumption of the birth control pill as the pharmaceutical industry becomes increasingly profitable, and as new variations of the same oral contraceptives are presented as innovative products which can offer women empowerment through pharmaceutically-enabled control over their bodies. Increasingly, this has more to do with the 'lifestyle' benefits of the pill rather than its contraceptive purpose. More and more, different variations of the pill are marketed for their ability to relieve symptoms of PMS, improve skin, regulate moods, and suppress menstruation. Elizabeth Kissling describes the implications of current discourse surrounding hormonal menstrual suppression through continued use of oral contraceptives, explaining that "such cultural texts about menstruation reinforce and even help create negative attitudes toward menstruation, toward women, and toward women's bodies, and that these attitudes are exploited to enhance corporate profits" (2006, p. 6). While new oral contraceptives are frequently introduced into the market and offered to women as lifestyle-enhancing options, Watkins points out that in fact, the options available today differ little from those accessible to previous generations (2012,

p. 1464); it is merely a shift in emphasis on the part of marketers that contributes to an illusion of enhanced choice for women.

#### **4.4. Lifestyle Enhancement**

It is well-demonstrated by current iterations of the pill that it now fits into the category of lifestyle drugs, which Mamo and Fosket describe as “relatively new pharmacological therapies... that promise a refashioning of the material body with transformative, life-enhancing results” (2009, p. 925). There is a pervasive trend within contemporary marketing of the birth control pill to emphasize the ways in which particular oral contraceptives can generally improve women’s lifestyles; these discursive trends have largely replaced discussion about the contraceptive purpose of the pill. The implications of this transformation of the pill from a contraceptive to a lifestyle enhancement are significant. Mamo and Fosket explain that in the case of lifestyle drugs,

The changes they produce are socially and culturally meaningful in their aim to improve life in general—relationships, pleasures, comfort, and so on. Such assumed improvements directly implicate the boundaries of health and illness and, we argue, often do so in particularly gendered ways. (2009, p. 925)

In current discourse surrounding oral contraceptives, which frequently emphasizes their capacity to solve the putative problems associated with being a woman (menstruation, moodiness, bloating, cramps, irritability, and so forth), more aspects of women’s bodies are problematized, and the ways in which women understand and live with their bodies are increasingly mediated by biomedical processes. Once again, the process of biomedicalization is facilitated by the commodification of health. Conrad and Leiter explain that “in the climate of increased corporatization of health care and decreased public regulation, the creation or expansion of new medical markets are a significant force toward medicalization” (2004, p. 160). Women are under increasing pressure to manage their lives and their bodies through medical means, and this often means that their choices are tied up in the logic of consumption.

Beginning even before their official FDA approval, pills such as Yaz and Seasonale were framed as uncontestedly beneficial to women, and their position as lifestyle drugs was celebrated. At a press release announcing the pill's approval, President and CEO Reinhard Franzen proclaimed, "Yaz represents a clear advancement in oral contraception, and underscores the Berlex commitment to provide novel and innovative options in birth control to allow for individual choice" (Bayer Healthcare Pharmaceuticals, 2006). Perhaps more than any other pill, Yaz has been marketed almost exclusively as a lifestyle drug, rather than as a contraceptive; this is particularly problematic given the increased health risks associated with these pills due to the inclusion of drospirenone, the ingredient that gives these pills their supposed advantage. Similarly, Seasonale and Seasonique have become notable competitors in the birth control market, as they are the first oral contraceptives intended to suppress menstruation; these products, along with the more recently approved Lybrel, are also distinctly marketed as lifestyle drugs.

The ideology of optimization is illustrated by advertising campaigns for both Yaz and Seasonale, which have recently employed the slogans "Beyond Birth Control" and "Fewer Periods. More Possibilities", respectively. These phrases urge women to consider how the birth control pill can enhance their lives in ways perhaps not previously considered; this is accomplished by borrowing the language of empowerment, specifically in relation to the women's movement. The utilization of terms like "possibilities" connotes a sense of freedom and self-actualization (Mamo and Fosket, 2009, p. 939). Advertisements for Yaz emphasize that the pill combats fatigue, bloating, moodiness, and acne—and in more recent and controversial ads, it is explicitly stated that the pill treats the symptoms of PMDD. The strategy for Seasonale is similar, yet comparatively understated. Seasonale and Seasonique are promoted for the fact that they allow women to experience less frequent periods and therefore, apparently, lead more active, satisfying lives.

Bayer's Yaz was approved in 2006, and quickly became one of the most popular pills on the market due to an extensive marketing campaign that touted the pill's ability to treat a variety of symptoms of PMDD due to the inclusion of drospirenone. By 2009, Yaz was the most popular birth control pill on the American market, and ranked highly among prescriptions overall, with annual retail sales of \$700 million (Watkins, 2012, p. 1469).

The condition of PMDD, which Yaz helped to popularize, presents an example of a contested medical condition that relies on extensive marketing in order to ensure recognition and treatment. Ebeling explains that disease marketing campaigns often begin years before approval of the relevant drug (2011, p. 825-826). This phenomenon was well-demonstrated by the Merck-funded cervical cancer awareness campaigns that preceded Gardasil, and can also explain the recent designation of FSD in light of the potential development of a ‘female Viagra’. The development of such marketing strategies primes patients and doctors alike to recognize a particular condition (perhaps in themselves) and to choose the branded pharmaceutical product advertised to treat it. Yaz is not the first drug marketed to treat PMDD; the condition was in fact classified, with the help of clinicians hired by pharmaceutical company Eli Lilly, in order to protect their patent for their infamous Prozac. With the patent for the popular antidepressant about to expire, Eli Lilly worked to rebrand the drug into Sarafem—a drug chemically identical to Prozac, which was found to effectively treat undesirable menstrual symptoms. Testimonies to the FDA by Eli Lilly’s hired clinicians prompted the FDA to recognize PMDD as a disease, and Sarafem as an appropriate treatment; this allowed the company to renew their patent on the drug for another twelve years (Ebeling, 2011, p. 827).

With PMDD classified in the DSM-IV, the condition received increased attention in popular discourse, and Yaz became an accepted treatment of the disorder through an extensive marketing campaign. Ads for Yaz, like other birth control pills, typically feature young, attractive women, looking directly into the camera, who convey the sense of empowerment that ads of all sorts suggest is a result of the consumption of the advertised product. One print ad for Yaz features a young woman of mixed ethnic background, at once confident and coy, situated in a clean urban setting. She looks directly at the camera, hands on hips; underneath her image is Yaz’s previously identified slogan, and a caption that goes on to say “Take action and go beyond birth control with YAZ”. The text then goes on to explain that Yaz is *the only*<sup>3</sup> birth control pill proven to treat symptoms of PMDD that are “enough to impact the lives of women”. The petition to “take action and go beyond birth control” suggests a number of things. The

<sup>3</sup> Original emphasis.

first is that Yaz can do much more than simply prevent pregnancy. Secondly, it suggests that to be 'on the pill' is no longer empowering *enough*; while previous generations of women were liberated by the ability of the pill to prevent pregnancy, women today are expected to take advantage of the pill and enjoy the lifestyle enhancements that modern variations of OCs can offer. There is a subtle implication here that the woman who chooses Yaz—who *goes beyond*—is more empowered than the woman who does not. Framing Yaz in this way makes the decision to choose this brand of oral contraceptive seem like a superior one; this is particularly problematic because of recent discoveries about the escalated severe health risks of Yaz and Yasmin. Finally, the suggestion that Yaz goes “beyond birth control” situates a much broader range of women within the target market of the product; not only are women who are seeking a contraceptive option targeted, but all women who experience any unfavourable symptoms associated with menstruation are hailed by the campaign.

Another print ad for Yaz features a young woman crowd surfing at an outdoor concert, looking into the camera and laughing. In the sky above her, the numbers '24/4' appear to have been written by a jet stream, referencing the “unique 24/4” regimen that means women on Yaz only experience withdrawal bleeding for four days, rather than the typical seven. Presumably, this shortened cycle has afforded the young woman increased freedom that allows her to participate in exciting activities like attending concerts. The woman is youthful, and dressed in vibrant clothing and sneakers, and appears younger than the women in typical birth control ads; this ad seems to target a younger generation of current or would-be pill users.

A recent television commercial for Seasonique similarly implies that choosing a birth control pill that offers more than simply birth control is a superior decision that appeals to both the “logical” and “emotional” needs of women. In the ad, two different women represent these polarized female identities. The former is, unsurprisingly, signified by muted earth tones, good posture, a practical hairstyle and an argyle sweater, while the latter appears more feminine and carefree, with pretty clothing and hair against a colourful green background. The women address each other, and hail female viewers, as “emotional” and “logical”, as if by name, and the dialogue continues on to explain why choosing Seasonique—the pill that allows women to have fewer periods—appeals to both sensibilities. The logical side is satisfied by the ninety-nine percent effectiveness



rate of the pill, while the emotional side appreciates having only four periods a year (presumably because she experiences the moodiness and bloating associated with menstruation in ads like those for Yaz). While the narrator explains the risks and side effects of the pill, the “logical” woman is seen researching Seasonique on her laptop, and the “emotional” lounges on a chair, kicks a ball, and dances in high heels. The commercial concludes with the narrator urging women to “learn more by visiting Seasonique.com, or ask someone logical like your health care provider”.

The suggestion put forth by this commercial is that women themselves might lack the logic and knowledge to make an informed decision about their health, but that health care professionals can give them the information they need to make a decision. Of course, the implication is that choosing Seasonique is the correct one. The option to take Seasonique is presented almost as an ‘upgrade’ from regular birth control, and the commercial includes a woman in the role of a doctor urging women to consider menstrual suppression, reassuring them that “There’s no medical need to have a monthly period on the pill. Lots of women are having four periods a year”. This particular ad, along with many other popular texts related to women’s health, emphasizes medical authority over women’s bodies, and implies that pharmaceutical consumption is a necessarily productive choice for women. The ad is sophisticated in that it drastically broadens the target market for birth control; Mamo and Fosket explain the discourse that advocates menstrual suppression as follows: “By packaging itself as a menstrual-managing device, Seasonale targets every woman who is imagined as desiring or benefiting from fewer menstrual periods” (2009, p. 932). Hence, the potential market for the drug extends far beyond those seeking contraception.

The argument used in this ad is common among sources promoting menstrual suppression; the idea that menstruation is unnecessary has become increasingly popular, particularly when it comes to women on the pill. This is because the withdrawal bleeding that occurs when placebo pills from a conventional pill cycle are taken is different from a normal period. First generation pills were developed this way in order to replicate women’s natural menstrual cycles, in hopes of increasing the pill’s acceptability in the Catholic church (May, 2010; Watkins, 1998). What is remarkable about the commonly made argument that pill periods aren’t real periods at all, is that instead of seeking to educate women about the physical implications of taking the pill, it persuades

women to simply accept what they didn't know (that they were not getting real periods), and to continue—if not increase—their consumption of the pill. Another commonly cited advantage of extended OC use is that reducing the number of placebo pills taken increases the effectiveness of the pill at preventing pregnancy (Sucato, 2002; Contraceptive Technology Update, 2008). This is extremely problematic because the pill is generally presented as being exceptionally effective; women are rarely encouraged to question the efficacy of the pill, which most sources claim is 99% effective. It is only in this instance of a potential increase in profit that women are encouraged to question the efficacy of the birth control pill. Discourse promoting menstrual suppression capitalizes on common misconceptions about the pill (that pill users get normal periods, and that the pill is completely effective) by highlighting its potential problems, and then providing a solution to these shortcomings by simply promoting different use, and so the pill becomes a solution to itself.

An important implication of ads such as those for Yaz is that women's bodies are increasingly problematized; this has been demonstrated repeatedly over time by proponents of numerous biomedical agents. Another print ad for Yaz, which asks the question "Ready for birth control that goes beyond?" portrays a young woman against a blue sky, physically combating the various threats—fatigue, bloating, moodiness, and acne (depicted textually)—that women face. The ad once again suggests that women can be empowered through the consumption of the advertised brand of contraceptive that "goes beyond". The woman depicted is once again looking directly into the camera, demonstrating her physical power by assuming a boxing stance. That her posture is rather masculine is important, especially because the problems that she is combating are conventionally associated with problematic femininity. The bloated, moody woman suggested by the advertisement summons the idea of a hysterical woman, plagued by her very womanhood. Indeed, ads for a variety of products associated with women's cycles suggests that women are hindered by their physical bodies, which not only limit their capacity to function in a productive manner, but are also something to be ashamed of; this is particularly true of ads for feminine hygiene products. The Yaz ad presents a number of symptoms of femininity—at once vague and nearly universally experienced (likely by men as well as women)—that can be treated through pharmaceutical consumption.

A television commercial for Yaz from 2010 not only advocates the pill as a lifestyle drug, but also importantly utilizes the strategy of self-diagnosis to present the pill as a viable and empowering option for women. In the ad, three attractive and well-dressed women are seen in a bustling lounge, discussing the benefits of Yaz—established by the women’s dialogue as the only reason one of the women could make it out of the house. Speaking of her doctor, the woman explains, “I told her how I was an emotional wreck a week or so before my period- I thought I had PMS so I tracked my symptoms, and my doctor told me “That’s not PMS, that’s PMDD.” The woman’s friend interjects, providing her friends—and, as required, the audience—with information on the risks and side effects of Yaz, as well as an explanation of the symptoms of PMDD which, unlike PMS, “Are actually severe enough to interfere with your life”. As she explains this, text fills the screen that identifies symptoms of PMDD, including irritability, mood swings, feeling anxious, fatigue, headaches, bloating, muscle aches, and change in appetite (symptoms that the majority of women likely experience occasionally), and the ad urges women to track their symptoms at Yaz’s website.

This strategy of listing symptoms, which consumers can identify in themselves for the purpose of self-diagnosis, is problematic because it implies that a large number of women are unwell. This DTC strategy could realistically result in a significant number of women believing they have a medical problem that needs pharmaceutical treatment, when in fact these experiences are normal and not problems that typically warrant medical attention. This is exacerbated by the fact that it is not clear what constitutes interference in one’s life; arguably, an individual could interpret experiencing any of these symptoms at a modest level as interference. The Yaz advertisement concludes in a significant way: after the knowledgeable narrator character completes her dialogue, her impressed friend applauds her knowledge, to which she responds by revealing that she is in fact a doctor. She concludes by saying, “Seriously, track your symptoms, talk to your doctor, and ask if Yaz is right for you.” The woman in this ad is one that viewers can relate to as a peer, but at the same time plays the role of medical authority in order to validate the notion that Yaz should be taken for lifestyle purposes.

Another television commercial for Yaz, which is no longer available online, features balloons emblazoned with the same symptoms mentioned in the previously mentioned ad, floating up into the sky, to the delight of the female actresses in the ad.

The rising of the balloons seems to symbolize the breaking of the shackles of undesirable symptoms of femininity, and women's subsequent empowerment and freedom. This is emphasized by the music playing throughout the commercial—a female-sung pop-rock anthem that chants “goodbye to you!” A similar ad from the campaign uses 1980's hair metal anthem “We're Not Gonna Take It” to highlight the emancipation offered through consumption of Yaz—a rather ironic choice, given the distinctly anti-authoritarian message of the song. The problem with Bayer implying that Yaz liberates women from undesirable symptoms is articulated most clearly by a subsequent ad, ordered by the FDA, that explains the health risks associated with the product. The commercial features the same actress who played the doctor/friend figure in the previously discussed commercial. She begins the ad by stating, “You may have seen some Yaz commercials recently that weren't clear. The FDA wants us to correct a few points in those ads.” She then goes on to clarify that Yaz is intended for pregnancy prevention and the treatment of PMDD—*not* for the treatment of PMS or mild acne, as previous ads suggested. It then explains the increased risks associated with drospirinone, such as blood clots, strokes, and heart attacks. This commercial ran extensively in order to fulfill the FDA's requirement that Bayer put \$20 million into correcting their misleading ads. The fact that these health concerns were raised only after Yaz had become the most popular OC in the United States highlights the problem of undue enthusiasm for pharmaceutical developments related to women's sexual health, which has had fatal consequences over the past half century.

## **4.5. Normative Femininity**

The transformation of oral contraceptives over the past fifty-two years since their initial approval is profound. As has been established, the pill has gone from a pharmaceutical breakthrough that empowered (primarily married) women from male partner and physician controlled contraceptive devices and protected against unwanted pregnancy, to a drug so ubiquitous and accepted that it is now promoted for nearly all women, from adolescent girls to pre-menopausal women, to treat anything from acne to irritability. That the pill is now firmly situated as a lifestyle drug in popular discourse is incontestable, and it is important to consider the broader cultural implications of this transformation. Not only does the pill work hormonally to alter—or implicitly to

'improve'—women's bodies in relation to fertility, menstruation, appearance, and mood, but these changes have important social meanings. It is not only the tangible, physical impacts of the pill that deserve attention; the more subtle, yet certainly powerful, ways in which it mediates and perpetuates standards of femininity are significant. In an important argument about the reproduction of femininity, Susan Bordo explains,

Through the pursuit of an ever-changing, homogenizing, elusive ideal of femininity—a pursuit without terminus, requiring that women constantly attend to minute and often whimsical changes in fashion—female bodies become docile bodies—bodies whose forces and energies are habituated to external regulation, subjection, transformation, “improvement.” (1993, p. 309)

It is my argument that popular discourse surrounding the pill positions it as yet another agent of feminization and improvement. Along with ensuring a feminine appearance and graceful mannerisms, the act of being 'on the pill' further constitutes normative feminine embodiment.

Marketing for the pill commonly suggests that not only are women's lifestyles enhanced through the consumption of modern generation oral contraceptives, but that these material changes facilitated by the pill in fact make women's bodies more ideally feminine. For instance, campaigns for Yaz that emphasize the pill's secondary benefits conjure a woman with perfect skin, a slim, unbloated body, and a fun, emotionally stable demeanour. Ads for Seasonale similarly suggest that the pill helps to produce femininity—in this case, one that is superior to 'natural' femininity—by helping women to avoid regular menstruation. Menstrual-suppressing versions of the pill in particular draw on and perpetuate unfavourable assumptions about menstruation that suggest a woman's period is messy or unclean, and impairs her desirability. “By drawing on scripts about menstruation that resonate with North American ideals of femininity, (menstrual suppression advocates) first produce women's bodies as messy and requiring intervention and then produce menstrual suppression as a seemingly natural solution to an age-old problem” (Mamo and Fosket, p. 930). By framing menstruation as a problem—implicitly, as a barrier to ideal femininity—drugs like Seasonale become a means to achieving a more ideal and desirable body. Kissling argues that through such campaigns, “cultural texts about menstruation reinforce and even help create negative

attitudes toward menstruation, toward women, and toward women's bodies, and that these attitudes are exploited to enhance corporate profits" (2006, p. 6).

Certainly, popular discourse that plays upon anxieties about femininity is not unique to menstrual suppression specifically, or the pill in general. For instance, previous discussions about hormone replacement therapy and treatment for female sexual dysfunction draw upon rigid and heteronormative assumptions about what constitutes ideal femininity, and position pharmaceutical products as necessary solutions<sup>4</sup>. However, it is interesting to note how popular discourse related to the pill has shifted over the last half a century, and has come to emphasize an increasing number of putative feminine problems. In its original form, the contraceptive function of the pill allowed women to be more sexually available without the consequence of intended pregnancy, and without the mess and hassle of previous contraceptive devices. More recently, the pill has been positioned as mood stabilizing, skin enhancing, PMS eliminating, and so forth. And now, with seasonal birth control pills, oral contraceptives liberate women from the unpleasant taboo of menstruation. Increasingly, the pill is represented as a solution to the 'symptoms' of being a woman, and cultural expectations of ideal femininity are shifting correspondingly.

## **4.6. For Physicians**

In addition to marketing materials directed towards consumers, pharmaceutical companies also target advertisements to medical professionals in order to create brand awareness and, hopefully, increase rates of prescription. A print ad for Seasonale directed towards physicians features an image of four attractive, ethnically diverse women, driving in a convertible, laughing candidly. The woman driving is looking at the camera and holding up four fingers to represent the number of periods indicated in the text, which reads, "Take her life in a whole new direction with just 4 periods a year." The ad also employs the drug's slogan "Fewer Periods. More possibilities." and urges doctors to "Prescribe the OC that offers just 4 periods a year!" This statement seems to imply that the extended use of oral contraceptives for menstrual suppression should be

<sup>4</sup> See discussion in chapter 2.

universally prescribed; it does not suggest that this regimen is appropriate for women who experience severe problems related to menstruation such as endometriosis or anemia (as many proponents of menstrual suppression advocate). Rather, four periods a year is presumed to be favourable to any and all women.

Publications in medical journals similarly promote menstrual suppression to clinicians. An article from the *Journal of Pediatric and Adolescent Gynecology*, “Tips for Clinicians: Extended Cycling of Oral Contraceptive Pills for Adolescents” (Sucato, G. and Gold, M., 2002), urges doctors to promote menstrual suppression for their adolescent patients for a variety of reasons, ranging from “dance/theatre performances” and “athletic participation” to “developmental or behavioural problems” and “desire to simplify menstrual hygiene”. The article explains, “The potential benefits of extended cycling are being reported by the lay media with increasing frequency, and clinicians may receive increasing numbers of patient queries regarding extended cycling” (p. 325), suggesting that these lay media representations should inform physician’s practices. The article explains how to prescribe extended cycle contraceptives, and paints the practice in a positive light, despite the acknowledgement that many patients experience increased breakthrough bleeding as a side effect, and despite the fact that, at the time of writing, no studies had examined extended use of estrogen/progestin pills, nor had any determined the longest amount of time pills could safely be taken (p. 325-326). The fact that physicians are presumed to willingly prescribe the pill to adolescent girls for non-contraceptive reasons confirms that the trend towards lifestyle-enhancing utilization of drugs is pervasive at a number of levels, and suggests that the choice to use OCs has become a standard.

Another article directed towards physicians advises them on how to assuage women’s anxieties about skipping their period using oral contraceptives (Contraceptive Technology Update, 2008). The article highlights the ‘problem’ of women’s discomfort with menstrual suppression, compared with doctors’ willingness to prescribe extended cycle OCs. The article reports the results of a survey that indicate 77% of physicians raise the topic of menstrual suppression with their patients (p. 16); this figure suggests that medical professionals frequently reiterate the ideological assumptions about the problematic nature of women’s bodies with their patients. This, combined with the positive representation of menstrual suppression in popular media, surely contributes to

an attitude that assumes women's bodies can be improved by novel consumption of the birth control pill. The article quotes a professor of obstetrics and gynecology as saying, "women have assumed for years that a regular menstrual bleeding episode is a sign of normality... to change this perception will take a significant effort" (p. 17). This quotation implies that menstruation is abnormal and inherently problematic; according to this logic, menstrual suppression is the obvious choice, not just for women who experience negative side effects due to their monthly periods, but for *all* women. This is aligned with the rhetoric of Seasonale's advertising campaign, which is "fundamentally aimed at rewriting dominant biomedical and cultural narratives about what is and is not presumed to be natural when it comes to birth control. Put simply, the Seasonale campaign begins by disrupting the taken-for-grantedness of monthly menstruation" (Mamo and Fosket, p. 933). The argument of this article is problematic in that it emphasizes medical professional's expertise over women's individual experiences, and attempts to discount women's potential reasons for declining menstrual suppression (or OC use in general). In an environment where popular media are generally promoting pill use for a variety of reasons, and physicians are reiterating the benefits of oral contraceptives to patients, there is little room for discussion of alternatives, and it seems that in most spheres, the pill is given primacy.

## 4.7. Conclusion

A discourse analysis of texts directed towards women and clinicians reveals a pervasive trend towards marketing the pill as a lifestyle enhancement that is necessarily suitable for virtually all women, from virginal adolescents hoping for clearer skin to older women seeking the increased flexibility and freedom associated with menstrual suppression. Notably, most of these materials emphasize these sorts of advantages over pregnancy prevention itself. There seems to be a common assumption that women are already on the pill, but they need to be educated about the additional advantages of particular brands of OCs so that they make the obvious choice to upgrade their birth control and enjoy greater benefits. For the most part, these advantages are associated with enhanced femininity. Women on Yaz, for example, are depicted as more attractive and upbeat, while those on Seasonale are portrayed as avoiding unattractive monthly menstruation. Interestingly, most of the maladies that newer versions of the birth control



pill are said to remedy connote a conventional—and negative—femininity. Like the hysteric, the unmedicated woman is emotionally unstable, and her body, controlled by her reproductive organs, is unpredictable and requires management. In this way, popular discourse surrounding the pill at once problematizes women's natural bodies, and at the same time produces an enhanced or preferable femininity that still complies with normative gender roles. The woman on the pill is attractive, positive and fun-loving, and unencumbered by her monthly period—which not only ensures that she is more able to balance the many roles of the modern woman, but is also regularly sexually available, given her protection against pregnancy and also her (and her partner's) ability to avoid menstruation.

The ways in which the pill is presented in popular discourse are important to address, because these representations both inform women about acceptable contraceptive practices, and reflect common ideologies about contraception specifically, and femininity in general. The discursive trends identified here confirm the ways in which biomedicalization is promoted in popular culture, and also help to illustrate the relationship between biomedicalization and gender. Trends in dialogue related to the birth control pill reveal important ideologies that impact how women interpret oral contraception, and also how they experience their bodies in general.

## 5. Personal Experience

While it is instructive to position the pill within a biomedical narrative in order to understand its current role in mainstream society, this theoretical perspective cannot adequately illustrate the more concrete implications that the pill has for women in their lived experiences. In order to understand how women's personal experiences correspond with popular discourse surrounding the pill, which implicitly promotes a biomedically managed model of sexual and reproductive health, a series of interviews were conducted with women who were on the pill at the time, or who had been in the past.

### 5.1. Methodology

Participants were recruited through posters placed in coffee shops and community centres in central Vancouver neighbourhoods.<sup>5</sup> Because response to posters was minimal, snowball sampling was used to find an adequate number of participants. In addition, several acquaintances agreed to participate in the study. A total of ten interviews were conducted with women aged twenty-four to twenty-eight who had taken the pill from as young as fourteen years old.<sup>6</sup> One half of the participants were currently on the pill, and half had discontinued use. It is necessary to acknowledge that this sample cannot be considered representative of all women, given the similar age, and socioeconomic and ethnic backgrounds of the participants. It would be worth investigating how factors such as age, education, socioeconomic status, ethnicity, and access to health care resources impact women's experiences with the birth control pill. While a larger and more diverse sample would surely provide more nuanced results, this would be beyond the scope of an exploratory master's thesis. It is also arguable that the

<sup>5</sup> See Appendix A.

<sup>6</sup> Demographic information for participants located in Appendix B.

recruitment methods would produce biased results, in that those who responded to posters may have more of an interest in discussing the topic for a number of reasons, and so their responses may not reflect those of the average woman. While it could also be argued that interviewing acquaintances might produce biased or homogenous results, the experiences and responses of the women interviewed reflected a diverse range of experiences. Further, most participants were extremely candid during the interviews, and contributed to a rich and compelling set of data.

Interviews were semi-structured and followed a series of open-ended questions <sup>7</sup>. Participants were assured that they could offer as much or as little information as they liked, and the confidential nature of the research was emphasized. All participants provided written consent <sup>8</sup>, and also filled out a brief questionnaire <sup>9</sup>. Interviews were audio recorded, transcribed, and coded for common themes. Overall, the interviews were extremely revealing, and many themes that emerged highlight previously addressed issues. Here, the results of the interviews will be described according to the following topics that emerged and guided the coding process: normalization of the pill, media representations, male partners, side effects, risk negotiation, barriers to access and education, performative femininity, and transformation of the body. The incorporation of direct quotations from the participants will illustrate what meanings the pill has for women, and this primary data will serve as a useful supplement to the theoretical perspectives previously offered.

The qualitative interview method employed to collect this data has been previously used by feminist scholars studying young women's sexual behaviours and sexual health practices. Holland et al. conducted similar interviews and emphasized that while the information provided by participants is valuable, it cannot necessarily be taken at face value or assumed to provide an accurate or 'true' portrayal of their practices. They explain, "What is available in an interview is not a simple documentation of social life or sexual culture—although such information is available in part. An interview produces fragments of accounts of both common and variable ways in which people present their experiences, make sense of them and offer them to another" (1998, p.

<sup>7</sup> Interview guide located in Appendix C.

<sup>8</sup> See Appendix D.

<sup>9</sup> See Appendix E.

203). While these interviews cannot be claimed to reveal an authentic truth about women's experiences, they can provide an understanding of the influences that motivate women to take the pill, and what meanings they make of this practice.

## **5.2. The Pill: Influences of Normalization**

Women's experiences with the pill were mediated by a variety of influences, including medical professionals, peers, parents, male partners, and the media. Each of these sources normalized the pill, and contributed to an understanding of the pill as an imperative for young women. Through the interviews, it was repeatedly revealed that the birth control pill was seen as a default of sorts, among both participants and their physicians. It was overwhelmingly suggested that the pill is an accepted standard, not only as a method of contraception, but also for enhancing the lifestyle of adolescent girls and young women. In most cases, the pill was the only contraceptive option advocated by physicians, and it was presented as an obvious remedy for a number of other common issues. This notion was reinforced by popular media representations of the pill. Overall, participants described being on the pill as a normalized practice among their peer groups, as most influences worked to situate the pill as an obvious and universally appropriate choice for young women.

### **5.2.1. *Medical Authority/ Pushing the Pill***

One of the most compelling results that emerged from the interviews was that, in virtually every case, doctors were overwhelmingly supportive of women (or, more accurately, adolescent girls) taking the birth control pill. In fact, in many cases this support more closely resembled encouragement or promotion. Every participant indicated that the medical professional they saw either immediately complied with their request to be on the pill, or advocated pill use of their own accord, for a variety of reasons. Instead of acting as a barrier to access, physicians frequently prescribed the pill, even when it had not been specifically sought out. One participant, who was sixteen when she began to take the pill, recalls that she initially took the pill

Mostly because my doctor told me it would help with acne, and also because that was when I started becoming sexually active. So it was just-

my doctor really kind of pushed it on me, I guess. Well, I wouldn't say "pushed it", but I didn't come up with it. She just gave me all the good reasons and I was like, "okay." (Carly, 24)

Several participants referred to being "put on" the pill, usually by doctors (and for one woman, by her parents). That particular participant was fourteen when she began taking the pill. She said,

I started taking the birth control pill really early, so I was fourteen-maybe a little bit before fourteen, and it wasn't my decision, it was my mother's decision. I don't want to say it was forced upon me, but it kind of was in a lot of ways, because at that age it was before I had a consciousness about the whole sexual health thing... it was like a very authoritarian preventive measure that she imposed on me. (Shalon, 27)

She recalls her mother bringing her to the doctor to get a prescription for the pill for contraceptive purposes, long before she became sexually active, and the doctor advocated the decision as well. She said, "I kind of felt like I was taking the prescription like I was told. And I mean, I also feel like at the same time I was like, "Yeah!", just because these authority figures were telling me it's what I should do" (Shalon, 27). Another participant, who was twenty-six at the time, described being surprised that a physician "put me on" a hormonally strong brand of the pill, despite her sensitivity to birth control hormones (Clarice, 28).

Several participants recalled their physician's unwavering support for the pill, despite the fact that their patients reported negative side effects. When participants related their symptoms or side effects, doctors tended to respond in ways that downplayed the concerns of patients, and frequently encouraged them to ignore or wait out symptoms: "Oh no, it's not an issue, just keep taking it" (Lauren, 27) and "Oh, just stay on it, this is normal. In a few weeks or months it will go away" (Christina, 25) are examples of doctors' responses to participants' concerns. Other participants described severe or persistent problems, which doctors addressed by simply prescribing another brand of the pill. One woman, who eventually stopped taking the pill because of side effects, described her doctor's response as follows: "But he was actually always like, "Here's this one", "Try this", "Oh, you're still having problems? Here's a lower dose, try this one instead". He was just following the trends... I've changed brands pretty much ten times" (Jess, 28). Another woman who continues to take the pill said she had to try

four or five different brands before she found a brand that worked for her (Elise, 24). While it is encouraging that doctors were open to addressing the concerns of women by providing them with different options, their responses generally privileged the pill as the best form of birth control, with little regard for individual experiences and no discussion of alternatives. Several participants felt that the pill in general was simply not a good option for them because of the physical and emotional side effects it produced, and yet alternative methods of contraception were never discussed. One participant said, “I don’t even think that stopping was an option. It wasn’t even discussed” (Shalon, 27). Another woman explained, “I remember asking them about different kinds (of birth control), but they always just kind of wanted to stick to the pill” (Christina, 25). In nearly all cases, the physician promoted the pill, and presented a different brand as an option if the woman’s current brand was producing undesirable side effects. Understandably, this was frustrating for women who eventually discontinued using the pill altogether and found this to be the only adequate solution to the side effects.

While many participants were, in retrospect, perplexed by their doctor’s unwavering enthusiasm for the pill, others had opinions on why this might be. Two participants, who eventually switched from the pill to the IUD, suspected that there are financial motivations to prescribe the pill, and also believed that doctors are more inclined to write a prescription than they are to perform a more complicated and time-consuming procedure. One of these women said, “I think the pill is a lot more... probably pushed on (doctors) by pharmaceutical companies” (Lauren, 27). Indeed, her suspicion is well-founded, as there is substantial evidence that pharmaceutical representatives play a key role in the education of health care practitioners (Moynihan, R. & Mintzes, B., 2010). Given that the IUD has only an initial cost and no necessary follow-up until its removal years later, the increased profit to be made through monthly pill prescriptions is substantial. This participant reflected on her experiences with both the pill and the IUD, saying, “You know, it’s easier to prescribe someone a pack of pills than it is to do an IUD insertion, and I think a lot of doctors might be uncomfortable with that if they don’t have the experience, so that could be a factor as well” (Lauren, 27). She explained how she perceived a lack of options other than the pill, saying, “Everything just seemed so less common and less available, the pill just really did seem like the only reliable option... it’s unfortunate because I don’t think there are that many great, viable options, especially

when you're a young woman, because the IUD seems to be ruled out instantly" (Lauren, 27).

Another participant noted, "You know, the IUD hasn't really been talked about. It's always the pill, the pill, the pill. That's your best option" (Jess, 28). She speculated on the lack of discussion about alternatives, as well as the absence of progress towards a male contraceptive, saying, "I think it isn't changing now because of economic implications. Like, if you think of all these women paying thirty dollars a month for birth control, that's a massive industry" (Jess, 28). The two participants who had used the IUD felt that they had limited access to information about the device, and that their doctors were unwilling to prescribe it, despite the fact that it's a preferable option for two reasons. First, the copper IUD that each woman chose contains no hormones, which is beneficial for those who experience negative side effects from the pill. In addition, the IUD is a much more reliable option, as its efficacy does not depend on perfect use. Both of these women expressed disappointment that the IUD is so rarely discussed, given the significant advantages it has over the pill.

Naturally, medical authority has mediated women's experiences with the pill. Although the current biomedical landscape facilitates education through different means—particularly the Internet and marketing—doctors generally act as a gatekeeper when it comes to women's decision to take the birth control pill. This is frequently considered to be a barrier to access, and advocates of birth control often suggest that the fact that the pill requires a prescription is an obstacle to overcome. This is certainly a valid concern, particularly in the United States, where physicians and pharmacists have the ability to decline providing medication or services based on their personal moral position on issues like abortion and contraception. In Canada, where health care is universal and it is comparatively easier to access medical care, the need for a prescription is a less substantial barrier to accessing birth control. At the same time, it is important to acknowledge the role of health care professionals in women's contraceptive education and practices.

### **5.2.2. *The Pill as a Lifestyle Drug***

The notion that biomedicalization is increasingly characterized by an emphasis on lifestyle or optimization of one's body was consistently demonstrated through the reasons that physicians prescribed, and women took, the pill. Notably, the majority of participants explained that they went on the pill for reasons other than contraception; four cited using the pill for menstrual regulation, and three used it to improve their complexion. A number of the participants recalled having severe menstrual cramps when they were younger, and went on the pill as young as fourteen years old to manage these symptoms. Those who experienced cramps and heavy periods sought medical advice, and each doctor prescribed the pill for regulation of their periods. One participant who experienced particularly debilitating cramps when she was young was initially prescribed Depo-Provera, a hormonal injection administered every three months that eliminates periods entirely. This participant experienced alarming side effects of the shot over the year that she took it, including migraines, numbness in half of her body, and episodes of confusion and distorted vision. After several trips to the hospital due to such incidents, her doctor took her off of Depo-Provera and prescribed her the pill instead. Justifiably, she expressed disbelief that her physician would prescribe such a hormonally strong drug to such a young patient (she was fourteen at the time), and felt that the risks of the injection vastly outweighed the benefits (Jess, 28). Another participant similarly used Depo-Provera as a teenager, and in retrospect felt uncomfortable with the idea of such a drastic hormonal regimen with little information about how it works or potential side effects (Clarice, 28).

One of these women went directly from Depo-Provera to the pill, which her physician explained would also reduce cramps, and advised her that she could take the pill continuously to avoid getting her period altogether (Jess, 28). Another participant who was on the pill for ten years, starting at age sixteen, initially began in order to reduce cramps, and admitted that she had also continued using the pill because she liked that it made her breasts larger. While she had no complaints about the pill, she did describe switching brands a number of times because the pill made her feel extremely emotional (Elise, 24). One participant, who had been on the pill for ten years at the time of the interview, recalled a physician "trying to encourage me to change pills and skip periods" (Cara, 26). When asked about this experience, she said,



She wanted to get me on a low-dose estrogen pill, and she told me about them and wanted me- she said it made no difference on how your body reacts to it, because I thought maybe skipping periods would be bad for your body. Umm, but she tried to convince me that it's not, that the periods you get when you're on the pill are synthetic anyways, and that it makes no difference, and if you want to even save ten dollars a month, that's a good enough reason to skip periods. (Cara, 26)

This physician's behaviour seems to reflect the attitude conveyed by Sucato and Gold (2002), who urge doctors to encourage women to skip their periods. It is concerning that physicians would promote such behaviour for an adolescent who felt uncomfortable with the idea, and also that they would offer medical advice that has more to do with a particular brand than with a patient's actual experience and attitude. This example clearly illustrates how corporate motives are increasingly ingrained in health-related decisions, and suggests that doctors may indeed be prescribing the pill in their own best interest, rather than for that of their patients. Further, it demonstrates that physicians are also complicit in perpetuating the notion that women's natural bodies are in need of 'fixing' through pharmaceutical products.

While no women reported using pill brands specifically meant for menstrual suppression, such as Seasonale or Seasonique, nearly all participants used ordinary birth control pills continuously to achieve this effect. Some participants learned about this strategy from their doctors, while others heard from their peers that this was possible. Interestingly, each participant who had taken the pill in this way explained that they had done so only in the instance of being on vacation. The fact that they used the pill for menstrual suppression only occasionally challenges the assumption promoted by popular media that any woman, if given the choice, would chose to eliminate monthly periods entirely.

Even more surprising than physicians recommending the pill for menstrual suppression or regulation is the demonstrated willingness of doctors to prescribe the pill to young girls for issues as superficial as their complexion. Three different participants initially began taking the pill to clear their skin; one requested the pill for this reason from her physician, while the other two had their doctors recommend the pill as a solution for acne. One said she began taking the pill "mostly because my doctor said it would help with acne" (Carly, 24). Another explained, "I actually went on it more because I thought I

wanted clear skin... because that's what the ads said" (Lauren, 27). Overall, physicians were extremely compliant with patients' request for the pill for lifestyle reasons, and in fact, several recommended it without prompting from the patient. The experiences of these participants reveal that the pill has indeed become a lifestyle drug, and doctors and patients alike frequently perceive being on the pill as the preferable choice. The pill was nearly universally understood to not only prevent pregnancy, but to regulate periods and clear skin, and frequently, these benefits were cited without equal emphasis on the potential risks or negative side effects of being on the pill.

### **5.2.3. Media Representations**

Given the increasing role of the pharmaceutical industry in the contemporary biomedical landscape, it is important to address how popular marketing materials for the birth control pill have contributed to women's knowledge about contraception. As Watkins noted, marketing decisions have played an enormous role in framing how the birth control pill is perceived (2012), and so one objective of these interviews was to determine how representations of the pill in popular media informed women and their decisions about birth control, and whether they correspond with women's lived experience. In general, popular media representations reinforced the choice to be on the pill as a normative decision.

A number of participants cited advertisements as sources of information about birth control, and noted that they became aware of particular brands or uses of the pill through television and magazine advertisements. For instance, one participant decided she wanted to be on a particular brand because advertisements emphasized that it would improve her complexion; she cited magazines such as *Cosmo* as particularly memorable sources of advertising information. She recalled being influenced by this type of marketing, in combination with the popularity of the pill among her peers, and explained, "I definitely notice the pill is advertised as a lifestyle, it's not necessarily advertised as birth control anymore. It really is marketed, you know, as "You can be this empowered girl with great skin", and all your friends are doing the same thing" (Lauren, 27). Another woman joked about being persuaded by advertisements for a particular brand and jokingly explained that she thought, "Oh, modern women like Alesse, and I'm very modern" (Clarice, 28). For these women, the ideologies of empowerment and

freedom attached to the birth control pill in contemporary marketing were effective in shaping their contraceptive decisions.

Several participants expressed frustration over the fact that the ideal representations of birth control seen in advertising contradicted the reality of being on the pill. One woman shared her observations about marketing of the pill, and said she felt as though ads were conveying the idea that

If you're on the pill, then you're liberated, and you're a part of something. The women are always really attractive... it's always like, "Look at me, I'm sexually active!". I don't know, I think it's also targeted towards teenagers and girls that are young, because if they start using it at a young age, they'll probably keep it going. (Christina, 25)

Her response was similar to that of another participant, who observed of a particular brand, "(the) marketing campaign made it seem like a breezy sort of choice for a modern woman who's responsible, and it just seemed all very carefree, it didn't seem like there was any drawbacks to it and it was definitely featuring a woman who at that time, maybe you would aspire to be like" (Clarice, 28). Another participant recalled frequently seeing ads for Yaz, and noted how problematic it is that the most aggressively promoted pill was eventually discovered to have the most serious consequences (Jess, 28). For each of these women, the representations they observed in marketing materials were particularly problematic because they perpetuate a notion that the pill is a necessarily liberating product, and this starkly contrasted their own experiences of severe side effects when on the pill.

Not only were participants aware of the tendency of ads to understate risks and side effects of the pill, one was critical of the more subtle implication that the pill would necessarily improve women's bodies. She explained:

For me what stands out the most about the media portrayal of birth control is the naturalization and normalization of it, and one in particular that stands out for me is Seasonale, which says, "Don't get your period, and that's normal"... basically the message is "it's perfectly normal to do this, and that's okay"... (It's) also the media's constant attempt to show that that's the most desirable way to be. Like, "of course nobody would ever want to have their period!"... Like it's just a nasty mess that nobody wants to deal with and here's this sort of technology that allows us not to. (Shalon, 27)

Her response very aptly articulates some of the key implications of the pill as an agent of biomedicalization, and addresses the problem of the increasingly dominant notion that women's bodies need to be improved through pharmaceutical consumption.

#### **5.2.4. Male Partners**

Since the time that the pill was initially conceptualized by Margaret Sanger, it has been celebrated for its ability to place responsibility for birth control in the hands of women, rather than their male partners. While this has certainly benefited many women who may not have had complicit partners, it is also worth exploring how this characteristic of the pill might negatively impact women's contraceptive practices and their sexual relationships. While several participants described their current male partners as knowledgeable about their birth control practices, most described the general attitudes of male sexual partners as involved in contraceptive choices at a cursory level, or as entirely oblivious to the necessity and implications of contraception. Overall, women suggested that their male partners assumed that they would be on the pill, and that this was necessarily the best method of contraception.

When asked to what extent her male partners have typically involved themselves in contraceptive decisions, one participant stated, "They don't really. All of the guys I've been with have been pretty progressive people, but they just ask if I am (on the pill) and that's the end of the conversation" (Jess, 28). Another participant recalled her first sexual relationship as completely lacking any discourse about contraception. She said, "The *only* birth control conversation we ever had was the first time we had sex: "I don't have a condom", "I'm on the pill", "Okay". Like, that's really not an in depth conversation... it wasn't even until after we had broke-up that he asked me if I was a virgin" (Jessie Anne, 28). While she was more comfortable avoiding these conversations as a young woman, in retrospect she was surprised about her ambivalence, and regretted the fact that the risk of STIs was never a concern or a topic of discussion for her and her partners. She also recalled that her partner was unwilling to buy condoms because he felt embarrassed to do so, to which she retrospectively responded,

Really, you're not going to do this because you're embarrassed? That's ridiculous, when I still have to go and do all of this other stuff, and I always did it- I feel like it's really unequal. Like, when I was trying to

get him to do a physical, because I went and got tested for everything, he wouldn't do it! (Jessie-Anne, 28)

Her experience with this particular partner highlights the fact that women are the assumed bearers of responsibility for contraception, which can have negative implications for relationships between men and women.

Overall, men's disregard for sexual health was articulated by a number of participants. One woman described the general attitude of her male partners as "Are you on the pill? Okay, let's go for it". So I think for most of the people I've been with, to them it's more just a pregnancy thing, like am I going to have a baby? And they don't really care about like, "Okay, if I had a disease, then I'd be giving it to you" (Carly, 24). Another participant reiterated this, and said of using condoms, "Most guys don't if they don't have to. Umm, it's normally me that insist on using condoms as well, especially with new partners. But yeah, guys generally- I've never had a guy be like, "I'm wearing a condom, and that's that. It's usually me that votes for that" (Nyssa, 25). One participant described her discussions about contraception with male partners in a way that highlights the potential for power struggles in sexual relationships. She said that conversations about contraception occurred

Only in the case where I would say that I wanted to use another form on top of the pill, of birth control, and the guy tries to convince me it's not needed... the boyfriends I've had, I guess the most recent two, because that's been over the last five years that that I've been with the two guys, and they've both tried to convince me that the pill is good enough and that I don't need to use withdrawal method or condoms. (Cara, 26)

In this case, the participant's partners were not willing to make sacrifices in order to increase the effectiveness of birth control, nor did they demonstrate a sharing of responsibility or a regard for her anxieties surrounding contraception. For one participant who became pregnant while on the pill, her male partner placed the responsibility of this onto her, with a response of, "Well, what happened? You were covered" (Jess, 28). This type of attitude suggests that the woman is solely responsible for birth control to protect *herself* against pregnancy, and when it failed it was framed as her problem, not the problem of the male or of the couple together.

This unwillingness of men to participate in sexual health practices emphasizes the fact that women's bodies are more readily medicalized than men's, and suggests that there is a dramatic inequality when it comes to who bears the responsibility for contraception and sexual health in a heterosexual relationship. While the birth control pill provided many women with a new means of control over her reproduction, the long-term effect seems to be that men assume that women are solely responsible, and men are thus excluded from important conversations about sexual health and contraception. One participant described her perception of the current discursive climate, saying, "I think most guys either just assume you're on the pill, or are smart enough to ask, or are dumb enough *not* to ask... I think most boys are in the boat of, unless you insist on using protection, will assume that you're on something" (Lauren, 27). It was apparent through the interviews that women's male partners played an important role in normalizing the pill. Furthermore, these perceptions of how young men and women have such different relationships with issues of contraception and sexual health highlight an important problem. In order for young women to make safe and informed decisions and apply them to their actual lived experience, their male partners need to be included in this conversation and recognize they also have something at stake in sexual relationships.

### **5.3. Women's Experiences: Making Meaning of the Pill**

For each of the participants, influences from multiple directions contributed to an assumption that to take the pill was a natural and necessarily positive decision. In the climate in which women came of age, the pill was an imperative to reproductive control, to a hassle-free lifestyle, and to successful heterosexual relationships. However, women's actual experiences of the pill were much more complex and challenging than these influences suggested. Here, the ways that women experience and make meaning of the pill will be explored.

#### **5.3.1. *Not So Easy: The Down Side of the Pill***

It has been previously established that generally, popular discourse surrounding the pill is enthusiastic, and within a biomedical model, the pill is promoted by medical professionals and positively portrayed by popular texts such as advertisements, news,

and entertainment media. Generally, the negative implications of the pill are overlooked and the benefits overstated. This section will explore the risks and barriers that women identified as negative aspects of their relationship with the pill.

### **5.3.2. Risk Negotiation**

Many of the participants—including some who currently use the pill—felt that the efficacy of the pill is often overstated, and that their physicians didn't adequately explain to them factors that can alter the pill's effectiveness. When asked if she recalled whether her doctor gave her comprehensive information about the pill when it was first prescribed, one participant responded, "Nope, definitely not at all, no. Just got the script and started the prescription. Actually, the only reason I knew that you are supposed to back up your birth control when you're on antibiotics was because my mom told me. Not because the pharmacists or doctor told me that (reduced efficacy) was even a possibility" (Lauren, 27). Another participant said, "Well, considering I don't really know (how the pill works), I'm assuming they didn't tell me" (Elise, 24). Several of the participants noted that their doctors essentially told them the information that was contained in the brochure or patient insert, without giving them any further information about sexual health or addressing their use of the pill on a more personal level.

Disappointingly, four of the participants explicitly noted that their physicians gave them no information whatsoever about sexual health more broadly, nor did they mention the risk of STIs. One participant recalls, "I probably would have really appreciated some more discussion about different forms of birth control, and also about STDs and if this effective or not against STDs and other things, because I didn't really consider that" (Lauren, 27). For her, the reality of the risk of STIs did not occur to her until she experienced one first hand. She said, "I became very aware of it because I had an abnormal pap. So, it just made me very aware very quickly of a lot of different things that were going on" (Lauren, 27). Given the persistently high rates of STIs like HPV, gonorrhea and chlamydia—all of which are frequently asymptomatic in women—it is alarming that physicians consistently failed to address these risks with young women. While two participants noted that their doctors urged them to use condoms in addition to the pill, the majority did not. It is worth considering whether the generally positive attitude towards the pill contributes to a discursive climate in which the risk of STIs is

overshadowed by the more positive associations with the pill, such as a perceived sense of safety and empowerment. Indeed, it seems that many young women perceive being on the pill to mean having 'safe sex', and their physicians frequently contributed to this misconception.

Another important risk associated with the pill is that its efficacy depends on perfect use, but the risk of failure is typically understated. As has been established, physicians frequently failed to inform participants about proper use of the pill, and about factors that might affect efficacy such as interactions with antibiotics. The general belief seemed to be that if one is on the pill, she is 'safe'; not only does this attitude deny the risk of STIs, but it also glosses over the fact that the pill requires consistent and calculated use in order to be highly effective against pregnancy. One participant recalls, "The amount of times I probably took three pills at once, or really wasn't taking it consistently... Quite a lot, actually. Or, you know, if you get sick and throw up a pill, it can affect how effective the pill is, and it can decrease its effectiveness by quite a lot, and I actually wasn't really aware of that." (Lauren, 27). For this participant, inconsistent use never resulted in an unplanned pregnancy, but another was less fortunate. She explained switching from the pill to the IUD, saying, "I tried. I tried after getting pregnant, a number of times. The other problem I had with the pill was that I'm a fertile myrtle, apparently if I missed a day- and I'm very strict about things, and I missed *one* day and I got pregnant. And it happened twice" (Jess, 28). For her, the pill simply was not effective enough against pregnancy, and so she had to switch to something more reliable. While she by no means blamed this on her doctor, she—and several other participants—emphasized the fact that her physician did not thoroughly explain proper use of the pill to her. Another participant also expressed anxiety over the efficacy of the pill, saying, "It's still not a hundred percent effective, do you know what I mean? Like, a lot of people are on it, and I have a couple of friends who are on it who haven't taken it regularly and have gotten pregnant, you know? So it's like, you really have to take it, so I would do that. I would feel pretty secure, but you never know, right?" (Christina, 25). For each of these women, the pill does not live up to the assumption that it is the simplest and most effective form of contraception.



### **5.3.3. Side Effects**

While the pill was generally promoted as a solution to an array of problems, this did not correspond with the experiences of all of the participants. In fact, only half of the women interviewed were happy with their experience of the pill; the other half all reported side effects, many of them severe. Women cited a variety of negative side effects, including spotting and weight gain, but the most common and severe noted were dramatic mood swings and emotional instability. In fact, all five participants who reported any side effects at all experienced mood-related side effects; for four of the five women, they were severe enough for them to discontinue use. One participant explained her reaction to the pill as “Extreme mood swings. I really didn’t feel like myself. I felt like one minute I’d be over the moon, the next minute I could just be screaming about nothing, and I felt like I just couldn’t control myself. And it felt like it erased the line between rational and irrational” (Clarice, 28). She eventually decided to discontinue using the pill after several months of these symptoms, saying, “I wasn’t naturally regulating my emotions and hormones and... I just didn’t see the pointing taking it any more. Condoms were more than adequate when it comes to the difference between how you feel on a day-to-day basis” (Clarice, 28). For her, the emotional side effects significantly outweighed the benefits of being on the pill.

Another participant also recalled feeling “emotionally crazy” and having “crying fits” (Jess, 28) while on the pill, and noticed marked improvement during periods that she stopped taking it. Her history with emotional problems began before her use of the pill, and in fact corresponds with when she began taking Depo-Provera. She reflected on her experiences, saying, “Ever since I started birth control, I’ve started having emotional issues. It started when I was on Depo, and my parents thought I had a problem, and so I’ve been on antidepressants as well” (Jess, 28). She explained that she went off of the pill

Because I realized that I’ve spent almost a decade, where the whole time, I was starting to get paranoid and be crazy. And I mean, there were times- it wasn’t non-stop, there were times when I was single, or I was in school, or I moved away and I just didn’t go on it for a year, I didn’t sleep with anyone for a year, and I was more emotionally stable than I’d ever been. (Jess, 28)

For her, the correlation between her emotional well-being and her use of birth control became apparent rather recently, and she recognized, "I'm not on it now, and I'm the healthiest I've ever been" (Jess, 28).

One participant experienced a series of negative side effects, each associated with a different brand of pill. Her experience with the pill started when she was seventeen, and the particular brand she was prescribed (Tri-Cyclen) resulted in spotting. She switched brands, and then experienced the same emotional side effects mentioned by previous participants. Her third attempt resulted in weight gain that corresponded with a dramatic increase in appetite. Each time she presented her symptoms to a doctor, the response was to switch brands, and she frequently felt as though her doctor was dismissing her concerns. After three different tries, she recognized that the side effects of the pill outweighed the benefits, and she stopped taking oral contraceptives. Unfortunately, she described ongoing problems even after discontinuing the pill; six months after stopping, she says, "It's completely messed with my body. Like, I've gotten my period two times in the same month, and then not at all for three months. Just things like that. I never know when it's coming- it just really messed up my cycle" (Christina, 25). This participant felt that her erratic use of the pill had been the cause of this ongoing problem, and now regrets the fact that she was so willing to use oral contraceptives without consideration of how the hormones might impact her body beyond their intended benefits. She was not the only participant who experienced irregular cycles after going off the pill. One participant took the pill for nearly ten years after being put on it by her mother at fourteen years old, and once she stopped taking it, did not get her period for three years; at twenty seven years old, she commented that she still has a highly irregular cycle. She explained that she thought this was related to the pill, as she went on it well-before her body ever developed a natural cycle (Shalon, 27).

The fact that such a high proportion of women experienced side effects that were severe enough to motivate them to discontinue pill use is an important finding. While the benefits of the pill are highlighted in popular marketing and emphasized by physicians, the risk of side effects is frequently minimized. While the elevated risk of blood clots and stroke are typically acknowledged, side effects like emotional instability and mood swings were never mentioned; indeed, current pills like Yaz are marketed as improving moods, which contradicts the experiences of many women. Doctors similarly

downplayed the side effects that participants experienced, and typically suggested that patients simply switch brands when they weren't happy with their current pill. Several of the participants switched brands three or four times before finding an appropriate brand or, more often, giving up the pill altogether. Generally, discontinuation of the pill was seen as a last resort, and women were encouraged to wait out the side effects, rather than educated about alternative options. For most women, negotiating between the risks and side effects of the pill and the benefits it offered was a challenge, yet this process was normalized and its significance was often overlooked. The experiences of these women importantly highlight the fact that the pill may not be as universally desirable as popular media and medical professionals would have one think; it is imperative to acknowledge these issues and consider how discourse around contraception needs to change in order to emphasize alternative methods that might be more suited to many women than the pill.

#### **5.3.4. *Barriers to Access and Knowledge***

Women's experiences with the pill did not only contradict the ideal picture of oral contraceptives in terms of physical responses to the drug; many also identified barriers to information and access, making the pill less of a simple decision than is frequently assumed. Several participants noted that it was difficult for them to access reliable information about contraception as a teenager. One explained how she felt as a young woman seeking information, saying, "Even accessing the information as an educated person can be very difficult, let alone if you're young, embarrassed, and maybe not knowing where to look. So yeah, it probably wasn't until University that I realized that there are different options" (Lauren, 27). She recognized that many adolescents might perceive barriers in accessing information, and advocated for improvement in this area. She said,

I really do think it would be a lot better to have a lot more information up front, and maybe even do it on a one-to-one basis between the woman who's talking about it and the health care practitioner, and someone who knows about that age group of people, because, for instance, my doctor was a sixty year old Pilipino Christian woman, so talking to her about birth control was pretty uncomfortable. And when you're not comfortable asking questions, that's never really a good thing. (Lauren, 27)

In her experience as an adolescent, she did not have a comfortable place where she could receive comprehensive information about contraception and sexual health; this limited her contraceptive options (the pill was the only one she perceived to be accessible) and also resulted in the contraction of an STI, as her physician never emphasized this risk to her.

One participant who experienced both negative side effects and unplanned pregnancy while on the pill felt that there were barriers to accessing information about contraception in her small city. She said,

I find in Saskatchewan they don't really talk about the IUD as much because I don't think they have- I've noticed Vancouver has a lot more private clinics, or walk-in clinics. It's a lot more hospital-based in Saskatoon. I guess that's their infrastructure, they maybe don't have enough doctors, and they don't really promote the IUD because it's a procedure... there were no women's clinics in Saskatoon at the time. (Jess, 28)

Another participant also felt that there was a lack of information and resources in her rural area. She went on the pill at fourteen and explained, "it was interesting because it was a male doctor that prescribed it to me, which I mean, I'm talking like backwoods, this town is like... I don't even know if they had a lot of different options at that point" (Shalon, 27). The experiences of these women reveal that in rural or less progressive locations, young women may have particularly limited access to information and resources.

Not only was geographic location correlated with barriers to access, but another participant also perceived her education in a Christian school to be particularly detrimental to her level of knowledge. She said, "I came from a Christian school and we never talked about that, and I feel like that was super unhealthy... I think that the severe lack of conversation about anything sexual was a huge handicap for me" (Jessie-Anne, 28). Other participants expressed similar perceptions of the lack of information that was available to them in high school, but she was the only one to address religious education in particular. This same participant also identified a third barrier to accessing contraception, and that was cost. She was without health care and unaware of any clinics that she could visit for free, so the cost of birth control plus the doctor's visit was a burden for her. She explained, "I mean, it's only twenty bucks plus the sixty dollars a

visit, but when you're dead broke, that's- like at times I was like, "I don't even know if I can afford it this month!" (Jessie-Anne, 28). She saw both the mandatory doctor's visit and pap test, as well as the monthly cost of birth control, as problematic, and believes that if reproductive freedom is truly a priority, then these barriers should be eliminated: "I just think it should be free. I mean, like I said, I get that you have to check in. But at the same time, I don't know... Especially with younger people as well, it's like, are we protecting our youth? I don't know" (Jessie-Anne, 28). This perspective reiterates the fact that although many women do feel a greater sense of control over their reproductive bodies through the pill, the necessary mediation of medical professionals is a barrier to achieving this empowerment.

For many participants, the decision to be on the pill was not as simple as popular discourse surrounding it suggests. A significant barrier for many participants was that they lacked viable information about contraception. Resources like women's clinics were not always available, and this was a particularly limiting for women in less metropolitan locations. Another participant cited the cost of birth control as a significant barrier, and was frustrated that this is often overlooked. She said,

When it's like, "Everyone can do it!" I'm like, when I think back to those years in Calgary when I was so poor... like, the whole process of trying to be on it to take care of myself and be in a space that felt like I was in control of my own body was such a hassle. So to see these ads that are like, "Whee, it's the easiest thing in the world!" it's like- well, it does cost money. (Jessie-Anne, 28)

For other participants, once the decision to take the pill had been made—frequently without enough information to assure them they had made an informed decision—they experienced negative side effects such as mood changes, weight gain, and spotting. Overall, these findings reveal that the pill is not necessarily as accessible and health-ensuring as it is often thought to be, and it is important to address these risks and barriers so that more women can make informed decisions about contraception.

### **5.3.5. *Performativity***

While the pill is primarily recognized for its impact on women in terms of their physical and reproductive bodies, many participants' responses suggest that for them,

taking the pill had greater meaning for their identities as young women. Frequently, participants explained that they were motivated to go on the pill because it was common among their peers in high school. When one participant was asked why she decided to go on the pill, she responded frankly, "Because I wanted to be cool... I don't know, all my friends at the time, a lot of them were on it, and I guess I wanted to be on it too, because they were... it was socially cool at the time to be on birth control" (Christina, 25). Another articulated a similar feeling, saying, "It made me feel as if I was just doing what every other girl was doing... I think a lot of my friends were on the pill before I was, and maybe that's the reason I chose to be on it too, without knowing much about it" (Cara, 26). Another participant recalled that being on the pill was an important part of social discourse when she became a bit older, saying,

Everybody talked about it all the time. Like, basically you could go to a party and be like, "Hey, what pill are you on?", "Oh, I'm on this pill". Everybody was on some pill. And it was like, "Oh yeah, I feel kind of weird, I just started the pill". Actually, to this day people still talk about when they go on the pill. (Jess, 28)

Her experience suggests that being on the pill was a way for women to relate to one another, and it may have offered them a sense of solidarity. Another participant explained that even the brand of pill she chose to be on was a result of peer influence; she recalled choosing the brand Alesse because it was the pill the majority of her friends were on in order to improve their complexions. She said, "The reason I actually picked that specific one is because I had a bunch of friends who were all on birth control, like different forms of the pill, but the main reason they were on birth control was to clear up their skin... it's kind of what all my friends did, so I thought, "Oh, I should do this too" (Lauren, 27).

Most participants cited their peers as influential sources of information about birth control, and in general it appears that among female adolescents, oral contraceptives were a popular choice for a variety of reasons. Seemingly, the nature of discourse surrounding the pill was overwhelmingly positive, and participants felt like taking the pill was a natural decision associated with reaching maturity. One participant reflected, "I think to an extent it was a little bit of a rite of passage, just because it's that time in your life where you're making sexual decisions about your body, and I thought I was, you know, probably at the time- I just kind of thought that's what you did: you get your period,

you get a boyfriend, you go on the pill. It's just kind of one of those things" (Lauren, 27). This attitude reflects the belief that taking the pill marks girls' transition into womanhood, and a large part of this seems to be the sexual availability that results from using birth control. It is possible that the pill was also a preferred method of contraception because it required little discourse with male partners; certainly to many adolescents, the prospect of discussing contraception could be uncomfortable, and so the pill would allow girls to be sexually active without having to engage in conversation with their male partners, thus embodying a non-threatening, sexually available femininity.

One participant recalled her first sexual relationship and the minimal dialogue she had with her partner. She summarized the exchange as, "Wait, I don't have a condom", and I was like, "Ahh, it's okay, I'm on the pill!". She perceived her partner to be uncomfortable discussing sex, and similarly, she recalled thinking, "Okay, well (the pill) is one thing I feel comfortable about because I don't really have to talk about it much" (Jessie-Anne, 28). For this participant and several others, being on the pill facilitated a sexual relationship without having to address potential consequences, and this was perceived to be preferable by most of the participants when they were younger. Most participants expressed an increasing concern with sexual health—and valued increased dialogue with their partners—as they grew older, but as adolescents, most were eager to be in sexual relationships without making such considerations. One participant expressed concern with this state of discourse, saying, "I think it's really hard because I think a lot of teenage girls get kind of stuck in the boat where they just want to do what their friends are doing, and they think they're making a really informed choice... but I think particularly at that age, most of those decisions are not given enough thought, and a lot of it is peer influenced" (Lauren, 27). Her own experiences, as well as those of other participants, indicate that there is a need to encourage a more critical discourse about sexual health and contraception for adolescent girls so that they can make informed decisions that ensure effective birth control and sexual health more generally.

### **5.3.6. Transformation of the Body**

An important theme that emerged from the interviews was that the pill had implications for how women understood and experienced their physical bodies. While several participants enjoyed the sense of security that being on the pill offered them in

terms of pregnancy prevention, others had less positive experiences on the pill. One participant who dealt with extreme mood swings on the pill explained, "I knew that the reasons my hormones were going crazy was because my body wasn't doing what it should and it was this unnatural thing" (Clarice, 28). This corresponds with the experience of another woman who experienced a range of negative side effects, and after ten years on the pill, realized she felt most comfortable and like herself when she was not on hormonal birth control (Jess, 28). Another participant realized that the physical side effects of the pill had a broader effect on both her health and her mental well-being, saying,

It makes me feel like shit. But that's why I don't take it, and I don't like it because it really, really affects me. Like, you know, I won't be able to stop eating. And also, too, I had a pretty mild eating disorder, and I think a lot of that had to do with being on birth control. Because I would just eat until I started to throw up, and I actually think that the two are related. And since I haven't been on birth control. I haven't had that problem. (Christina, 25)

Importantly, she went on to note, "Actually, I didn't even think of that until now!" This reflection is interesting in that it clearly reveals that the pill impacted both her physical and her emotional health, and also highlights the fact that many women take the pill without a critical understanding of how it affects their body on a more holistic level.

Several of the participants who experienced negative side effects said that they did not fully realize the correlation between the pill and their well-being until they discontinued use. One woman, who initially went on the pill at the insistence of her mother, explained how she went from taking it without question to becoming much more critically aware of the pill's implications:

I feel like in my late teens I had a significant shift in consciousness, as far as becoming critically aware, and started really questioning a lot of things, so I felt like that was kind of my new identity in a way... So I feel like (by stopping taking it), you come to know your body because of it. And I felt like when I was on any kind of hormonal birth control, it wasn't my body. Do you know what I mean? It felt like something else was controlling it. (Shalon, 27)

Another participant did not experience negative side effects, but still felt uneasy with the fact that she had been on hormonal birth control for eight years. She said, "I kind of felt



like my body had been on the pill for so long, I just wanted to see what my cycle was like without being on it, because I didn't know what my body was like" (Lauren, 27). For each of these women, being on hormonal birth control emerged as problematic after years on the pill, and after discontinuing use, each felt a heightened sense of awareness of her body. While the pill offered some participants a sense of control, for others it actually took away their sense of control over their body as they felt it was being superficially regulated. These experiences were extremely revealing, and they highlight the problem with the assumption that the pill necessarily affords women a sense of control and empowerment. Ultimately, for these women, the pill was an agent of transformation and creation of a feminine body, but this construction frequently impaired, rather than benefited, their physical and emotional well-being.

#### **5.4. Conclusion: Discursive Confines**

The theme that appeared repeatedly over the interviews—across all of those previously mentioned—is the fact that overall, women's choices about birth control were limited by a striking lack in comprehensive discourse on the subject. Portrayals in the media, information obtained through physicians, and interactions with their peers and partners were frequently one sided, and in a climate where the pill was generally celebrated, there was little space to discuss the potential shortcomings of the pill or to explore alternatives; this finding supports the need to discuss the birth control pill in a more critical manner.

When asked whether the physician who initially prescribed them the pill explained to them how it works or described potential side effects, most participants responded negatively. One participant recalled, "My doctor was not a man of many words. It was basically me going in and saying, "I want to be on the pill", and him saying, "Okay, let's put you on this one with a low dosage." So yeah, the interaction was very minimal, and the information he provided me came in the form of brochures, and not verbalizing stuff to me" (Nyssa, 25). Another participant related a similar experience and said her doctor did not discuss anything with her, including side effects and the risk of STIs; she said she got no information "besides what was in the pack of my first pill"

(Cara, 26). One participant recalled a particularly discouraging scenario with her physician. She said,

I've had some really negative things happen to me, where I've had to talk to doctors, and sometimes I've felt like, especially about sex stuff, they're really... I don't know, it's hard to say. I've talked to so many doctors, and they just kind of want to refill it, and like... for example, the last time I was at my doctor, I was going to talk to him when he was doing a pap, about something, and his response was "Oh, it's nothing", and then just left the room. (Christina, 25)

One participant remembers specifically bringing up concerns about Yasmin, which she was taking, after seeing ads on television explaining the increased risks associated with the brand and advertising legal services for those affected. She said her doctor's response was that "She's done her research on it, and that her opinion is it isn't harmful, and that what's going on in the States is kind of a silly thing that happens with a lot of drugs and pharmaceuticals there" (Carly, 24). In both of these cases, doctors dismissed the concerns of their patients and failed to engage with them in a dialogue about the issue.

Not only were interactions with physicians frequently inadequate in terms of education about contraception and sexual health, but relationships with male partners were also characteristically lacking in such dialogue. The implications of this were described well by one participant, who said,

I definitely think young men really need to be in the loop about this, because I don't think they realize the risks that- you know, the risk and responsibility that is really put onto the shoulders of women to carry birth control, and I think maybe they'd have more respect if they understood the importance of it, and the risks that we have to take in order to go through some of this stuff. So they really should be informed in it. (Lauren, 27)

Another participant perceived a lack in health discourse overall, which she said is articulated particularly well by conversations surrounding the pill. She said, "I think there's a holistic element missing, or just an awareness about your own body. I think that is definitely missing from public health discourse. Like, it's an assumed thing that taking the pill is the natural, healthy thing to do" (Shalon, 27). This demonstrates that there is a lack of emphasis on individuals knowing their own body and making personal health

care choices for themselves; indeed, the pill is currently positioned as an ideal solution for any girl or woman to a variety of 'problems', whether that is the issue of contraception, imperfect skin, or inconvenient monthly periods.

These interviews reveal that women experienced a lack of information about birth control, and this absence of dialogue frequently contributed to unfavourable results, including severe side effects, unplanned pregnancy, and unequally distributed responsibility for contraception in their sexual relationships. A reflection upon the experiences and perceptions of these women confirms the fact that birth control has become something of an imperative for contemporary femininity, and illustrates the need to challenge this assumption and foster a discursive environment in which women have the information and opportunity to make individual and informed choices about contraception.

## 6. Conclusion

Through this project, I have identified a number of important issues concerning the birth control pill that demand critical attention. The rise of biomedicalization and lifestyle drugs, direct-to-consumer pharmaceutical marketing, safety concerns, and standards of performing femininity are all important for understanding the current position of the pill. The central goal of this research was to identify problematic sociocultural implications of the birth control pill, particularly in terms of the biomedical and performative ideologies it reproduces. By situating the pill within a broader historical context, I have demonstrated the emergence of a biomedical model that increasingly governs sexual and reproductive health, and the implications that decades of pharmaceutical developments have had on hegemonic standards of femininity have been made apparent. Currently, the influence of the birth control pill extends far beyond contraception; the normalization of the pill has contributed to a standard of femininity for young women that entails enhanced appearance, freedom from menstruation, and sexual availability, while effectively minimizing the space for individual inquiry and holistic dialogue about contraception and sexual health.

Through exploring the birth control pill in contemporary North American culture, the relationship between biomedicalization and performativity was illuminated, and the pill was established not only as an agent of biomedicalization, but as a facilitator of normative gender, which women used to perform and embody acceptable femininity. Popular discourse and women's personal experiences of birth control suggest that to be "on the pill" is a rarely questioned standard for women today, essential to the process of constructing a more desirable feminine body. Indeed, the pill has achieved a mythological status, and it has come to signify modern feminine empowerment. In most popular discourse, and among many young women, the pill is necessarily equated with guaranteed pregnancy prevention (and thus, guaranteed control over many other aspects of one's life, such as romantic relationships, education and career, travel, and so forth). The limitations of the birth control pill are frequently overlooked, and the pill is

normalized as a contraceptive and as a lifestyle-enhancing asset by the media, health care professionals, and by individual women and men.

This investigation of the popular/public discourse and personal/private experience related to the birth control pill reveals that the former has profound influences on the latter, and yet there is distinct incongruity between the two. While the pill is generally celebrated and normalized in popular dialogue, women identified many barriers to experiencing the assumed liberating potential of the pill. The results of the interviews constitute an original contribution to scholarly research about the birth control pill, and this data reveals a number of important findings for future consideration. For instance, women faced significant barriers when it came to accessing information about birth control. Significantly, their interactions with medical professionals were often cursory, and participants felt that their physicians inadequately discussed the risks and side effects of the pill with them. Their concerns were often undermined, and physicians were frequently unwilling to discuss alternatives to the birth control pill with young women. Overall, women did not feel adequately informed about the pill, nor did they feel they had access to alternative contraceptive options. This presents a significant barrier to informed choice and individual well-being that must be addressed.

Another important finding was the distinct lack of engagement and responsibility among the male partners of young women; men were frequently identified as assuming that their sexual partners were on the pill, and as unwilling to take responsibility in preventing pregnancy or ensuring sexual health. Arguably, this could be a result of widespread use of the birth control pill, which places contraceptive responsibility onto women and dismisses men from the conversation. While the woman-controlled nature of the pill has merits in some circumstances, I argue that it is in fact counterproductive to the state of discourse about sexual and reproductive health, and to equality in heterosexual relationships. Future research could interview young men in the same way that women were interviewed in this project, in order to identify barriers that exclude men from contraceptive and sexual health discourse.

The ways in which the pill facilitates performance of normative femininity are numerous. The influence of the pill can, of course, be understood as producing and perpetuating standards of heteronormativity, but it should also be understood on a

broader level, and I argue that the pill can be considered in terms of performativity rather than heteronormativity for a number of reasons. The performance of femininity is undertaken by women who exist both within and outside of the hegemonic, heterosexual majority; those who do not identify with this do still perform their femininity, although in arguably more complex ways. Further, while the birth control pill used to be targeted exclusively towards heterosexual women, current generations of the pill are positioned as optimizing the health and lifestyle of any woman, whether or not they are sexually active, fertile, or heterosexual. In common practice and popular discourse concerning oral contraceptives, the pill comes first and sex is secondary. Indeed, many of the interview participants confirmed that they began taking the pill for reasons other than contraception, and heterosexual sex was frequently irrelevant to women's decision to go on the pill. For these reasons, I argue that while the pill can and does help to facilitate heteronormative femininity, it also works at a deeper level in that it is part of a daily practice—separate from sex and potentially undertaken by women of any orientation—to embody what is currently understood as ideal femininity. Indeed, a lesbian woman could enjoy the lifestyle benefits of the pill, for which is it now frequently promoted and used, as much as a heterosexual one.

It could be useful here to revisit Judith Butler's description of performativity, in which she described gender as "an identity instituted through a stylized repetition of acts. Further, gender is instituted through the stylization of the body and, hence, must be understood as the mundane ways in which bodily gestures, movements, and enactments of various kinds constitute the illusion of an abiding gendered self" (1998, p. 402). Keeping this notion on mind, the performative aspects of the pill are clear. As a daily ritual, the pill constitutes a repetitive act that helps women to perform their femininity, transforming their bodies on a biological level, and also enabling them to project their femininity through the visible gestures and the meaningful dialogue that they can share concerning being 'on the pill'. That women expressed a sense of solidarity with one another through openly discussing their decision to take the birth control pill demonstrates that it is a performative act, and the associations they made between taking the pill and reaching maturity illustrate the fact that young women use it as a means to help them express and experience femininity.

The implication that oral contraceptives can enhance and optimize the feminine body is clearly rooted in the ideologies of biomedicalization, which suggest that the pharmaceutically mediated body is superior—more predictable, manageable, customizable, and optimizable—than the imperfect natural body (although it is interesting that rhetoric surrounding medical optimization seems to value and draw from the natural, suggesting that the biomedically enhanced body is in fact *more* natural). This is well-demonstrated in the areas of sexuality, mental health, cosmetic surgery, genetics, and so forth. It is commonly understood that any perceived flaw can be remedied through biomedical means, and pursuing these solutions has become less of an individual option than it is a social obligation. The rhetorics of empowerment and success are foundational to popular discourse concerning self-improvement and management in a biomedical model, and these messages are reiterated by various sources that normalize the biomedically enabled quest for bodily perfection.

Through this work, I attempt to challenge the assumption that to be ‘on the pill’ is an empowering decision that necessarily produces a more manageable and desirable feminine body; in fact, I argue that it demonstrates docility rather than empowerment. While popular discourse surrounding the birth control pill suggests in ways both implicit and overt that women who make the personal decision to take the pill will experience various liberating benefits, women themselves experienced something much different. One of the most striking results of the interviews was that most women did not consider their decision to take the pill in a critical manner, and most took it to fulfill the expectations of their doctors, partners, parents or peers, or to embody hegemonic forms of femininity promoted in popular media. Even those who experienced negative side effects that outweighed the benefits of the pill often continued to use it in order to live up to these expectations, which often seemed to be internalized to the point that the option to discontinue use was not perceived as a possibility. Thus, to be ‘on the pill’ was more of a way to comply with dominant standards of femininity—a passive and docile state rather than an informed and empowering decision. Of course, I do not wish to argue that these women are inherently docile or at fault for failing to recognize the hegemonic ideologies that the pill perpetuates. However, it is well-demonstrated that the birth control pill is so firmly entrenched and rarely questioned in popular discourse that to take it is viewed as a natural and empowering decision, when in fact it is frequently performed

out of direct obligation or more subtle compliance with hegemonic gender roles. Indeed, to be “on the pill” was, for many women, a dutiful performance of femininity that complied with the expectations of doctors, their peers, and their sexual partners.

While the multi-method approach employed to understand the contemporary role of the birth control pill enabled me to demonstrate the relationship between biomedicalization and performativity, there are limitations that are important to address. It was difficult to conduct a comprehensive discourse analysis of popular media texts concerning the birth control, given the wealth of texts that exist, coupled with the lack of accessible, archived information. The ethnographic interview method also presented challenges; namely, the recruitment of participants was difficult, and so the sample size is smaller and less diverse than I had initially hoped. However, the participation of acquaintances resulted in a number of in-depth and honest interviews, the results of which are rich and diverse. Together, the discourse analysis and interviews successfully highlight the ways in which biomedicalization and performativity are linked, and reveal what this means for women today.

The goal of this research was to produce an account of the contemporary position of the birth control pill, and to explore what implications it has for women’s subjective experiences. It has answered questions about how the pill is represented in popular media, what space it occupies in the contemporary biomedical model, and what meanings it has for young women, as individuals and in relationships with their peers and their sexual partners. This work has the potential to inform scholars, health care professionals, and young women and men, and can hopefully serve as a useful contribution to understanding the implications of the relationship between biomedicalization and gender roles. It is imperative to challenge widespread assumptions about the universal appropriateness of the birth control pill, as a contraceptive option and as a lifestyle drug, in order to foster an open dialogue that encourages individual and informed choice, and questions new imperatives of femininity reinforced within the current biomedical landscape. Such a dialogue could be facilitated by a school-based education program for adolescents that de-stigmatizes issues of sexual health and contraception and promotes gender equality and shared responsibility in sexual relationships. Of course, there are a number of barriers to implementing comprehensive sexual education in schools, but the results of this research provide



further justification for such a program. Another important priority to be pursued is the development of alternative methods of contraception (non-hormonal or male-targeted, for example), for the purpose of enhanced choice and improved outcomes, rather than for increased profit. It was well-demonstrated through participant interviews that the birth control pill is a less than ideal means of contraception for many women, yet they perceive a lack of alternatives and limited opportunity to discuss their experiences with physicians. The need for a more open dialogue between women and their doctors, as well as women and their sexual partners, is as important as the need for alternatives to the birth control pill, and these are two important priorities that this work advocates.

## References

- Andrist, L. (2004). Women's and providers' attitudes toward menstrual suppression with extended use of oral contraceptives. *Contraception*, 70(5), 359-363.
- Arnold, M. (2009). For Pristiq, Wyeth deploys wind-up doll. *Medical Marketing and Media*, 44(7). 8.
- Barthes, R. (1972). *Mythologies*. (Lavers A., Trans.). New York: The Noonday Press. (Original work published 1957).
- Basalmo, A. (1996). *Technologies of the gendered body: Reading cyborg women*. U.S.A.: Duke University Press.
- Bayer Healthcare Pharmaceuticals. (2006). *17 March 2006- FDA approves Yaz, the first oral contraceptive to offer drospirinone in a 24-day, active-pill regimen*. Retrieved from [www.pharma.bayer.com/scripts/pages/en/news\\_room/news\\_room/archive/newsroom\\_archive47.php](http://www.pharma.bayer.com/scripts/pages/en/news_room/news_room/archive/newsroom_archive47.php)
- Bordo, S. (1993). The body and the reproduction of femininity. In Conboy, K., Medina, N. & Stanbury, S. (Eds.), *Writing on the body: Female embodiment and feminist theory*. (pp. 309-326). New York: Columbia University Press.
- Briggs, L. (2002). *Reproducing Empire: Race, Sex, Science and U.S. Imperialism in Puerto Rico*. Ewing, NJ: University of California Press.
- Butler, J. (1988). Performative acts and gender constitution: An essay in phenomenology and feminist theory. In Conboy, K., Medina, N. & Stanbury, S. (Eds.), *Writing on the body: Female embodiment and feminist theory*. (pp. 402-417). New York: Columbia University Press.
- Cacchioni, T. and Tiefer, L. (2012). Why medicalization? Introduction to the special Issue on the medicalization of sex. *Journal of Sex Research*, 49(4), 307-310.
- Caseldine-Bracht, J. (2010). The HPV vaccine controversy: Where are the women? Where are the men? Where is the money? *International Journal of Feminist Approaches to Bioethics*, 3(1), 99-112.
- Casper, M. & Carpenter, L. (2008). Sex, drugs, and politics: the HPV vaccine for cervical cancer. *Sociology of Health & Illness*, 30(6), 886-899. doi: 10.1111/j.1467-9566.2008.01100.x
- Clarke, A., Shim, J., Mamo, L., Fosket, J., & Fishman, J. (2003). Biomedicalization: Technoscientific transformations of health, illness, and U.S. biomedicine. *American Sociological Review*, 68, 161-194.

- Clarke, A., Shim, J., Mamo, L., Fosket, J., & Fishman, J. (2010). Biomedicalization: A theoretical and substantive introduction. In A. Clarke & L. Mamo & J. Fosket (Eds.), *Biomedicalization: Technoscience, health, and illness in the U.S.* (pp. 1-46). Durham, NC: Duke University Press.
- Clarke, A., Shim, J., Mamo, L., Fosket, J., & Fishman, J. (2010). Biomedicalization: Technoscientific transformations of health, illness, and U.S. biomedicine. In A. Clarke & L. Mamo & J. Fosket (Eds.), *Biomedicalization: Technoscience, health, and illness in the U.S.* (pp. 47-87). Durham, NC: Duke University Press.
- Conrad, P. (2005). The shifting engines of medicalization. *Journal of Health and Social Behaviour*, 46. 3-14.
- Conrad, P. (2007). *The medicalization of society*. Baltimore: John Hopkins University Press.
- Conrad, P. And Leiter, V. (2004). Medicalization, markets and consumers. *Journal of Health and social Behaviour*, 45. 158-176.
- Contraceptive Technology Update. Menstrual suppression- how do women feel? (February 2008).
- Coutinho, E. & Segal, S. (1999). Is menstruation obsolete? How suppressing menstruation can help women who suffer from anemia, endometriosis, or P.M.S. New York: Oxford University Press.
- De Beauvoir, S. (1952). *The second sex*. New York: Vintage Books.
- Dunn, N. (2011). The risk of deep venous thrombosis with oral contraceptives containing drospirenone. *BMJ*, 342, 1-2.
- Ebeling, M. (2011). 'Get with the program!': Pharmaceutical marketing, symptom checklists and self-diagnosis. *Social Science and Medicine*, 73. p. 825-832.
- Eldridge, L. (2010). *In our control: The complete guide to contraceptive choices for women*. New York: Seven Stories Press.
- Future II Study Group. (2007). Quadrivalent vaccine against human papillomavirus to prevent high-grade cervical lesions. *New England Journal of Medicine*, 356, 1915-1927.
- Glasier, A., Smith, K., van der Spuy, Z., Ho, P., Cheng, L., Dada, K., et al. (2003). Amenorrhea associated with contraception: An international study on acceptability. *Contraception*, 68, 1-8.
- Hammersley, M. (1997). On the foundations of critical discourse analysis. *Language & Communication*, 17(3), 237-248.
- Holland, J., Ramazanoglu, C., Sharpe, S., and Thompson, R. *The male in the head: Young people, heterosexuality and power*. London: The Tufnell Press, 1998.
- Johnston-Robledo, I., Barnack, J. & Wares, S. "Kiss your period goodbye": Menstrual suppression in the popular press. *Sex Roles*, 54, 353-360.

- Kissling, E.A. (2006). *Capitalizing on the curse: The business of menstruation*. Boulder: Lynne Reinner Publishers, Inc.
- Kramer, P. (1993). *Listening to Prozac*. New York: Penguin Books.
- Lamm, S. & Couzens, G.S. (1998). The virility solution: Everything you need to know about Viagra, the potency pill that can restore and enhance male sexuality. New York: Fireside Books.
- Lippman, A. (2004). Women's cycles up for sale: Neo-medicalization and women's reproductive health. *Canadian Women's Health Network*, 6, 8-11.
- Loe, M. (2001). Fixing broken masculinity: Viagra as a technology for the production of gender and sexuality. *Culture, Health and Sexuality*, 5(3), 97-125.
- Loshny, H. (2004). From birth control to menstrual control: The launch of the extended oral contraceptive, *Seasonale*. *Canadian Woman Studies*, 24, 63-67.
- Mamo, L., & Fosket, J.R. (2009). Scripting the body: Pharmaceuticals and the (re)making of menstruation. *Signs*, 34(4), 925-949.
- Marshall, B. (2002). 'Hard science': Gendered constructions of sexual dysfunction in the 'Viagra age', *Sexualities*, 5(2), 131-158.
- May, E. T. (2010). *America and the pill: A history of promise, peril, and liberation*. New York: Basic Books.
- Moynihan, R. & Mintzes, B. (2010). *Sex, lies and pharmaceuticals: How drug Companies plan to profit from female Sexual Dysfunction*. Vancouver, BC: Greystone Books.
- Oinonen, K. & Mazmanian, D. (2002). To what extent do oral contraceptives influence mood and affect? *Journal of Affective Disorders*, 70, 2299-40.
- Parlee, M.B. (1973). The premenstrual syndrome. *Psychological Bulletin*, 80(6). 454-465.
- Polzer, J. & Knabe, S. (2009). Good girls do... get vaccinated: HPV, mass marketing and moral dilemmas for sexually active young women. *Journal of Epidemial Community Health*, 63(11), 869-870.
- Riska, E. (2010). Gender and medicalization and biomedicalization theories. In A. Clarke & L. Mamo & J. Fosket (Eds.), *Biomedicalization: Technoscience, health, and illness in the U.S.* (pp. 147-172). Durham, NC: Duke University Press.
- Seaman, B. (1969). *The doctors' case against the pill*. New York: A Dolphin Book.
- Smith, D.E. (1990). *Texts, facts and femininity: Exploring the relations of ruling*. United States: Routledge.
- Sutton, M. J., Brown J. D., Wilson, K.M. and Klein, J.D. (2002). Shaking the tree of knowledge for forbidden fruit: Adolescents learn about sexuality and contraception. In Brown, J. D. et al. (Eds.), *Sexual teens, sexual media: Investigating media's influence on adolescent sexuality*. (pp. 25-55). Mahwah: Lawrence Erlbaum Associates, Ltd.

- Tiefer, L. (1995). *Sex is not a natural act and other essays*. San Francisco: Westview Press.
- Tiefer, L. (2012). Medicalizations and demedicalizations of sexuality therapies. *Journal of Sex Research*, 49(4), 311-318.
- Todd, A.D. et al. (1988). *Gender and discourse: The power of talk*. United States: Ablex Publishing Corp.
- Tone, A. (2001). *Devices and desires: A history of contraceptives in America*. New York: Hill and Wang.
- Tone, A. (2012). Medicalizing reproduction: The pill and home pregnancy tests. *Journal of Sex Research*, 49(4), 319-327.
- Triese, D. and Gotthoffer, A. Stuff you couldn't ask your parents: Teens talking about using magazines for sex information. In Brown, J. D. et al. (Eds.), *Sexual teens, sexual media: Investigating media's influence on adolescent sexuality*. (pp. 173-189). Mahwah: Lawrence Erlbaum Associates, Ltd.
- van Dijk, T. (1993). Principles of critical discourse analysis. *Discourse & Society*, 4(2). 249-283.
- Walsh-Childers, K., Gotthoffer, A., & Lepre, C. From 'Just the facts' to 'Downright salacious': Teens' and womens' magazine coverage of sex and sexual health. In Brown, J. D. et al. (Eds.), *Sexual teens, sexual media: Investigating media's influence on adolescent sexuality*. (pp. 153-171). Mahwah: Lawrence Erlbaum Associates, Ltd.
- Watkins, E. (1998). *On the pill: A social history of oral contraceptives. 1950-1970*. Baltimore, Maryland: The John Hopkins University Press.
- Watkins, E. (2007). "Educate yourself": Consumer information about menopause and hormone replacement therapy. In A. Tone and E. Watkins (Eds.), *Medicating modern America* (p. 63-96). New York: New York University Press.
- Watkins, E. (2012). How the pill became a lifestyle drug: The pharmaceutical industry and birth control in the United States since 1960. *American Journal of Public Health*, 102(8), 1462-1472.

## **Appendices**

## Appendix A. Recruitment Poster

# On the Pill? Were you in the Past?



I am a graduate student at Simon Fraser University conducting research on young women's experiences—past or present—with the birth control pill. I am seeking women ages 19–28, and am interested in hearing about all sorts of attitudes and experiences. I will be conducting a series of individual interviews over February and March 2012.

Have something to say? I'd love to hear from you.

If interested, please contact Shannon by email [REDACTED] or phone [REDACTED]



SIMON FRASER  
UNIVERSITY

## Appendix B. Participant Demographics <sup>10</sup>

Cara	26	Common law	Physiotherapist
Carly	24	Single	Service industry
Christina	25	Single	Service industry
Clarice	28	Common law	Graphic designer
Elise	24	Single	Human resources
Jess	28	Common law	Artist
Jessie-Anne	28	Single	Student
Lauren	27	Single	Politics
Nyssa	25	In a relationship	Service industry
Shalon	27	Single	Student

<sup>10</sup> All participants identified as caucasian and heterosexual



## Appendix C. Study Details and Interview Guide

The study you are to take part in is meant to explore how the birth control pill is constructed within popular media, and how the pill contributes to young women's lived experiences. The interview portion of the study has been developed to give women a space to talk about their thoughts and experiences, with the objective of helping to contribute to an open and non-judgmental discussion, and to hopefully apply the insights gathered to promote education and informed choice surrounding contraception. You will be required to participate in one individual interview lasting no longer than one hour. Questions will deal with your decision to take birth control, your knowledge about the pill, and how you feel the pill has impacted your life. As the principal investigator, I will personally conduct the interview, which will also be audio recorded. The interview will be semi-structured and open-ended. The following is a list of questions that will guide the interview:

1. When did you start taking the birth control pill, and for what reasons? Do you use it primarily as a contraceptive, or are other uses (acne treatment, period regulation, et cetera) important to you? Have your priorities or reasons changed over time?
2. Do you remember where you got information that helped you decide to start taking the pill?
3. What was your interaction like with the doctor who prescribed it to you? What did they tell you about how it works, potential side effects, or about sexual and reproductive health in general?
4. What do you think are the risks of being on the pill, if any?
5. What do you know about alternative methods of contraception?
6. How does taking the pill make you feel? What impacts do you think it has on your everyday life?
7. If you are no longer on birth control, why did you stop taking it? What do you use for contraception now, and how does this impact you differently than being on the pill did?
8. Do you have any thoughts about the marketing of the birth control pill, or the representation of the birth control pill in popular media such as newspapers and magazines?

Your participation is entirely voluntary, and you are free to withdraw from the study at any point. You are also free to contact the researcher at any point following the interview to view your transcripts. All information gathered from the interview will be stored in a locked case for five years, to which only the researcher has access. Your confidentiality is important, and you are thus free to choose a pseudonym if you wish. If at any point during the interview you feel uncomfortable, you are free to refrain from answering a particular question, or to withdraw from the interview process. If you feel any emotional distress following the interview, or if you wish to access any health or information services, you will be provided with a list of organizations that can provide counselling and other health services.

*Options for Sexual Health* (<https://www.optionsforsexualhealth.org/>)

Provides online education, as well as a list of clinics throughout the province that provide confidential education, birth control distribution, and STI testing. Medical coverage is required.

Youth Vancouver Coastal Health ([youth.vch.ca](http://youth.vch.ca))

Provides a list of clinics that provide free, confidential drop in services that include birth control and condom distribution, education, STI testing, as well as general counselling. Medical coverage is not required, and services are open to anybody under the age of twenty-five.

Please feel free to contact the researcher should you have any questions or concerns at any point by telephone or email.

## Appendix D. Consent Form

### Researchers:

Principal Investigator: Shannon Vogels  
MA Candidate, Communication Studies  
Simon Fraser University, Vancouver, Canada



Supervisor: Gary McCarron  
Associate Professor, School of Communication  
Simon Fraser University, Vancouver, Canada

**Purpose of the Research:** The objective of this research is to gain an understanding of how young women understand and experience the birth control pill. Given that ‘the pill’ has become a ubiquitous form of birth control, I hope to gain insight that will contribute to an understanding of what taking the pill means for users. Ultimately, the objective is to contribute to a body of knowledge that emphasizes education and informed choice regarding contraception and sexual health.

### Voluntary Participation and Confidentiality:

1. Your participation in this study is entirely voluntary.
2. You will participate in individual interview that will last no longer than one hour. The interview will be semi-structured, meaning that while several predetermined questions will be asked, the conversation will be free to develop naturally. Should you feel uncomfortable at any point, you are free to decline to answer any question or to withdraw from the interview.
3. Your confidentiality is of utmost importance, so you will be free to choose a pseudonym if you wish.
4. The interview will be conducted by the principal investigator, and will be audio recorded. The digital audio recording will be listened to and transcribed by the principal investigator within two weeks, and will then be permanently deleted.
5. Your participation will not affect your relationship with the investigator and/or Simon Fraser University.
6. You are free to contact the researcher or suggested resources at any point following the interview, as well as to view the transcripts once the interview has been conducted.
7. All physical documents, voice recordings and relevant computer files will be stored on a memory stick and kept in a locked case under the supervision of the principle investigator at their private address for a period of five years.

**Risks to Participants:** There is no physical risk for your participation. You will be asked questions that relate to your personal attitudes towards, and experiences with, birth control. If you experience any discomfort during the interview, please inform the principal investigator. If you wish, or if the principal investigator feels you may have experienced discomfort as a result of the interview process, you will be referred to a contact list of local supportive service (see participant study details).

**Benefits to Participants and Society:** Your participation will provide valuable insight on how the birth control pill influences the experiences and attitudes of young women. Gathering this information through the interview in which you will participate will help to foster and open and non-judgmental discourse surrounding important issues of contraceptive practices that will have positive potential for women.

**Questions:** If you have any questions about the research or your participation in this study, or if you wish to review your interview transcripts, please contact Shannon Vogels by phone at [REDACTED] or by email at [REDACTED]. Any concerns can be directed to Dr. Hal Weinberg, Director, Office of Research, at [REDACTED] or [REDACTED]

Consent:

I, \_\_\_\_\_, consent and wish to participate in  
(please print name)

this study. I understand the nature of this project, that this is a completely voluntary activity, and that the information I provide is confidential. My signature below indicates that I have read the study details and am providing my informed consent to participate, and that I have received a copy of this form for my personal records.

\_\_\_\_\_  
Participant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Principal Investigator Signature

\_\_\_\_\_  
Date

## Appendix E. Participant Questionnaire

Name:

Pseudonym (if preferred):

Age:

Ethnicity:

Sexual Orientation:

Relationship Status:

Time period during which you took the pill (age \_\_\_\_ - \_\_\_\_ ; provide additional detail if necessary):

Other contraceptive practices (past or present):

Consent form read and signed: \_\_\_\_ Yes \_\_\_\_ No