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1.4 *From the doctor's psychotropic medication to the patient's remedies, or subversion of medicalisation*

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At the previous seminar we analysed the prescription of antidepressant drugs by general practitioners (GPs) in western Brittany (HAXAIRE C. - BODÉNEZ P. - BAIL P. 2002). Our survey (funded by MILDT, HAXAIRE C. *et al.*, 2003) focused on asking GPs to talk about problems of dependency involving patients seen in the doctor's office in the week preceding the interview. But the practitioners' remarks went far beyond this topic, as they brought up everything which, in their view, came under the general heading of "*psychological*" problems. In addition to certified cases of psychiatric disturbance that the practitioners treat directly or monitor, this vague term encompassed reasons given by the patients for their visit to the doctor, ranging from "*life events*" to "*psychic suffering*" (LAZARUS A. ed. 1994) engendered by new social circumstances (familial or professional pressures, loss of social ties, isolation, exclusion). Prescription of antidepressants, which was the outcome of some of these visits, appeared to be not only treatment of clearly identified depression, but also in some cases a tool in the care relationship. For the practitioner the goal was to liberate speech, to unblock a situation that seemed to obstruct the patient's future. This was done so as to be able to develop a supportive relationship that these GPs value, because it opens up a pathway to more appropriate relief for the problem given as "*the reason*" for the initial distress [(1)]. In these interviews, rather than presenting their practices as treatment of the cardinal symptoms of depression, the practitioners

showed that they were attentive to caring for patients that they knew well and that they felt "*were having a bad time*."

Use (consumption and prescription) of psychotropic medication has been analysed as one of the examples of the increasing medicalisation of social problems in the western world (Jaeger M. 1998). These public health issues are the subject of debate in France (Legrain M. 1990, Zarifian E. 1996). Practitioners are seen as prescribing too many anxiolytics and hypnotics in the benzodiazepine family, but too few antidepressants. It is claimed that they do not properly diagnose full-blown depression, while indiscriminately treating grief due to mourning and other circumstantial events. It is clear that if only purely quantitative information is taken into account we will not see the very different practices hidden behind the data, and will fail to understand the prescribing physician's viewpoint, and hence the meaning of this medicalisation.

From the consumers' point of view, recent studies among young people (Le Garrec S. 2002, Fernandez I. 2003) clearly show that psychotropic medication is one of several possible types of psychotropes that can be used in ways not necessarily related to medicine. Attempts at self-medication to treat the blues or psychiatric disorders with all sorts of psychotropes are increasingly well documented (in Barrow S.M. 1999). For earlier generations, tonics and digestive aids, that calmed the nerves, belonged to the class of foodstuffs (Brabant-Hamonic J. 1996, Haxaire C. 2002). One can therefore wonder, in the case of psychotropes, how robustly the medication is controlled by medical practice (cf. the return to etymology effected by Raynaud and Coudert, 1987). What would the situation be if these medications, unrestricted, were left to their function of remedy, a remedy being, according to the same authors, that which fills a gap between what is perceived, by non-specialists, as pathological, and that which is accepted by them as normal. As a minimum, is deviation from the norm perceived as an "illness", for example where sleep is concerned? The tolerance level for insomnia has indeed varied historically. Should the mandatory visit to the doctor (for these products are only available with a prescription) be interpreted as recourse to medical care on the part of those who often submit to care very unwillingly? In this respect as well there is room to wonder what lies behind this medicalisation.

We propose to pursue this question of medicalisation from the standpoint of anthropology of pharmaceuticals (Van der Geest S. *et al.* 1996). As we do not believe that the "naturalisation" of pharmaceuticals goes without saying, either for patients or for their doctors in the context of a therapeutic relationship, we will attempt to grasp the meaning that patient and doctor

ascribe to prescription and to consumption. We follow D. Cohen et al. (COHEN D. *et al.* 2001) when they maintain that «prescribed medication [should be viewed] as a multifaceted, fluctuating, and mutating object... constructed ... [as thought and behaviour] in the exchange of symbols between individuals and collectivities», but we shall explore some of those exchanges further.

We will cover here all kinds of psychotropic medication prescribed in general medical practice, and not antidepressants alone as before. We will analyse the traces of consumers' strategies in the prescribers' practices, and confront the two.

Survey and Methodology

We have adopted a consistent methodology for the surveys conducted with general practitioners and consumers. This methodology consisted of compiling accounts of practices along with physical traces of these practices. For the practitioners these traces were notes extracted from the patient's file. Consumers were asked to situate each medication from the family medicine cabinet in relation to the prescribed treatment and the incident of illness involved. Prescriptions for psychotropes were gathered in the broader context of the doctors' daily practice: we asked the practitioners to elaborate on any eventual questions regarding dependency that occurred to them in relation to each patient. Psychotropes were given along with other medication, but also in conjunction with recourse to other non-medication treatments, practices or commonly used products, as the case might be. In this survey we queried ten general practitioners in western Brittany, chosen among those whom we could assume had reasonably up-to-date knowledge, given their proximity to a hospital environment (TAMBLYN R.M. *et al.* 1997). Six of these practitioners treated patients on opiate substitute products. These doctors practice in towns as well as in rural areas, with diverse types of clientele (small towns, rural areas, but also so-called tough neighbourhoods in cities, and remote districts in the centre of the region). We met with ten consumers from the same region (including one man). The majority were middle-class women in their 40s or 50s, with some experience – past or present – with antidepressants. Consumers of alcohol, cannabis and tobacco as well (but not of opiates), some had recourse to alternative practices. The small number of interviewees is explained by the fact that in this research we sought to validate earlier survey involving some 30 interviews (HAXAIRE C. *et al.* 1999), as well as the above-cited results

obtained by Fernandez (FERNANDEZ I. 2003) in other regions and among populations with different characteristics (middle-class people, average age 60, in Normandy, and individuals of varying ages, social status and pathologies in Toulouse).

It is noteworthy that, for practitioners and consumers alike, psychotropic pharmaceuticals constitute a group distinct from other types of medication (set generated by the ALCESTE software for statistical analysis of textual data, semiotically based) [2]. It is therefore legitimate to undertake an analysis of the specificity of this set [3]. We will describe the subsets that emerged, both in terms of content and in terms of the forms of discourse that characterise them, and look at these results in relation to the practices observed.

General Practitioners and Their Psychotropes

For the general practitioners, the specific lexical universe of psychotropic medication is in this analysis a subdivision of the larger set of psychotropes in general (alcohol, ...), which is opposed to ordinary medical practice and treatment.

This lexical universe encompasses the names of psychotropic medications (including Subutex® [4]) as well as the names of the therapeutic class to which they belong (*antidepressant, tranquilliser, hypnotic, neuroleptic*). It includes words that divide up the day (*morning, noon, evening, night, daytime, day*) and the year (*January, October*) as well as words referring to dosages and their fractions (*quarter, milligram*) and adjustment of dosages (*reduce, increase, add, stop*), as we will also see in the patients' discourses. The illnesses or problems are related to sleep (*to sleep, insomnia*), to distress (*anxiety, depression,* "angoisse" – *suffocation*) and to somatisation (*stomach, colopathic disease*). These words are associated with verbs that express the acts of both partners in the therapeutic relationship (*take, prescribe, put*) as well as negotiation on the part of the patient (*ask for, try*) as well as the doctor (*explain, talk about again*). The outcomes of negotiation never seem to be final, and appear to be subject to "*steps taken*" by the patient; the results are called into question at each new "*appointment*". Confronting the "*need*" of a patient who takes a product "*over a long time*", doctors, as we will see below, call medication or behaviour over which they have no control "*stuff*" or "*foolishness*" respectively.

Many adverbs of quantity are found in this universe (*at least, more, how much, more, less*), and temporal adverbs (*at the time, since, always, early, until,*

when, right away, quickly). There is reference to the patient (*she, he, her, him*) and to the medication that the patient has (dominance of the auxiliary "*to have*") rather than what it is. Modal marks (*why, because, that is to say*) outline a posture in which the interlocutor feels obliged to justify explanations regarding positions that she or he does not dare to declare outright (*I think, maybe*) and acts that she or he "*should*" or "*wants*" to undertake.

The universe of this type of medication consists, for the doctors, of ongoing negotiation about dosage and frequency of medication that the prescriptions imply. For this reason substitute products are not just a part of this universe, they are indeed prime examples of it.

As a general rule it seems that the doctors seek to set a framework for the practices of their patients. Is this because these practices tend to escape their control?

To answer this question we must go back to an analysis, "treatment" by "treatment". It is noteworthy that we can clearly identify enunciatory postures that vary depending on the "treatment".

Within the broad class of "psychotropic medication" distinct categories appear, distinguished not only by the therapeutic class of each pharmaceutical, but also according to the nature of the treatment in which the medication is used (Haxaire - Richard - Bodénez - Locquet, *in press*). In other words, a hypnotic or an anxiolytic associated with an antidepressant or a neuroleptic will be regarded differently than if it is used without other psychotropes. It is thus possible to distinguish the following four categories: hypnotics or anxiolytics prescribed alone ("*little pills in the evening*"), treatment with antidepressants (eventually in association with hypnotics or anxiolytics), "*psychiatric*" treatment including a neuroleptic (with or without antidepressant, hypnotic, anxiolytic), and replacement therapy [(5)].

If there is one type of treatment that appears to elude the practitioners' control, it is those "*little pills in the evening*". Indeed, the doctors seem to want to keep their distance from treatment involving only hypnotics or anxiolytics, as psychotropes. In these cases the doctors do not assume responsibility for their prescriptive practices, evoking their patients' requests in statements such as "*he takes his little X* [a hypnotic]". These prescriptions are never justified by a medical argument or reasoning, the GPs reiterate the patients' classifications: "*to get to sleep*". The term "*dependency*" does not arise, or is denied. In some cases it may be mentioned, but using the patient's terms and justifications: "*he needs some…*". These treatments are minimised and neutralised in various ways. Lastly, what really distinguishes this category from the viewpoint of discourse analysis is the absence of

signs of the doctor's investment in what s/he is saying. The patient emerges as the active subject of consumption: "*he takes his* X", or more crudely, "*he comes to get his stuff*", where the medication is attributed to the patient by the possessive adjective "his".

By contrast, the discourse on antidepressant treatment is medical, both in the way the diagnosis is established and justified, and in the evaluation of the treatment. It is not foreseen that these forms of treatment, undertaken in the wake of serious problems, could lead to addiction. The doctors use the term "*care for*", they take responsibility for this care and the prescription: "*I put her back on X* [antidepressant] *and Z* [anxiolytic]."

Treatment involving neuroleptics is characterised as serious by doctors who use adjectives such as "*awful, monumental, weighty, burdensome*". From the outset their excessive nature leaves the doctors little room for taking charge of treatment. In fact, the diagnoses are not always reported. In half the cases it is a matter of following the prescription of another doctor, the psychiatrist. In other cases problems of violence are mentioned, that go beyond the doctors' habitual capacity for assuming responsibility. In their discourse the doctors keep their distance from their patients, by the way in which they speak of them. Generally they use introductory sentences such as "*This is a lady who...".* Likewise the pharmaceuticals, when they are named, are given in the form of a list, without qualifier and without indication of posology. This contrasts with medication for associated somatic pathologies; *"He came out of the hospital with W [neuroleptic]- 5 drops, I [hypnotic]- one a day, Y [another neuroleptic]- one in the evening*." Inversely, when the GP is the initiator of the treatment we once again find statements like those formulated for treatment (antidepressants) for which the practitioners assume responsibility: "*I was the one who took charge of her treatment.. she has T* [neuroleptic]."

As for replacement therapy, among the doctors surveyed this form of treatment is classed with therapeutic acts for which they assume responsibility, and which they justify and evaluate. Negotiating from one renewal of the prescription to the next, they are precisely attempting to maintain their patients within the framework of treatment, and keep them from sliding back into substance abuse, which one practitioner distinguishes from dependency. Here we find once again the markers of the doctor's viewpoint that we have already noted, i.e. the shift from "*his*" or "*her*" toxic substance to "*undergoing*" treatment. The responsibility for consumption is pushed onto the patient when there is substance abuse – "*he takes his Subutex® in secret*" – in contrast to "*the other patient who is on Subutex®*". The abundance

of verbs such as "*explain, convince*", the specific details of posology and dosage reported, attest to the subject of negotiation. But regarding replacement therapy, the aims of patient and practitioner are clearly set forth, each seeks to maintain or restore insertion in society. The doctor evaluates this just as much as the state of the patient's health. In this respect the doctor is fully implicated, and associated with success or failure.

With benzodiazepines, given as treatment to patients who are being weaned from alcohol, there is a change of register. The use of the expression "*on benzodiazepine*" marks a modification of the enunciatory posture of the GP [6].

We could conclude from this corpus that the general practitioners appear to distinguish between several classes of medication according to their degree of investment in the treatment underway. Among these classes, the "patient's treatment" ("*little pills in the evening*") and medication from another doctor (the psychiatrist, the first to prescribe) appear to elude their control. When they implement the treatment and are fully in charge of care, they assume responsibility for the "medication under doctor's orders". Replacement therapy (for opiates, alcohol or benzodiazepines) underscores this change of perspective: it is a question of shifting from the "patient's psychotrope" which carries a relationship of substance abuse, to the "psychotrope under doctor's orders".

If one class of medication is clearly attributed to the patient, it is important for us to understand what, on the consumer's side, is reflected by this distinction.

In the Patient's Perspective: Products or Practices that "Calm the Nerves"

For the consumers of psychotropic medication, these pharmaceuticals are clearly differentiated from pharmaceuticals prescribed for any other illness. This conclusion is based on the results of the survey methodology described above, and on the findings generated by the ALCESTE software for middle-class population groups in two different regions (lower Normandy, western Brittany) and for two successive generations (ages 40-70 and 30-50 years) (HAXAIRE C. *et al.* 1999, HAXAIRE C. *et al.* 2003).

It is noteworthy that, in both cases, the ALCESTE software generated a specific class in which are found all the names of psychotropic pharmaceuticals, to the exclusion of other medication. This lexical universe is characterised by the absence of any reference to the medical world, whether with respect to the actors involved, or to acts, objects or naturally the institu-

tions [7]. All the vocabulary is centred around that which "calms". Associated with this central notion are certain words for organising time (*day, night, hour, morning, noon, evening*, etc.) and time markers (such as *at the time, before, yesterday, the day after*, etc.). This shows the extent to which the discourse on psychotropes encompasses issues of rhythm, cycles and habits.

Both corpuses also include many terms referring to dosage of medication (*quarter, pills... half, dose, tablets, drops*). But the fact that the personal pronouns carry little weight, and their non-specific nature ("*I*" and "*You*" as terms of address directed at the interviewer in the first corpus, solely "*I*" in the second corpus), and the infrequent references to prescribers, signal that these pharmaceuticals are considered from the viewpoint of *taking them*, rather than from the viewpoint of usage regulated by *a prescription*. This is the universe of the consumer's autonomous practices.

The weight of verbs, such as *sleep, take, feel*, which are the most present in this class, likewise characterise more intimate and personal practices. In the second corpus, verbs such as *think, calm down, relax, tense up, forget*... further accentuate the impression that the speaker is in a reflective posture, attentive to his or her emotions.

It is in these contexts that the speakers comment on problems of drug dependency (*dependency, habit-forming, habit, habituated* in the first corpus, *need, lack, stop* in the second corpus).

Having analysed these common features, we observe that the universes are slightly different with respect to the courses of action that can be envisaged. They differ between retired people, the majority in the first corpus, and the still active generation which follows, which is more familiar with "*depression*", the disease of the century, as well as with the commonly consumed psychotropes tobacco and cannabis.

For the first group, retired women in Normandy, the world of "*depression*" is fraught with dangerous and deviant behaviour and must be kept at a distance, it belongs to a another universe. Drugs in the class of antidepressants are not recognised as such, but are given as "*medicine for nerves*" or "*for anxiety*". It is not a question of illnesses designated as such, but of "*problems*" encountered in daily life, notably problems with sleep (*stress, insomnia, nightmares* or even *states of anxiety*). Consequently, medication relieving these problems appears as *drugs* in the sense of something that is out of place (Becker H.S. 2001); they are a bad habit, a rut that one falls into when it would be better to get back to more a more appropriate lifestyle.

For the second group, antidepressants – sometimes but not always recognised as such – appear with "sleeping pills" and with certain hypnotic or

anxiolytic drugs in the context of other psychotropes: "*drinks, cigarette, cannabis*" also have the capacity "*to calm, to relax*". This is something that obviously could not be approached by the old people in the first corpus.

In the Normandy corpus, no names of diseases are found in this lexical world. In Brittany, these problems are evoked in the same context as high blood pressure, which for non-specialists is related to "*nervous tension*" (or *hyper-tension* in the English-speaking world, according to Blumhagen, 1980), "*migraine*", also caused by nerves, and "*arthritis*" (undoubtedly a recurrent "*problem*" that it is hard to think of as a "disease".)

Psychotropic medication emerges as products handled in an autonomous fashion, as Haafskens (HAAFSKENS J. 1997) as well as Karp (KARP D. A. 1993) have already shown. This is not a matter of self-medication however, in the way of consumers re-appropriating medical knowledge for themselves, as is the case with common analgesics, for instance. This is shown by the analysis of denominations carried out for the first corpus (CAMBON E. - HAXAIRE C. 2000). It is confirmed by the Brittany corpus, in which we find a specific lexical world for these self-medication products, clearly linked to the universe of medication and medicine, and distinct from the universe of psychotropes, which are attached to events in daily life (TERRIEN K. in HAXAIRE C. *et al.* 2003).

In addition to being autonomously handled practices, these are practices that consumers do not seem to consider to be legitimately part of the medical domain, if the enunciatory marks in the discourses produced are to be believed.

Looking now at the practices, as reported to us, it emerges that for both corpuses, psychotropic medication belongs to the vast category of medication "*for nerves*", with less stable subcategories: "*for sleeping*", "*for 'angoisse'*" (antidepressants). Quite clearly, this medication "*for nerves*" is in a class unto itself. This is reflected in the fact that the products are sometimes kept in plastic bags or in their boxes, separately from the ordinary items in the family medicine cabinet. Their status is ambiguous, they are described as "*dangerous*" but also as capable of inducing dependency, regardless of their therapeutic class.

The respondents' remarks reveal considerable autonomy with respect to the prescription, which is quite surprising on the part of the retired women in Normandy, who follow all other prescriptions very closely, and are not rule-breakers. They follow doses and posology of antidepressant treatment, for instance, even while warning those around them of the dangers of "*falling into the trap*" of psychotropic medication in general. Comparing them-

selves to others, who are their counter-examples, they see themselves as less old, less dependent (the old man is always older than oneself). Daytime doses of anxiolytics are neglected, in favour of bedtime doses. Doses of medication "*for sleeping*" tend to be diminished, and are taken only on very windy nights, or periodically. Long-term treatment, when it is perceived as circumstantial (problems in relationships at work, for instance) are suspended without difficulty when the problems cease (retirement). When the disorder be attributed to an organic cause, dependency is no longer a concern for the patient even if and when it's occurs. Otherwise, the hypnotic is described as a bad habit, that traps the patient and that must be shaken off. But this is linked to the routines of the patient's daily life, and not to the physician. Thus it is not necessarily a great degree of pharmaco-dependency that means the doctor's control is seen as irrelevant, but simply that sleep, problems, emotions are not legitimately in the doctor's domain, even if the patient talks about them with the practitioner. One is better advised to go to specialists (mediums) who deal with "*life's problems*" (a revealing expression).

Among the younger women encountered in Brittany, it would seem that prolonged or repeated use incites them to develop a certain degree of autonomy. They feel that they "*know*" the drug(s) they take well enough and are capable of suspending, lowering, starting up again or increasing doses without asking their doctors' advice. At this stage they claim that they advise colleagues, and sometimes exchange drugs. It is not infrequent that individuals "*try out*" medication that was not prescribed for them. Antidepressants are dropped after a while. Anxiolytics are taken "*when I feel the need*" and in some cases the doctor leaves them free to decide when they should or shouldn't take the medication. Prescribing this latitude is often, and paradoxically, a way for the physician to keep a degree of control over the prescription and the way the patient follows it. The latitude left by medical personnel is mentioned. The pharmacist is assumed to provide extra quantities of psychotropes other than antidepressants in case of need, and this is experienced, or in any event recounted, as giving the patient broad freedom of access. As the patient tells it, the GP who leaves it up to the patient to adjust doses is giving him or her control over the treatment. Whatever the reality, the interpretations given by the patients reveal their desire to handle this type of problem in their own way [(8)]. Indeed, temporarily suspending treatment in all likelihood does have a function, that of reassuring the patient that he or she is in control of the situation. This management can extend to family or friends – it is primarily medicalisation that seems to be rejected.

Paradoxically, while the interviewees in Brittany are wary of developing a habit and dependency due to the use of psychotropic medication, we observe that some of them use or have used other products, have had addictive behaviour vis-à-vis other substances (alcohol, tobacco, cannabis). These products "*have nothing to do with being depressed*", they say. Some, however, declare that psychotropic pharmaceuticals and alcohol can be considered similar, but with the (significant) difference that prescription drugs do not induce social disruption. Still others turn to cannabis rather than to prescription drugs – the latter make it possible to "*hide*" and are seen as "*running away*" from psychotherapy, and therefore one must "*get rid of them*". Cannabis is regarded as a good substitute for hypnotics: "*she stopped all the prescription drugs, and she smokes little joints in the evening, and she sleeps like a baby*". More frequently use of tobacco, cigarettes, are described as psychotropes for "*calming the nerves*" ("*when you're irritated, you light a cigarette*"), a perception which is denied by the one man interviewed.

Just as the lay person's apprehension of the pathological character of any use of psychotropes is variable, because culturally determined, the deviant nature of consumption of psychotropic medication is estimated and gauged according to autonomous processes within certain communities. These women, whose exchanges we have reported previously, have their own definitions, which are always subject to discussion among themselves, of who is "*strung out*" and who consumes "*normally*". Circumstances, chance events in life, can lead them to transgress their own norms regarding consumption of psychotropes, to preserve their economic and social emancipation by professional activity when they must deal with conflicts at work, or when upheaval within the family is added to work pressures, exceeding their ability to keep on (Terrien K. - Haxaire C., *in press*). Here again it is a question of "*life's problems*" that medicine cannot resolve. Psychotropes, as medication or "drug", are an ersatz of a solution, a decoy or cosmetic, in short a *pharmakon* [9] in the perception of our interlocutors themselves.

Conclusion

The "*real remedy*" for depression, as given by certain interlocutors, would be "*a close-knit family*". For life's irritations, the best thing, they say, would be to get on the telephone; as for insomnia, the thing to do would be to establish different daily routines, another lifestyle. This touches upon the

way in which individuals take care of other people, but also of themselves. "Taking care of myself," "having other people take care of me", are not tasks corresponding to the physician's prime function, which is to diagnose and treat diseases. This is true even if the physician, in carrying out this function, also takes care of patients at the same time as treating them. The medicalisation of "psychic suffering"– in the sense that all psychic suffering should be approached via a diagnosis of "disease" and chemically treated – puts the physician in a position of a substitute – in replacement of social ties – and of prescriber of pharmaceutical substitutes which are supposed to enable the individual to treat the processes that restore and rebuild identity, i.e. sleep, emotions. The patients are not fooled, and intend to use physicians and the substitutes they prescribe, for lack of anything else, but use them in their own way. This is what creates the paradoxical situation of the "*little pills in the evening*" and similar practices. For the patients the pills do not belong to the medical domain but nonetheless they can only be obtained with a prescription. Health care professionals all confront in their practice various strategies for getting around the problem, strategies which seem to focus on resolving this paradox by denying institutional control [(10)].

The fact that in the popular perception all therapeutic classes of psychotropes are subsumed in the category of "*medication for nerves*", along with the shifting acceptation of the entity "*depression-depressed*" which tends to encompasse all instances of feeling bad, would be an incentive for patients to adopt this sort of attitude towards new antidepressants (if not towards neuroleptics). This would be especially true if doctors were to relax the strict principles that they appear to continue to maintain regarding these prescriptions, if the discourse of their patients is to be believed. As for the prescribers, the set of "psychotropic medication" is characterised by concern with control over posology and dosage. Even so, as revealed by analysis of their discourse, the "little pills in the evening" escape their control. They are aware of the behaviour described above, and try to uncover it. For general practitioners, prescription of psychotropes is set in the context of taking the patient's problems of daily life into account, a practice which seems to fall into a universe that is distinct from the universe of common medical practice. This opposition could be analogous to the opposition care/cure. The "little pills in the evening" would in this view come under the heading of care, and the way in which the patients take care of themselves. By this acceptation doctors appear to endorse this paradoxical subversion of what is called "doctor's care".

Notes

(1) It would be too simplistic to say that in these cases the general practitioners anticipated a "hidden depression" because this analysis does not do justice to the more global perspective evinced by the doctors.

(2) The ALCESTE software, designed by M. Reinert, extracts from a body of text classes of enunciations that are related by their vocabulary, called "lexical worlds". Reinert hypothesises that "at the time of locution the speaker invests various successive worlds, and these worlds, in imposing their objects at the same time impose their vocabulary. Consequently, a statistical study of the distribution of this vocabulary should enable us to pick up the trace of these "mental spaces" that the speaker has successively inhabited, traces that are perceptible in terms of "lexical worlds", these lexical worlds referring back to a way of choosing one reference system or another, at a given moment in the discourse." One of the latest papers by the Author presents the software analysis as semiotically based (REINERT M. *in press*).

(3) We do not have room here to go into the contrast with other sets (see report, HAXAIRE C. *et al.* 2003).

(4) Buprenorphine. A

(5) Our corpus included very few mood regulators.

(6) We verified this by searching for all occurrences of the term using the Lexico software (SYLED-CLA2T, Université Sorbonne Nouvelle Paris 3).

(7) The terms *doctor, physician, pharmacist, nurse... renew... shots, medication, prescription, hospital* etc. are found elsewhere.

(8) The interviews reveal various arrangements. Some consumers use their personal contacts with pharmacists to obtain more hypnotics and anxiolytics than prescribed, and later to get them without a prescription; or obtain prescriptions from doctors who are friends; or use multiple prescribers to accumulate the quantities they want. Some borrow the recommended medication from friends or family, or use family members' prescriptions to avoid seeing the doctor. When a visit to the doctor cannot be eluded, it is well known that the request for renewal of a prescription for this type of psychotropic medication will come at the end of the visit, as if in passing. In some extreme, but exemplary, cases reported to us, the doctor is placed in the situation of having to deliver a product designated by the client, the latter totally rejecting any request for an explanation.

(9) Cf. the deconstruction of this term by Derrida (DERRIDA J. 1972 [1968]).

(10) Cf. Previous note.

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