

Girls and the pill:  
Sex, health and managing the self

by

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## **Abstract**

This thesis examines the place of the oral contraceptive pill within the context of girls as subjects in contemporary Canadian society. In many ways, discourses that associate pill use with choice, reproductive rights and increased control over the body for women are still prevalent today. Yet, there is an increased emphasis placed on autonomy, self-realization and empowerment, as well as the life-style benefits of the pill; further, young women, not women generally, are the target of campaigns that seek to encourage pill use. In attempting to examine the discourses that constitute young women as subjects on the pill, I have brought together interviews with young women currently taking it and texts from the print news media, pharmaceutical advertising and public health communications. This thesis contributes to Foucault's later work on ethics and care of the self and practices of freedom, which examines how government of the self occurs within the context of relationships with others. However, through engaging in a dialogue with post-structural feminist accounts of gender and the body, feminist studies of science and technology and recent work on emotional regulation and emotion management, I consider the particular characteristics of subjects and the way that work on the self occurs on an ongoing basis in daily life. In this thesis I argue that young women are actively engaged in constituting ethical conduct, while at the same time the conduct of young women is shaped by various pill discourses. As such, in this thesis, I do not determine whether young women should or should not use the pill, nor do I establish the degree to which it enables or limits choice, reproductive rights and freedom. Instead, I am interested in how tensions surrounding the pill produce ethical dilemmas that young women navigate on an ongoing basis.

## Acknowledgements

This thesis represents many parts of me and during the course of my studies my life has altered dramatically. In studying the pill, I had many unexpected revelations, and I think my conclusions are stronger for it. As an academic, there is perhaps no greater joy than realizing you had it wrong. Thus, I am grateful to the women who participated in my research and took the time to share why and how they used the pill, as this research would not have been possible without their participation.

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This thesis received support from the Social Sciences and Humanities Research Council and the Ontario Graduate Scholarship program. I am also grateful that during my studies I was living in Quebec and was able to benefit from universal childcare. Having access to affordable childcare allowed my partner and I to complete our graduate studies with children in tow. As much as we need devices to allow individuals to prevent pregnancy when desired, it is equally important that programs are available to support families who do have children at any stage in life. I will leave this topic for another thesis.

Finally, I would like to acknowledge my grandmother, Minnie Smith. Around the time of the completion of this thesis, I received a package in the mail from my father, containing my Grandmother's memoirs. She grew up in a small town in interior British Columbia and like many women of her time she had little access to good reproductive care. After giving birth to my father, she suffered severe infections and was unable to have more children. In a very simple and honest way, her memoirs explore the difficulties facing many women of her time. I am sure she would have been a sociologist if she had had the chance. My grandmother has had a profound impact on my life, and I am in awe of her perseverance and passion. I dedicate this thesis to her.

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## Girls and the pill

Entre les années 1960 et 2000, plus de 200 millions de femmes y ont eu recours [à la pilule]. Selon Statistique Canada, 1,3 million de Canadiennes comptent aujourd'hui sur la pilule, soit 18 % des femmes de 18 à 49 ans. Aujourd'hui, conclut la Dre Louise Charbonneau, «on dit “la pilule” comme “le kleenex”, c'est la façon commune de parler de la contraception» (LD2<sup>1</sup>).

Il y a trois ans, Marie-Claude Lemieux a fait son entrée dans le tableau 6, à la page 18 de la monographie de la pilule contraceptive Tri-Cyclen - le tableau des effets indésirables. Le 16 février 2010, Marie-Claude Lemieux a fait un accident vasculaire cérébral (AVC) qui l'a laissée totalement paralysée, sauf les muscles de la paupière gauche. Cause la plus probable: le contraceptif de troisième génération qu'elle prenait depuis quelques mois (LP30).

*Lisa:* When you think of contraception, do you think of it as a moral issue?

*Allison:* Umm... I don't. Well... I think of it as a moral issue in terms of for yourself. Maybe not morality, but responsibility, do you see yourself as a responsible person, are you responsible in your health. And if there are people I've heard of and who are just using a condom, or like a pull out method, I'm like, "You are playing with fire." I see that as not very responsible. I definitely was really glad when my sister went on the pill for her cramping, because well she's very different from me, she's very private and not as talkative. I was sort of worried she would be shy about getting it and would maybe be sexually active before she went on it. So because she went on the pill before she was sexually active, I remember feeling a real relief... she's covered, I thought. Yeah and definitely friends that have had sex without being on the pill, like I have a friend who goes off and on it and it's just like she goes on and off of it. I'm like, "Why don't you just take it consistently"?!"

Since its introduction on the market, the oral contraceptive pill—or the pill--has produced wide-ranging and complex issues which women around the world continue to struggle with. In Canada, the pill continues to be associated with women's reproductive control and rights, choice and sexual freedom. As in the above article from *Le Devoir*, the author observes, 1.3 million Canadian women were using the pill in 2010. Such a statistic emphasizes the pervasiveness of the pill; it is the “kleenex” of the contraceptive world. Yet, today in Canada, the pill is most commonly taken by young heterosexual women—or girls—and its use is increasingly associated with a personal desire to control fertility and manage short and long-term health concerns. Even so, the actual impact of the pill on the lives and bodies of young women, as well as on wider social and cultural processes, is still a source of contentious debate. Many young women do benefit from controlled fertility, reduced acne and menstrual cramps, even if the pill does not

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<sup>1</sup> Excerpts from texts collected for research will be referenced using a code. Complete bibliographical details for each article can be found in the text research index, Appendix D.

bestow positive effects on all users, as evidenced by the case of Marie-Claude Lemieux discussed in *La Presse*. Yet, as Allison states, taking the pill concerns the morals of the individual. As she observes, “Maybe not morality, but responsibility, do you see yourself as a responsible person, are you responsible in your health.” In this context, morality refers to ethical work—or the attempts of an individual to transform the self as a free subject. Indeed, if you are a responsible young woman, why would you not just take the pill consistently?

In this thesis, I situate the pill within contemporary conceptions of sex, health and by extension the body and the self. Drawing on the later work of Foucault (1985), I consider the ways that a young woman constitutes herself as a moral being capable of exercising her freedom correctly and responsibly by taking the pill. According to Foucault, western philosophy tends to understand freedom as liberation from external social forces; his work on ethics encourages us to carefully pull apart the ways that individuals call upon ideals in constituting the self as free or unfree. In this thesis, I understand freedom as a socially and culturally situated ideal that shifts over time within the lived worlds of individuals. As a device commonly associated with liberation, Foucault’s work is helpful for unpacking the ways that ideals of freedom manifest in relation to particular subjects. To gain access to the pill, a young woman engages with knowledges and truths about the body and sex, and draws on relationships with others. As I will demonstrate, in constituting the self as ethical, a young woman refers to historical feminist struggles for agency and bodily autonomy, as well as wider changes in the status of girls in contemporary North American culture and society. In this thesis, I consider the particular characteristics of girls as subjects on the pill and explore the way that they recount choices within the context of their own lives and experiences. I argue that young women are actively engaged in creating, critiquing, and debating what constitutes ethical conduct, while at the same

time, the conduct of young women is shaped by various pill discourses that emerge from diverse and diffuse social spaces. In this thesis, I do not aim to determine whether young women should or should not use the pill, nor do I establish the degree to which taking it enables or limits choice, reproductive rights and freedom. Instead, I am interested in the tensions that are produced when particular subjects take the pill; as I will demonstrate, tensions produce relationships, knowledges and truths, and various ethical dilemmas that young women navigate as they take the pill on a daily basis.

In this thesis, “girls” refers to feminine adolescence and early adulthood or late teens to early twenties, which Driscoll (2002) refers to as a sub-category of “girl culture” more generally. Girls are not tweens or pre-tweens, even though all groups are part of “girl culture”. Unlike tweens and pre-tweens, young women are expected to engage in sexual activity and to be aware of and use technologies like the pill to have “safe sex”. While tweens and pre-tweens are often encouraged to be empowered, they are still protected from and discouraged from engaging in sexual activity. Young women are encouraged to embrace the control offered by technologies like the pill to ensure future success and stability. In contemporary Canadian society, young women are simultaneously “at risk” and empowered, vulnerable and powerful (Gonick 2006; Harris 2004).

The research that informs this thesis includes a series of twenty-seven interviews with young women currently taking the pill and living in Montreal, and an analysis of pharmaceutical advertising, public health information and print news media. This thesis does not reflect the experiences or views of all Canadian young women. Some young women will never take the pill; some young women will use it for a very short period of time. Others will use it for upwards of twenty years for a variety of purposes, from contraception, to acne, to managing

polycystic ovary syndrome. Some young women will experience side-effects, such as blood clots, nausea, loss of sex drive, gall bladder failure, breast tenderness, and liver lesions, while others will experience no negative side-effects. In this thesis, I assume from the outset that there is an incredible diversity in how the pill is used by young women. Equally, I assume that the pill can affect bodies in multiple and often unexpected ways. I start from an assumption that seeking to represent the views and experiences of all young women glosses over difference and diversity. What I provide in this thesis is a sense of the tensions that emerge in some texts. I explore how some young women in Montreal use it to work on the self and the body and shape the conduct of those around them in particular ways.

### **Research problem**

According to Cream (1995), taking the pill is an activity that is expected of middle-class heterosexual women in North American society. As she observes, in most late modern capitalist societies,

The heterosexual, fertile woman on the pill, wanting to plan the size of her family, for example, makes sense. Her body is both legitimate and intelligible. Located in another position, such as the post-menopausal single woman, or even as a man, she is less 'intelligible' (158).

Like Cream, I recognize that taking the pill is a widely accepted and expected part of performing femininity in particular places in the world. Yet, it is important to recognize that today in North American society taking the pill is an act primarily associated with young women, not women in general (Smith 2014; Sundstrom 2012, 5). Also, young women often use the pill as a lifestyle drug, meaning it is used for purposes beyond its primary prescriptive function as a contraceptive (Flower 2004). Further, a young woman can use the pill in various ways that are not intended by her doctor or health professional. The pill might affect her body in unexpected ways that could be experienced as pleasant or unpleasant. In taking the pill, a young woman will most likely manage and navigate a series of ongoing dilemmas as they arise. Thus, in getting on the pill she

engages with ethical standards that form the self; but equally, in taking the pill she will work with ethical issues on a daily basis.

In text materials I found that tensions and conflicting positions about the pill produced ethical problems that needed to be resolved by subjects. For example, print news media articles discussed the various effects associated with taking the pill, such as reduction of acne, control of fertility and shorter periods, but also bloating, loss of sex drive and death. Pharmaceutical advertising for oral contraception explicitly targeted young buyers and placed a particular emphasis on the “lifestyle” benefits of taking the pill, such as regulated emotions and period suppression; while required patient package inserts discuss the possibility of blood clots, gallbladder disease and depression. Public health information on-line targets young women and informational pamphlets emphasize the benefits of the pill for global health, as opposed to only reproductive health. But public health information only provides piece-meal descriptions of what the pill actually does to the body and highlights the extent to which individual responsibility is always limited. Texts that circulate in public space celebrate the pill, but they also highlight that it is an object with uncertain outcomes.

Similarly, in interviews I found that young women identified the pill as an important device in maintaining ideals of freedom for women more generally, such as reproductive rights and the choice to control fertility. Yet, many young women found that taking the pill often limited their freedom and control. Further, they recognized that individual responsibility was often limited and they were often frustrated by the expectations placed on their conduct by friends, parents and doctors. Most young women assumed that women today were more informed about contraception and pharmaceutical devices, yet, they were often unsure of how the pill actually worked and the impact it was actually having on the body. Managing unpleasant

side-effects often challenged ideals of freedom and self-realization; yet, many young women I interviewed were somewhat blasé about the negative side-effects of the pill. In this thesis, I am interested in the ways that young women's conduct is organized by various discourses, but I am also interested in how tensions are managed on an ongoing basis.

### **Research questions**

This thesis is concerned with the following three questions:

#### ***1) How do young women constitute themselves as ethical subjects on the pill?***

This first line of inquiry aims to elaborate the ethical work young women engage in when taking the pill. Foucault defines ethics as the "...manner in which one ought to 'conduct oneself'" with reference to a "given code of actions" (Foucault 1985, 26). Through practices or "techniques of the self" individuals' act to,

...effect by their own means or with the help of others a certain number of operations on their own bodies and souls, thoughts, conduct, and way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection, or immortality" (Foucault 1988, 18).

For Greek and Roman men, "the individual's attitudes towards himself, the way in which he ensured his own freedom with regard to himself, and the form of supremacy he maintained over himself were a contributing element to the well-being and good order of the city" (Foucault 1985, 79) and justified his right to care or govern others (Foucault 1991, 7). Foucault argues that in ancient Greek and Roman societies, the Delphic principle of "care of the self" was the organizing principle in moral formation of the self as a free subject. Today, Foucault's approach draws our attention to the ways that the conduct of young women is organized by ideals of freedom and autonomy. He also draws our attention to the ways that individuals enact and embody ethical standards in social relations on an ongoing basis.

For young women in late modern capitalist societies, such as Canada, ethical conduct is governed by unique principles--empowerment, autonomy and self-realization. This does not

mean that ethical conduct is individualistic, as a young woman who manages her body contributes to a good society by valuing her physical appearance, maximizing her health and remaining unencumbered by unwanted pregnancies. The mass media, pharmaceutical advertising and public health promotion contribute to the discursive formation that constitutes the ethical girl subject on the pill. The discursive formation is also refined and added to by girls as they use it, as well as in everyday interactions between girls and their peer groups, parents and medical health professionals.

***2) How is taking the pill productive of diffuse and multi-directional power relations?***

In working through this second line of inquiry, I draw on Foucault's (1977; 1978) notion that power is diffuse, and productive rather than repressive. Taking the pill does not make young women *powerful* or *powerless*, as power is not something that is held by individuals. I am also not interested in claiming that the pill is a good or bad and determining whether young women should or should not use it. I am instead interested in how power and knowledge come together to produce certain truths about young women as subjects vis-a-vis the pill and how young women draw on various relationships to constitute the self.

Post-structural feminists have highlighted the importance of offering differentiated accounts of ethics based on the subject in question (Grosz 1994; Valverde 1998). Unlike those aimed at Greek men, the discourses that govern young woman draw on her status as an incomplete subject. For example, various pill discourses incite a young woman to know her body, to have honest sexual relationships and to develop good rapport with her parents and relevant medical professionals. These individuals ought to be enlisted so that she might correctly manage herself. But at the same time young women are not always capable of making the "right" choice in relation to managing sex and health and the pill is sometimes taken to be a

dangerous object which young women ought to be protected from. Further, I found that young women were actively involved in governing the conduct of close friends, but also the conduct of young women emerged as a general moral problem requiring intervention and regulation in both intimate and wider social settings. While there is a strong moral imperative that compels young women to take the pill, I found that the difficulty lay in that there was ultimately no “right” way for a young woman to manage herself. As I will discuss, even taking the pill was fraught with all manner of difficulties and was rarely identified as a straightforward action linked to moral freedom.

### ***3) How do women produce stories about the pill within the context of wider social ideals about progress and liberation?***

In the print news media and in interviews, I found that the history of the pill is commonly situated within the history of women more generally in an unproblematic way. Within these sources, narratives about women’s history and the history of the pill, as well as ongoing assumptions about technology and progress, figured prominently. Historians of contraception and the regulation of reproduction have pointed out that fertility control is not unique to “modern” societies (Jutte 2008; McLaren 1990). Further, historians continue to challenge the actual effect of advances in reproductive technologies, like the pill, on the fertility decline, the sexual revolution and women’s freedom more generally (Klausen 2009, 118). More and better reproductive technology has not always meant more and better reproductive control for women. However, in the twentieth century, there has been a multiplication of discourses of fertility control across a variety of social spaces, such as public health, feminist activist communities, and the government, but equally within more intimate spaces, such as between friends, parents and children and increasingly the internet (Ruhl 2002, 642).

As I will discuss, the pill is a popular cultural icon and figures prominently in public narratives of women's history. Granzow (2007) observes that contemporary reproductive politics continue to struggle with dilemmas of freedom particular to women, such as choice and control, as well as issues surrounding the use of reproductive technologies. While themes of choice and control do still arise in public texts and young women's talk about the pill, these ideals are equally reinterpreted by girls within the unique context of "girl culture".

### **Outline of research**

The object of this thesis is to explore the various discourses that contribute to forming what constitutes ethical conduct for young women as responsible reproductive and health-conscious subjects in contemporary Canadian society. But I also seek to show the ways that young women are actively involved in creating ethics and standards of ethical conduct. The research informing this thesis thus aims to provide rich data that will contribute to theorizing the dynamic nature of subjectivity and the complex process of self-formation.

With this in mind I have gathered materials from across social space. I have examined the pharmaceutical advertising campaign for Alesse,<sup>2</sup> articles from the print news media, and public health information in order to understand the ways that young women's conduct is organized in relation to the pill. As I will demonstrate, the text sources I gathered do have a normative effect; but pill discourses are not uniform and I found contradictory accounts of the various risks and benefits of the pill. I have also conducted twenty-seven in-depth interviews with young women aged eighteen to twenty-eight living in Montreal and currently taking the pill. Special attention was paid to recruiting a variety of participants who could offer different

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<sup>2</sup> Alesse is a brand of the oral contraceptive pill manufactured by Wyeth Canada. It is marketed as a low-dose version of the pill and is recommended to doctors for young patients who seek contraception, but also side-benefits such as acne and menstrual regulation.

viewpoints, such as French and English speakers, and women from different socio-economic and racial/ethnic backgrounds. The sample discussed in this thesis offers a variety of perspectives. However, it is not representative of the general Canadian population. What I can offer is an exploration of the ways that a young woman might use the pill, individuals that help her to make decisions in relation to reproductive control and health, and a sense of issues she might confront. Participants often made reference to how choices were affected by sexual orientation, race, ethnicity, socio-economic status and geographical location, and I highlight these instances. However, I am unable to offer meaningful comparisons on the basis of social status and identity.<sup>3</sup> In-depth interviews allow for an exploration of the ways that individuals negotiate social expectations for behaviour and both accept and reject standards of conduct – often adjusting their behaviour based on perceptions about the intentions and motives of others. The young women I interviewed did not always follow standards of ethical conduct and were actively engaged in creating alternative frameworks for action.

This research draws on the insights of feminist qualitative methodologies, which recognize that women are actively involved in the construction and production of texts (Smith, 1990), acknowledge how diverse racial, ethnic and socio-economic backgrounds contribute to young women's lives (Doucet & Mauthner 2006), and encourage the use of a reflexive approach where the researcher identifies the ways in which her social-position and personal life experience

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<sup>3</sup> For a discussion of how contraceptive use is affected by various socio-demographic factors see Balakrishnan, T.R., Evelyne Lapierre,-Adamcyk, & Karol J. Krotki (1993) *Family and Childbearing in Canada: A Demographic Analysis*. Toronto: University of Toronto Press; Black, Amanda, Qiuying Yang, Shi Wu Wen, Andre Lalonde, Edith Guilbert, William Fisher (2009) Contraception use among Canadian women of reproductive age: Results of a national survey, *JOGC*, July; Black, Amanda, Diane Francoeur, and Timothy Rowe (2004) Canadian Contraception Consensus, *SOGC Clinical Practice Guidelines*, 143, February; Blackburn, R. D., Cunkelman, J. A., and Zlidar, V. M. (2000) Oral Contraceptives – An Update, *Population Reports*, 18: 9, 1

affect her orientation to research (Doucet 2007). I have also drawn on narrativity which emphasizes the important role played by stories in contemporary accounts of the self and subjectivity (Plummer 1995). Analysis is informed by Foucault's (1985, 26-32) four dimensions of the study of ethics, Hall's (1997, 45-46) guidelines for the study of discursive formations and an adapted version of the "Listening Guide" (Doucet 2007, 278-284), a voice-centred relational approach that builds reflexivity into the analytic process. Working between these methods required multiple and layered approaches to reading and analysis which I will discuss in-depth in the methodology chapter.

### **Context**

The pill has garnered substantial interest from historians who have sought to understand the impact of the pill on different groups of women and wider social issues such as the fertility decline, the sexual revolution and the rise of consumerism and Big-Pharma (May 2010; Tone 2001; Waktins 1998). Sociologists, feminists, and demographers continue to produce literature examining the role of the pill in changing patterns in gender relations, family forms, and the implications of pharmaceutical and medical control over reproduction and health (see Baker 2008; Fennell 2011; Granzow 2007; Kissling 2013). Within feminist scholarship, reproductive technologies have sparked debate. While some claim that technologies like the pill liberate women, others argue that reproductive technologies are part of "a continuing story of pathologizing and medicalizing women's reproductive bodies" and are "a new and more pernicious means of coercive male appropriation of the female body" (Weir 1996, 375). However, the pill is not only a contraceptive and as I will discuss, many women use it for treatment and life-style purposes.

Drawing on Foucault's later work on ethics and care of the self, recent feminist scholarship has sought to move beyond accounts of reproductive and pharmaceutical technologies as inherently liberating or oppressive. Ruhl (2002) and Weir (1996) encourage us to understand how the use of reproductive technologies mobilizes and creates various techniques of government and organizes the conduct of women in particular ways. Such an approach highlights the ways that the management of reproduction through technologies involves the "conduct of conduct", which refers to the ways that individuals constitute the self in a manner consistent with liberal discourses of freedom and autonomy (Weir 1996, 375). Similarly, Fox & Ward (2008) and Casper & Carpenter (2008) draw our attention to the various ways that individuals use pharmaceutical technologies, as well as how such devices are tied into gendered social processes. In a similar vein, I am interested in the ways that the conduct of young women is organized in relation to the pill and I assume that there will be changes over time.

The pill is commonly understood as a "feminine technology," meaning it is used by and predominantly associated with women (McGaw 1996, 14). Similarly, as Cream (1995) observes taking the pill is an accepted and expected act for white heterosexual women; in another context, used by another subject taking the pill does not coincide with social expectations. For example, the pill is also used by women transitioning to stop menstruation and in some cases for hormone-replacement therapy during menopause. As Tone & Watkins (2007) note, the effect of a pharmaceutical is often as important as the social meaning ascribed to it. For example, we can look to how the emergence of antibiotics contributed to a widespread faith in the possibilities of laboratory science or, more recently, to the role of Viagra in redefining sex (Loe 2006). Widespread use of the pill by women is often associated with a more general shift to "modern" methods of fertility and health management, wherein women have individual control over

reproduction and health (Granzow 2007; Ruhl 2002). As I will discuss, cultural and social characterizations of the past and technological advances in women's reproductive health are central in shaping contemporary pill discourses. Equally, in contrast to the past, it is often assumed that women today are informed about the risks and benefits of contraceptive devices and they make calculated decisions between multiple options.

Yet, as I will explore, themes traditionally associated with the pill are being reshaped in the context of issues particular to young women and increasingly draw on notions such as empowerment, autonomy and self-realization and the distinct social relationships that are connected with this group, such as the importance of mothers and peer groups in facilitating contraceptive decision-making (Franzetta & Manlove 2007) and health management. As McRobbie (2000) observes the new "girl culture" is characterized by discourses of self-realization that link together consumption of the latest beauty and health technologies with a feminist message of empowerment.

Generally speaking, in North American society, a young heterosexual woman is in a formative period wherein she is in the process of defining her future. Post-puberty is a time when she is learning techniques for managing and controlling her health and sexuality, but it is equally a time of crisis. A young woman is potentially engaging in her first sexual relationships and she is often beginning to manage her menstrual cycle. Young women always make choices in relation to pharmaceutical and reproductive technologies; yet, they are equally governed by the manner in which those choices are constructed within wider systems of social meaning. In this thesis, I seek to understand the characteristics of new formulations of the self by exploring the creative ways that young women use the pill in daily life. Women are not forced to use the pill and in fact pill use is at its lowest amongst less educated women and ethnic minorities who

have been the target of eugenics campaigns in the past (Black et al. 2009). Sundstrom (2012) and others have found that pill use amongst young women is not generally correlated with age, race, ethnicity or class (5). Yet, among sexually active women in Canada pill use rates vary between 35-50% and pill use is often paired with condoms (Balakrishnan 1993; Black et al. 2004; Black et al. 2009; Blackburn et al. 2000). Young women use other contraceptive methods, such as withdrawal, condoms, and IUDs. Even so, there is a general expectation for pill use for young women in Canadian society that draws on upper and middle-class ideals of individual responsibility and family constitution. It is assumed that delaying childbearing and taking steps to maximize health are desirable. Further, it is assumed that access to reproductive and to pharmaceutical technology is distributed equally to all individuals. In this context, taking the pill is linked in an unproblematic way to individual choice without reference to personal health issues, as well as socio-economic, cultural, ethnic or even geographical circumstances that might limit a woman's capacity to choose. While taking the pill might be seen as an example of positive moral conduct, there are equally implications to discourses that encourage certain forms of conduct over others, for the individual pill user as well as those around her.

## **Chapter Overview**

In Chapter 1, I introduce key theoretical concepts and discuss the methodological considerations for the thesis, including the way that data was selected and collected. This thesis contributes to Foucault's work on governmentality, ethics and care of the self, and draws on the insights of post-structural feminists on gender and the body, feminist studies of science and technology and recent work in the area of emotional regulation and emotion management. Foucault emphasizes the productive effects of power and discourse and examines the work of individuals as they manage the self. Post-structural feminists have added to his observations by highlighting the

importance of offering differentiated accounts based on the subject in question. Feminist studies of science and technology have drawn attention to the importance of social and cultural understandings of the ways that women are configured as female subjects by technologies. Emotional regulation and emotion management adds a framework from which to consider interior processes of self-constitution and the relationships of power that are at work.

During the course of my research, I found that women use the pill in unexpected ways. I drew on the insights of feminist qualitative methodologies and narrativity to attend to the dynamic and fluid character of subjectivity, while at the same time recognizing the ways that social expectations shaped the conduct of young women. In this chapter, I will also acknowledge the importance of reflexivity to social science research and discuss how my research was shaped by my background, identity, and personal experience with taking the pill. This chapter concludes with a discussion of the analytical framework and I provide examples of analysis.

In Chapter 2, I situate the thesis within existing research and literature on the regulation of reproduction and the pill more generally, the sociology study of girls and “girl culture”, and pharmaceutical technologies. Existing literature does not take into account the specific ways that the pill is situated within reproductive and sexual health issues particular to girls and “girl culture”. In Canada today, the majority of pill users are young women, and they use it for a variety of reasons, from contraception, to acne regulation, to treatment of severe menstrual cramps. Further, as I have already mentioned taking the pill is increasingly associated with empowerment, autonomy and self-realization, as opposed to choice and reproductive rights for women more generally. Existing scholarship on the sociological study of pharmaceutical technologies highlights the importance of recognizing the ways that technologies are situated

within key social changes, such as individual responsibility for adolescent health, the downgrading of state responsibility for health and welfare, as well as the importance of the internet in normalizing and domesticating pharmaceutical consumption.

In Chapter 3, “The past of the pill in the present”, I discuss the important contributions of historians to our understanding of the regulation of women’s reproductive bodies and contraception more generally. In this chapter, I examine accounts of the history of the pill in the print news media and interview data. I explore how everyday accounts of the past are involved in shaping the self and framing reproductive dilemmas that women confront in the present. As I will discuss, the pill remains a particularly salient reference point within public discussions about the history of women and reproductive technologies more generally. While popular accounts, like the print news media, draw on the insight of historians who have tended to emphasize multiple histories of the pill, the diversity of women’s experiences is often glossed over. I conclude with a discussion of how accounts of the history of the pill also shape perceptions of what is possible in the future.

Chapter 4, “Tricking the body”, engages with Emily Martin’s classic article, “The Egg and the Sperm” and discusses descriptions of how the pill functions in interview data and public health literature. In this chapter, I unpack the commonly used metaphor of how the pill functions: “it tricks the body into thinking it’s pregnant”. Like Martin (1991), I recognize that scientific descriptions of natural processes reproduce gender norms, but I also argue that knowledges configure subjects and devices in particular ways. I begin by providing an account of how the pill functions and also what it is made of. I then discuss how the pill is classified in relation to other contraceptives in public health literature, exploring the importance attached to distinguishing between “natural” or “traditional” devices as opposed to “scientific” and

“modern” technologies. Finally, I discuss the importance placed on “informed consent” and knowledge for women about the pill. Studies of women’s contraceptive knowledge often focus on the ways that women are misinformed or have incorrectly interpreted scientific “truths”. However, I argue that women’s supposed lack of knowledge about what the pill does represents the more general lacuna in scientific knowledge and the impossibility of knowing exactly how the pill will function. I found that for the young women I interviewed, the knowledge they had about the pill was contingent on various relationships, such as doctor/patient or mother/daughter and bodily experiences that were not always easy to identify and understand.

In Chapter 5, “Girls, ethics and getting on oral contraception”, I turn to the specific characteristics of the ethical work that young women engage in when getting on the pill. In this chapter I challenge the dominant view of the use of the pill as an expression of choice and reproductive rights. I explore interview data and a pharmaceutical marketing campaign for a particular brand of the pill, Alesse. I engage explicitly with Foucault’s (1985: 26-32) four dimensions of the study of ethics to understand the ways that young women engage with freedom in taking the pill. Drawing on de Courville Nicol (2013) I found that themes of empowerment, autonomy and individuality are consistent with a rhetorical campaign of desire that associates pill use with self-realization. Foucault’s approach is helpful for demonstrating the importance of relationships at various levels and how the communication of various knowledges contributes to the constitution of the self. However, as did Valverde (1996), I found that problems of freedom and liberation do not emerge in the same way for young women as they might for the average adult female “liberal citizen”. In many ways, young women are compelled to use the pill because they are not fully capable of realizing liberal ideals of self-control. In this

sense, in getting on the pill a young woman engages with a complex negotiation of freedom that will change over time as she uses it in different ways.

Chapter 6, “Disturbing ethics?” explores the mobilization of “pill scares”, as defined by Barnett and Breakwell (2003), within the context of more general concerns about the pill. In producing a rhetorical campaign of fear—or discourses that aim to associate the pill with pain and horror (de Courville Nicol 2013, 179)—the print news media encourage subjects to manage their emotional response to the pill. I discuss the unfolding of the recent “pill scares” in Canada relating to Yaz/Yasmin and Diane-35. However, I challenge the notion that the potential “negative” or “side” effects of the pill offer disrupted accounts of autonomy and freedom. Instead, I demonstrate how these discourses contribute to a broad field of uncertainty surrounding the use of reproductive and pharmaceutical technologies and prompt ongoing processes of emotion management that are productive of the constitution of the self. As I will discuss, “pill scares” occur alongside more mundane concerns about the effects of the pill and interview participants were often only moderately interested in the serious side-effects of the pill. I conclude this chapter with a discussion of the ways that women make up their own techniques for managing the potential side-effects of the pill, such as pill swapping and discussing worries with friends and mothers.

## **Conclusion**

*Lisa:* What do you think about the idea –hypothetically—of a male contraceptive pill?

*Hannah:* [laughs] I think that would be amazing!

*Lisa:* If it existed, would you encourage your partner to use it?

*Hannah:* Yeah, and I think my partner would use it. Cause he’s just as paranoid as I am [laughs]. But yeah, I think also it’s kind of unfair. I mean I guess it’s the natural way of things. If the woman were to get pregnant, she would be carrying the baby, so she has to be responsible for her body. But I feel like sometimes men take it for granted and it’s like oh, we just have to slap on a condom and everything’s ok. I feel like it would make sex a more balanced... in terms of responsibility. When a woman gets pregnant, like sometimes I know a man is like, well that’s you ... you didn’t protect properly or whatever. You weren’t on the pill. So I think it would be a good thing.

*Lisa:* Do you think it would be hard for you to relinquish that control?

*Hannah:* Oh, you mean if he was taking it only ... No. I need to ... for myself, feel like I'm in control. I don't know if I could trust the other person to take it. That's why I feel like the pill gave women power, because we feel more in control of our bodies. Before it was like, whatever happens naturally, we just go with. But I feel like now, the pill and stuff like Plan B, we feel like we can control situations that have to do with our own bodies. Like for me, I feel like I can be irresponsible and just take the Plan B and I'll be ok. It gives me more power, which is maybe a good thing. Maybe a bad thing [laughs]!

No woman can call herself free who does not own and control her body. No woman can call herself free until she can choose consciously whether she will or will not be a mother (Margaret Sanger).

Ensnared by nature, the pregnant woman is plant and animal, a stock-pile of colloids, an incubator, an egg; she scares children proud of their young, straight bodies and makes young people titter contemptuously because she is a human being, a conscious and free individual, who has become life's passive instrument (De Beauvoir [1952] 1989, 495).

In popular historical accounts, Margaret Sanger is commonly identified as a key player in prompting the scientific research that led to the development of the pill. Like many others of her time, she dedicated her life to liberating women from the confines of the reproductive body. Yet, Sanger and others set the bar incredibly high—we cannot be free unless we control our bodies. In the face of such lofty expectations, we (women *and* men) cannot help but be failures at freedom. Today, the primary users of the pill in Canada, young women, engage in ongoing attempts to make do with what is before them. As Hannah observes, having the kind of control afforded by reproductive technologies like the pill and “Plan B” is “maybe a good thing” and “maybe a bad thing”.

My aim in writing this thesis is not to declare whether the pill is a good thing or a bad thing for young women. There is no one truth about the pill. The pill is part of a global pharmaceutical industry, which has arguably served the interests of women in very limited ways. However, women today expect and demand a high degree of control over the body that is not always attainable without pharmaceutical intervention. The interviews I gathered were replete with contradictions and an incredible diversity of experiences. Equally, the texts I collected were not unified or straightforward. The pill can control fertility with a relatively high degree of

reliability, it can make breasts bigger, it can reduce acne, it can result in death, it might increase certain types of cancer and it might decrease others. As a commodity, the pill produces dilemmas, such as how to regulate pharmaceutical companies, where responsibility lies for side-effects, how the pill should be distributed, and who should give women advice and information. In this thesis I explore how the messy grey uncertainty that comes with taking the pill produces tensions, is implicated with various relationships at the macro and micro level and incites ethical work by young women on the self and body. While there is certainly continuity between ethical dilemmas that faced women fifty years ago surrounding freedom, the regulation of desire and the use of reproductive and pharmaceutical technologies, the pill is increasingly part of the unique domain of girls and “girl culture” in contemporary North American society and at issue is sex, health and the formation of the self. With this in mind, this thesis starts from the experiences of young women and the texts that shape the ways they might use the pill.

# 1 Unpacking the pill

*Lisa:* What do you think the pill has meant for women in general?

*Alexandra:* Oh my god! Well, there's the individual kind of narrative, but there's also the broader cultural narrative. On an individual level, I don't think a lot of women think about what the pill actually does for them, whether that's positive or negative or indifferent. On a broader cultural level, I think in a certain period of feminist history, I think it could be said that it was a very good thing. I think that it also could be critiqued in some ways too. But it's like a very nuanced field. I don't think there's one answer for that question at all. I think it's hard for me to subscribe to a dominant narrative that the pill has meant "this."

***Advantages [of the oral contraceptive pill]:***

Highly effective in preventing pregnancy if taken properly;  
Can regulate your periods, making them more predictable;  
You may experience lighter blood flow and less cramping during your period;  
Reduces the risk of endometrial and ovarian cancers;  
May improve acne;  
Gives women control over their fertility;  
Does not interrupt the spontaneity of sex;  
Is not reliant on the compliance of your partner.

***Disadvantages [of the oral contraceptive pill]:***

Requires visit to a physician to obtain a prescription;  
Based on medical history and health concerns, it may not be suitable for every woman;  
If you forget to take your pill at roughly the same time every day, the pill becomes less effective;  
Does not protect against sexually transmitted infections (STIs);  
Some women experience side effects which can include: nausea, breast tenderness, slight weight gain, vomiting, or headaches;  
Side effects may go away after 3 months or you may not experience any at all;  
There are many variations of the pill. If one pill doesn't work for you, another pill may;  
A small number of women experience more serious complications including cardio vascular complications (heart attacks, strokes, blood clots in the veins) (CFSH3).

As Alexandra keenly observes, it is very difficult to determine once and for all the meaning of the pill. During the course of my research I realized that the pill can be used by a woman in many ways and the ways that she uses it will most likely change over time.<sup>4</sup> She might go on and off of it several times. She might start using it to regulate menstrual cramps, and stay on it when she becomes sexually active. I also realized that taking the pill is embedded in various types of relationships at the micro level, such as friendships, sexual relationships, the relationship between a parent and child, the relationship between doctor and patient and the macro structural level, such as pharmaceutical companies, the mass media and government and public health agencies. As the above quote from the Canadian Federation for Sexual Health indicates, the pill

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<sup>4</sup> See Appendix B for a breakdown of the details of pill use for participants in this study.

can be connected to sexual stories, health stories, and aesthetic stories. Further, taking the pill can lead to a variety of both pleasant and unpleasant outcomes for the user and those around them—from unexpected pregnancy, shorter periods, death and less acne. While some outcomes might be expected by women others might be completely out of the realm of imagined possibilities. In this thesis my aim is not to determine what the pill has meant for women once and for all, but rather to unpack the various ways that some young women use it to work on the body and self.

In this chapter, I begin by defining key theoretical concepts, such as governmentality, ethics and care of the self, and discursive formation. As I will discuss, post-structural feminists, feminist accounts of science and technology, and recent work on emotional regulation and emotion management advance Foucault's insights into the formation of the self by allowing for differentiated accounts of subjectivity, emphasizing the ways truths and knowledges are embedded within wider social inequalities, and acknowledging the internal processes of governance that shape the conduct of young women.

In this chapter I also discuss the methodological considerations for the thesis. I have drawn on the insights of feminist qualitative methodologies and narrativity to attend to the dynamic and fluid nature of self-formation. I explore the ways that my research was shaped by my own personal experiences and motivations. I explain and justify my data selection and discuss the ways that various institutional constraints influenced the research process. As I will demonstrate, research is an active form of knowledge construction embedded within both formal and informal relationships. Finally, I discuss the development of my analytical framework for the data and provide examples of analysis. While I have relied on Foucault's (1985, 26-32) four dimensions for the study of ethics, analysis was practically informed by Doucet's (2007, 278-

284) version of the “Listening Guide” and Hall’s (1997, 45-46) guidelines for the study of discursive formations. Though unlikely bedfellows, taken together, the insights of Foucault, Doucet and Hall provided me with a practical set of tools for consciously embedding theory, reflexivity and relationships within the construction of knowledge.

## **1.1 Foucault**

Q. Thus there has been a sort of shift: these games of truth no longer involve a coercive practice, but a practice of self-formation of the subject.

M.F. That’s right. It is what one could call an ascetic practice, taking asceticism in a very general sense—in other words, not in the sense of a morality of renunciation but as an exercise of the self on the self by which one attempts to develop and transform oneself, and to attain to a certain mode of being (Foucault 1997, 282).

In what way is taking the pill a technology of the self? How does a young woman form herself as a subject by taking the pill? At the outset of this thesis I was interested in questions about the formation of the subject that originate in the later work of Michel Foucault. In his earlier work he emphasized the ways that subjects are constituted by discursive practices and techniques of power. Later in life he increasingly sought to understand the ways that subjects contribute to their own self-constitution through ethical conduct and techniques of the self. In this section I will define key concepts in Foucault’s work—governmentality, ethics and care of the self and discursive formation--and explain how they relate to the research that comprises this thesis.

### ***i. Governmentality***

Government as a general problem seems to me to explode in the sixteenth century, posed by discussions of quite diverse questions. One has, for example, the question of the government of oneself, that ritualization of the problem of personal conduct which is characteristic of the sixteenth century Stoic revival. There is the problem too of the government of souls and lives, the entire theme of Catholic and Protestant pastoral doctrine. There is government of children and the great problematic of pedagogy which emerges and develops during the sixteenth century (Foucault 1991, 87).

In his lecture on “governmentality,” Foucault (1991) distinguishes between sovereign power and modern forms of government. He suggests that the rise of the centralized state and the “dispersion of religious dissidence” across Western Europe in the sixteenth century placed

problems of government at the forefront, such as “how to be ruled, how strictly, by whom, to what end, by what methods?” (Foucault 1991, 88). In contrast to the disciplinary techniques Foucault elaborates in *Discipline & Punish* that focus on techniques of power that constitute subjects, governmentality refers to the increasing tendency in modern liberal forms of government to encourage subjects to internalize surveillance and govern themselves without the need for state intervention. In this sense, government refers to the management of populations and at the same time the ways that the conduct of subjects is oriented towards particular ends.

Tangential to governmentality is Foucault’s concept of biopower. According to Foucault (1985), a genealogy of modern sexuality examines “...sexuality as a historically singular experience” (1) and elaborates “...the forms and modalities of the relation to the self by which the individual constitutes and recognizes himself qua subject” (6). In modern liberal states, beginning in the 18<sup>th</sup> century, there was an increased interest in documenting and tracking the health status of populations across a variety of institutions and social spaces, in order to direct and manage the characteristics of the population as a whole (Foucault 1984, 275). The rise of biopower was contingent upon new knowledges that identified the population as a whole as the “ultimate end of government” (Foucault 1991, 100; 1984, 277), but also as an entity that is divisible into unique categories or units of classification and analysis.

Foucault’s work on governmentality encourages us to recognize the “...increasing ordering in all realms under the guise of improving the welfare of the individual and the population” (Dreyfus & Rabinow 1982, xxvi). Further, he identifies that government is “a form of activity aiming to shape, guide or affect the conduct of some person or persons” (Gordon 1991, 2) and one which subjects are aware of and contribute to. In this sense, governmental strategies or rationalities refer to “a way or system of thinking about the nature of the practice of

government (who can govern; what governing is; what or who is governed)” (Gordon 1991, 3) that emerge from the state but also the conduct of individuals. As Dean (1999) observes,

On the one hand, we govern others and ourselves according to what we take to be true about who we are, what aspects of our existence should be worked upon, how, with what means, and to what ends. On the other hand, the ways in which we govern and conduct ourselves give rise to different ways of producing truth (18).

In recent years, girls have risen as a social category of concern and their conduct is an issue of public concern. State-based programs, parents, health professionals aim to manage the health and sexuality of young women by encouraging and directing particular forms of conduct and discouraging others (see Driscoll 2002; Harris 2004). This does not mean that young women are passive objects of governance. As I will discuss, young woman are actively involved in managing the self and producing new forms of government.

## *ii. Ethics and care of the self*

For a rule of conduct is one thing; the conduct that may be measured by this rule is another. But another thing still is the manner in which one ought to “conduct oneself”—that is, the manner in which one ought to form oneself as an ethical subject acting in reference to the prescriptive elements that make up the code. Given a code of actions, and with regard to a specific type of actions (which can be defined by their degree of conformity with or divergence from the code), there are different ways to “conduct oneself” morally, different ways for the acting individual to operate, not just as an agent, but as an ethical subject of this action (Foucault 1985, 26).

In *The History of Sexuality*, Volumes 2 and 3 (1985, 1986), Foucault extends his study of modern power beyond external modes of governance, to the autonomous modes of self-government engaged in by the individual as part of everyday life. Technologies of the self are the ways that individuals,

...effect by their own means or with the help of others a certain number of operations on their own bodies and souls, thoughts, conduct, and way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection, or immortality” (Foucault 1988, 18).

Technologies of the self differ from technologies of power that “determine the conduct of individuals and submit them to certain ends or domination” by objectivising the subject (Foucault 1988, 18). In contrast, technologies of the self refer to ethical conduct or “the manner

in which one ought to “conduct oneself” or “form oneself as an ethical subject” with reference to a series of accepted rules and guidelines (Foucault 1988, 26). Whereas technologies of power determine the ways that an individual becomes a “mad” or “sexual” subject, ethics refers to the ways that an individual acts on the self to become a certain type of subject—for example, a “free” or “good” person. Morals compel individuals to act in certain ways so as to conform to rules, while ethics refers to the conduct, both internal and external, through which subjects constitute the self as moral. In late modern capitalist societies, subjects are encouraged and expected to be free individuals (Valverde 1996).

Foucault (1985, 26-28; 1994a; 2005; 2008) identifies the four dimensions of the study of a genealogy of ethics as follows: 1) Determination of the ethical substance - What part of myself am I working on? 2) The mode of subjection - What rules do I follow and why? 3) The elaboration of ethical work - How do I embody ethical conduct? 4) Telos of the ethical work - What kind of person do I want to be? It is important to follow the four dimensions of ethics in a Foucauldian analysis of self-formation because these interrelated elements highlight both the productive and normative elements of moral conduct. Government of the self involves the individual subject, but is also fundamentally connected to the government of others. An individual is expected to draw on the help of experts in her quest for self-mastery as she shapes her conduct. In ancient Greece and Rome, Foucault (2005) argues that “care of the self” was the fundamental connection between “the question of knowledge of the subject” and “the subject’s knowledge of himself” (3). Foucault (1970; 1988b) argues that “modern thought” does not offer moral obligations that refer to a unified principle, such as “care of the self”. He argues that modern societies, like Canada, tend to place an emphasis on the truth of the subject as an end in

and of itself (Foucault 2005, 19). Thus, his aim in understanding “care of the self” is to create the possibility for an ethics of freedom that assumes the possibility of an autonomous subject.

Foucault’s study of ethics can be applied to contemporary strategies of self-formation. In late modern capitalist societies, the self is increasingly constituted through discourses that emphasize individuality, empowerment and self-expression (Cruikshank 2002; White & Hunt 1991) and the ways they are connected to “rational” and “scientifically” grounded practices of self-care that expect a high degree of control and foresight on the part of the subject (Hacking 1990; Lupton 1995; Rose 1991, 2007). Rose and Miller (1992) acknowledge the importance of considering how contemporary problems of government extend beyond the boundaries of the state and involve the constitution of neo-liberal citizens, who are actively engaged in functioning autonomously and without external intervention. An examination of ethics in the context of the oral contraceptive pill can illuminate the ways that young women actively shape the self and contribute to contemporary discourses that constitute freedom. Yet, as I will demonstrate, like all subjects, young women are situated in relation to freedom in particular ways. Further, they draw on various relationships, some of which involve expert knowledge like doctors and pharmacists, while others are more informal, such as friends and parents. Equally young women are actively involved in shaping the conduct of others through giving advice to friends and family. Such an analysis is particularly relevant for the pill in that discourses of freedom are frequently associated with its use.

### ***iii. Discursive formation***

We can now understand the reason for the equivocal meaning of the term *discourse*, which I have used and abused in many different senses: in the most general, and vaguest way, it denoted a group of verbal performances; and by discourse, then, I meant that which produced (perhaps all that was produced) by the groups of signs. But I also meant a group of acts of formulation, a series of sentences or propositions. Lastly—and it is this meaning that was finally used (together with the first, which served in a provisional capacity) – discourse is constituted by a group of sequences of signs, in so far as they are statements, that is, in so far as they can be assigned particular modalities of existence. And if I succeed in showing, as I shall try to do shortly, that the law of each series is

precisely what I have so far called a *discursive formation*, if I succeed in showing that this discursive formation really is the principle of dispersion and redistribution, not of formulations, not of sentences, not of propositions, but of statements (in the sense in which I have used this word), the term discourse can be defined as the group of statements that belong to a sign system of formation; thus I shall be able to speak of clinical discourse, economic discourse, the discourse of natural history, psychiatric discourse (Foucault 1969, 120-121).

According to Foucault, power is diffuse, and productive rather than repressive (1977, 1978). In this sense, the pill does not make women *powerful* or *powerless*, as power is not something that is held by individuals. Power and knowledge come together in discourse to produce certain truths about young women as both subjects and objects vis-a-vis certain objects (Foucault 1978). A discursive formation or field emerges, that makes it possible for certain statements to be “true” or “sayable”, when discourse becomes organized into a system or network that brings together disparate institutions and structures. While it is rare that discourses are uniform, it is still possible to distil common principles, while pulling out the tensions between opposing statements. Discourses produce the terrain within which we make ourselves, but we equally create discourses through doing ethical work as power relations are ever-present and involve a push-pull between individuals in social relations.

According to Sawyer (2002), the widespread use of the term “discourse” is actually a misreading and scholars commonly attribute a particular use of discourse that does not correspond to Foucault at all (435). He insists on the centrality of the discursive formation as opposed to discourse. He notes,

When contemporary theorists use the term ‘discourse,’ they often mean the concepts, enunciative modalities, objects of strategies that are part of the discursive formation, rather than a ‘group of statements’ that constitute a specific language event. For example, once a particular way of talking about gender (a discursive practice) becomes established – individualized and with discursive regularities – it can be analysed as a discursive formation, because it has crossed the threshold of positivity. Despite his many confusing usages of the term, Foucault never says that ‘a discourse’ is a type of discursive formation or is synonymous with it (Sawyer 2002, 447).

It is not within the scope of this thesis to resolve the issues raised by Sawyer or to do justice to the complex analysis he provides. I am aware that the use of discourse is problematic.

Following Sawyer's (2002, 450) suggestion, in this thesis I rely primarily on "discursive formation" and use discourse or discourses only to refer to specific textual events that might occur within a discursive field or various pill discourses. I also modify Hall's (1997) guidelines for studying discourses of "madness, punishment or sexuality". Instead, I examine current pill discourses as they circulate within a discursive formation particular to Canadian society. I will discuss Hall's six guidelines shortly.

Foucault's (1978) rejection of the "repressive hypothesis"—the notion that beginning in the Victorian era we were increasingly sexually repressed—highlights that repression multiplies the object that is targeted for containment. In the *History of Sexuality, Volume 1*, in "The Incitement to Discourse," he argues that there was a "proliferation of discourses concerned with sex—specific discourses, different from one another both by their form and by their object" (18).

He observes, that at the same time,

...there was a policing of statements. A control over enunciations as well: where and when it was not possible to talk about such things became much more strictly defined; in which circumstances, among which speakers, and within which social relationships (Foucault 1978, 18).

Subjugated knowledges are "whole set[s] of knowledges that have been disqualified as inadequate to their task and insufficiently elaborated: naïve knowledges, located low down on the hierarchy, beneath the required level of cognition or scientificity" (Foucault 1980, 81-82).

In my research, in analysing text materials and interviews, I paid attention to what was said or included as well as what was implied or excluded. Michelle Fine (1988) draws on the work of Foucault to explain the "missing discourse of desire" in public sex education for young women in the United States. She notes,

Within today's standard sex education curricula and many public school classrooms, we find: (1) the authorized suppression of a discourse of female sexual desire; (2) the promotion of a discourse of female sexual victimization; and (3) the explicit privilege of married heterosexuality over other practices of sexuality (30).

In a similar vein, Tolman (2002) has observed that girls are not encouraged to express sexual desire and lack a vocabulary to do so. Both Tolman and Fine argue that the “missing discourse of desire” reinforces the submission of young women to patriarchal desire. While I am sympathetic to the insights of Fine (1988) and Tolman (2002), I think they do not acknowledge a parallel set of discourses that express intense outrage and discomfort when young women do express sexual desire in public ways that often emerges from a desire to affirm liberation. More recently, Harris (2005) has drawn our attention to the ways that young women may use spaces such as the internet to move around standards that govern the utterance of sexual themes. Further, Gonick (2006) observes that discourses of “girl power” are in dialogue with discourses that construct young women as “at risk”. Thus, it is not only a question of patriarchal repression of young female desire, but also a concern among the more general population surrounding young women’s sexual conduct and the extent to which public expressions of desire are perceived as liberating or not. For example, the young women I interviewed were highly judgemental of their own conduct, often characterizing themselves as “sluts”. Many of the young women were also judgemental of the choices and conduct of friends and close family. In this context, discursive formation is a useful concept as we start from an assumption that there will be multiple and competing sets of knowledges and truths that will circulate about a given phenomenon.

## **1.2 Advancing ethics**

Foucault’s insights into the subject and formation of the self can offer a useful orienting point for understanding the tension at the heart of contemporary representations of girls and the pill. However, he does not address the application of ethics in a contemporary context nor provide guidelines for how to discuss ethics in the context of ethnographic work. In seeking build on

Foucault's work on ethics and care of the self, I have drawn on the following fields of scholarship: 1) post-structural feminism; 2) feminist studies of science and technology; and 3) emotional regulation and emotion management.

### **i. Post-structural feminism**

Generally speaking, post-structural feminism starts from an aim to displace universal categorizations, such as what it means to be a "woman". Post-structural feminists draw attention to the intersection of sex, race, class, sexual orientation and ethnicity and the ways that subjectivity is socially constructed.

Feminist appropriations of Foucault's work have generally sought to correct his failure to address the structural embeddedness of women's subjugation under the political technologies of the body that he described, and to develop positive and transformative accounts of agency and strategies of resistance to relations of power (Bartkey 1990; Bordo 1993; McNay 2000; Sawicki 1994). The recognition of the pervasive and yet unequal distribution of power relations accentuates the political nature of the everyday life experiences of women. Practices carried out in private, such as self-care and grooming, become potential sites of oppression and concurrently of resistance. Identities are considered in how they are representative of broader experiences of oppression, and yet constructed in attendant sets of activities which are performed by the subject (Butler 1990). Under this theoretical position the formation of the self is localized and personalized. As Butler (1990) observes, gender does not exist in a concrete sense, but it is rather a repetition of stylized acts which produce the illusion of a concrete subject.

The pill is part of the performance of the contemporary feminine subject but this does not mean that all women work this out in the same way (Cream 1995). There are detours and shifts, and it is a process which is negotiated and worked out on an ongoing basis. In making sense of

this, I draw on the work of Grosz (1994) who identifies bodies as being constituted by “representations and cultural inscriptions” (x). She further notes the importance of examining “culturally, sexually, racially specific bodies” in order to highlight their “ontological incompleteness” or lack of finality” (Grosz 1994, xi).

Foucault’s work on ethics has been critiqued for addressing only the concerns of white privileged men from classical Greek and Roman societies. While it is true that Foucault does not address ethics and women this does not mean that his work should be dismissed by feminist scholars. Indeed, the exclusion of women is more reflective of Foucault’s source materials, classic Greek and Roman texts which were intended to guide the conduct of ruling men. McLaren (2002) argues that Foucault’s insights into ethical self-formation can help to further feminist attempts to theorize agency and autonomous action. She notes,

Acknowledging that there are multiple sources of oppression and that all social relations are power relations can account for feminist insights into the interconnection of oppressions and the ways that individuals who are members of one oppressed group, for instance, white women, may also be oppressors (McLaren 2002, 163).

McLaren observes that there already exists a recognition that the formation of the subject is relational and social within feminist philosophy of ethics of care (see Held 2005; Gilligan 1982). However, she argues Foucault offers a better starting point from which to acknowledge “the variation of race, class, ethnicity, sexual orientation, physical ability, age, and religion even among women from the same historical and cultural period” (McLaren 2002, 79) because the subject is understood as always unfixed and engaged in forming the self.

Valverde (1996) points out that in the same way that earlier feminist interpretations of Foucault focused only on the disciplinary character of power, recent scholarship on ethical self-formation tends to examine text as *the* discourse in understanding self-formation. Further, Valverde (1996) observes that there is a tendency to describe ethical self-formation as a unified

process. She argues that modern liberal government is actually characterized by “contradictory modes of governance” that exist alongside one another. As Valverde (1996) observes, notions of freedom are central to liberal ethics. Like Valverde, I understand freedom the ability to act with autonomy. However, freedom is always relative, as autonomy involves a set of performances that occur within social relations by particular types of subjects. As she observes, the modern ethical subject can be ruled by both freedom and unfreedom at any given moment, and expectations for autonomy changes over the life course (Valverde 1996, 358). For example, she points out that we would not expect the same degree of discipline in a home as in an office. Age is another prerequisite for differing degrees of governance. Equally, a child is not expected to exercise the same degree of autonomy as an adolescent, nor is an elderly individual expected to have the same degree of autonomy as an adult. As I will discuss in Chapter 5, differences can also be found in different stages of female subjectivity as evidenced by the unique characteristics of discourses of freedom associated with girls and “girl culture”. In contrast to Greek and Roman society where male elites were the focus of discourses governing the right use of sexual pleasure (Foucault 1985, 1986), contemporary North American culture is inordinately fascinated with the sexual conduct of young women (Driscoll 2002; Mazzarella & Pecora 1999; McRobbie 1993). This research builds on post-structural feminist insights into Foucault’s work by acknowledging the ways that subjects are situated within social relations and by attending to the ongoing and productive nature of women’s work on the self.

## **ii. Feminist science and technology studies**

Feminist science and technology studies aim to displace claims of science as “rational” and “universal” and highlight how scientific knowledges and technologies contribute to the social construction of gender (Bauchspies and Puig de la Bellacasa 2009; Daly ([1978] 1990); Harding

1991, 2006; Martin 1987, 1991). In particular, feminist studies of science and technology have focused on displacing the claims of science and encouraging the production of knowledge from alternative sets of experiences and identities. In a similar fashion, Bowker & Starr (1999) observe the importance of categories of classification and in particular how “these properties inform the social and moral order” (5). They observe,

Each standard and each category valorizes some point of view and silences another. This is not inherently a bad thing—indeed it is inescapable. But it *is* an ethical choice, and as such it is dangerous—not bad, but dangerous. ... For any individual, group or situation, classifications and standards give advantage or they give suffering. Jobs are made and lost; some regions benefit at the expense of others. How these choices are made, and how we may think about that invisible matching process, is at the core of the ethical project of this work (Bowker & Starr 1999, 5-6).

As I will discuss in Chapter 4, preference for the pill relies on certain ideals around “natural” versus “hormonal methods” of contraception. Haraway (1991, 1994) demonstrates through the metaphor of “cyborg identity” that what appears to be “natural”, such as the body, is only an accumulation of ideas we have about it. Categories are attached to the choices we make about the body and thus the knowledges that contribute to classification are part of constituting the ethical work of self-formation.

In making sense of the ways that different kinds of knowledges are attached to relationships of power, I will draw selectively on risk literature. O’Malley (1996) and Dean (1997) highlight that the neo-liberal subject is distinguished by an individual desire to deal with risk by drawing on the advice of experts. In navigating the risks associated with taking the pill, a young woman is expected to be informed about side-effects, to be aware of her health, and to draw on the knowledge of her doctor and stay up-to-date on changes in the safety of particular pill brands. Fox (1999) advocates that we take a postmodern approach to analyzing risk and health, wherein “it is not just outlooks on *risks* that are dependent on social milieu, but also world views on *hazards* themselves. *Both risks and hazards are cultural products*” (22). Risk literature nicely parallels with feminist science and technology studies, in that both highlight the

ways that scientific or rational claims to universality are often situated in opposition to lay accounts and experiences (Lupton 1999, 4).

Feminist studies of science and technology have been further developed by Anne-Marie Mol (2010) who draws on insights from Actor-Network Theory (ANT), which offers an open-ended and relational way of understanding actors and the world they inhabit. She observes, “every time a new case is considered it suggests different lessons about what an “actor” might be” (Mol 2010, 257). According to ANT theorists, actors exist in relations with others, or in networks.

Actors are enacted, enabled, and adapted by their associates while in their turn enacting, enabling and adapting these. ... But as actors come to participate in different “networks,” discourses, logics, modes of ordering, practices, things get complex. The “actors” start to differ from one network, discourse, logic, mode of ordering, practice to the other (Mol 2010, 260).

As Mol (2004) observes, this means that the reality of medical conditions, such as anaemia or birth, differ substantially from one site to the next or from one actor to the next.

Her observations also displace straightforward accounts of the use of medical technologies. She notes that “...medical interventions hardly ever bring pure improvement, plus a few unfortunate “side-effects”; instead they introduce a shifting set of tensions” (58). Speaking about the management of hypoglycaemia, Mol (2004) observes,

Tight regulation is not good or bad for *the body* as a whole. It is good for some parts of the body and bad for others. Thus there are tensions, in both the body and people’s daily lives. What is the least bad option? To allow a higher blood sugar level and risk atherosclerosis, blindness or lack of neuronal sensitivity in 20 years? Or to hold it lower, but to risk hypoglycaemias that straight away mean that it is dangerous to drive or carry children because of the possibility of coma? Which life to live, and which body? One that loses count and has shaking hands but can feel? Or one with clogged arteries that has gone blind and can’t feel too well, but at least is clearheaded? Such are the options that confront people with diabetes (58).

Similarly, as I will explore in Chapter 4, the pill does not have one impact on one site in the body nor are its effects clearly predictable. The knowledge we have about technologies creates certain possibilities that users navigate on an ongoing basis as they draw on various knowledges in relations with others. Feminist studies of science and technology are helpful for unpacking

concepts such as “reproductive choice” and “being informed” in relation to taking the pill. As I will demonstrate, these concepts are not practices of autonomy per se; rather subjects engage with moral and ethical work in attempting to reach these ideals.

### **iii. Emotional regulation and emotion management**

We often say that we *try* to feel. But how can we do this? Feelings, I suggest, are not stored “inside” us, and they are not independent of acts of management. Both the act of “getting in touch with” feeling and the act of “trying to” feel may become part of the process that makes the thing we get in touch with, or the thing we manage, *into* a feeling or emotion. In managing feeling, we contribute to the creation of it (Hochschild 1983, 17-18).

The sociological study of emotions recognizes that what we feel is connected to social processes that attune subjects to the experience of certain events, objects and encounters. As does Hochschild, Barbalet (1998) observes that macro level social relations are essential to understanding emotions. More recently, sociologists have begun to acknowledge the importance of “post-structural theorizations of power and its influence on the sociology of emotions” (Spenser et al. 2012, 5).

Even so, Reddy (1997) argues that post-structural accounts of emotions are limited in that they fail to “capture the two-way character of emotional utterances and acts, their unique capacity to alter what they “refer” to or what they “represent”...” (327). He suggests that emotives—which refers to the ways that the interiority of subjects is shaped through the management of emotions in relation to social expectations—often generates emotional deviance—wherein subjects experience ambivalence due to a simultaneous desire to resist and conform to social expectations. According to Reddy (1999), the management of emotions involves encouraging subjects to adopt appropriate responses and discourage inappropriate reactions and thus, engages with relationships of power (334).

Similarly, de Courville Nicol (2013) has argued for the inclusion of emotional regulation and emotion management in how we conceptualize the constitution of subjectivity through moral

work. As she notes, emotional regulation and emotion management are unavoidable and we would not necessarily want to avoid them. She draws attention to how subjectivity is formed through the social and embodied experience of emotions of fear and desire as felt capacity or incapacity. de Courville Nicol explains that rhetorics of fear and desire are constantly circulating and aim to produce particular emotions effects in subjects. She notes,

Both fear and desire campaigns are based on the expectation that the responsabilized or moral anticipation of emotional pain can cause a subject to seek to transform a morally threatening, pain-producing desire, whether this desire is illegitimate, erroneous, latent, or immature, into a morally promising, pleasure-producing desire—that is, a legitimate, a correct, an activated, or a mature desire. The campaigns structure subjects' moral responses. In the fear campaign, self-discipline will constitute the moral means through which morally problematic desire can be acted upon in the implementation of security, while in the desire campaign, self-realization will constitute these means (de Courville Nicol 2013, 179).

She uses the example of Health Canada's anti-smoking advertising campaign to explore the use of a rhetoric of fear to produce feelings of disgust, guilt and horror (de Courville Nicol 2013, 180). In my own research I found that pharmaceutical advertising campaigns, such as Alesse, employ a rhetoric of desire to associate self-esteem, empowerment and individuality with taking the pill. However, as I will discuss, in the print news media and public health literature, rhetorics of fear and desire were both present.

In this thesis I draw on the notion that individuals are encouraged to work on themselves “not only through the repression and correction of their desires but also through their activation and formation” (6) through the management of emotional responses.

As such, collective feelings may be said to develop through a process of situation assimilation in which selves adopt others emotional orientations toward specific objects of fear and desire, namely through the decoding of emotives, as well as the ability to understand those objects once their emotional sense has been acquired. For instance, agents may be prompted by other agents to experience homes without alarms as objects of fear and homes with alarm systems as objects of desire through risk/precaution, or to experience smokers as objects of fear and nonsmokers as objects of desire through social disapproval/social approval. ...In short, agents' capacity to understand what others feel, as well as their capacity to understand the feelings that become attached to objects, provide them with important information that will affect their capacity to exercise embodied autonomy, the quality of their relations with others, and the quality of relations between selves and others more generally (de Courville Nicol 2013, 81-82).

In Chapters 5 & 6, I will discuss how taking the pill involves the negotiation of emotions through embodying expectations for appropriate fertility control and managing side-effects.

A focus on emotions is also helpful for making sense of social preferences for particular devices, such as the pill, without falling back on a discourse of repression or false-consciousness. Watkins (2011) highlights the importance of the way users feel about a reproductive technology in determining its success or failure. This means that the pill is not necessarily ideal because it is the *most* effective—most of the young women I spoke with highlighted the “ideal” intervention would have no side-effects and be 100% effective. As Fisher & Szreter (2003) have keenly observed, the perception of certain contraceptive methods as frustrating and others as easy involves the cultivation of feelings about a given contraceptive method and equally defining a potential outcome as desirable or pleasure producing. Preference for the pill over withdrawal for contraception, or the pill versus diet for the treatment of acne, is not necessarily a logical or rational response, but reflects the formation of certain emotional responses toward types of acts (medical treatment), devices (medical technologies), and social relationships (doctor-patient).

### **1.3 Feminist methodologies and narrativity**

This thesis is concerned with the ways that debates over knowledge, meaning and truth contribute to tensions, as opposed to uniform standards, surrounding young women and the pill. Further, tensions are productive of multi-directional power relations and are part of wider social ideals surrounding progress and liberation for women. Feminist methodologies and narrativity place diversity and multiplicity at the forefront and provide practical tools for orienting one’s self to the data and developing analysis that embraces the complexity of self-formation.

## **i. Feminist methodologies**

It is difficult to delimit what constitutes feminist methodology because such a label assumes unity in a prolific and diverse field of scholarship. Doucet & Mauthner (2006) focus on what feminist methodologies tend to amplify and equally highlight the fields where debate has taken place. They observe that in general feminist methodologies have tended to struggle with the connection between knowledge construction and relationships of power. In the case of research, this has emerged as a concern for the relationship between researcher and participant, between researcher and data, and the relationship between the researcher and knowledge construction.

In this research I acknowledge that race, ethnicity and socio-economic background contribute to the way that a young woman might take the pill, and adopt a reflexive approach where I identify the ways in which my social-position and personal life experience affect my orientation to my subject matter (Doucet 2007). Feminist methodologies tend to highlight the subjective nature of knowledge and directly state the ways that personal interactions, identity and social relationships are present in knowledge construction. While Smith (1990) argues for the importance of situating oneself from within the field of study (standpoint feminism), others have argued for the importance of always recognizing the research relationship as productive of power relations even if the researcher is an “insider”.

Issues of power are also present in our attempts to know and represent the intimate details of others who live in close proximity to us. Even where researchers and respondents share structural and cultural similarities of, for example, gender, ethnicity, class, and age, this does not guarantee “better” knowing (Doucet & Mauthner 2006, 40).

In this sense, being an insider does not necessarily give the researcher a privileged position as the research-participant relationship is always productive of power relations. As I will discuss shortly, I built reflexivity into the analysis and attempted to acknowledge how my social position impacted the construction of knowledge.

Drawing on feminist qualitative methodologies, I also recognize that women are actively involved in the construction and production of texts (Smith 1990). Currie (1997) highlights the importance of theorizing subjectivity in such a way that government is not understood as a merely top-down endeavour where individuals become objectified through discourse. If discourse is ever-present, it becomes impossible to see how it is creative or productive of new and innovative subjectivities. Like Radway (1984), Hall (1980) and Morley (1986) I identify media audiences as “active” not “passive”. Individuals read and watch the media according to their particular life circumstances (for example, their social class position, their ethnic identity) and draw on their personal preferences. This means that the way audiences watch the mass media will not necessarily align with “encoding” intentions of programme makers (Hall 1973).

As McRobbie (2000) argues, “adolescence... is given meaning and made comprehensible through magazine topics such as “problems,” and “romance,” and “jealousy”. Yet, women are not passive actors but are subjects actively producing meaning, within a wider social context. This does not mean that we can pick and choose in an absolute sense those aspects of the mass media which are meaningful and discard others (see Fiske 1989). In *Reading the Romance* Janice Radway (1984) explores the ways in which women selectively engage with romantic novels and “take emotional benefits for themselves” reclaiming “the patriarchal form of romance for their own use” (184). In a similar vein, Currie (1997) examines how young women draw on stereotypical depictions of adult femininity, but at the same time reject others. Finding this middle ground has been an ongoing site of debate within feminist scholarship which has continued within debates over ethical self-formation. In this thesis, I explore the ways that young women engage with texts, such as pharmaceutical marketing and the print news media,

and explore the complex process through which individuals work with meaning on an ongoing basis.

## ii. Narrativity

Girls, if you ever find yourself “rounding third base,” but you haven’t had the sex talk yet, it’s still not too late. . . . Because of the risks of pregnancy or disease, sex is a big responsibility. So, if you find that you’re way too uncomfortable to talk about these things with your partner, think about this: Maybe it’s a sign that you’re not totally ready to have sex with them yet (SU5).

*Lisa:* When I say “the pill” what are three things that come into your mind?

*Tara:* My Mom is the first thing. I was just so awkward and so 16 and she came and sat down on my bed, and she was like, we need to start talking about “the pill” and it like reverberated in my mind. Time slowed [laughs]. Oh my god, she knows I’m having sex...! Looking back it’s hilarious, but at the time it was really crazy.

In *Sexual Stories* Kenneth Plummer (1995) observes that talking about sex is fundamental to contemporary formations of the subject in that the truth of the self lies in an individual’s capacity to reveal his or her personal sexual stories. As Tara recounts, the first time she talked about the pill with her Mom was a very significant moment. Further, on [sexualityandu.ca](http://sexualityandu.ca), the Society of Obstetricians and Gynecologists identifies being able to talk about sex as a marker of sexual responsibility. Taking the pill and talking about it are part of expectations for responsible conduct by a young woman. Doing so declares to the world that she is responsible, that she is ready to be a sexual subject capable of exercising her freedom appropriately. In Canadian society, a young woman will likely be bombarded with information about the pill as soon as she reaches puberty. Stories about the pill circulate constantly across social space, on television, in magazines, on-line, and even at bus stops and in metro stations. Narrative theorists recognize that stories are fundamental to human culture and societies (Bruner 1991; Czarniawska 2004; Riessman 1993; Clandinin & Connelly 2000; Mischler 1986).

As White (1980) observes, the use of narratives is the key to successful advertising campaigns and providing media which entertains. Similarly, Seale (2002) observes that in reporting on health issues, the media rely on storytelling.

Let us take it that an important overall 'story' told in media health coverage is the life of the body, its struggle against the evil of death, its search for an admiring gaze, its elevation of Everyman or Everywoman to the status of hero or victim. Helper-heroes may take the form, say, of doctors or research scientists bearing magical cures, nurses behaving like angels, or fitness gurus pointing the way to beauty. Villains may take the form of disease, disease carriers, pollution of the environment or of food supplies, wicked or incompetent doctors, commercial interests selling foodstuffs that damage both health and appearance, and the like (Seale 2002, 30).

In a similar fashion to feminist methodologies, a narrative approach to research tends to highlight the socially constructed nature of knowledge. However, narrative methodologies focus more explicitly on the social character of storytelling. A narrative approach emphasizes that all discourses are attempts to contain the "real" through organizing experiences and events in the social interaction of telling stories. Two implications of this are: 1) When we talk to women about their lives, we cannot get at experience, we only get stories about their experiences; and 2) Stories are "active" processes of subjectification (Bruner 1990, 85) where meaning is produced by subjects.

Taking a narrative approach can also contribute to a dynamic understanding of agency because storytelling occurs within the context of wider social relationships and structures. As Somers (1994) observes, "...it is through narrativity that we come to know, understand, and make sense of the social world, and it is through narratives and narrativity that we constitute our social identities" (606). When we talk about narratives, we recognize that talking about one's life is not a straightforward chronology, but rather a social exercise that validates the story, and expresses "emotions, thoughts and interpretations" (Chase 2005, 656).

Taking a narrative approach means disrupting the traditional researcher-participant relationship. In a classic interview format, the researcher uses questions to uncover the reality of an experience. In contrast, narrativity recognizes interviewing as a form of storytelling where context and audience influence the outcome (Chase 2005, 657). Similarly Elliott (2005) notes, "...the discourse of the interview is jointly constructed by the interviewer and the interviewee"

(Elliott 2005, 21). A researcher has objectives in listening to the story. In the same sense, a participant will probably have a particular story that they wish to tell before coming to the interview.

A narrative approach is helpful in moving beyond the ways that the bodies of women are ruled, managed and administered in a top-down fashion by governmental or medical professionals. Instead, narrativity draws attention to the ways that subjects create themselves and work with the conditions of freedom through the stories they tell about their bodies, but also the bodies of others around them (Czarniaski 2004, 5). I found that women picked up and picked apart texts that produced stories about the pill. Similarly, women governed and were governed by stories told by those around them, such as their peers, parents, doctors and sexual partners. They referred to and fit their experiences into wider social frameworks produced by the mass media, the government and health agencies and pharmaceutical companies.

#### **1.4 Doing research**

As I discussed in the previous section, feminist qualitative methodologies and narrativity encourage the illumination of power dynamics between the researcher and knowledge construction in order to produce dynamic accounts of subjectivity. The research process is understood as an active process and is fundamentally embedded within the researcher's social position, experiences and motivations as well as the institutional constraints she confronts. I will now turn to the various ways in which the knowledge in this thesis was shaped, beginning with a discussion of how my personal motivations impacted my orientation to the data. I will then discuss the selection and collection of data. Finally, I will discuss the ways that institutional constraints limited and shaped the knowledge that comprises this thesis.

### **i. Reflecting on reflexivity**

Writing the methodology chapter required me to think back to a qualitative methodology graduate seminar that I had taken during the first year of my PhD program with Andrea Doucet, entitled “On Knowing”. Previous methodology courses I had taken taught me how to fit data into neat boxes, tidying up the social world. In contrast, in this class we were encouraged to work with and embrace the “mess” as opposed to cleaning it up (Law 2006). Doing this meant reflecting on reflexivity or recognizing how the social positioning and experiences of the researcher are an integral part of how we know what we know as sociologists (Mauthner & Doucet 2003). Reflexivity encourages the researcher to become aware of how wider social inequalities and relationships of power can be reproduced during interviews and fieldwork (Denzin & Lincoln 1994). Embedding reflexivity in the research process acknowledges that all knowledge is subjective and co-constructed. The researcher, while differentially orientated, is not above the data, nor does she exist outside the social structures she studies. Reflexivity encourages the researcher to move beyond taken-for-granted assumptions about participant experiences and confront her personal situation and motivations (Mauthner & Doucet 2003, 417). A reflexive approach can be embedded within all levels of the research process (White 1980), from interviews (Denzin 2001; Holstein & Gubrium 1995) to analysis (Mauthner & Doucet 2003) and to writing (Jasper 2005).

My own interests and experiences have shaped my orientation to this research. For me, studying the pill was in many ways a departure, as my previous interests lay in the realm of critical criminology and sociology of religion. I was living in Montreal around the time I began my PhD program and the Alesse advertising campaign was very prominent. It was impossible to miss the large posters displayed in the metro boldly asserting, “Express yourself. Talk to your

doctor and pharmacist about Alesse”. Like most of the young women I interviewed, without knowing what Alesse was, I knew the ad was about the pill.

**Figure 1**



I was curious about the appeal to individuality, liberation and lifestyle. The ads struck me as unique, but also seemed to reflect contemporary notions of self-realization through consumption. I really wanted to understand the Alesse advertising campaign. Did it actually correspond with contemporary women’s experiences with the pill? Did it reflect the nefarious aims of Big-Pharma?

While these questions kept me up at night, I was also motivated to study the pill because of my own experience. Beginning at fifteen, I had used the pill for seven years. Like many of the women I interviewed, I cannot pinpoint exactly how I knew the pill existed. It somehow seeped into my consciousness. Also, like many of the participants, I grew up in a middle-income suburb with relatively liberal-minded parents. Talking about sex was not taboo, but it was not discussed at any length. My father’s sex-education talk for all five children involved the same stock phrase, “Just keep your pants up”. Not getting pregnant was a given and when I became sexually active, I knew I ought to take the pill. When I went to get my prescription, my doctor pointed out that being on the pill would also reduce my acne and make my periods lighter. I did

not get pregnant, my periods were lighter and I did have less acne. But several months after starting the pill I began struggling with debilitating migraines and other health complications. For years after that, I went on and off the pill; for me, it was like a bad relationship I could not shake. I did not seek out other options and was unaware that they existed. I stopped using it entirely, to the chagrin of my doctor, when I was 22 and have not gone back on it since.

When I began my research I was highly critical of the pill and I was very motivated to offer a scathing report of the multiple ways in which women were oppressed by it. I was encouraged in my efforts by my sister, who was also an academic and who had also used the pill. At twenty-five she was diagnosed with gall bladder disease and liver lesions. Though the doctors could not confirm the cause, the pill was listed as the most likely. My writing and research have been punctuated by discussions with my sister where we shared stories, regrets, and frustrations around the oral contraceptive pill. Equally, upon hearing about my topic I was often bombarded with stories from women who used to use the pill. Like ex-cult members I found women were often very eager to unload their ‘story’ about the pill. Individuals were drawn to recount negative experiences and I was drawn to narratives where individuals recounted horrible side-effects and pressure from medical professionals. In my own life and in my relationships with participants, I was less attuned to individuals who had “no problem” with using the pill. In fact, half way through my research my mother brought up in conversation that she had used the first-generation oral contraceptive pill for ten years and had never had any complications as a result. I also noticed that I was less attuned to women who were using it for treatment purposes, such as polycystic ovary syndrome or endometriosis. I had not even thought about women who were using for the purposes of sex-change therapy.

As I began conducting interviews and going over the mountains of text I amassed, my own views were challenged as I came to realize the complexity of how the pill fits into women's lives. I began to see how wider tensions around its use play out on an individual level. The pill was both a site of safety/risk or liberation/constraint or treatment/lifestyle drug. As a researcher I had to find a common ground between myself and my participants, and this involved embracing diversity, and recognizing the multiplicity in the ways the pill is used by women.

For me, I was able to find common ground in what was not said. Like many of the participants in my study, I vaguely remember an afternoon in Grade 6 and some discussions in Grade 11 where teachers discussed the pill and other contraceptive devices under the umbrella of sexual health. But to this day I cannot recall any specific things about contraception told to me by my parents or teachers. As I was working through the transcripts a shadow figure which continually emerged for me, but also for participants, was the "pregnant teen". In grade 8 a young woman in my school got pregnant. She was 14. News of her pregnancy spread like wildfire in whispered exchanges in the school corridors. I remember the gym teacher pulling her aside during class to give hushed instructions for alternate exercises. When she was further along in her pregnancy she disappeared from school altogether as if by magic and did not return, at least to my school. I think why I remember this so vividly was because the whole episode was saturated with shame and embarrassment. But no one said, "Getting pregnant as a teenager is shameful!" or "Getting pregnant as a teenager is so embarrassing!" Nevertheless, the message was clearly transmitted through the subtlety of body language, euphemism and lowered voices. The way in which it was dealt with by the school through indirect messages and institutional responses that no doubt occurred behind closed doors. Between students, her story was slipped into hushed conversations.

I did not ask questions about teenaged pregnancy. Yet, I found that during the course of interviews many participants recounted a similar story of a young unplanned pregnancy occurring for a family member, someone in their social circle or a distant acquaintance. This was the case even for women who were using the pill for reasons other than contraception. When recounting these stories, participants would lower their voices and employ euphemisms, “she did *what she had to do*”, “*it’s* not what I would have done”. For me, and I think for many of the participants too, in the silence surrounding unplanned young pregnancy was a warning: each one of us “girls” could just as easily be her, if we were not careful. The social implications of imprudent behaviour stuck with me more than any information I received in sex-ed class. As a “good” middle-class young woman I knew what was at stake and what would happen if I was “unsafe” or “not careful” even though this was never stated directly, as sexual education was always presented in a preventative framework. There was never a recognition that sex could lead to uncertain outcomes nor were there open discussions about how to get an abortion or treat STDs. I did not know until my early twenties that several STDs were contractible even with the use of a condom nor did I understand the “effectiveness” of various contraceptives; for example, even the effectiveness of oral contraceptives can vary. The emphasis placed on prevention created the sense that all outcomes were the result of the success or failure of individual responsibility and that certain methods reflected a higher degree of responsibility than others.

I found in this exploration of the shadow character a space for common ground among the diverse experiences of participants, and also between myself and participants. Using the pill engages with a set of highly contested domains that make up the regulation of the body: reproduction, health and aesthetics, self and emotions. In spite of feeling frustrated by pressure by doctors, sexual partners or family members, equally, women I interviewed had strong

opinions about whether individuals should or should not use the pill. In spite of my own experience with the pill, which was primarily for contraception, I did not want to fall in line with all the many others telling women what to do, either to take the pill or not. I wanted to create space for what was unspoken, what was left unsaid. I wanted to create a space where women's questions, concerns, and the multiplicity of their experiences could come to light. In doing so, I sought to highlight the way in which women are active in creating and doing ethics. However, I found that they work from within social expectations which define appropriate behaviour, which I have directly experienced and of which I am a part of.

## **ii. Selecting data**

Having discussed how my personal motivations shaped my research, I now turn to how I selected and collected data. Of central importance was pulling together interviews and texts from multiple sites that would allow me to consider different subject orientations and backgrounds. My initial enthusiasm and lofty expectations for studying everything there was to know about the pill were somewhat dampened as I realized the reality of time limitations and space when researching and writing a doctoral thesis. Due to time constraints, there are several omissions from this study, most notably other geographical locations and other individuals that are involved in shaping women's decision to use the pill. Important groups I identified in the course of my research were parents, peer groups, doctors and other medical professionals and to a lesser extent sexual partners. While these actors are present in the narratives of women and will be discussed, they are not a focal point of this particular research.

Further, it is not my intention to suggest that the pill is omnipresent or the only method of contraception used by young women. Not all women use the pill and even those women who do use it, do not use it forever. Absent from this research are the voices of women who no longer

use the pill. I chose to focus only on women currently taking the pill for several reasons. In writing this thesis I was not aiming to offer a comparison between different types of contraception, as I was equally interested in the “life-style” uses of the pill. I was primarily interested in how the act of getting on and taking the pill on a daily basis engages a young woman with various ideals relating to sex, health and ideals of freedom. If I discussed pill use with women who no longer used the pill the study would become a comparative analysis of pill-users versus non-pill users. This would have been counter to the aim of my study, which involved understanding the ways women take the pill as a technique of self-formation.

I chose to interview only young women because I wanted to begin with an understanding of the unique characteristics of girls as subjects. As such, this study involved interviews with young women aged eighteen to twenty-eight currently taking the pill. Women within this age group have the highest rate of pill use in Canada (Black et al. 2004; Black et al. 2009; Wilkins et al. 2000). Second, while women in the upper part of this age range are arguably no longer “girls”, all women in the study began using the pill between the ages of sixteen and twenty. Including this age group thus allowed for a retrospective account, as well as a confirmation of the shift that takes place as a young woman transitions from being a “girl” to an adult woman. Participants over twenty-five years of age indicated that they were actively seeking out other contraceptive options and identified that they now relied less on the advice of peers, parents and doctors than when they were younger. Finally, the choice to limit the age at eighteen was to facilitate ethics and informed consent, which as I will discuss shortly, proved lengthy and difficult. The text materials were selected to provide a broad range of materials that young women are likely to see on a daily basis, such as pharmaceutical advertising, print news media and public health information.

Fisher (2006) argues for the importance of exploring women and men's experiences when discussing contraception. While I agree with her, I would argue that discussing contraception with men and women is not equally relevant for women of all ages. Today, in Canada, the pill is primarily used by young women until their late twenties (Baker, 2008; Black et al., 2004); it is primarily associated with heterosexual women (Cream, 1995; Fennell, 2011) and it is often used for purposes beyond contraception. In taking the pill young women engage in relationships with other women, doctors and female family members. Generally speaking, participants identified these relationships as more important in influencing the decision to use the pill (whether for treatment of health issues or for fertility control) than sexual partners. While the voices of young men could be considered absent from this study, I found that generally participants identified contraception and in particular hormonal contraception, as a woman's concern. The opinions of male sexual partners were generally secondary, and often absent. In this sense, my findings are consistent with Fennell (2013), who found that at least in heterosexual relationships, hormonal contraception is perceived to be the domain of women.

Over a three year period, I conducted interviews with twenty-seven women aged eighteen to twenty-eight. All women were living in Montreal, but only a few of the participants in the study actually grew up in Montreal. Most participants grew up in the suburbs or in smaller towns across Canada. A population drawn from Montreal is not representative of the Canadian population at large. There are, however, significant advantages to basing research out of Montreal. Montreal blends English and French cultures, and has an ethnically diverse population. While the sample comprising this study is not representative in a quantitative sense, it pulls together French and English accounts, and women from different socio-economic, racial and ethnic backgrounds (see Appendix A). Another advantage of conducting research in

Montreal is that many women come from other provinces, allowing for the inclusion of experiences from outside Quebec.

Of the women who participated in my study two identified as Asian-Canadian, four as African-Canadian, three as Caucasian-American, one as Aboriginal-Canadian, fifteen as Caucasian-Canadian and two as Arabic-Canadian. Eight women grew up in single parent households, eight identified as growing up in lower-income neighbourhoods in Montreal or elsewhere. All women were currently using the pill. Some of the women had just started taking the pill, while others had used it for over ten years. Some women were using the pill for contraception or health reasons exclusively, while for others it was a mix of factors. (For more detailed characteristics of the sample population and details on pill use, see Appendices A and B.)

When I began this study I expected to find more differences between individuals based on such things as race, ethnicity, and socio-economic background. The experiences of participants were indeed different. However, I found difference was more often experienced in terms of how the pill adapted within the body. I think in part this can be explained by the sample. If a young woman is taking the pill it is likely that she aligns with a particular philosophy surrounding the body, health and sex. A difference that did come up that I did not fully expect was geographical location. I also expected to find greater differences between anglophones and francophones. At least within this sample, I did not find that participants contextualized their experience of using the pill within struggles particular to Quebec versus Canada. Further, I did not notice any significant differences between anglophone and francophone participants, at least in terms of how they described their reasons for taking the pill. I also did not find that participants found anything particular about being in Montreal beyond the

fact that it was easier to get the pill in an urban as opposed to rural setting. I will discuss issues of difference in more depth in Chapter 5.

Recruitment for participants began in January 2010 and was completed in February 2013. Calls for participants were circulated using Facebook and university classifieds at McGill, Concordia, Université de Montreal and Université du Québec à Montreal. I displayed posters at university health clinics and several health clinics around Montreal that service primarily young clients. I did not have difficulty recruiting participants, but rather had to eliminate individuals who did not meet the criteria: for example, many women who were no longer using the pill were eager to share stories. In soliciting participants I wanted to ensure that I also found people who were less reluctant to talk and who were not in my immediate social circle. Employing multiple recruitment techniques and offering a financial incentive ensured this was the case.

The majority of participants were recruited through responses to advertisements, eight were recruited through snowball sampling, whereby a friend or fellow participant referred them to my study and two volunteered at my place of work. Most interviews lasted around one hour and all participants received fifteen dollars compensation. While most women said they would have done the interview for free, I found for the younger participants in particular the fifteen dollars (and coffee) were greatly appreciated. I am also convinced that it motivated individuals actually to *come* to the interview. I personally conducted all interviews face-to-face. Most interviews took place in a coffee shop (twenty), some in quiet rooms on university campuses (five), or at the participant's home (two). The choice of location was left to the participant. Interview participants were given the option to speak French or English during the interview and some spoke both.

As I discussed in the previous section, both feminist methodologies and narrative approaches recognize the power relationships inherent in the interview process. The interview is not a natural environment; it is a conversation with a purpose. Because of this, when we interview individuals, we cannot get at experience or the reality of participants' lives. Interviews are valuable insofar as they highlight the ways that individuals talk about their lives. This means that what we get from interviews is a very particular type of data. However, as I am interested in formation of the self, interviews are particularly appropriate. I am not interested in reality *per se*, but rather the ways that individuals talk about their choices and experiences as an activity of meaning formation. The data I discuss in this thesis is thus understood as stories individuals tell about their lives and these stories are in many ways selected by the participant. Indeed, I became aware that many participants wanted to participate because they had a story they wanted to tell about the pill, either positive or negative. Equally, the researcher can suppress or encourage storytelling through her behaviour and the types of questions she asks. As Elliott (2005) observes,

...many forms of research interview suppress stories either by 'training' the interviewee to limit answers to short statements, or by interrupting narrative when they do occur. This is perhaps clearest in the case of structured interviews where the respondent is encouraged to give succinct answers to relatively closed questions (21).

While I worked with an interview guide (see Appendix C), questions were rarely asked in a given order and I attempted to follow the thread set by the responses of the participant.

Following the recommendations of Elliott (2005), I asked participants to "tell me about..." "specific times and situations, rather than asking over a long period of time" (30).

I also became aware that participants had aspects of their lives that they did not want to disclose or that they saw as irrelevant to what they perceived as *my* research aims or agenda. While I did not find that women were generally uncomfortable discussing sex and contraception,

I did encounter a silence surrounding participants' accounts of sexual encounters and genitalia more generally consistent with Fine (1988), Harris (2005) and Tolman's (2002) observations that there is a "missing discourse of desire" that discourages the discussion of sex by young women. I found participants tended to refer to body parts using euphemisms, such as "down there" to refer to genitalia and "getting together" to refer to sex. Equally, not all participants were as open or comfortable discussing sexual matters.

Following the advice of Fisher (2006), I provided different prompters for discussing the pill and often individuals were more comfortable discussing general opinions about the pill and then relating it back to themselves then responding to direct questions about sexual experiences. The questionnaire was divided into two sections. The first section addressed the particular experiences of the participant in taking the pill. For example, I asked participants when they first started taking the pill, who they discussed their discussion with and what they knew about the pill before starting to use it. The second series of questions discussed participants more general views about women and the pill. For example, I asked participants what they thought the pill meant for women more generally, what they thought of the idea of the male contraceptive pill and what for them would be the ideal contraceptive. I found asking similar questions in different ways provided participants with different entry points, allowed for varying degrees of comfort and openness. Individuals would often refer to and add to observations they made at the outset of the interview. While interview data does have many limitations, we should not assume that individuals are unable to adequately talk about and represent their lives and experiences.

Another issue that came up during interviews was how individuals wanted to portray themselves and their choices. Participants often felt self-conscious recounting behaviour they perceived as "irresponsible", such as not using condoms or using "unreliable" methods, such as

withdrawal. In other cases, I found women were worried that having multiple sexual partners made them look like a “slut”. As Lynn notes, she found it awkward to admit to her mother that she was having sex all the time.

*Lisa:* Were you able to talk to your doctor?

*Lynn:* Yeah, I actually did talk to my mom, she’s a nurse and she’s like, “oh, you should be fine. But if you’re really concerned about it, go see your doctor.” She’s like, “it’s ok. It’s just cause you messed up your pills”. And I was like crying [laughing]. It’s like not the most fun to be like [makes funny voice], “But Mom, I’m having sex all the time!”

I found participants felt less awkward in recounting these experiences once I made it clear that I identified with them. Participants were curious about and wanted to know about my experience with the pill and my reasons for doing the research.

*Marie:* Well, what’s your focus on generally?

*Lisa:* For the project I’m writing about, I’m interested in how women use the pill, how they understand it. But also I’m interested in how it’s represented in popular culture and public health information. So what is the information that we have about the pill and how does this translate into our daily lives.

*Marie:* Are you finding that women are like well versed on ... like all aspects of it in terms of like medical?

*Lisa:* I think what I find is that there’s an emphasis placed in our culture on this idea modernity, so we are different from previous generations who were ignorant and didn’t have choices and wanting to have tons of babies. I think a lot of that is true. But at the same time, we don’t actually know a lot about what we’re doing, about what we’re taking. We place a lot of emphasis on choice, but then we don’t actually feel like we have a lot of choices, except for the pill.

*Marie:* Yeah! It’s such a weird thing where it’s like freedom, but imprisonment, convenient, but inconvenient. Oh, what a relief, but it’s also super scary when you actually think about what that little thing is doing every day. It’s like a world of contradictions.

*Lisa:* I think that contradiction is what interests me the most. How do people live with that? How do they deal with that and I find it almost, I almost wish I was interviewing women who were not using the pill, because even when you talk to women who are not using the pill, even they don’t really know why they’re not using it. They’re like, “I think it’s toxic and I think it’s bad”. But nobody really knows, so we have this very vague scientific knowledge, very vague perceptions about why we’re using it. So what I find is really interesting is that there are more similarities than differences with women of the past.

*Marie:* Yeah! That’s true.

*Lisa:* And I was inspired to do this project because of the Alesse ads, and I wanted to understand what was going on there. And the newsmedia is so schizophrenic... one month the pill is so scary and the next month it’s revolutionary.

*Marie:* Yeah, and I think that applies to things like the IUD too. It’s like some of the girls I know are like, “I would never do that! Having that object inside of you, controlling and you can’t touch it and it’s scary, and what if it rips”. And other people are like, “It’s the ultimate freedom!”

While my identity as a heterosexual woman was important to building a relationship of trust and confidence with participants, I think it was more important to participants that I was not judging

them for their decisions. As someone older and as a researcher, many women saw me as someone who could offer advice and had access to specialized knowledge. Participants asked me if certain myths about the pill were true and asked for my advice. There was a perception that I would tell the truth where medical professionals might not.

My secondary data set included texts about the pill from pharmaceutical advertising, public health information and print news media. When I began my search I was overwhelmed with the amount of data available. Because this thesis is concerned with texts about the pill in contemporary Canadian society I started by collecting available documents over the past five-years (March 2009-September 2013). In this thesis I examine only Canadian texts and because interviews took place in Quebec I have placed an emphasis on materials that were available in French and English.

**1) Pharmaceutical advertising.** Advertisements produced by pharmaceutical companies have played a key role in producing social and cultural understandings of the pill (May 2010; Tone 2001; Watkins 2011). Recently, the increased presence of pharmaceutical advertising in the media and in online formats has contributed to what Fox & Ward (2008) call the domestication of pharmaceuticals. Women I interviewed often mentioned pharmaceutical advertising campaigns without prompting and most noted that they had seen some form of advertising for the pill.

In order to situate women's use of the pill within existing campaigns for pharmaceutical advertising in Canada I chose the Alesse print, online and television advertising campaign. Alesse is a brand of contraceptive pill produced by Wyeth Canada. In Canada there are many brands of the pill available for prescription, but I found Alesse was a brand with which participants were very familiar, and it was also the pill most commonly used by the women

participating in this study. Alesse's marketing strategy was easily accessible on the internet. I recorded the text from the website, wrote descriptions of the dialogue and images from the television advertisements and collected copies of the images from the print campaign. The Alesse data will be discussed in Chapter 5 where I consider the ethical work young women engage in when getting on the pill.

**2) Print news media.** The print news media are an important site for the production of discourses of health and sexuality where notions of femininity are reproduced and contested (Currie 1997; Gill 2007). I chose the print news media because I found there was a greater volume and range of narratives about the pill, when compared to television broadcasting and women's magazines and more focus when compared to online news sites and blogs. I selected the following newspapers, which all have national distribution: the *Globe and Mail*, *La Presse* and *Le Devoir*. The newspaper with the highest circulation in Quebec is *Le Journal de Montreal*. However, this newspaper had very few articles relating to birth control and contraception. In contrast, *La Presse*, which has the second highest circulation in Quebec, places a greater emphasis on health editorials in a manner similar to *The Globe and Mail*, which is second in Canada to the *Toronto Star*, (see <http://j-source.ca/article/7-interesting-facts-newspaper-canada-2012-circulation-data-report>). In contrast to *La Presse* and *The Globe and Mail*, *Le Devoir* has a lower circulation. I included *Le Devoir* because it is the only independent newspaper in Quebec. During the time period for this study there were only six articles discussing the pill in *Le Devoir*, as opposed to thirty-eight in the *Globe and Mail* and thirty-four in *La Presse*. *Le Devoir* reported on the fiftieth anniversary of the pill and provided some coverage on the Yasmin and Yaz health scare, but did not discuss the pill on an everyday basis.

Articles were found using the on-line archives of each newspaper using the search terms “birth control”, “birth control (pill)”, “the pill”, “oral contraceptive pill” and “contraception” and in French, “la pilule contraceptive”, “la pilule”, “contrôle des naissances” and “contraception”. My original search yielded over 500 articles and I narrowed my selection by focusing on particular themes which came up in the interviews.

The first selection of articles focused on the side-effects of the pill and are discussed at length in Chapter 6. I followed the coverage of the recent Diane-50 and Yaz/Yasmin “pill scares”. These two “pill scares” were selected because they were the most recent and were both mentioned frequently by participants. I also included articles discussing general health concerns about using the pill, ranging from the environmental impact of hormones and loss of sex drive.

The second selection of articles focused on history, either in commemorating the fiftieth anniversary of the pill or discussing the history of the pill more generally. I found that the history of the pill was a particularly salient theme in women’s talk about the pill and in the media more generally, as well as a subtle undercurrent against which participants understood their own experiences of reproductive control. In Chapter 3, I discuss the ways that the print news media produce narratives about the history of the pill. I also discuss the ways that young women draw on perceptions of the past in understanding their own use of the pill.

**3) Public health communications.** Materials produced by government agencies and medical associations are another important site where discourses about health and sexuality are deployed (Casper & Carpenter 2008; Connell & Hunt 2010; Lupton 1995). Yet, large-scale campaigns to regulate health and sexuality are no longer coercive, as individuals are encouraged to actively take up initiatives of their own accord (Rose 1991). In selecting sources for texts of this type I chose sites that sought to promote sexual health and describe the functioning of the pill to young

women such as the Canadian Federation for Sexual Health (previously Planned Parenthood Canada) and [sexualityandu.ca](http://sexualityandu.ca), the website produced by the Society of Obstetricians and Gynecologists of Canada. These websites were selected because they are national in scope and produce information in English and French. Texts from these two sites will be analysed in Chapter 4, where I explore women's descriptions of what the pill does to the body alongside informational materials that are made available to women.

The second range of public health communications I collected were produced by Health Canada and the Society of Obstetricians and Gynecologists of Canada, in response to “pill scares” surrounding Diane-50 and Yaz/Yasmin. These texts were collected from the websites for Health Canada and the Society of Obstetricians and Gynecologists of Canada and will be analysed alongside the print news media in Chapter 6 where I consider the side-effects commonly associated with using the pill.

Finally, I have gathered patient package inserts for Yasmin and Diane-35 (see Appendices F & G). Patient package inserts are now required to be included in all pharmaceutical products. These pamphlets contain details on the product as well as a list of potential side-effects and product interactions that should be avoided.

### **iii. Governing ethics**

As my research involved interviews, I was required to comply with the ethical guidelines for research as outlined by the Carleton University Research Ethics Board. The Graduate Student Research Ethics Protocol Application requires the researcher (me) to outline among other issues the research, as well as the methodology and procedures that were used.

Section 5 of the application requires the researcher to outline the “Risks and Benefits” of the research. The researcher must detail potential risks to participants, how she will manage risk

and “reduce harm to participants”, as well as any benefits of participating in the research. In completing this section, I communicated that as participants were going to be asked about issues relating to their physical and sexual well-being there was a possibility that during the course of the interview painful or unpleasant experiences might arise. With this in mind, I prepared a list of Counselling and Health Services available in the Montreal area. However, my central aim in designing interviews was to talk about the pill and thus I did not expect that interviews would involve discussing sexual encounters in any detail. Because of the general nature of my interest, I identified that my research carried “minimal risk” for participants.

I found the Research Ethics Board did not agree. In my original ethics submission I proposed focus groups with young women to understand the joint construction of knowledge and skype, email and telephone interviews to allow me to access populations outside of Montreal. I received a list of modifications to my research proposal from the Research Ethics Board. In particular, the committee found that focus groups were not appropriate due to the “sensitive” nature of the topic. Young women, I was told, were uncomfortable discussing sex in a group setting. Further, interviews had to take place in Montreal so I could provide participants with health and counselling services close by should problems arise during the interview thus ruling out the use of skype, email or telephone interviews in other locales.

The Research Ethics Board identified young women as a potential at-risk population and sexuality (or in this case a device associated with sexuality) as a potentially problematic topic. I do not object to the concern expressed by the Research Ethics Board and I was happy to comply with most of their recommendations. I did however find it interesting that none of the women requested the list of clinics or social services for issues that arose during the interview. They did however ask for a list of clinics that could provide the birth control pill easily or for free. Many of

the young women I interviewed noted that it was often difficult to access the pill and to find doctors that were non-judgmental. Further, the Research Ethics Board's insistence that I provide resources for institutions is also interesting in light of the fact that many of the young women I interviewed identified peers and not medical professionals as the most helpful resource in talking about the pill. Doctors, and in particular university health clinics, were often identified as unhelpful and as an unpleasant necessity. It was not so much that participants were uncomfortable; there was no language for talking about sex beyond euphemism. Further, once I began conducting interviews (as opposed to focus groups) most of the young women I spoke with saw talking about the pill as mundane, somewhat innocuous and commonplace.

Section 7 of the form focuses on "Anonymity and Confidentiality" and Section 8 on "Informed Consent." All interview participants who participated in my study signed an informed consent form that guaranteed anonymity, outlined the nature of the research, discussed what types of questions they would be asked in the interview, and provided the participant with contact information should they have concerns about the research. Participants were also reminded that their participation was voluntary and that they could withdraw their participation during the course of the interview or after the interview was completed by getting in touch with me. I guaranteed participants that their identity would be protected through assigning a pseudonym in the communication of results. However, because I asked participants to suggest potential participants, I reminded participants to respect the anonymity of their fellow participants. Confidentiality and anonymity were a given in filling out the required paperwork. However, I found that participants were not concerned or worried about their identities being shared. They often laughed or joked about it. I also found it ironic that the rigours of informed consent were stricter for me, a lowly graduate student, than for doctors and pharmaceutical companies providing

the pill to women. Most of the young women I talked to indicated that doctors usually listed off various side-effects and sometimes did not bother to ask about previous health problems at all. No one I interviewed had to sign a form indicating that they understood the risks of using the pill.

Ethics can act as a helpful guide and ensures that the interests of participants are protected during the course of research. However, ethical guidelines also serve to limit the actions of the researcher. As Becker (2004) notes:

What began years ago as a sort of safeguard against doctors injecting cancer cells into research patients without first asking them if that was OK has turned into a serious, ambitious bureaucracy with interests to protect, a mission to promote, and a self-righteous and self-protective ideology to explain why it's all necessary (415).

Similarly, Haggerty (2004) notes the increasing drive towards the bureaucratic regulation of social research does not necessarily lead to better or more ethical research. As Haggerty (2004) observes, research is constrained by institutional guidelines which “structure what truths can be spoken and by whom” (392). In my case, the Research Ethics Board reified social expectations surrounding young women, sex and risk that were the focus of my thesis.

## **1.5 Learning to listen**

As I explored earlier, feminist methodologies and narrative approaches to research encourage the researcher to recognize and address power relationships at all levels of the research process, including analysis. In the same way that scholars have recognized certain types of interviews can be more conducive to storytelling, certain types of analysis lend to storytelling from data. In my research I have brought together multiple data sets and I demonstrate the ways that themes emerge across different social spaces. As I will discuss, stories emerge from multiple sites and are told, retold and reworked on an ongoing basis. In analysing materials, I have drawn on Foucault's four dimensions of the study of ethics are applied explicitly in Chapter 5. However, I found it limited in terms of providing practical guidelines for the gritty work involved in picking

through the data. There are four analysis chapters, and each one engages with a unique set of methodological issues which will be revisited at the outset of each chapter. What I will lay out here are the general guidelines I drew on in conducting analysis and provide some examples for the reader of analysis.

According to Doucet (2007), the “Listening Guide” “is an approach to data analysis that combines reflexivity and subjectivity while focusing on narratives and storytelling” (65). I found the “Listening Guide” helpful because it provides a practical account of how to build theory from research and conduct reflexive analysis. Through reading materials several times, with different intentions the researcher is encouraged to think about “Who precisely is speaking, and under what concrete circumstances?” and “who is listening and what is the nature of her relationship with the speaker – especially with respect to power?” (Brown, 1998: 32, cited in Doucet, 2007: 66). As my research is interested in drawing links between the interview data and texts, I conducted multiple readings with all materials and read them alongside one another. Reading the materials together was important in order to treat both subjects and texts as constituting narratives, but at the same time acknowledging that they do so in different ways and with different objectives in mind. Texts and interview data sometimes overlapped, at other times were mutually contradicting, and at other times existed side by side.

### **Reading 1**

The first reading involves “a reader-responsive reflexive strategy.” In this first reading the researcher is encouraged to look for the “plot or narrative” by highlighting “recurring words, themes, events, protagonists, the central plot, subplots and key characters” (Doucet, 2007: 278). This reading is similar to Seale’s (2002) analysis of media health stories, in that attention is paid to stories and characters, but Doucet adds a reflexive component. The reader is encouraged to note her response to what is being said and draw on an awareness of how she shaped the

outcome of the data. Doucet encourages researchers to conduct group analysis to understand identities and individuals with which they are less familiar. While I was unable to do this, throughout my doctoral studies I volunteered at a free health clinic. The clinic provided contraceptive services and health care and care for adolescent youth and transitioning men and women. As a volunteer at the clinic I was confronted with the multiple ways women use the pill.

This first analysis involves tracing multiple layers and below is an example of one of those layers. Here I have provided a selection of repeated words from two interviews and a cross-section of articles from *La Presse*.

### **Repeated words, Christie:**

Regulate (period), heavy/light flow, period/rag, intense, Tri-cyclen, Diane-35, Sweating, uncomfortable, strong (hormones), chemicals, normal, acne, yeast infections, STD, cortisone cream, eat better, lifestyle, Nuva-ring, herpes, blood test, creeps me out, time, stupid, regulate (period), heavy/light flow, period/rag, intense, bleeding, extra safe, pregnant, genetic, operation, foolish, kids, sterile, Plan-B, 99%, PMS'ing, headaches, contraception, family, psychologically, career, getting sick, continuous, Yasmin, birth defects, trust, antibiotics, bad for you, crap you're putting in your body, it's all junk, control of your life, not be stuck, flexibility and time, diaphragm, shot, side-effects, emotional, crying, cramps, nausea, advice, experience, weird, condoms, pink, sleeping around, prejudiced, weight gain, loss, young, Yaz, Alesse, knowledge, nauseous, sick, puking, bile, sensitivity, patch

### **Repeated words, Alicia:**

Pregnant, sex, condoms, control, responsibility, awkward, need, checkup, change, waiting room, low dose, less/more hormones, regulate, pain, period/cycle/menstruation, acne, drug, smoking, blood clots, weight gain, stroke, worried, time (morning/evening/months/days), difference/no difference, shortage, switch, better/worse, reproduction, ovulating, cost, going on/off of the pill, possibility, sick, focus on myself, financially/emotionally, ready, choose/choice, right time, struggle, surprise, nuva ring, migraines, weird, putting a ring up there, vacation, pamphlet, should know, reassurance, definitely not pregnant, failed, low chance, at a certain age, family, developing countries, babies/children, religion, health, be aware of how it works, haven't had a problem

Christie was 22 years old at the time of the interview. She identified as an African-Canadian Anglophone. She grew up in Montreal in a lower-income neighbourhood and her mother was a single parent living on welfare. She was a part-time student and was also working part-time. She was in a relationship at the time of the interview. She first started taking the pill when she was fifteen. She decided to go on the pill because she wanted to regulate her periods, but also

because she had boyfriends and wanted to be extra safe not to get pregnant. She talked about heavy menstrual flow and how this problem ran in her family. Her experience with doctors and at the clinic was often negative and she often felt judged. Christie did not link this experience to her race or social status. Her friends were an important source of information for her about available pill brands. Christie threw up every night when using the pill and she also had persistent yeast infections. In spite of this, she preferred the pill to other options and insisted that it was very important for women.

Alicia was 26 at the time of the interview and was living with her boyfriend. She identified as a Caucasian-Canadian Anglophone. She grew up in a middle-income suburb and was currently pursuing graduate studies in Montreal. She started taking the pill when she was seventeen for contraception. She went to the clinic with her mother to get the pill and did not remember it being a long or particularly significant appointment. She describes her experience with the pill as unproblematic and sees it as a very practical thing in her life, because not getting pregnant is very important for her. She has had friends who have had negative experiences, but she does not identify with this. Repeated words used by Christie and Alicia highlight the various experiences, emotions, and relationships that were involved in shaping how they used the pill.

**Repeated words, *La Presse*:**

Diane-35, Alesse, Yasmin, Yaz, peurs, gynécologues, santé, docteur(e)/médecin, santé publique Risque, femme, thrombose veineuse, caillot dans le sang, enceinte, contraceptif, décès, la pilule, danger, maladie, acné, SOGC, France, grossesse, grossesse non-désirées, des pilules contraceptives de première, deuxième, troisième et quatrième génération, contraceptifs combiné, synthétiques, estradiol, progestérone, hormones, confortable, gonflement des seins, nausées, migraines, trouble vasculaire, noréthistérone, les années 60, 70, 80, Merck, Pfizer, Bayer, prescription, gynécologues du Québec, professionnel de la santé, États-Unis, FDA, CLSC, bénéfiques, cancer, accessibilité, pharmaciens, autorités médicales américaines, interdite, sciences, gains politiques des femmes, dissocier la sexualité de la procréation, le pape Paul VI, les catholiques, morale, 50 ans, l'Église, conception, mère, menstruel, régulariser, révolutionné la vie des femmes, règlements hormonaux, réforme du code criminel en 1969

This list of repeated words from *La Presse* is a good example of the various themes explored in the media in relation to the pill, such as health risks and benefits. It also highlights key actors, such as pharmaceutical companies, the government and doctors, and the importance of women more generally in print news media narratives. In contrast, pharmaceutical marketing targeted young women, as opposed to women more generally.

## **Reading 2**

The second reading “traces the ‘I’ or central protagonist within the narrative” (Doucet, 2007: 280). In this reading, the researcher acknowledges “...the particular *person* in the interview transcripts and pays attention to the way this person speaks about her/himself and the parameters of her or his social world” (Doucet, 2007: 280). Like Doucet, I traced the ‘I’ and ‘we’ in interview transcripts and in text materials I followed the story of the various characters which emerged. In interview transcripts, drawing these statements together produces an ‘I poem.’

### **From Serena:**

*I had a boyfriend...*  
*I didn't have a car...*  
*I just really felt like going to do it myself...*  
*I came here and I went to the McGill clinic...*  
*I just stayed on it...*  
*I'm not ready for a kid...*  
*I've known people who got pregnant...*  
*I didn't want to use female condoms...*  
*I just went with that...*  
*I called my Mom...*  
*I had friends that had taken it in high school...*

### **From Lucie:**

*J'étais en secondaire 4, j'avais un chum...*  
*J'avais toujours un mal de ventre...*  
*J'avais plus mal au ventre...*  
*J'ai arrêté de broyer...*  
*J'ai eu un chum...*  
*J'avais un rendez-vous chez le médecin...*

*J'ai pas vraiment réfléchi à ça...  
J'étais ben contente de ne plus avoir mal au ventre...  
Je veux être au courant avec des trucs...  
Je sentais qu'elle me jugeait...  
J'étais la première à être menstruée à 11 ans...  
J'ai pris Alesse pendant un bon bout de temps...*

**From Alexandra:**

*I was 16...  
I went off of it when I was 25...  
I decided to go back on it...  
I was diagnosed pretty early as having polycystic ovaries...  
I felt like I didn't completely have really accurate information...  
I did feel like it was kind of coercive...  
I wasn't as in touch with what was going on with my body...  
I have flipped back and forth between Diane-35 and Tri-Cyclen, Yasmin...  
I've felt a bit stigmatized...  
I guess people question my authenticity as a queer person...*

Following the 'I' provides a very clear picture of the place of the narrator. How does she see herself, what type of image does she project through telling her story, how does she situate her choice within other relationships.

In text materials there were many narrators and several characters. I used an adapted version of the 'I poem' to trace the emergence of a central narrative and highlight the actions of key characters.

***Globe and Mail*, "Yasmin, Yaz birth control pills may raise blood clot risk: Health Canada"**

*Health Canada has asked drug giant Bayer to change the labels...  
It [Health Canada] concluded use of the medications is linked to higher rates of blood clots...  
the drugs are about to undergo scrutiny from the U.S. Food and Drug Administration...  
Studies suggest that the drugs are associated with higher rates of blood clots among users...  
Yasmin and Yaz were heavily promoted as having fewer side-effects...  
Health Canada began the review earlier in the year...  
Yasmin and Yaz are the only oral contraceptives containing drospirenone...  
Health Canada issued a statement...  
Women using them may be at a 1.5-to-three fold increased risk...  
The Department said the labels for the two drugs have been updated...*

*Bayer inc. contested the suggestion ...  
Signed by Dr. Shurjeel Choudhri, senior vice-president for medical and scientific affairs,  
said the company's own studies show a clot risk for Yasmin and Yaz that is in line with  
other oral contraceptives...  
It suggested the studies have significant methodological issues...  
Bayer won't say how much it earns in sales...  
Health Canada did not urge women to stop using Yasmin and Yaz...  
Women and their doctors should discuss the risks and benefits...  
FDA estimates the increased risk of clots... at 1.5 times the risk...  
They [FDA] would expect to see 10 blood clots in women taking ... drospirenone...  
Class action lawsuits ... have been filed... by women who say they have experienced  
serious health problems...*

Another example is provided below from an article giving advice to parents talking to teens about contraception and birth-control, on the Society of Obstetricians and Gynecologists of Canada website Sexualityandu.ca.

### **Sexualityandu.ca, “Contraception-Birth Control”**

*Some teens may choose to become sexually active ...  
It's important for them to be given the proper information...  
No parent wants his or her child to experience an unplanned pregnancy or exposure to a  
sexually transmitted infection...  
Teens need to be informed and know to choose and consistently use dual protection...  
The choice is theirs to make...  
As a parent you can offer your support and guidance to help them make healthy  
decisions...  
Being a teenager is about exploring life and getting to know who you are...  
Encourage them to choose an effective method...  
The Pill, the Patch or the new vaginal ring, used with a condom, are highly effective...  
The diaphragm, cap and sponge have a higher rate of failure...  
Teens may become frustrated or impatient and not use anything at all...  
Make sure you're willing to allow them the freedom to choose whatever method they're  
comfortable with...  
Steer your teen to reliable information...  
Help her or him to locate an accessible and hospitable family planning center, teen  
clinic, or physician...*

Tracing the ‘I poem’ alongside both materials allowed me to explore how common themes emerged in different ways across materials and highlighted the ways different actors were identified across different spaces.

### Reading 3

In the third reading I looked for descriptions of relationships at the micro level, for example how the decision to use the pill was connected to various intimate relationships (between parents, friends and sexual partners) (Doucet, 2007: 284). Below is an example from an interview where I have broken down the narrative by different actors or agencies who figured centrally in the narrative.

#### From Renée:

##### *Doctor*

*Le médecin m'a recommandé de prendre la pilule...  
Le médecin a suggéré. Il m'a posé des questions,  
pis après, il a dit, « La pilule »...  
Il a expliqué que ça va m'aider, mais pas comment. Comme, tu vas être menstruée une fois par mois, mais pas plus que ça.  
Le médecin aussi, il te parle pas d'autres options, il te dit, « la pilule... », pis c'est tout. Avec le médecin c'est le plus vite possible là, il te pose pas beaucoup de questions...  
Ben... « est-ce que t'as déjà pris la pilule avant? Pourquoi tu veux prendre la pilule? »  
Pis, après, mais chaque médecin a sa pilule aussi, comme j'avais un médecin qui m'a dit, « Prends celle-là » et un autre médecin, dit, « Non, prends l'autre »...  
Elle m'a dit un certain nom, et qu'il y avait eu beaucoup de problèmes avec Yasmin, alors elle m'a donné Alesse...  
Elle m'a dit que les études ou ça va pas bien pour Yasmin. T'sais ils sont tellement pressés.  
... elle me disait, « Est-ce que tu fumes? », j'ai dit « oui »...  
... elle m'a dit, « Il faut que t'arrête ça marche pas bien avec la pilule ». C'est tout...  
Elle signe le papier, puis elle me l'a donné... Il te donne pas beaucoup d'information...  
Elle me disait que ça prenait un mois avant que ça soit efficace...  
Elle m'a dit, protégé toi encore, parce que dès que tu prends la pilule, c'est pas efficace tout suite...*

##### *Sexual partner*

*Les partenaires, ils savent bien, unh! (laughs) C'est comme, prends la pilule, et le problème est réglé...  
Il te rappelle pas, c'est comme « Ah, les filles elles vont s'arranger avec ça. »  
Ben, j'ai pas eu beaucoup de partenaires... alors j'ai pas peur pour ça...  
J'arrête quand j'ai pas de relations...  
Les gars veulent pas trop utiliser le condom après un certain temps aussi...  
Mais, moi c'est le gars qui a dit ça... Comme je veux prendre contrôle.*

*Mother (parents)*

*Je suis allée chez le docteur avec ma mère, quand j'avais le problème à 12 ans...*

*Friends*

*Elle (amie) a eu une mauvaise expérience avec la pilule. Elle a vomit et tout...*

*School*

*La deuxième fois que j'ai pris la pilule, c'était à l'école secondaire à 15 ans...*

*J'étais au secondaire, je suis allée voir l'infirmière parce que j'avais des questions... comme je voulais pas aller demander à ma mère...*

*Fais-que, je suis allée voir l'infirmière, et elle m'a donnée comme 2 boîtes gratuites...*

*J'ai eu des cours de sexualité... mais... on a jamais vraiment parlé d'autre chose...*

*Women*

*Liberté (laughs)... Pis, quand-même, mais c'est sûr que les filles commencent plus tôt... de ne pas tomber enceinte. Je trouve que ça quand-même réglé un petit problème là...*

*Pharmaceutical companies*

*Il y avait eu beaucoup de problèmes avec Yasmin, alors elle m'a donné Alesse...*

*Il y avait des problèmes avec Yasmin...*

*Il n'y a pas beaucoup de marques, il y a Yasmin, Alesse...*

Renée was 22 at the time of the interview. She was a Caucasian-francophone, was currently in a relationship and was studying in Montreal. She also worked part-time. In Renée's narrative, her doctor was identified as a key individual in identifying the pill brands she would use. Her mother and friends provided support and guidance. Sexual partners did not figure prominently in her narrative and she tended to generalize about men as opposed to talking about specific individuals. She also touched on wider social themes, such as the meaning of the pill for women and the role played by pharmaceutical companies in determining what is available.

**Reading 4**

In the fourth reading I expanded my gaze out to relationships at the macro level. In conducting this reading, Doucet draws on concepts from Smith's institutional ethnography. Given my theoretical orientation I found it made more sense to ground this reading in Hall's (45-46) criteria for studying discursive formations. In studying a discursive formation Hall (1997)

suggests looking for the following: 1) statements ... which give us a certain kind of knowledge about... things; 2) the rules which prescribe certain ways of talking about ... topics and exclude other ways...; 3) 'subjects' who in some way personify the discourse...; 4) how this knowledge about the topic acquires authority, a sense of embodying the 'truth' about it...; 5) the practices within institutions for dealing with the subjects... whose conduct is being regulated and organized according to those ideas; 6) acknowledgement that a different discourse or *episteme* will arise at a later historical moment, supplanting the existing one, opening up a new *discursive formation*... (45-46). Following Hall I read for what types of statements were made about the pill, what is 'sayable' and 'thinkable, which 'subjects' have the authority to speak, and a recognition of how conduct is organized in social relations and institutions. I looked for how women situated taking the pill in the context of wider social processes and institutional relationships and pulled together themes explored in interviews and text materials.

I conducted in-depth readings with a selection of the interviews and texts. I worked across interviews and texts by using common themes drawn from the data. For example, below is an example of the mobilization of themes of "girl power" and empowerment across interviews and pharmaceutical marketing.

### **Girls and empowerment**

#### **From Serena:**

*I had seen commercials...*

*They were running some sort of contest about why you're a powerful woman or something.*

*And they even had an ad in the metro...*

*It's always one of those awkward things, like tampons...*

*Like I am a strong athletic woman because I use this brand of tampons...*

*It's like they're trying their best to make it cool, but it's always like ... yeah, it's kind of weird because when you think about it, and because it's a generic brand, you have to wonder why people are taking birth control...*

*Like if you're taking birth control just so you can sleep with a lot of men and then you're saying I'm a powerful woman because I'm on Alesse, than it's a bit weird...*

**From Marie:**

*Alesse had a big campaign going on at that time...  
It was really pink and for young girls and like, "Wow, you're on Alesse! Cool!"  
I remember feeling like I had heard the name before, or like read about it in Cosmo and seen it on TV...  
...it was like young women, and it was fun and it was like, I feel like the ad campaign, but I feel like there was superheroes...  
It was fun and young, so I imagine the pharmaceutical company was really targeting girls exactly like me, who were just like, who had been watching Sex and the City secretly since they were 15. Who were like [making funny voice] "Oooh, sexual adventures! But got to be safe..."  
So it was like safe and it was like be responsible and [whispering] (have sex)...  
But I remember it was like bright pink, the commercials, and the packaging and so it was very feminine...*

**From the Alesse website:**

*You have taken the responsibility for your sexuality and decided to take control...  
By taking the pill, you're taking control...  
Sex should be exciting and amazing – but it should be safe!  
...before you and your partner get started on your sexual journey together, you should talk about how to keep things healthy...  
You're young and healthy – and sexually active...  
If you put aside time to care for yourself, you'll benefit from your efforts. And it doesn't take much...  
A few regular check-ups and some common sense skin care tips can go a long way...*

In analysing the interview data alongside the text data, I saw that Marie and Serena did identify with the themes of “girl power” expressed in the Alesse advertising campaign. But they also saw aspects of the advertisements as a bit silly and critiqued the message.

## **1.6 Conclusion**

At the outset of this chapter I discussed a quote from a participant, Alexandra. As she observed it is difficult for her to say what the pill represents for women. Indeed, in writing this thesis it is not my aim to define what the pill represents for women and I would be wary of anyone who

claimed to be able to do so. In this chapter I have demonstrated that unpacking the pill requires an approach that embraces subtlety, diversity and complexity. I defined key theoretical concepts, such as governmentality, ethics and care of the self and discursive formation. I discussed the ways that post-structural feminism, feminist accounts of science and technology, and recent work on the sociology of emotions can help to build on Foucault's insights when dealing with lived accounts of ethical work. Feminist methodologies and narrativity allow for a methodological approach that attends to the dynamic flow of power. Research is an active form of knowledge construction embedded within formal and informal relationships, and the research which comprises this thesis was shaped by my own motivations and experiences, as well as various institutional constraints.

Finally, I outlined the analytical framework for the data which draws on Foucault's four dimensions for the study of ethics, Hall's guidelines for the study of discursive formations, and an adapted version of the "Listening Guide." Taken together these provide a practical set of tools for consciously embedding theory, reflexivity and relationships within the construction of knowledge and adopting a detailed approach to analysis. In the next chapter, I discuss how this research will advance knowledge in the field of feminism and the regulation of reproduction, the sociological studies of girls and "girl culture," and pharmaceutical technologies.



This thesis builds on three bodies of scholarship: feminism and the regulation of reproduction, the sociological study of girls and “girl culture”, and the sociological study of pharmaceutical technologies. I begin with a discussion of how reproduction has emerged as a problem within the context of feminist philosophy more generally. The regulation of women’s reproductive bodies continues to be central to understanding the unique ways that women embody subjectivity. Equally, feminist demands for agency and autonomy shape contemporary reproductive politics and discussions of choice and rights are still central in academic literature about the pill. However, recent feminist scholarship tends to place a greater emphasis on the ways that women’s conduct is organized within particular institutions and sets of practices. In a similar vein, this research explores the pill as part of the performance of gender and diverse types of subjectivities.

I then turn to situating the pill within existing scholarship on girls and “girl culture”. In Canada today, teenaged and young adult women are the primary users of the pill, not women generally. Taking the pill is connected to a distinct discursive formation that produces discourses about girls. This research also fits into existing literature on sociological studies of pharmaceutical technologies. As a multi-purpose lifestyle drug the pill can be used by young women in a variety of ways and thus can be productive of multiple truths about the self and the body. Sociological literature that examines pharmaceutical technologies encourages us to situate medical devices as complex commodities that are used by particular types of subjects. In this sense, the pinkness of the pill is no accident, but is one of the most obvious ways it is demarcated as a product to be used by young heterosexual women, not men or boys.

Historical scholarship in the area of the regulation of reproduction and contraception constitutes a significant and extensive body of research and literature. During the course of my

research I found that the pill is deeply entrenched within both lay and popular accounts of women's history in North America. Equally, academic accounts of feminism and twentieth century history of women in Canada and the United States usually include at least some acknowledgement that the pill is significant and worth mentioning. Even though there is very rarely consensus amongst different factions, the pill remains a common reference point for discussing more general historical changes in the status of women in the twentieth century. In this chapter, I will situate the pill within feminist literature more generally. The following chapter is dedicated to a detailed discussion of historical scholarship on the regulation of reproduction and contraception.

## 2.1 Feminism and the regulation of reproduction

*Lisa:* When I say “the pill”, what are the first three words that come into your head?

*Allison:* Well after this conversation, contraceptive, but... I feel like I more have images, which is like the 1960s, women burning their bras, like these radical feminists, “Whoo hoo the pill!” Just like this radical, ra, ra “Girl power”, just like, “We’re gonna rule the world!”

You’re on the pill. You have taken the responsibility for your sexuality and decided to take control (Alesse 2009).

Like Allison, participants commonly associated the pill with “bra-burning” feminists of the 1960s. Indeed, linking the pill with feminists pursuing liberation in the 1960s, as opposed to the scientists in the laboratory who created it, highlights the importance of the pill as an iconic representation of women's struggles for choice and reproductive rights. A more recent incarnation of the association between women's autonomy and fertility control is expressed in the above quote from the Alesse website. Allison and the Alesse advertisement imply that gaining control over the reproductive body leads to an increase in autonomy for women.

Speaking broadly, liberal feminists have tended to argue that women and men are fundamentally equal and deserve the same access to rights and status (see Mill, [1869] (1977), Wollstonecraft, [1792] (1975). Within liberal philosophy, “One of the core principles ... is the

universal human capacity to reason; rationality in the liberal sense rests in the individual's capacity to remove himself from the particularities of his circumstances" (Ruhl 2002, 644).

Autonomy of the mind is based on the individual's capacity to subvert the body. A woman was often characterized as unable to attain the idealized state of liberal personhood because her reproductive system tied her to uncontrollable natural processes, such as menstruation and menopause. No state was more a threat to a woman's autonomy than pregnancy, which occurs "spontaneously" and in the absence of one's will (Ruhl 2002, 651).

As Tone (2001) and Watkins (1998) have observed, the pill was an innovation of science; but its invention was contingent upon a system of social values and beliefs that emphasized the importance of a woman-centred contraceptive as *the* solution to the modern woman's problem. The link between a woman's freedom and control of her fertility found a practical political expression in the tireless campaigning of birth control activist Margaret Sanger. In *Women and the New Race*, Sanger (1920) states:

Millions of women are asserting their right to voluntary motherhood. They are determined to decide for themselves whether they shall become mothers, under what conditions and when. This is the fundamental revolt referred to. It is for women the key to the temple of liberty (5).

Sanger emphatically believed that women's freedom was equal to freedom from unplanned pregnancy. Because the pill allowed a woman to decide when she would become pregnant, it allowed her to enter the public sphere as a rational individual, capable of making choices because she was no longer constrained by the material conditions of her body.

However, Sanger was also a fierce advocate of population control and eugenics. Unfettered fertility, particularly of the "unfit under class" meant the degeneration of women, and the population as a whole. She observes:

Even as birth control is the means by which woman attains basic freedom, so it is the means by which she must and will uproot the evil she has wrought through her submission. As she has unconsciously and ignorantly brought about social disaster, so must and will she consciously and intelligently *undo* that disaster and create a new and a better order (Sanger 1920, 5-6).

According to Sanger, a woman is implicated in the engineering of a better future as she regulates her fertility. The notion that fertility is a woman's choice, but also that the right exercise of that choice is a social responsibility that will shape wider social conditions, is still present in contemporary discourses that construct the pill. However, as I will examine, it appears in new ways and with new subjects as the target.

The call for women-centred control of reproduction was heard across feminist philosophy in the latter half of the twentieth century. The influential existential feminist, Simone de Beauvoir (1952), argued that a woman's reproductive system limited her capacity to act as an autonomous individual. According to de Beauvoir, a woman's embedded status as a "natural," rather than a "rational," subject was particularly evident in pregnancy (de Beauvoir 1952, 495). According to de Beauvoir, for a woman to become an autonomous subject she had to regulate and control her body, and in particular her reproductive body. For this reason, de Beauvoir (1952) argued that access to reliable contraception and abortion were essential preconditions to freedom for women (513). The radical feminist philosopher, Shulamith Firestone (1970), argued that a feminist revolution required "the full restoration to women of ownership of their own bodies" and the "seizure of control of human fertility" by women (11). Marxist-feminist philosopher, Mary O'Brien (1981), insisted that freedom for women from patriarchal domination required the freedom to choose parenthood (21).

However, the pill has also sparked animated critique by feminist health activists. In *The doctors case against the pill*, American medical journalist Barbara Seaman (1980) wrote a scathing report of the pill and like many others of her time suggested that the pill was actually dangerous to women's health, and its use led to women's enslavement within the medical establishment by male doctors. Wide-spread critique of the pill led to calls for the inclusion of

informational pamphlets in the pill package listing potential side-effects to ensure women understood the risks involved with using the pill. There are ongoing tensions within feminist philosophy over reproductive technologies and more recently new reproductive technologies. At times they are rejected for how they medicalize and pathologize women's bodies, disrupting narratives of choice. At other times they are embraced as expressions of empowerment and the celebration of choice through endless options and consumption (Ruhl, 2000).

Contemporary feminist scholarship in the area of reproduction still recognizes the importance of themes of choice and reproductive rights, and continues to engage with questions around autonomy and control. However, there is an increasing tendency to recognize the complex nature of these concepts. As Ruhl (2002) observes, the degree to which fertility, or indeed the body more generally is controllable, always "lie midway between rational control and "simple" biology". She points out that pregnancy is sometimes planned, sometimes unplanned, but rarely a fully engineered and predictable process (Ruhl 2002, 655). The appeal to choice has very real practical and theoretical limitations, as there is a tendency to emphasize the power of the individual while failing to provide a deeper examination of the power relations within which choices are made. The belief in late modern societies that choice exists for everyone invites the notion that one ought to act responsibly by making the "right" choice. Against this backdrop, choice is not an absolute reality, but is instead a social construct through which we come to understand our actions within the wider context of social relationships. Similarly, Weir (1996) argues that the techniques with which we govern reproduction are part of "practices of freedom within liberal governance" (375). She invites us to engage in an analysis that "displaces investigation from the critique of new reproductive technologies to an exploration of the government of pregnancy and human procreation" (Weir 1996, 375).

Discourses that emphasize the importance of reproductive choice and rights imply that women possess choice and rights as commodities. In this sense, we can calculate what amount of freedom women have and what amount of constraint is present. Calculations like this in the context of reproductive technologies are complicated by the fact that both freedom and constraint are always present in varying degrees. My aim is to instead draw attention to the discourses that construct the pill and what types of relations become possible when it is used by young women. Such an approach draws attention to the productive, rather than repressive nature of devices and technology, and highlights the various relationships involved. Such an approach also situates reproductive technologies within wider sets of social relations and sets of knowledges, allowing for an acknowledgement of subjects as they use technologies in particular ways.

In late modern societies, there is an increased emphasis placed on empowerment, control and autonomy. The “modern” young woman is distinguished from prior generations by her use of the latest technologies to manage reproduction and health. Further, she does so of her own volition, without state intervention. As Granzow (2007) argues, “the same discourse that reveals an assumed direct correlation between control (over the body) and increased choice [and autonomy] (in women’s lives), is in operation today” (47). Yet, there is an ongoing tendency to see the pill as reflecting a woman’s expression of choice. In doing so, we ignore how the pill is constitutive of specific feminine subjects at different times, places and spaces (Cream 1995). When the pill was first released, the majority of users were white middle-class married women (Watkins 1998). Advertisements emphasized that the pill was the ideal accessory for a married woman interested in spacing and limiting pregnancies (Tone 2001). It is important to consider are the subtle changes in how control and choice come into play based on the context and the subject in question. Cream (1995) argues that using the pill has become an accepted and

expected act by a heterosexual woman in western democratic societies. She asserts that taking the pill is one of the most significant ways she asserts her identity as a woman.

In this vein, recent research on the pill has explored how using the pill is connected to gender. Fennell (2011), Campo-Engelstein (2013) and Lowe (2005) examine the ways that expectations for women's and men's roles in contraceptive decision making operate to reinforce existing gender dynamics in developed societies. Kissling (2012) and others have begun to recognize the multiple ways that women use the pill; for example, period suppression. Medley-Rath and Simonds (2010) discuss how web-based contraceptive advertising "promote conventional sex and gender norms, using a scientific discourse" and appropriate feminist ideals of "independence and bodily integrity" (783). While I am sympathetic to their observations, I think it is misleading to imply that the claims of pharmaceutical marketing are somehow a distortion of feminist ideals. The association between bodily autonomy and reproductive choice has been a strong current in feminist philosophy.

Taking a more fluid approach, Malwade Basu (2005) has explored the social construction of "modern" methods of contraception in relation to social class and family planning in India. She challenges the association between the use of "modern" contraceptives and changes in demographic patterns. Also, she found that in contrast to North American society, in India "traditional" family planning methods were "the preserve of the 'elites'" (319) who increasingly value the "natural" and "authentic" body. As she observes:

Magazines and journals today have returned to this tradition of the early twentieth century. All the health and beauty and lifestyle advice they offer is geared to such an Indianized westernization. Traditional methods of birth control fit well into this new paradigm in which a concern for the body is combined with an interest in 'nature' and in the 'authentic' as the body's best friend (Malwade Basu, 2005: 317).

Her research demonstrates the importance of shifting ideals in relation to devices. Malwade Basu does not assume that contraceptive devices have a fixed meaning or outcome. In Canada,

the story of the pill is no longer as strongly attached to women in general, nor is its use always primarily attached to fertility control. The majority of Canadian pill users are young women in their late teens and early twenties (Black et al. 2004). Some young women will start using the pill as young as twelve or thirteen, even before they are sexually active, as a precautionary measure and most will stay on it for upwards of ten years, seeking the benefits of shorter periods and clearer skin (Wilkins et al. 2000).

My research advances knowledge in the study of reproduction and contraception by exploring the many ways that young women use the pill to work on the self, as well as the tensions that emerge from public texts about the pill. As I found in interviews, sometimes women described the pill as negative or having potentially serious implications in their lives. For other women, using the pill was “no big deal” and was expressed using very mundane language. By pulling together young women’s experiences with the pill and situating these experiences within texts from the print news media, pharmaceutical advertising and public health information, my aim is to understand how the pill reflects key changes in the status of young women. Women, and men, can be differentially situated in relation to practices, and construct subjectivities as users of technologies. Women engage with and construct the discourses that situate new reproductive technologies as objects of fear and hope (Bloomfield and Vurdubakis 1995). I would argue similar work is being done by women in the discourses that compel use of the pill. This does not mean that women engage in “free” play in constituting the self (Lee 2014), or that there cannot be varying degrees of freedom and unfreedom (Grosz 1994; Valverde 1996, 1998), but avoids taking for granted agency and choice and problematizes notions of control and autonomy.

## 2.2 Sociological study of girls and “girl culture”

Starting an oral contraceptive is an important decision, and you are encouraged to involve your parents if possible. However, your health care provider does not need your parents' permission to prescribe contraception, providing you understand the potential risks and potential benefits of your decision. Your health care is confidential. Unless there is abuse, or issues related to the criminal code, your interaction with your health care provider is kept private and will not be disclosed to other members of your family (SU11).

*Lisa:* And how was your experience at the McGill clinic?

*Serena:* Actually it was a clinic just north of McGill... when I first went there it was literally a five hour wait, because it was in September and there were a lot of teenage girls. And from what I've heard that's why it's so busy with teenaged girls in September cause it's their first time away from home and they really want to get on the Pill [laughs]. They asked me if I wanted to do a vaginal exam, but I wasn't ready for that. I had never had one, so he gave me two months worth and then said, "If you come back, we need to do one if you want a full prescription". So yeah, it was a long wait and it was kind of uncomfortable. It was the first time I had ever been asked by a grown man, like, "Are you in a monogamous relationship? Do you pull out..." It was uncomfortable... but that's part of the process I guess.

As Driscoll (2002) observes, the term “girl” does not refer to a particular age, but rather refers to a type of female subjectivity, the form of which is constructed and demarcated by a given society (4). In most twenty-first-century western cultures, “girl” refers to a stage in a woman’s life when she is “immature and malleable” and in the process of becoming a woman (Driscoll 2002, 4). As I have mentioned previously, in this thesis, I draw on a more specific cultural usage of the term “girl” to refer to feminine adolescence and early adulthood. Driscoll (2002) identifies young women or girls as a sub-category of “girl culture” more generally. In the context of young women, “girl culture” does not necessarily refer to pre-teen or tween phenomena, although it shares similar characteristics. Unlike tweens and pre-teens, there is an expectation for sexual exploration, but unlike adult women, there is an expectation that long-term commitments and children will be put off until later (Baker 2009). Further, standards that guide the ethical conduct of young women refer to and draw on feminist ideals such as choice, control and empowerment (Smith, *forthcoming*). But as Curtis & Hunt (2007) observe there still remains a “generalized anxiety about the sexual comportment of adolescents” and young women in particular. Taking the pill is an activity associated with problems facing young women, as opposed to women more

generally. Taking the pill involves the negotiation of particular types of relationships, such as between daughters and parents, and doctors and young female patients.

Use of the pill by young women has been supported by relaxed sexual mores (Baker 2008), as well as rising concerns over the sexual health of young people. Fifty years ago this concern might have prompted state programs compelling parents to regulate their children's behaviour. Significant advancements in knowledge in the health sciences and the development of pharmaceuticals, like the pill, have meant that the response to sexual health problems is increasingly found in the use of pharmaceutical technologies on behalf of the individual adolescent (Alderman 2003). In light of these changes, it is not surprising that pharmaceutical companies marketing the pill have shifted their focus to a much younger demographic and emphasize the pill's status as a multi-use lifestyle drug. While there are remnants of the discourse of choice which were present when the pill was first released, there are significant differences which reflect the unique status of young women within modern liberal states.

Contemporary understandings of girls, girlhood and use of the pill are situated within the wider context of neo-liberalism, empowerment, and healthism. Late modern societies are characterized by an intensification of individualization, meaning there is an increased emphasis on individual, as opposed to state-based, responsibility for health and welfare (Beck 1992). The new emphasis placed on the individual has led to significant changes in the ways in which young women are regulated. As Harris (2004) observes:

In the modern period of the late nineteenth century, youth were disciplined directly by the state and its agents so that they would develop slowly, under close supervision, to serve a unified and progressive nation. Later modern times, however, are characterized by dislocation, flux, and globalization, and demand citizens who are flexible and self-realizing ... Direct intervention and guidance by institutions have replaced by self-governance; power has devolved onto individuals to regulate themselves through the right choices. The social and economic logic of late modernity compels people to become self-inventing and responsible citizens who can manage their own development and adapt to change without relying on the state (3).

The ideal neo-liberal young female subject is characterized by her heightened sense of individual autonomy. She pursues her freedom and autonomy by consulting various experts in order to maximize her health, wealth, and happiness.

The heightened expectation for individual responsibility for all manner of social problems is exemplified in calls for empowerment. Dispossessed groups and problematic populations are no longer segregated for direct disciplinary action, but are increasingly subject to policies which seek to empower them to change their lives. Empowerment refers to the need for an individual to discover her true essence and express she is an individual through her choices. Yet, as Cruikshank (1993) observes, despite seeming to be an intensely personal process, being empowered “is no longer a personal or private goal as taking up the goal of self-esteem is something we owe society, something that will defray the costs of social problems” (328). Both women and girls are encouraged to make choices which will express their individuality and lead to a sense of empowerment, which is increasingly related to the consumer decisions they make (Gill 2008). While in the past beauty routines were paramount, increasingly, a woman’s relative empowerment is measured by her capacity to seek out the appropriate expert advice and technologies to manage her short and long-term health (Lupton, 1995).

But these social trends are equally shaped by the unique status of young women in late modern societies. Over the past fifty years, youth have emerged as an integral population in constructing the future. However, according to Harris (2004), “it is young women, rather than youth in general, who are now the subjects of this scrutiny and regulation” (2). During this period, the presence of girls in the media and popular culture has increased exponentially (Driscoll 2002; Gonick, 2006; Mazzarella & Pecora 2007; McRobbie 2000; Zaslow 2009). The manner in which a young woman becomes a woman has become an issue of public interest.

New discourses have emerged from diverse fields, from psychology and health sciences to popular culture, all of which attempt to guide a young woman's conduct in relation to her self during this period of transition. These discourses represent "girls" or young women as "one of the stakes upon which the future depends" (McRobbie 2000, 4). Harris (2004) argues that young women have emerged as the "vanguard of new subjectivity ... Power, opportunities, and success are all modeled by the "future girl" — a kind of young woman celebrated for her "desire, determination and confidence to take charge of her life, seize chances, and achieve her goals" (1). As young women become responsible for the future, they are celebrated, but they are equally governed and regulated by expectations placed on their behaviour.

There is a tension at the heart of the discursive formation that produces discourses about girls and girlhood in late modern societies as exemplified by discourses of "girl power". "Girl power" has emerged as one of the most important phrases in making sense of young female identity in late modern society. "Girl power" represents a new form of female subjectivity: assertive, dynamic, and unbound from the constraints of passive femininity. The phrase "girl power" was first popularized in the 1990s by Riot Grrrl bands, such as Bikini Kill. "These bands challenged the sexism and racism of punk rock, expressing a general desire to make things better for girls" (Currie et al. 2009, 7). For these bands, "girl power" was for women who were either teens or in their early twenties. Gonick (2006) observes that, "Girl Power celebrates the fierce and aggressive potential of girls as well as the reconstitution of girl culture as a positive force embracing self-expression through fashion, attitude, and a Do-It-Yourself (DIY) approach to cultural production" (6).

In spite of its counter-culture roots and even though the initial "girl power" movement was intensely anti-consumerist, the message of "girl power" was quickly picked up within

mainstream culture in order to market products to young women. The message behind “girl power” was picked up by more mainstream music groups, most notably the Spice Girls, and it has echoed throughout numerous television programs, such as Buffy the Vampire Slayer and Sabrina the Teenage Witch. Today, a variety of consumer campaigns promote diverse products from t-shirts to lipstick as empowering young women (Gill 2008).

While it might seem that “girl power” is one-dimensional, Currie et al. (2009) point out that “‘girl power’ is a discursive field within which competing meanings associated with ‘being a girl’ are made available within popular culture” (15). The emergence of “girl power” cannot be separated from a series of opposing discourses that construct young women as weak, vulnerable and in need of special care and guidance (Gonick 2006; Harris 2004). Gonick (2006) characterizes this counter-trend as “Reviving Ophelia”, which refers to a popular psychology book published in the 1990s. This more fragile incarnation of the modern girl “is a sign of disordered development and [is] a threat to the new social order” (Gonick 2006, 15). Similarly, Harris (2004) identifies the “at-risk” girl. In both cases, young women are portrayed as harbouring chaotic emotions, engaging in out-of-control behaviours, and making inappropriate consumption choices. Thus, while “girl power” portrays young women as potentially strong and powerful feminine subjects, girls who embody “Reviving Ophelia” or “at-risk” girls are compromised by their in-between status and are characterized by disordered development. Because young women are constantly represented as teetering on the edge of becoming unstable, they are often identified as an “at risk” or “high risk” population in need of guidance, intervention and regulation to prevent them from becoming disordered (Mazzarella & Pecora 2007).

In this way, the discourses that construct young women as *powerful* and autonomous, such as “girl power”, and the discourses that construct young women as *powerless*, problematic and dependent, reflect the complex positioning of young women as subjects in late modern society. Under neo-liberalism, “success and failure are constructed as though they were dependent on strategic effort and good personal choices” (Harris 2004, 32). Yet the belief in individual choice and responsibility obscures the economic, social and cultural factors that structure the options before a young woman.

The tendency within girl studies has been to examine the emergence of “girl power” within psychology, the consumption of clothing and beauty products, and within the television, film and music industries. Far less attention has been paid to the deployment of discourses of “girl power” within the domain of sexual health and the use of pharmaceutical technologies. As a device which regulates multiple aspects of the body and emotions, and which is used by a large number of young women, the pill is an incredibly important device to consider when seeking to understand the production of discourses about “girls” and “girl culture”.

Adolescents and young women today are distinguished from fifty years ago by an expectation of sexual exploration, as opposed to avoidance, and the introduction of the management of short and long-term health strategies with this in mind (Driscoll 2002, 4). A good example of the demarcation between pre-teens and young women is the popular HBO series *Girls*. The show follows a group of twenty-year olds living in New York City as they fumble through life in random jobs, countering conflicts with friends and engaging in sexual misadventures. The show has explicit sexual content and discusses health, contraception, and sexually transmitted diseases on a regular basis. Another distinguishing characteristic of young women as opposed to girls more generally, is that they are identified as incapable of fully

exercising idealized representations of liberty or individual agency, nor is this really the end goal for the moment (Gonick 2006). A young woman must conduct herself in such a way that recognizes the nature of the work being done as formative, not necessarily, definitive. As I will discuss in Chapter 6, girls are works-in-progress or free subjects in the making. Many of the young women I interviewed described the pill as generally incompatible with ideals of freedom and bodily control, yet it was acceptable for the moment. They also often remarked that later, in their thirties, absolute control might not be as valuable, and thus the dangers of the pill might outweigh the benefits.

I have examined in previous work the way that pharmaceutical advertising for the pill is directed at young women, as opposed to women more generally; drawing on discourses of “girl power”, pharmaceutical advertisements associate taking the pill with empowerment, autonomy, and self-realization (Smith 2014). This shift should be in no way be taken as uniform; indeed there are many groups within Canada that oppose access to contraception for young people and encourage abstinence as a means to avoid pregnancy. The particular formulation of girlhood discussed in this thesis should be understood as one of many competing discourses that aim to guide the conduct of young women. Nevertheless, there are few instances where young women under the age of twenty-five are actively encouraged to get pregnant. The pill can thus be understood as a relatively common way of managing the issue of pregnancy for young women.

### **2.3 Pharmaceutical technologies**

*Lisa:* Est-ce que tu vois la pilule comme un médicament?

*Camille:* Eh... c'est une bonne question. C'est sûr que c'est un médicament, parce que c'est quand-même des produits là. Moi, je dirais comme un médicament, mais c'est pas dans la même catégorie que les médicaments prescrits met-on anti-dépresseur ou j'sais pas trop quoi. Une catégorie à part.

While the pill is an effective method of birth control, it has many other benefits that you may not be aware of. Users of birth control pills have less menstrual blood loss and more regular cycles. There may be a decrease in painful menstruation and premenstrual syndrome symptoms. The Pill can also reduce the likelihood of developing ovarian cysts, endometrial cancer, ovarian cancer and benign breast disease (Alesse 2009).

Unlike condoms or diaphragms, which arguably have limited uses, individuals can and will use pharmaceuticals, like the pill, to achieve other ends beyond their primary intended function (Fox & Ward 2008). In fact, the pill has long been identified as one of the first lifestyle drugs – meaning it is used to treat conditions that lie at the margins of health and illness (Flower 2004). Pharmaceutical companies have long touted the benefits of using the pill to dissuade concerns over continual use in the absence of an identified illness (May 2010; Tone 2001, 2007; Watkins 1998). The concept lifestyle drug refers to a pharmaceutical which is used to enhance quality of life as opposed to treating a particular medical condition (Fox & Ward 2008, 857). The changing characteristics of users and usage of the pill have resulted in companionate shifts in how it is being sold as a cultural commodity by pharmaceutical companies. As the above quote from the Alesse website emphasizes, the pill is now marketed as a multi-purpose accessory for a young woman.

Most academic scholarship on the pill continues to treat the pill as a woman's contraceptive device (Granzow 2007; Ruhl 2002), no doubt recognizing the important historical connections to the development of the pill and feminist philosophy and activism for reproductive rights (May 2010; Tone 2001; Watkins 1998). Yet, as I have already mentioned, in most western countries, the pill has come to be primarily associated with young women. Wide-spread use of the pill by adolescent girls has been supported by relaxed social mores around adolescent sexuality (Baker 2008) and it is now commonly assumed that young people will engage in casual sexual relationships. The regulation of this behaviour by pharmaceuticals has been further supported by an emerging interest and available knowledges produced within the health sciences and pharmaceutical industry relating to puberty and adolescent health. Over the past twenty years, adolescents are increasingly expected to take an active interest in managing their health

and wellness (Alderman 2003). The current social formation of the pill is part of these trends, but it also has effects that are specific to young female subjectivity.

The rise of “healthism” and the growing prominence of pharmaceutical solutions to everyday “problems” have led to what Fox & Ward (2008) call the “pharmaceuticalisation of everyday life”. Pharmaceutical advertising increasingly situates the consumption of pharmaceuticals as the act of a responsible individual, who is interested in personally identifying and caring for her body (Fishman 2004; Fox & Ward 2008). Against this backdrop, pharmaceutical marketing has become a “de facto arm of large-scale public health projects, working together with the government and the medical industry to manage and organize targeted populations” (Connell & Hunt 2010, 73). In this context, empowerment is linked to the individual’s capacity to identify and seek out the appropriate pharmaceutical given her particular set of “problems”.

Increasingly, what certain pharmaceuticals do is as important as their symbolic status as consumable commodities bought as accessories to one’s life. As such, the consumption of pharmaceuticals is linked to an active project carried out by individuals as they care for and identify the needs of their bodies (Fox & Ward 2008; Fishman 2004). As Casper & Carpenter (2008) observe in relation to the vaccine for genital warts (human papilloma virus or HPV), culture and politics are always at issue in pharmaceutical technologies, but particularly so when “sexual and reproductive health” are at play (887). Similarly, Loe (2006) in her examination of Viagra has argued that the use of gendered medical technologies shapes social relations, “...both exposing politics of gender and sexuality and transforming practices” (3). Similarly my research will examine the various knowledges that circulate within the discursive formation that produces

discourses about the pill. I will the ways that discourses produce certain truths about modern young women as ethical subjects as they use a pharmaceutical technology.

## **2.4 Conclusion**

As I discussed at the outset of this chapter, the pinkness of the pill establishes it as a product uniquely produced for girls. The pinkness of the pill also emphasizes the extent to which women's relationship more generally to reproductive technologies that involves multiple cultural and social overlays that bear examination. In this chapter I have situated this thesis within existing scholarship on the regulation of reproduction, paying particular attention to recent sociological analyses of contraception and the pill. As I discussed existing scholarship highlights the importance of the regulation of reproduction in shaping contemporary forms of female subjectivity. However, the pill is increasingly a technology associated with young women, not women more generally. Second, I examined existing literature on the sociological study of girls and "girl culture." This thesis aims to build on the sociological study of girls and "girl culture" by exploring the way that the pill is used by young women to constitute the self.

Finally, I discussed literature relating to the sociological study of pharmaceutical technologies. The pill is a multi-purpose lifestyle drug that can and is used by young women in a variety of ways. It is also a gendered medical technology that is associated with particular problems relating to young women as ethical subjects. In the next chapter I will provide an in-depth consideration of the historical literature on contraception and the pill, and begin presenting the analysis.

### 3 The past of the pill in the present

Bonne fête pilule! Cinquante ans. Voilà un demi-siècle que les femmes ont la maîtrise de leurs corps, de leur sexualité, leur procréation. Un demi-siècle qu'elles ne vivent plus chaque mois dans l'angoisse de ne pas avoir leurs règles (LP22).

*Lisa:* What do you think the pill has meant for women more generally?

*Valerie:* Well I think what little I know about it, like the ability to make a choice for yourself. I don't know if you watch *Mad Men* ... but there's an episode where she goes to the doctor to get the pill and she has to pretend she's married. So the fact that she could make that decision and didn't have to be afraid to have sex. But I mean she didn't know what it was... so I guess it wasn't really a choice. And it's also tricky because it's one more thing as women we're supposed to do, you know. I thought about that just this morning, my boyfriend was getting ready for work. And I was in the bathroom at the same time and I opened my side of the cupboard... there's deodorant, eye cream, makeup... and he's like brush my teeth, comb my hair, leave the house. And I was like... oh my god, like I think I do it for myself, but there's also a certain degree of things that are presented to you, so it can also fall into the category of coercion.

As Tone & Watkins (2007) note, what a pharmaceutical can do to the body is as important as the social and cultural meaning ascribed to it; for example, we can look to how the emergence of antibiotics contributed to a widespread faith in the possibilities of laboratory science (2) or, more recently, to Viagra in redefining sex (Loe 2006). During the course of my research I found that the history of the pill was a recurring theme in public communications, but also in interview data. The aim of this chapter is to make sense of the centrality of history in social constructions of the pill and to think about the implications of these historical “truths”. The print news media and young women discussed the ways that women's lives have changed since the pill. In doing so, both participants and newspapers are involved in debating contemporary parameters for constituting the self as a free subject and the ways that the pill is a part of this.

In this first analysis chapter, I situate this thesis within scholarship on histories of the pill and contraception more generally, recognizing that the construction of the past also occurs in more public spaces. Historical themes in the interview data and the print news media are identified for how they contribute to wider discursive formations that highlight ongoing tensions surrounding women's freedom as subjects. The three formations I identified are as follows: 1) “Women, liberation and the pill”, where a historical narrative of women's liberation is used to

make sense of ongoing tensions surrounding liberal ideals of autonomy and freedom; 2) “A dangerous necessity”, where historical references are used to negate and minimize the risks of the pill in the present; and, 3) “Imagining the future”, where a narrative of progress through technological innovation shapes the perception of the future of contraceptive devices.

Taking account of history and subjectivity is consistent with narrative approaches to research that highlight the importance of public and shared stories. It also adds to feminist considerations of social location, by highlighting the ways that contemporary subjects situate themselves within common historical struggles, such as the battle for women’s reproductive choice and freedom. The young women I interviewed drew on history as a powerful reference point in situating their own conduct as ethical and distinguished themselves from women in the past. As I will demonstrate, the history of the pill is a particularly salient reference point used by the print news media and young women for making sense of ongoing tensions and conflicts surrounding the regulation of reproduction and women’s health more generally and thus is a key component in the formation of the self. In this sense, perceptions of history are not confined to the past, but are directly implicated in the present and perhaps more importantly, shape what is perceived to be possible in the future.

### **3.1 Histories of the pill**

There are many well-researched and well-written histories of contraception and abortion in western societies (Fisher 2006; Himes 1970; Gordon 2002, 1990; Jutte 2008; McLaren 1990; Riddle 1997, 1994; Tone 1997). More specific historical accounts have examined changing dynamics in gendered expectations for contraceptive responsibility (Cook 2004; Fisher 2000a; Fisher & Szreter 2003) and challenged the belief that new contraceptives led to wide-spread use of birth control (Fisher 2000b). Historians have also noted the ways that the management of

contraception and abortion have been impacted by the rise of pharmaceutical companies and a consumption based economy (Tone 2002) and the formation of global manufacturing and production chains to produce pharmaceutical products (Laveaga 2009). Historians of contraception and abortion in Canada and Quebec have highlighted changes to intimate relationships and family forms and shifting government and institutional regulations of sexuality and health (Gauvreau et al. 2007; McLaren & McLaren 1986).

In conducting a global history of contraception and abortion in the west, McLaren (1990) defines a contraceptive device as an object used to control fertility. As he observes, contraceptive devices reflect a particular society's "reproductive ideology", or the value system that supports given beliefs about the control of fertility (McLaren 1990, 23). What is defined as the "best" contraceptive is a social construction and as such is constantly changing based on how it is embedded within accepted bodily modalities and established gender roles in intimate relationships (Fisher 2006). Canadian historians highlight that contraception (and abortion) is a key means through which women's bodies have been policed and regulated by the state, but equally an issue that has mobilized women in redefining and reshaping the political terrain (Sangster 2001, 2002), particularly during the twentieth century (Sethna 2000; Stettner 2012). Sethna (2006) has also examined the developments that led to the Birth Control Handbook in Montreal during the 1960s. She argues that the handbook was a key feminist self-empowerment text within the Quebec context during the 1960s and 1970s. In my research, I did not place an emphasis on participants perception of history. History was a secondary focal point. No one brought up the particular context of reproductive issues within Montreal, or even Quebec more generally. Some participants did mention the Catholic Church more generally in relation to contraceptive politics. However, I found that differences in terms of place and politics were

more likely to be brought up within the news media. In general, interviewees were more concerned with barriers to access that they had personally experienced, as opposed to global issues facing women.

There are also several historical accounts of the pill specifically (Asbell 1995; May 2010; Watkins 1998) that explore the scientific, social, and economic factors that led to its development. These authors emphasize the complicated process that brought the pill to the market for public consumption. Generally, the pill is identified as a significant, but not necessarily determining factor in shaping contemporary sexual relations and the condition of women. More localized histories have examined women's varied capacities to gain access to the pill on university campuses in the United States (Bailey 1997) and Canada (Sethna 2005). Historical accounts have been helpful for highlighting how the pill is constitutive of specific feminine subjects at different times, places and spaces (Cream 1995). For example, when the pill was first released, the majority of users were white middle-class married women (Watkins 1998). Advertisements emphasized that the pill was the ideal accessory for a married woman interested in spacing and limiting pregnancies. In contrast, for young or single women, getting access to the pill proved more difficult and required finding a doctor who was sympathetic and willing to bend the rules (Waktins 1998; Tone 2002). Generally speaking, historians have acknowledged that there is no one history of the pill, but rather many histories. Histories of the pill are connected to social and cultural definitions of the status of women and men more generally, as well as the economic and political context within which individuals make decisions about how to regulate the body and self.

### 3.2 Public history of the pill

In *America and the Pill: A History of Promise, Peril and Liberation*, May (2010) recognizes that the pill is as much a marvel of scientific innovation, as it is a cultural icon relating to the status of women more generally. Her book discusses and makes reference to the representation of the pill in popular culture, such as songs and marketing. Similarly, Watkins (1998) and Asbell (1995) note that the pill is a public object that is part of our collective memory. However, as I will explore the public history of the pill is generally far more one-dimensional than the histories offered by historians.

The increasing tendency to include insights from cultural studies and post-structuralism within historical scholarship has disrupted straightforward accounts of the past, by calling into question the existence of “objective realities” that are uncovered by historians (Dirks et al. 1994, 6). In seeking to understand memory as a social and political activity, historians have drawn our attention to the invented nature of “traditions” and the ways that “ideas about history change over time” (Hobsbawm & Ranger 1983, 1). Further, through studying “collective memory”—which refers to a set of shared historical narratives of a given culture or society (Halbwachs 1992, 80)—we see that history is actively produced, contested and debated in public spaces on an ongoing basis. As Bodnar (1992) argues, “The shaping of a past worthy of public commemoration in the present is contested and involves a struggle for supremacy between advocates of various political ideas and sentiments” (13).

In studying the way we collectively remember key events, places and people, historians seek to understand “how various versions of the past are communicated in society through a multiplicity of institutions and media, including school, government ceremonies, popular amusements, art and literature, stories told by families and friends, and landscape features designated as historical either by government or popular practice” (Glassberg 1996, 9). In

representing history, “[p]opular culture tends to repeatedly return to certain events and images, making particular parts of history familiar and vivid, while rendering others distant or unknown” (Morris-Suzuki 2005, 17). Historical scholarship on memory highlights that the past is shaped in different types of spaces in different ways.

In the print news media, historical representations “circulate in public on a wider scale” (Cannandine 2007) and are intended for consumption by a mass audience. Representations of history in the print news media are highly selective in several ways. First, in writing an article an author is limited in terms of space. Second, stories are selected for their entertainment value and seek to appeal to the reader (Kitch 2005, 2). Further, even though an author will most likely draw on or refer to prominent historians as “experts”, the insight of the historian is generally characterized as one part of the overall narrative of the article. History is also present in everyday talk between individuals where the past is represented on a micro-level (Glassberg 1996, 9). In this case, personal accounts of the past are not necessarily interesting because they are historically accurate, but because they are part of the way individuals constitute the self. Shaping ethical conduct can involve positive expressions of what we might seek to amplify—conduct that increases freedom, as well as negative expression of types of conduct we find undesirable—conduct that constrains freedom. In this sense, public history can be conceptualized as an active space where ethical dilemmas from the past are brought up as a way of clarifying current tensions.

### **3.3 Women, liberation and the pill**

Cinquante ans plus tard, la Dre Louise Charbonneau se souvient de l’aura de suspicion qui entourait la pilule à ses débuts. Mais dans les années 1960, après un premier enfant, elle n’hésite pas un instant lorsque son médecin lui tend une plaquette en lui demandant: «Voulez-vous compléter votre spécialité?» «Ç’a été une libération, raconte celle qui pratique aujourd’hui à la clinique des jeunes du CLSC des Faubourgs. Je n’ai jamais oublié de la prendre. Enfin, j’avais le contrôle sur mon corps et sur ma vie.» (LD2).

One of the most obvious instances of historical accounts in the news media were articles commemorating the pill. The above quote from a *Le Devoir* article underlined the fiftieth anniversary of the approval of the pill by the United States Food and Drug Administration. All three newspapers had at least one article celebrating this anniversary, and *La Presse* had a full-page spread with several different articles. While these articles tended to represent multiple viewpoints and highlight the contested nature of the pill, women's liberation through the pill was a recurring theme.

The reader is reminded that the uncontrolled nature of a woman's reproductive system was a significant barrier to her freedom. One of the heroines in this narrative is the housewife with five plus children trapped in the home because of her fecundity. She had little or no access to reliable contraception, which was illegal and banned under the doctrine of the Catholic Church. Under these circumstances gaining access to a woman-centred reliable contraceptive is equated with freedom. An example of this narrative comes from an article published in *The Globe and Mail* entitled "The Triumph of the Pill".

The idea that a woman's place was in the home sounds unbearably quaint now, but it passed for inescapable logic. Domestic fundamentalism rested on the belief that pregnancy was ultimately unpredictable and inevitable, and therefore should be desirable (GM25).

In general, all three newspapers recounted a "Canadian" national narrative with little attention to differences between provinces. *La Presse* and *Le Devoir* did recognize the unique characteristics of the situation in Quebec in terms of breaking with the Catholic Church.

«Au début, l'Église laisse planer une doute. Le pape ne prend pas de position ferme jusqu'en 1968. Là, c'est clair, c'est interdit!» dit Denyse Baillargeon. La cassure survient. «Le refus d'entériner la pilule, c'est le dernier clou dans le cercueil» de l'Église catholique, juge-t-elle (LD2).

Historians have shown that there were significant differences in how the pill was taken up by different populations in different locations. It was not embraced equally by all women (McLaren & McLaren, 1986). Even today, use of the pill by women is dependent on many factors, such as

income, level of education, and ethnic background (Black et al., 2004). While it is still a popular method it is not the only method used by women.

A recurring heroine across all anniversary articles was Margaret Sanger, sometimes with her accomplice Katherine McCormick. News articles in all three papers recounted the details of Sanger's personal life history which motivated her passionate commitment to improve the situation of women by finding a reliable and woman-centred contraceptive device. There was a tendency to emphasize the role played by individuals motivated by a social vision to improve the status of women and to downplay or ignore the role played by actors with a profit motive, like pharmaceutical companies. Most articles noted that the Canadian government was slower to approve the pill and legalize contraception compared to the American government.

In constructing these commemorative accounts, authors drew on various "experts", such as doctors, scientists and historians to highlight the diversity of opinions on the meaning of the pill for women and society. Christabelle Sethna and Elizabeth Tyler May were interviewed for *The Globe and Mail* piece and Denyse Baillargeon for both *Le Devoir* and *La Presse*.

"After 50 years of the Pill, we're still wrestling with the idea of what it means," says Christabelle Sethna, a professor of women's studies at the University of Ottawa. "Whatever people said at the time, it's taken decades to understand the Pill's effects medically, culturally and politically." Indeed, the Pill ended up hastening modernity almost in spite of the early, extravagant claims made for and against it. "The biggest mistake in the early days was to see the Pill as a magic bullet," Prof. Sethna says. "It was supposed to do all these amazing things - mend unhappy marriages, make sex lives more satisfying, eliminate the need for abortion, eradicate global poverty, stave off communism and solve the population crisis. Those beliefs now seem funny and even poignant."  
(GM25)

In this instance, a historian is drawn on to demonstrate the complicated nature of the pill in relation to women's freedom. Yet, Sethna's narrative is contrasted with the accounts of doctors who highlight the ongoing importance of the pill in women's lives. This type of back and forth between various experts is typical of journalism. A historian's view is presented as one of many

opinions. The conclusion of the article reinforces the title, the “Triumph of the pill,” and situates women’s freedom as bound up with the pill.

And yet after 50 years, it’s hard to dispute the Pill’s place in the annals of reproduction: It’s outlasted and outdistanced its cumbersome rivals, made the leap from utopian and dangerous to everyday and normal, offered easy liberation in a convenient oral format and fended off all its critics, as if they were the exception and it had become the rule (GM25).

In spite of highlighting various struggles and difficulties, the general conclusion is that women in the past were limited and had no choice—in short women were *unfree* and powerless. In contrast, after the pill, a terrain was opened up where women had options for the first time—in short women became free and powerful. In this sense, the print news media presents the issue of freedom as resolved.

The association between women’s freedom and the pill in history was also very present in interview data. In interviews I asked participants directly about what they thought of the role of the pill in women’s lives. The young women I interviewed did not generally discuss particular events as important. However, the 1950s and 1960s were identified as periods of momentous change in the lives of women. Below Alicia, discusses her view of what the pill has meant for women.

*Alicia:* I think it’s helped them get more sense of power over their bodies. I think things have changed a lot since the 50s, the role of women and their career and stuff. It’s meant control of their lives and not being controlled by their husbands. I think the pill has kind of helped in that sense, they can decide when they want to... they can control their bodies and when they want to have children without having to depend on a man. I feel like it’s empowerment for women.

In interviews, I found that participants tended to link the pill to a broader set of social changes that were accepted as part of recent history, such as the women’s movement and the fertility decline. Below, Evelyne, notes that the pill represented a dramatic shift in how women related to procreation.

*Lisa:* Qu’est-ce que tu penses la pilule représente pour les femmes?

*Evelyne:* Ben, j’imagine que c’est une forme de liberté. Avant la pilule, c’était tant-pis t’as un enfant, mais je généralise. Peut-être... met-on, on parle d’une autre époque là, mais c’est on faisait l’amour pour avoir les enfants. Pis, le fait qu’une femme puisse prendre la pilule et dire, mais j’ai

pas présentement envie des enfants, j'ai envie genre... d'avoir le plaisir, mais c'était pas pour tomber enceinte. Je trouve que c'est bien.

A recurring theme in participants' views of the past was a perception that before the pill women had very large families and that they had no choice in how many children they would have.

Below, Christie describes her perception of women in the past.

*Lisa:* What do you think the pill has meant for women?

*Christie:* Hmm.. that's a nice question. I think it just gives women a chance, to have the life that they want and to be more in control of their life, and their paths, and their partners and not to be stuck. Cause before the pill they had like nineteen and twenty kids and all that. It was a completely different era too, but I find it's more for people, they can take charge and all that.

Equally, young women saw themselves as privileged in comparison to previous generations. As Anna explains below, the pill was “huge” for women.

*Lisa:* What do you think the pill has meant for women more generally?

*Anna:* Oh my gosh, I think it's huge! I can't imagine... I mean even my Grandmother taking the pill when she did, and it was so, it was just a bottle and she had to count it out. And my other Grandmother, we were just asking my Grandma if she and my Granddad had kids before she moved to Canada and my Grandma went into too much detail!! But she was like, "Well there was that time on the boat and things were different. We didn't have the pill, the pill wasn't an option". But even if it was there she didn't think of it as an option and I think that's huge.

The young women I interviewed drew on ideas about the past in making sense of their own experience. Even though participants recognized that the pill did not have a clear meaning, they situated it within a set of broader social changes that led to the freedom they (as women) enjoyed today.

Historians have observed that almost as soon as it was available, the pill was picked up by women as an icon of the feminist movement and became inseparable in the public imagination from key changes in the situation of women in society more generally (May 2010). To some extent, this explains why the pill and the liberation of women remain intimately connected in popular understandings of the history of the pill. As Granzow (2007) observes,

The same discourses used in the campaign for the invention and introduction of The Pill, and the same discourse that reveals an assumed direct correlation between control (over the body) and increased choice (in women's lives), is in operation today (47).

As Ruhl (2002) notes, "Underlying contemporary discussions of both population control and (self-) control over conception and birth lies the concept of the willed pregnancy. ... Women, especially, recognize that they cannot take control of their lives without first taking control of their fertility" (643). Collective expressions of liberation from the past are reflected against increasing demands for individuality in the present, particularly through women's consumption patterns and use of available medical technologies as a way of organizing conduct. In this sense, in forming the self as an ethical subject young women draw on and refer to ideas about the past, but also exclude others from narratives of liberation through omission.

In celebrating the history of the pill, both news articles and participants tended to ignore that the woman who has choice is a particular type of woman. She is young, single, middle-

class, educated and North-American. She exercises a particular type of freedom--liberation through use of the pill. In studying what makes of a discursive formation, Fine (1988) and Hall (1997) encourage us to look for what is given little attention, missing or left out. Absent and shadow characters throw into relief the way in which the freedom of women is demarcated. An example of a group excluded from the history of the pill in popular accounts is Puerto Rican women on whom the pill was tested. In a health editorial published in *La Presse*, the author writes: "C'est auprès des femmes portoricaines que la première pilule a d'abord été testée" (Galipeau 2008). The portrayal of Puerto Rican women as a step in the development of the pill leading to its access by the real intended users--North American women, diverts attention from the colonial and global history of the pill. Further, excluding the experience of Puerto Rican women situates the pill within North American women's history as opposed to emphasizing differences between women's experiences in different geographical locations as equally relevant reflections of the history of the pill. What I found surprising was that the lack of diversity was even more marked in interview data. Participants rarely referred to differences among women. Historians have often pointed out that the pill has not resulted in liberation for all women, but rather for a select group of privileged individuals. Yet, the complexities of this narrative disappear in a more general celebration of the pill as a turning point with generally positive outcomes for women, with some setbacks along the way.

### **3.4 A dangerous necessity**

Health Canada has asked drug giant Bayer to change the labels on two popular brands of birth control pills after it concluded use of the medications is linked to higher rates of blood clots than seen with older brands of the pill (GM20).

In commemorative news articles, the history of the pill was a focal point. In articles documenting the latest benefits or risks of the pill, history was not central, but rather a more subtle presence called upon for clarification of present day events. Articles frequently referred to

“older” versions of the pill, as in the above article, and contrasted previous outdated “high-dose” formulations with newer and more modern “low-dose” versions. The ongoing dangers of the pill were a troubling shadow discourse that in many ways disrupted the narrative of women and liberation. Within this discursive formation, the body is not so easily controlled and technologies are still in many ways unpredictable. Technological innovation is a mixed bag of pros and cons which a woman is expected to calculate carefully as she navigates the many possibilities out there.

In this context, the journalist emerges as a heroine exposing the latest health-risks. As I explored in the literature review, Barbara Seaman’s book, *The Doctors’ Case Against the Pill*, exposed the health-risks of the pill and was pivotal in launching the Senate-inquiry which led to the inclusion of informational pamphlets with pill packets. Similarly, today, in Canada, news articles about the pill were often aiming to inform readers of the latest health risks. Some articles documented more mundane risks, such as weight loss, not attracting the right male partner, while others discussed more serious side-effects, such as gall bladder failure, cancer, and blood clots leading to death. As I will explore in Chapter 6, during the time I was collecting data there were several health scares relating to Yaz, Yasmin and Diane-50. In articles discussing health concerns authors did not mention that there have been many similar cases over the past fifty years, instead the past was drawn on to minimize the “risks” of the pill in the present. Here, the author, a doctor, writes about how the pill a woman takes today is not her “mother’s pill.”

It is important to consider several factors when considering risk. Most important is the fact that the birth control pill you take today is not the same as the one your mother may have taken. The dose of female sex steroids present in today’s birth control pill is much lower than that in the pill of the 1960s and 70s. This means that modern preparations are less risky (GM7).

A consideration of the pill’s use across generations, or comparing women from different generations was also a common theme in the print news media. The article “3 Femmes, 3

Pilules, 6 Vérités sur la pilule” published in *La Presse* discusses use of the pill by three women of different ages showing how far women and the pill have come.

Aujourd’hui, on la prend quotidiennement. Machinalement. Mais il n’en a pas toujours été ainsi. Loin de là. L’histoire de la pilule, c’est aussi l’histoire d’un combat. Un combat pour gagner la liberté de sa sexualité. Trois femmes, issues de trois générations, racontent leur expérience. Récit d’une petite pilule qui a fait bien du chemin (LP23).

Another health-editorial published in *La Presse* documents the ways in which the different “generations” of the pill have changed over time.

Les pilules de quatrième génération sont les dernières à avoir fait leur apparition. Le progestatif le plus utilisé est la drospirénone employée par les laboratoires Bayer, Effik et Biogaran (Servier). Les spécialités les plus connues sont Jasmine et Yaz. Leurs effets secondaires sont globalement les mêmes que ceux des pilules de troisième génération. Dans cette catégorie, on trouve aussi le chlormadinone (Grunenthal), le diénogest (Bayer) et le nomégestrol (Laboratoires Théramex (Teva). Mais contrairement à ce qu’on pourrait imaginer, ce n’est pas la pilule, mais bien la grossesse qui entraîne le plus grand risque de thrombose veineuse, soit 6 cas pour 10 000 femmes enceintes contre 4 cas pour 10 000 femmes utilisant des contraceptifs de 3e ou 4e génération, et 2 cas pour 10 000 utilisant des contraceptifs de 2e génération, comme le rappelle l’ANSM (LP5).

As the author recounts, the new pills are significantly less dangerous than those of the past.

Situating the pill within the history of women in this way dilutes present-day side-effects, and also reinforces its status as the privileged contraception of the “modern” day woman. Taking the pill is a form of conduct we have come to expect of women.

The young women I interviewed also distinguished the pill they were using from that of previous generations of women. Participants often situated their own use of the pill within the experiences of close relatives, such as mothers and grandparents. Negative experiences were often attributed to the fact that “back in the 1960s” the pill was much stronger. As Kim

Lisa: Do you know what your mom used for contraception?

Kim: I know she used IUDs. And I know she used condoms and I know she tried the pill and had a really bad experience, cause it was like back when it was really heavy, a heavy-dosage.

As Tara expresses, her mother was willing to put up with the side-effects of the pill because at

the time nothing else was available.

Lisa: What was [your mother's] experience like?

Tara: Oh my god it was bad! Well, it was a one-size fits all kind of thing and the doctors didn't know a lot about it, the patients didn't know a lot about it and you were just sort of blindly taking it. She told me she got sick a lot, a lot of nausea. But at the time it was the only option, so, having an option is better than nothing.

As I will discuss in Chapter 5, in spite of identifying choice, liberty and freedom as something that distinguished their own experience from women of the past, participants still saw their choice to use the pill as very limited. A common theme drawn on in many of the articles is that because women have come so far, it is better to have something than nothing at all, even if it is imperfect. Most news articles suggested that in spite of all the pitfalls, the pill is still the best and most popular option available because in spite of its draw-backs it is reliable, easy-to-use and cost effective.

As Ruhl (2002) observes, in contemporary North American society we value a body that is predictable, contained, and ordered. As a pocket-sized medication, the pill produces the ideal body bent to one's will by repetitive and meaningful intention. The history of women informed participants' accounts of safety and danger, but was equally something that weighed heavily in terms of setting expectations for freedom vis-à-vis the pill. In this sense, a construction of the past was a subtle presence that served to neutralize and minimize the risks of the pill in the present.

In my research, I found that taking the pill is an expected act for a young heterosexual woman. But as Cream (1995) argues, this has not always been the case. As Hobsbawm (1983) points out, in the case of 'tradition,' "the past, real or invented, to which they refer imposes fixed (normally formalized) practices, such as repetition" (1). While taking the pill is not a tradition in the conventional sense, use of the pill is normalized by highlighting its use across generations of

women. In this sense, using newer low-dose versions of the pill distinguishes the present, but equally, aligns a young woman with struggles for freedom across generations.

### 3.5 Imagining the future

*Lisa:* For you, what would the perfect contraceptive look like?

*Elaine:* Something that a switch in my brain, where I could be like I don't want to get pregnant until I say I do want to get pregnant. And then 30 years from now, or if I ever decide to have kids, I could be like, "Ok brain... I want to turn that on again". I mean that's crazy hypothetical. I mean or even a pill that you take and it works for however long you need it to and you take another pill when you need to and it turns it off. There's a sci-fi series called *The Uglies* and they take this pill... it's this post-utopian world and once you get to the age, you go through this surgery, where they put a chip in your brain. It makes you beautiful, but it also controls you, so you don't really want to question what's going on beyond your own life. And a few people rebel and they develop this drug where you have to take one pill, and it eats away the part of your brain that the chip is put in. So it gets rid of the chip, but then you have to take another pill to stop the one that's eating your brain. If you don't take the second pill, it keeps eating your brain. Yeah, so it's just like something that works until you take another pill and then it turns it off and there's no side-effects... permanency unless you don't want it.

Another way the past appeared across interview data and the news media was in describing the future. Van der Geest et al. (1996) and Asbell (1995) both emphasize the important role of pharmaceuticals in the twentieth century in popular accounts of technology and progress. "As powerful technical devices and status symbols, medicines acquire a status and force in society" (Van der Geest et al. 1996, 156). As Watkins (1998) argues, when the pill was first released it was perceived as the way of the future. Since its creation, all kinds of revolutionary qualities have been ascribed to the pill, even likening it to the discovery of fire and the combustion engine. She also notes that excitement was dampened during the 1970s and 1980s when concern over health-risks was heightened. Today, the pill is still identified as problematic at times, but it is generally accepted as a device that women ought to have access to.

One of the final questions I asked participants was what the ideal contraceptive would look like. I found that young women described the future of contraceptive devices in a manner consistent with narratives of progress through technology. In this sense, technology was highly associated with liberal ideals of freedom and would facilitate the formation of an autonomous

self. For example, barrier methods were perceived as outdated.

*Lisa:* Do you remember prior to seeing your doctor if you got information from other sources, maybe school?

*Marie:* Not school, but perhaps the internet. I think I remember before making an appointment I had done like some research. I definitely read a little bit before and after I got on the pill to see what my alternatives were in terms of like the diaphragm and spermicide and all the junk. And seeing what else was out there and what those things were all about. It didn't seem like they were immediate options. My doctor didn't talk to me about diaphragms and I kind of felt that was an old woman's thing. It has this like image of being antiquated, and something that's on Seinfeld [laughing]. It's like, "My diaphragm" [making funny voice]. And I was like, what is that, what does that do?

None of the women I interviewed identified improved barrier methods as the way of the future. Significantly, this was not because of how well they functioned to prevent pregnancy, but because of their association with out-dated ways of controlling contraception. As Marie observes, the diaphragm is an "old woman's thing"; the pill is a young woman's thing, and has paved the way for the next-generation of devices.

Similarly, in news articles, the pill is represented as in "constant evolution". This vision of innovation is captured in an article from *The Globe & Mail*, entitled "Period-free birth-control pill a step closer after study". The author writes:

Life without monthly periods has always been one of the things women look forward to as they grow old – but thanks to a new birth control pill, Canadian women of all ages may soon be able to stop menstruating (GM5).

The article and others like it, suggest that science has mastered the problem of contraception and in the future will master other troubling bodily functions facing women as well. In the same article the doctor states that "in the past it would have been thought to be impossible to stop periods for a prolonged time" (GM5). But scientific innovations, like the pill, have allowed us to envision the possibility of stopping periods for good.

All three newspapers also had articles discussing the latest developments in the male

contraceptive pill.

In a distant, seemingly sci-fi world, men could take their Pill, apply a gel or undergo ultrasound therapy without necessarily discussing the details with a girlfriend, just as many women do with their contraceptive choices and boyfriends now. ... As Dr. Amory put it: "Men are very interested in this. Men like to have sex. Your choices if you're a man: You can put on a sheath or have surgery. There's room for options" (GM9).

In these articles themes of choice still emerged but they were not prominent. Instead, articles focused on how such technologies might potentially conflict with masculinity. While choice in relation to reproductive control is characterized as highly problematic for women, this is not really the case for men.

Similarly, while some women thought a male contraceptive pill would be a "great idea!" others were more skeptical. As Serena describes it, she prefers something that allows her to have the majority of control.

*Lisa:* In a hypothetical world, what would the perfect contraceptive look like?

*Serena:* It would be something that had 80% effectiveness if one person used it and 100% accuracy if both people used it, man and woman. So it's put on both parties. I would not trust a guy to take a birth control pill individually! No, that would never happen. Furthermore, because they're not the ones who would deal with the consequences if the girl got pregnant. But I think something where both parties are involved, the majority on the woman because the guy can't handle it. I think that would be really good. And I think like it's sexier if you don't see it. So if it were even say like some sort of spermicide thing where you don't see it, or even a pill where it came together.

The importance of female-control of contraception and fertility control draws on a perception of women as always being primarily responsible for these activities. As Ruhl (2002) observes, "The modern family structure has created a demand for highly effective forms of contraception; such contraceptives and the reproductive technologies to which they are linked serve present needs, but also create future options" (264). The need to control one's body with a high degree of reliability, and specifically to control women's processes of reproduction, reflects social values about the place of women in society, about the place of children in women's lives and about the risks we are willing to take to create the desired reality. As Fisher & Szreter (2003) point out, the wide-spread portrayal of woman as contraceptors is contrasted with the reality that

men were traditionally expected to use and have knowledge about contraception. However, in contemporary Canadian society, using contraception is now a practice that we have come to associate with women.

Perceptions of the future of the pill also reflect the association in late modernity of technology with progress. According to Leonard (2003), technology is often perceived as inherently “good” for how it moves society towards a better end (2). As Leonard is concerned with the relationship between women and technology, she argues that we ought to instead consider technology by examining “their development and implementation in terms of diverse groups of women” (ix). She calls into question:

...the pervasive Western belief that connects technological development with continual improvement for all. Reflection on the experiences of women encourages us not only to question the veracity of such claims, but to ask more specifically who benefits from technology and indeed how we define progress (Leonard 2003, x).

The distinction between “science” and “nature” or between technology as “good” or “bad” involves a process of social differentiation that often reifies existing social inequalities.

The ongoing association of science and medical professionals with increased control over the body diverts attention from how there are other possible ways of imagining the management of reproduction and the body. It also situates technology as a force functioning independently from social and political changes. McLaren & McLaren (1986) note:

...effective fertility control has been largely a cultural and social, not a technological problem. Before reliable birth control devices such as the pill were introduced, the birth rate in Canada had already dramatically declined. Technological advances in birth control were only important when the social and economic variables, such as employment levels and education opportunities, gave individuals a reason to limit their fertility. ...Their use was largely suppressed by the practices and policies of the law, medicine and the church (140).

When Trudeau introduced the Omnibus Bill, which legalized contraception, he stated, “There’s no place for the state in the bedrooms of the nation” (CBC Digital Archives). But the pill and the legalization of contraception more generally, arguably increased rather than decreased public

intervention into women's reproductive bodies and health. In spite of this, the pill is often generally accepted as a device that allows women to fully experience freedom and autonomy. As I will explore over the next three chapters, freedom and autonomy in relation to the pill remain as complex now as they were in the past and are worked out by young women on an ongoing basis.

### **3.6 Conclusion**

As I have shown, the print news media and young women are actively involved in constructing and recounting the past of the pill. The history of the pill was a focal point in commemorative articles and participants' descriptions of what the pill has meant for women more generally. Yet, the past was also a subtle presence in characterizing present-day side-effects of the pill and understanding what will be possible in the future. It is possible to see popular accounts of the past as distortions and misappropriations of scholarly historical work. While in some instances this might be the case, the past is always circulated and produced in different types of places and spaces and as such is a way that young women constitute the self and determine what constitutes ethical conduct. In the next chapter, I turn to descriptions of how the pill functions in public health literature and interview data.

## 4 Tricking the body

*Lisa:* Did [your doctor] talk at all about how the pill works?

*Marie:* Uh, I remember vaguely having that conversation, yes. And I was given pamphlets of information. So I think I was pretty well-versed.

*Lisa:* Do you remember what information stuck out for you?

*Marie:* I don't know. It was a really long time ago.

*Lisa:* Or even today?

*Marie:* It always sticks with me this whole thing of the pill tricking your body into thinking it's pregnant. And that feels like this thing that always comes up when you're talking with doctors or other women. It's like (uses funny voice), "oh the pretty hormones in your body, they trick it into thinking it's already pregnant and stuff." And so that's kind of the extent of it, I don't really know that much more, embarrassingly, about how the pill works.

*Lisa:* Why is that embarrassing?

*Marie:* Well, you know how you take this thing every day and you don't really notice, you're not quite sure, how it does its thing.

In "The Egg and the Sperm," Emily Martin (1991) observes that "scientific accounts of reproductive biology [rely] on stereotypes central to our cultural definitions of male and female" (485). She argues that the meanings attached to technologies situate them to work on certain bodies, in certain types of ways. In North American society, the pill can be used by different types of bodies, but it is a technology predominantly associated with the young feminine heterosexual body (Smith 2014). Before I get into the particular ways that the pill is used by young women, I want to draw attention toward the ways that the pill is described by young women and within public health communications. Like Martin I see that knowledge can be connected to the reproduction of social inequalities, but drawing on Bowker & Starr (1999) I argue that the classification of objects is also intimately connected to the moral work involved in constituting the self. Here I also draw on the insight of narrative approaches to the study of health that emphasize the importance of stories within scientific accounts of the body. The ways we describe bodily functions and processes, and the objects that intervene in these processes—pharmaceutical devices—contribute to our formation as subjects. As Marie observes, she is slightly embarrassed by her lack of knowledge, because being "well-versed" in available contraceptive and health technologies reflects the embodiment of responsible conduct towards

one's self and others. As I will demonstrate, in this instance being a free and informed young woman is contingent upon accessing information which is in and of itself unclear and often very confusing.

In this chapter, I consider public health communications available on the Canadian Federation for Sexual Health and [sexualityandu.ca](http://sexualityandu.ca) websites and data from interviews with young women about what the pill does to the body. I begin by offering a layperson's account of what the pill is made of and what it does to the body. As I observe, descriptions of how the pill functions often isolate the effects of taking it to the reproductive functions of the body. Further, the pill is taken to be highly innovative because it is entirely man-made or synthetic. Yet the "natural" components that make up the pill are obscured. I then consider the ways that contraceptives are classified into "natural" versus "non-natural" methods or "hormonal" versus "non-hormonal" methods. As I will discuss, these boundaries are social distinctions that attribute higher degrees of legitimacy to some methods over others. As Bowker and Starr (1999) observe, categories contain a moral or ethical dimension that serves to direct the conduct of individuals in particular ways.

I then explore how expectations for informed consent structure knowledge about devices and configure users of pharmaceutical technologies in particular ways. The metaphor of "tricking the body" implies that knowledge about the pill is dumbed down for consumption by women and the general public. In fact, the metaphor of tricking the body is part of a general uncertainty around what the pill actually does and the very real limitations of scientific knowledge. While participants identified doctors and medical professionals as important sources of knowledge, the young women I interviewed also drew on alternative and unconventional knowledge sources to navigate uncertainty.

#### 4.1 A tale of deception

*Lisa:* Do you remember when you first started taking the pill if you understood how it worked?

*Victoria:* I don't think accurately... I had an impression of what it was. I just figured I'm taking this hormone that tricks my body into thinking I'm pregnant. And it's important that I take them in order and they're programmed different doses for different days. And it would work in line somehow with my own body. But that's all I understood about it.

So how exactly does the pill trick the body? What is the source of the deception? According to the Canadian Federation for Sexual Health and [sexualityandu.ca](http://sexualityandu.ca) the synthetic hormones “trick” the ovary into thinking that it has already released an egg. In this metaphor the body is manipulated and controlled by science. Through the use of smoke screens and magic the pill pulls one over on the ovary. But this metaphor and even the descriptions of the biological processes provided, tell us little about the complex activities that take place in the body when the pill is swallowed by an individual woman.

Women's reproductive health is a field where knowledge is constantly emerging. It is true that during the twentieth century, reproductive health scientists have unprecedented access to the interior processes of the body through advances in surgery and x-ray imaging. Yet, in this thesis, I start from an assumption that scientific knowledge about women's reproductive health, like all knowledge, is contingent and partial. Scientific knowledges about the body are used by experts in particular kinds of relationships, such as that between doctor and patient or pharmacologist and drug manufacturer. Scientific knowledges are productive of techniques of the self through which individuals constitute themselves as subjects. Equally, technologies may be used by young women in ways unintended by health professionals and manufacturers. Thus, I assume that the outcomes of pharmaceutical interventions like the pill will always be unknowable in an absolute sense.

For example, the popular text *Robboy's Pathology of the Female Reproductive Tract*

(2002) contains a notice to the reader on the copyright page,

Medical knowledge is constantly changing. Standard safety precautions must be followed, but as new research and clinical experience broaden our knowledge, changes in treatment and drug therapy may become necessary or appropriate. Readers are advised to check the most current product information provided by the manufacturer of each drug to be administered to verify the recommended dose, the method and duration of administration, and contraindication. It is the responsibility of the practitioner, relying on experience and knowledge of the patient, to determine dosages and the best treatment for each individual patient. Neither the Publisher nor the authors assume any liability for any injury and/or damage to persons or property arising from this publication. *The Publisher.*

For all that scientists know there is still a great deal of uncertainty. I am not a reproductive health scientist, but rather a sociologist who has read widely on the topic of the pill. What I offer here is a lay account of what the pill does to the body. I have drawn on five popular texts:

*Robboy's Pathology of the Female Reproductive Tract, The Female Reproductive System, Molecular Biology of the Female Reproductive System, Drugs: The Straight Facts: Birth Control Pills, and Oski's Essential Pediatrics.* I will also refer to the patient package inserts for Yasmin and Diane-35 (see Appendices F and G).

The type of pill most commonly prescribed to women in Canada is the combined oral contraceptive pill. Examples of the combined oral contraceptive pill are Yaz, Alesse and Yasmin. These pill brands all contain varying levels of synthetic estrogen and progestin. The progestin-only or “mini-pill” and extended-release are also available. Diane-35 contains an anti-androgen and progestin explaining its more potent anti-acne properties. Oral contraceptives come in many different forms, but generally contain twenty-one pills with hormones, followed by seven placebo pills.<sup>5</sup> Multiphasic pills contain varying levels of hormones throughout the twenty-one days in either a biphasic or triphasic manner. Multiphasic low-dose pills, like Alesse, are generally recommended for adolescents as they are thought to minimize side-effects

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<sup>5</sup> Historians have observed that the original pill was taken continuously by women (see May, 2010; Tone, 2001; Watkins, 1998). Placebo pills were added to provide “comfort” to women and to confirm the absence of pregnancy.

while still offering protection against pregnancy (Black et al. 2004, 143; Crocetti & Barone 2004, 187).

Hormones are an essential part of the human body and influence many processes within the body from birth to death. In scientific descriptions of the menstrual cycle, what is generally described are the processes that occur within the reproductive organs. For example, the menstrual cycle begins when a woman's body has low levels of estrogen and progesterone in the ovaries. When levels of estrogen become low, the pituitary gland produces follicle-stimulating hormone. At this point, follicles produce more estrogen and the pituitary begins to produce luteinizing hormone. Once these three hormones reach a certain level, an egg is released. Due to the presence of the luteinizing hormone, the follicle transforms into the corpus luteum. The corpus luteum begins to produce progesterone while the ovary continues to produce estrogen. Usually, after about two weeks, the levels of these two hormones will stop. The lining of the womb is discharged as blood or what is commonly called menstruation. At this point, the level of estrogen is usually low and the cycle will likely begin again.

All women have a different cycle. The events described in the texts do not always happen at the same time. For example, some women will ovulate later or earlier in the cycle. Some women will not ovulate at all. Further, the effects of the hormones that occur during a menstrual cycle are not confined to the reproductive organs. For example, there are changes in vaginal discharge, and even body odour and sweat. During menstruation many women will experience cramps and headaches, or what is referred to as premenstrual syndrome. Equally, hormones are not confined to the reproductive system. The pituitary gland is located at the base of the brain. The anterior pituitary produces luteinizing hormone and follicle-stimulating hormone.

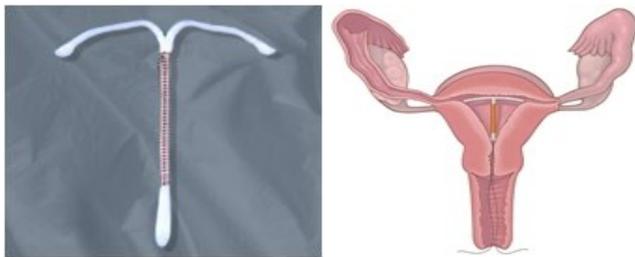
In the same way that the hormones that are part of the menstrual cycle are not isolated to the ovaries, the effects of the pill are not isolated to the reproductive cycle. The pill can stimulate events across the body. In spite of this, descriptions of the pill tend to focus only on the way the pill affects the reproductive system. When ingested orally each day the combined oral contraceptive pill introduces progestin and estrogen to the body. The presence of these synthetic hormones does have an impact on the reproductive system. For example, it decreases the release of follicle-stimulating hormone and luteinizing hormone such that the follicles do not grow. Because of this an egg will likely not grow. The endometrium is released when the hormones are withdrawn from the system; thus, what is often referred to as a period, is not a period, but rather “withdrawal” bleeding caused by the absence of the hormones. There is also speculation that the presence of progestin makes it harder for sperm to enter the fallopian tube by making the vaginal mucus thicker. Yet, some women who take the pill still ovulate and become pregnant. Blame for pregnancy is usually placed on the imperfect use of the pill by a woman. Both the Canadian Federation for Sexual Health website and [seuxalityandu.ca](http://seuxalityandu.ca) remind users that the pill must be taken consistently and regularly to maintain the correct balance of hormones. But, women’s bodies are all different which is why the pill works to varying degrees of effectiveness and also why it can have other effects.

In medical terminology, the effects of substances are often categorized into primary, secondary, and side-effects. For example, Potts (2004) observes in relation to Viagra,

In biomedical and popular depictions of Viagra use, the connection between the ‘synthetic’ drug and the ‘natural’ body tends to be limited to the effects on the penis (and the production of erections). It is explained in medical discourse that Viagra ‘works’ by increasing the effects of nitric oxide ... Viagra is thereby portrayed as having a certain target in the body: the penis. However, like most drugs, it impacts on/in the body in a variety of other ways as well. Many of the men in this study had suffered from Viagra’s more recognized ‘side-effects’ (for example, headaches, indigestion, congested nose, and blue vision); in some cases, severe headaches were more compelling and significant for participants than the production of an erection had been. Viagra is, therefore, not simply a drug for erections, although its effects are often represented as primarily genitally focused (26).

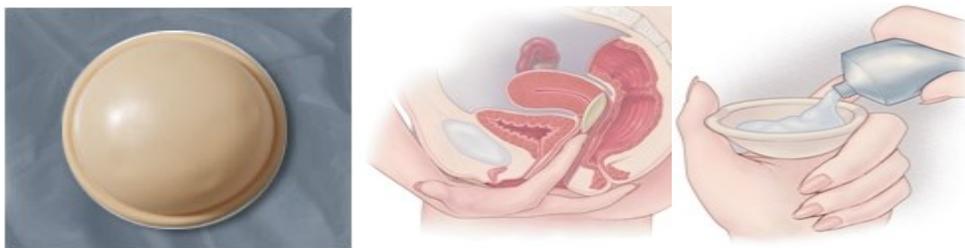
For example, the primary function of the pill is generally considered to be contraception, while secondary functions include treatment of acne, ammenhorea, endometriosis, and polycystic ovary syndrome.

The sexualityandu.ca website provides images of contraceptive devices in the body. For example, the intrauterine contraceptive device.



**Figure 3**

The site also provides a picture of the diaphragm inserted in the body.



**Figure 4**

Other devices equally contain a picture situate and the device is situated within the body. In contrast, the site uses the following image for the pill.



**Figure 5**

Unlike the other devices, the pill is a pharmaceutical that is portrayed as having a targeted effect that is separated from the body.

The Canadian Federation for Sexual Health website and [sexualityandu.ca](http://sexualityandu.ca) note that common side effects of the pill include nausea, headaches, breast soreness, acne, decreased libido, depression, moodiness, weight gain. Other more rarely experienced side-effects include high blood pressure, blood clots, strokes, heart attacks, liver tumours, and gallstones. While side-effects might be undesirable, they are equally effects of the pill. Take for example other effects of the pill that are desirable and therefore not classified as side-effects by the Canadian Federation for Sexual Health and [sexualityandu.ca](http://sexualityandu.ca) but rather as “side-benefits,” such as fewer menstrual cramps, less acne and prevention of uterine cancer. Like side-effects the degree of these effects is unpredictable. Equally, synthetic formulations of estrogen and progestin can be used to do other things to other bodies. Post-menopausal women and transitioning women are often prescribed the pill as well as men seeking treatment for prostate cancer. I now turn to the ingredients in the pill. As I will explore, existing descriptions tend to obscure the ingredients of the pill.

## 4.2 A synthetic fairy tale

Synthetic: noting or pertaining to compounds formed through a chemical process by human agency, as opposed to those of natural origin.

Apps & Games, Birth Control Brigade

The object of Birth Control Brigade is to use a collection of contraceptive methods to stop a gang of tenacious sperm from reaching the end of the game board and impregnating the waiting egg. Destroy the sperm waves using birth control “defenses” you buy and strategically place in the field of play. Each “defense” has its own attributes and varies in price. Score points and make more cash by destroying as many of the hapless haploids as possible. But spend wisely and watch your strategy, as each successive sperm wave is more determined than the last. Note that different methods of birth control have to be recharged at different rates depending on their real life characteristics. Contraceptive Pills provide you with a rapid fire attack. The more you upgrade this defense, the faster you can shoot, and the more damage you can inflict (SU8).

[Sexualityandu.ca](http://sexualityandu.ca) has a section entitled “Games and Apps”, one of which is the birth control brigade. As the text indicates, the pill provides a “rapid fire attack” against the increasingly

tenacious waves of sperm. The site reproduces many of the stereotypes observed by Martin (1991, 486) such as the active nature of the sperm and the passive waiting egg. But the site also situates the pill, as heavy-duty artillery, a key component in winning the contraceptive battle for women. Indeed, as I explored in the previous chapter, over the past fifty years advances in reproductive and new reproductive technologies have been celebrated as freeing women from the bonds of the body (Ruhl 2000). In this sense, synthetic interventions--made by individuals in a laboratory setting--are characterized as predictable and highly effective—even if they are at times dangerous. “Natural” devices are characterized as ineffective and unpredictable in relation to the pill.

Yet, from the 1970s onwards, a great deal of attention has been paid to informing women about their health, including the potential side-effects of devices like the pill (see Grant 1985; Seaman, 1980; see Appendices F and G). As much as scientific innovation and pharmaceutical technologies have transformed our lives for the better, they also entail dangers. There are currently detailed regulations surrounding the list of side-effects and contraindications for pharmaceutical companies in Canada. However, pharmaceutical companies are not required to list the ingredients in products beyond the patented names of the synthetic hormones. For example, the patient package insert for Diane-35 indicates that it contains “cyproterone” and “ethinyl estradiol”, while the Yasmin patient package insert indicates that it contains “drospirenone” and “ethinyl estradiol”. The user is not however provided with a list of raw materials. Similarly, both [sexualityandu.ca](http://sexualityandu.ca) and the Canadian Federation for Sexual Health websites discuss how to take the pill, where to get it, what to do if you miss a pill, how to talk to your parents/partner/teacher/brother/sister about contraception. However, what the pill is actually made of is nowhere to be found.

For example, on [sexualityandu.ca](http://sexualityandu.ca) in the section “what is the pill?” the text reads as follows,

The oral contraceptive pill (OC) is one of the most researched (and often most misunderstood) drugs in the world. It is also one of the world’s most prescribed medications - about 100 million women across the globe rely on it. The Pill is a contraceptive suitable for most healthy women, regardless of age, and can be used long-term. Some women only want to take the Pill when they are in a stable relationship and stop taking it when the relationship ends. However, doing so can put people at risk of unintended pregnancy while adjusting back to a new contraceptive method. With proper use, the Pill is 99.9% effective, making it the most reliable contraception available. However, there is a 3% user failure rate (SU3).

Equally, the information available on the Canadian Federation for Sexual Health website focuses on the contraceptive qualities of the pill, as well as its popularity. As a synthetic object and a commodity that can be purchased, the natural ingredients of the pill disappear.

Yet, even synthetic compounds still come from what were once “natural” materials. Synthesis involves modifying and manipulating the molecules in “natural” materials to produce patented compounds that can then be sold as a product to a consumer. The social changes that led to the development of the pill such as changing sexual mores and altered patterns in marriage and dating receive a great deal of attention from social scientists. Somewhat less attention is paid to the events that led to the mass production of cheap synthetic hormones. As Laveaga (2009) observes, in many ways what allowed mass availability of the pill was the “discovery” of a cheap source of synthetic progestin in the Mexican jungle by the American scientist Russell Marker. In the 1950s, Marker found that diosgenin--a steroid sapogenin--could be extracted in large quantities from the barbasco yam, which grew in enormous quantities in the jungles of Mexico.

The barbasco yam trade ended in the 1970s when it became possible to produce steroids using total synthesis, meaning that the production process no longer requires base materials to manufacture hormones. Yet, current formulations of the oral contraceptive pill probably continue to rely on some “natural” materials, like distilled urine from pregnant mares (Djerassi

2001, 45) which is the primary ingredient in many estrogens produced for commercial consumption. They also likely use water, ammonia, and other products that are involved in the isolation and manipulation of molecules.

Ironically, Marker “discovered” the barbasco yam because he found that some groups of indigenous Mexican women had been eating it for contraception. Today, alternative health web sites tout the potential of wild carrot seeds or “Queen Anne’s Lace” to act as a contraceptive and encourage women to use this method as an alternative to “synthetic” hormones. Riddle (1999) observes that wild carrot seeds have been used by women for centuries and it is a common plant found around the world. Like the barbasco yam, wild carrots seeds contain high levels of progesterone which probably explains why it has contraceptive properties. Arguably what makes the pill unique is not so much the science behind it but the mass production, commercialization and distribution of what in some ways could be considered a “natural” *and* “synthetic” method. As I explored in the previous chapter a key component of women’s preference for the pill lies in how it is perceived to be attached to modern ideals of bodily control that require targeted scientific interventions into the body. I now turn to how the classification of the pill as effective relies on the cataloguing of other methods as less so.

### 4.3 Naturally ineffective

Methods of birth control in the late 19<sup>th</sup> and early 20<sup>th</sup> centuries included withdrawal, the rhythm method, douches, pessaries and sheaths or condoms. Pessaries are barrier methods such as the diaphragm and cervical cap, which block sperm from entering the uterus. Forms of the pessary have existed since ancient Egyptian times when crocodile dung was inserted into the vagina to prevent contraception (SU1).

*Lisa:* If a friend was thinking of going on the pill what advice would you give them?

*Serena:* Well I've done this before... the first is like, what do you do now. My friend, the one who was pulling out, her boyfriend would forget to pull out, and I was like, "You can't do that!" And then, you know, I would tell them my experience, I've been on it for a year and a half. Like yeah, the first month is gonna suck, not gonna like. You can't take it and then the next day think that it's all good. And then I would tell them that I didn't gain weight, nothing bad really happened to me, except for my migraine. And I would mention that, just because I feel like a lot of the times these serious side-effects or whatever can seem very far away. But it's like, oh I think I might have actually had a stroke. So, be careful. And just like reiterate that you need to take it at the same time every day. It's very crucial. Cause I've read that it has like a .1% fail rate, but then when you don't take it at the same it can be 10 or 11% failure rate. Like when I first started, if I missed by 40 minutes, I would start spotting. Like now it's better, because maybe my body is more used to it... but it's not a get out of jail free card, where you can just say that you take it once a day and it's fine.

In Canada, the oral contraceptive pill is the most popular method of contraception, second to sterilization. However, Black et al. (2009) found that a surprisingly high percentage of individuals, six percent, still rely on withdrawal. As Serena observes, she advises friends against the pull out method even though she recognizes that the pill is equally uncertain. Indeed, many participants acknowledged that they had used the pull out method, but were often embarrassed about this, even if it had not resulted in pregnancy. Like Martin (1991), I see that knowledge about the pill can be connected to the reproduction of gender inequalities. But drawing on Bowker & Starr (1999), I argue that the explanation of reproductive technologies also relates to the classification of objects and hence the constitution of the self as a particular kind of subject who uses specific methods.

A common characteristic in informational materials for contraception and among participants was to break contraceptive methods down into types. For example, on [sexualityandu.ca](http://sexualityandu.ca) contraceptive methods are broken down into three categories.

- 1) “Natural methods”, including withdrawal, abstinence, lactational amenorrhoea and fertility charting;
- 2) “Non-hormonal methods”, the copper IUD, sponge, cervical cap, diaphragm, spermicide, sterilization, condom (male and female);
- 3) “Hormonal methods”, including the oral contraceptive pill, the patch, vaginal contraceptive ring, contraceptive injection and the hormonal IUD.

What distinguishes “natural” methods in this case are methods that do not require an external device and involve consultation with a medical expert. Non-hormonal methods involve the use of a barrier device. Hormonal methods refer to pharmaceutical technologies that introduce synthetic hormones into the body. As Martin observes biological processes can be described in other ways and so too can contraceptives. For example, lactational amenorrhoea and fertility charting require the individual to be aware of and manage hormonal processes. In fact, breaking methods down in this way situates contraceptives on a historical trajectory. As I explored in the previous chapter there is an emphasis placed on the pill as a “modern” contraceptive and barrier and “natural” methods as out-dated.

On the Canadian Federation for Sexual Health website and [sexualityandu.ca](http://sexualityandu.ca), each contraceptive method has a separate page where it is described in detail, along with percentages indicating how effective it is in comparison to other methods. The site also provides information on the Fertility Awareness Method which is categorized as a “natural” method. The site describes the method as follows,

Sympto-thermal teaches a woman how to observe, chart and interpret her waking temperature (basal body temperature or BBT) and cervical mucus to understand what days she is fertile and what days she is not fertile. She then knows when she is likely and when she is less likely to become pregnant from intercourse (SU3).

The site notes that the Fertility Awareness Method has an effectiveness rate of 95-98% with perfect use, meaning two to five women are likely to experience an unintended pregnancy and 75-88% for typical use, where the “user may not always follow rules”. [Sexualityandu.ca](http://Sexualityandu.ca) indicates that the pill is 99.9% effective, with a 3% user failure rate, which would mean three

women in one hundred are likely to experience an unintended pregnancy. However, Crocetti & Barone (2004) note that the failure rate amongst young women can be as high as 18% (187).

The Fertility Awareness Method involves tracking, charting, and measuring hormonal processes, but is not classified as “hormonal” because these activities are carried out by a woman in her home and do not involve a medical professional. Sexualityandu.ca notes that disadvantages of this method include: “requires time to learn” and “requires discipline and commitment”. In the case of the pill there is no mention of these disadvantages. The Canadian Federation for Sexual Health acknowledges that disadvantages include that women might not like having to take it every day and that there are potentially undesirable side-effects. The site also lists the work involved in using the pill, such as attending multiple doctor visits and being aware of and knowledgeable about health conditions that could cause problems. To be clear, I am not implying that one method is better than the other. I am interested in the ways that the active work of the individual is characterized in relation to devices.

One of the questions I asked participants was whether they thought the pill was different from other contraceptives. Generally, young women indicated that they thought the pill was different. As Lynn observes, in her view the pill is different because it changes the rhythm of the body.

*Lisa:* My first question is, do you think of the pill as different from other contraceptives?

*Lynn:* Yes. Because a condom is latex, you put it on the penis. And the pill is something you put in your body that ... you know, changes your rhythm.

Kim also saw the pill as different from condoms. As she observes, unlike condoms, the pill allows for skin to skin contact.

*Lisa:* Do you think of the pill as different from other types of contraception?

*Kim:* It's definitely different from condoms. I haven't tried other things like the IUD so I can't say. I think the thing that draws women to the pill is that it's not an object and that leaves a lot of room for sensitivity and there's no object between you and sex [laughs].

Allison also described the pill as different from other forms of contraception. As she observes it is a part of popular culture and is the contraceptive she identifies as the most common.

*Lisa:* For you is the pill different from other forms of contraception? Do you put it in its own category?

*Allison:* Um... I think because it's present in popular culture, I think I think of it as, "The Contraceptive", for women. I think of the condom as, "The Contraceptive", for men. But, I really think of it as the pan-ultimate contraceptive for women. And when I do hear friends taking other things, like one of my friends was on the Nuva-Ring, I was like ... that's so different. Because I think I see other things as more like, very different. Whereas the pill is the most common.

In contrast, Mona saw the pill as a contraceptive like any other, but still thought that it likely that it was the most popular.

*Lisa:* Ok, so those were my specific questions and now I move into more general questions. They're meant to be as such. So the first one is, for you, do you think of the pill as different from other kinds of contraception? Do you put it in its own category?

*Mona:* Um, no, I guess it just kind of falls into all the female contraception options for me. I imagine it's the most popular in that category.

Like the websites, participants tended to describe the popularity of the pill as a way of distinguishing it from other contraceptives. This rarely involved a consideration of the specific qualities that made the pill different.

#### 4.4 The real trick

Today women who read the patient package inserts know about symptoms to which they should be alert. These include severe headaches; dizziness; double vision; stiffness or paralysis (signs of an impending stroke); redness, pain, or swelling in a limb (signs of a blood clot); chest pain or coughing up blood (signs of a clot in the lung, or pulmonary embolism). Patients know that depression may be associated with the Pill, and that if they become yellow or jaundiced they should stop using it at once. The patient package inserts—which the AMA, pharmaceutical industry, and gynecologists' organizations opposed and fought for almost a decade—are probably helping to save lives (Seaman 1980, 189).

*Lisa:* Est-ce que t'es allée voir ton docteur pour avoir la pilule?

*Nathalie:* Le CLSC.

*Lisa:* Quelles informations il t'a donné sur la pilule?

*Nathalie:* Oh my god, ça fait tellement longtemps, je pense qu'ils m'ont parlé de comment la commencer. Hmm... bonne question... que c'est 99% sûr, pis que il y a quand-même 1%. Oui, je pense que c'est ça.

*Lisa:* Est-ce qu'ils ont parlé des effets secondaires de la pilule?

*Nathalie:* Oui, la prise de poids... sûrement. C'est que c'est vraiment loin... non, je pense que c'est tout.

What does it mean to be informed? To what extent can we be aware of how a device will affect the body? To what extent do patient package inserts assist young women in understanding the

risks involved in taking the pill or in identifying health complications when they occur? My object in including Nathalie's statement is not to imply that she is misinformed. The interview took place after she first took the pill at fifteen years old. In a recent study published in *Contraception*, Lopez-del Burgo et al. (2012) argue that "adequate knowledge is essential for making informed decisions" (69). In a series of interviews conducted with European contraceptive users, they found that participants had "low knowledge about mechanisms of action of [family planning], even if they have used the method" (73). While I am sympathetic to their research and I would certainly not argue that women should not be provided with information, I question the assumption that being informed is possible, or that doing so is always desirable and helpful to women. For example, even in the authors' "scientific" accounts of the pill which they compare to women's "misinformed" descriptions, the authors use the qualifiers, "may," "most likely" and "probably." I found that among the young women I interviewed, as in Lopez del Burogo's et al.'s research, little was known about how the pill worked and the ways it might affect the body. But, in contrast, I argue that this is indicative of a more general lacuna in scientific knowledge and a failure to account for the ongoing processes that occur when a particular pharmaceutical device is introduced into the body. As Mol (2009) has observed the effects of a drug are lived by individuals within the body on an ongoing basis.

For example, on the site [sexulatyandu.ca](http://sexulatyandu.ca) the section, "the pill, how it works," one article

reads as follows,

Just take the Pill on a daily basis, and try to take it at the same time each day so that it becomes a habit. Some women find it helpful to set an alarm clock, pager or beeper as a reminder.

***Benefits***

The benefits are numerous. In addition to being the most effective form of contraception, the Pill regulates the menstrual cycle, reduces menstrual flow, can reduce the number of periods per year, reduces acne, protects against certain cancers, and is completely reversible (once a woman is off the Pill, the body resumes its normal cycle).

***Disadvantages***

The Pill doesn't protect against STIs

It may cause side-effects such as irregular bleeding, breast tenderness, weight gain, headaches and nausea.

These side-effects generally disappear after a few months. In rare cases where these side-effects don't go away, you should see your doctor.

Similarly, the Yasmin package patient insert reads as follows,

Check with your doctor as soon as possible if any of the following side effects occur:

changes in the uterine bleeding pattern during or between menstrual periods (such as decreased bleeding, breakthrough bleeding or spotting between periods, prolonged bleeding, complete stopping of menstrual bleeding that occurs over several months in a row, or stopping of menstrual bleeding that only occurs sometimes)

- signs of depression (e.g., poor concentration, changes in weight, changes in sleep, decreased interest in activities, thoughts of suicide)
- *for women with diabetes:* mild increase of blood sugar, faintness, nausea, pale skin, or sweating
- *for women with a history of breast disease:* lumps in breast
- headaches or migraines (although headaches may lessen for many users, they may increase in number or become worse for others)
- increased blood pressure
- symptoms of liver problems (e.g., swelling, pain, or tenderness in upper abdominal area, yellowing of eyes or skin, skin itching)
- vaginal infection with vaginal itching or irritation, or thick, white, or curd-like discharge

Stop taking the medication and seek immediate medical attention if *any* of the following occur: abdominal or stomach pain (sudden, severe, or continuing)

- signs of blood clots (e.g., coughing up blood; pains in chest, groin, or leg - especially in calf of leg)
- signs of heart attack (e.g., sudden chest pain or pain radiating to back, down arm, jaw; sensation of fullness of the chest; nausea; vomiting; sweating; anxiety)
- signs of stroke (e.g., sudden or severe headache; sudden loss of coordination; vision changes; sudden slurring of speech; or unexplained weakness, numbness, or pain in arm or leg)
- shortness of breath

Some people may experience side effects other than those listed. Check with your doctor if you notice any symptom that worries you while you are taking this medication.

The provision of complex and seemingly detailed information creates an expectation for users about how the pill will function and how it will feel in the body. In reality how young women will feel on the pill will vary greatly. For example, the young women I interviewed indicated

that they were aware of the various health risks of the pill. Participants often listed off a range of potential ways in which the pill might affect the body. Yet, they often would end by saying that in general they did not understand how the pill actually worked and were often unaware of what impact the pill had on their body.

Alicia described herself as “not really” knowing how the pill worked when she first started taking it, but observes that she was aware of some of the potential side-effects.

*Lisa:* Did you know how the pill worked?

*Alicia:* Not really, no [laughs].

*Lisa:* Did [your doctor] talk about any potential positives of the pill?

*Alicia:* Yes, like it would regulate my cycle... it would make it slightly shorter, less painful.

*Lisa:* Did she talk about anything like cancer prevention or anything else?

*Alicia:* I think she did mention acne... but I don't remember anything else. I was going on this drug then I had to get back to school [laughs]. So that was it. But I think she probably did mention it and I forgot.

*Lisa:* Did she mention any side-effects of the pill?

*Alicia:* Uhhh... I think she sort of went through a bit like the stuff that is in the paper that come with the pill. Smoking, blood clots, that kind of thing.

*Lisa:* Did she talk about weight gain ...?

*Alicia:* Yeah, I really don't remember, she might have. I don't remember it being a really long meeting, it was pretty quick.

*Lisa:* Were there things that you were worried about when you were starting the pill?

*Alicia:* I don't think so. I had heard about weight gain. I had heard about the stroke thing from my Mom. I guess she knew somebody whose daughter had a stroke, so I guess I was a little bit worried about that, but the chances are really low.

She did not notice that many changes when she started taking the pill aside from shorter periods.

*Lisa:* When you first started taking the pill, do you remember noticing any changes?

*Alicia:* Not really. Some people get a bit more weight, it didn't happen for me. No I didn't really notice much difference, other than that my period was a lot shorter, which was great.

*Lisa:* Did you notice any changes in your emotions?

*Alicia:* No. I've heard of people that have had problems when they went on different pills, but that another level. I had some friends that had problems, like raging hormones!! But no, I didn't notice anything like that.

Renée notes that she also did not really know how the pill worked when she started taking it.

*Lisa:* Est-ce qu'il t'a expliqué comment ça fonctionne, la pilule?

*Renée:* Mmmm... il a expliqué que ça va m'aider, mais pas comment. Comme, tu vas être menstruer un fois par mois, mais pas plus que ça.

*Lisa:* Est-ce que tu savais c'était quoi la pilule?

*Renée:* Uh, pour la contraception?

*Lisa:* Mais, en général, est-ce que tu étais familière avec la pilule?

*Renée:* Non, pas vraiment.

*Lisa:* Est-ce qu'il t'a parlé des effets secondaires de la pilule?

*Renée:* Uh, oui, on a parlé des effets secondaires, comme ça peut te faire grossir... mais, je me souviens pas.

*Lisa:* Est-ce qu'il t'a parlé des bienfaits de la pilule?

*Renée:* Oui, que ça va régulariser mes menstruations, pour l'acné.

Like many participants, Renée could not really remember the conversation she had had with her doctor a year prior to the interview. As she indicates below, she has generally had a good experience with the pill.

*Lisa:* Quand t'as commencé à la prendre est-ce que tu as remarqué que tes menstruations ont changé?

*Renée:* Oui. Moi, j'ai quand-même une bonne expérience avec la pilule.

*Lisa:* Dans quel sens?

*Renée:* Ben, j'ai pas eu des effets secondaires, mes menstruations sont régularisées. J'ai peut-être pris du poids, oui, ... mais, si non...

Sheila had more to say about the information she had because of an awareness of a risk for cancer in her family.

*Lisa:* And what did you know about the pill before you started taking it?

*Sheila:* Ummm... yeah, a lot of myths... probably like weight gain, that wasn't true or always true. Like acne, mood swings, depression... which never happened. I knew there were a lot of different kinds and some were bad, or it could be linked to cancer, which is a concern for me.

*Lisa:* Just in general, or is there a specific reason?

*Sheila:* Well my mom had breast cancer and cancer runs in my family, so I was a little bit more hesitant. So when I chose the pill it was one, I guess, it was a low-dose, there no estrogen, and estrogen is what supposedly increases ... yeah. So mine was a low-dose, the mini-pill is what they called it.

*Lisa:* Where did you get information about the pill?

*Sheila:* Through the internet. Definitely the internet. And then of course with friends talking and you know what types they using or not and why that type of thing.

*Lisa:* Do you remember taking sex-ed classes where it was talked about?

*Sheila:* Um, well I would say it was mentioned in like sex-ed classes. Just as a form of contraception, but there wasn't a lot of detail.

*Lisa:* What did you know?

*Sheila:* Well, I didn't know the details, like I didn't know there was different kinds and you could have like a full 28 days or the 21 days and the placebo pills. So I just figured all of them were the same. So I didn't know there were different types. I just like, I knew the basic names like Alesse, the one's on commercials.

*Lisa:* So, when you went to get the pill, did you see a doctor?

*Sheila:* Yup. My doctor prescribed it, the progestin only, just because of the cancer risk. But I mean I kind of pushed for it. So, so we ended up doing it and that's why she put me on the low-dose one because she thought that would be the least risky, I guess.

*Lisa:* So you asked her specifically for the progestin only?

*Sheila:* Yeah.

*Lisa:* What did she say about it?

*Sheila:* She asked if I was sure, did I really want it. Because she said she doesn't really suggest it because I was 17, so she didn't really suggest it for girls that young. Just like kind of suggested to use condoms and stuff too, and again she brought up the less cancer risk and that was like the main reason. But also because of my age and stuff. I guess because of the discipline that it takes, I think that was kind of ...

*Lisa:* Did you find she answered all your questions?

*Sheila:* Well it was good, my family doctor she's very, what's the word, she's very relaxed. Like if you go in and there's a problem she'll play it down a lot. So this was the first time when I saw her and she was like a little concerned. So I talked to my Mom about it as well and we kind of made a decision. So I let her know what that decision was.

When she began taking the pill, Sheila notes that she expected that she would notice some changes. She did not really experience that many changes, however she did struggle with persistent yeast infections.

*Lisa:* When you first started taking the pill did you notice any changes in your body?

*Sheila:* No, I would like to say my boobs got bigger, but I highly doubt that [laughs]. I think I was imagining it. I was expecting all these different... I'm gonna break out. But nothing really, which is why I liked it. Even though, because of the yeast infections, because there haven't been any other problems, which is why I haven't changed it.

*Lisa:* Did you talk to your doctor about your yeast infections?

*Sheila:* Yeah. The latest thing I tried was this medication called Diflucan... so I just usually take one. It's good when it's, it's perfect when it's around my cycle, cause then I don't have to take it, and I kind of let everything just clear out by itself. But if it's like in the middle, like I have to take it. But recently, I took two Diflucan every other day for 2 weeks. So like the hope was that, that would clear it out. My biggest fear, even before she suggested that, was that I would become immune to it. Because I can't use canesten, like if I buy it, it just doesn't help me at all. It just doesn't work. But the oral pill, I've never done anything else, it was best. But even the oral pill, it's not as effective as the actual prescription, so I was kind of scared about becoming immune to it, because what do I do after that if my body isn't recognizing the drug. But she said it won't be an issue. So we tried that and I'd say it kind of worked, like I was getting them every single month, once a month. And now it's every 2 months. And like... before it used to be really bad, but now it's not too bad. It's kind of like, I'm not as quick to take the pill, because my body can fight it off on it's own. But she suggested other things like douching, doing it every day. But I know that it strips good and bad bacteria so I wasn't sure if that was something I was ready to try.

*Lisa:* And did this increase with the pill?

*Sheila:* I would say it increased. But I mean my frequency of like having sex has like really increased as well, so like cause I'm so sensitive, it's hard to know what can trigger it. It could be more just like... so it's kind of hard to say if it's because I'm on the pill or because I'm having more sex. I'm not sure where the correlation lies. But, yeah, so just trying to figure out why and where, like why it's happening. And I mean like, I can't eat any more yoghurt [laughing]. Not that I'm eating the best kind anyways!! I have to do like the sweet or fruity one. You're supposed to have the plain, but I need the sugar. And I've tried lowering the sugar in my diet.

*Lisa:* What did your doctor say about it?

*Sheila:* Well she told me that it's the estrogen that would increase it. But another doctor told me that it's the progesterone, and mine is a progesterone only pill. So, it's a little bit, but because I

like it so much, it's become a little bit more controlled and all that, so I wasn't too concerned to look into other options.

*Lisa:* So it's worth it, the trade-off?

*Sheila:* Yeah, it is. Like it's annoying, but it's not like, like I can just, like I can be a bit proactive as much as I can. Like after sex, making sure I shower right away. So it's kind of annoying, but I just know that it would make an issue in a couple of days. I think especially because I'm not using condoms. I don't know if it's the ingredients of like chemicals in the semen or what. One doctor said my boyfriend is probably giving it to me, but I don't know. But I'd say more often than not that after a lot of sex at one time, kind of thing. Any time where it's like irritation.

I found that participants had much more to say about the pill when they experienced an effect that was undesirable. This would often set off a pursuit of determining the reason for the unpleasant experience by consulting various experts, such as a doctor or pharmacist, and consulting with friends. As Sheila notes, she received competing views from the doctors she consulted. One doctor linked her condition to increased progesterone, while another doctor linked it to increased estrogen.

Like Sheila, Jennifer was also expecting to feel the pill in the body when she started taking it.

*Lisa:* Did you notice any changes in your body when you first started using the pill?

*Jennifer:* I was really expecting to notice a lot of changes, because I had heard horror stories of some other friends who had gone on different brands and had really bad experiences. The changes I noticed were my boobs grew and my periods got shorter. Of course they're not real periods, but whatever... and lighter and that was awesome because that had always been a problem for me. But I didn't notice any emotional changes and I didn't really gain weight. I was actually surprised ... I think I was expecting to feel different. But, I was expecting a bad reaction to the first pill I tried or something, but I didn't. It worked out really well actually.

*Lisa:* Why were you expecting that?

*Jennifer:* Well one of my friends had terrible mood swings and another friend bled for three months. Or some people gained weight... that didn't happen to me. I guess... I was just expecting something to maybe go wrong. I was aware of the possibility. And also in the package it says all the side-effects that you could experience. I think when I started taking the pill I was worried that if I smoked like 1 cigarette I would like have a blood clot. I'm not a smoker, but ... I guess mostly bad stories from friends and stuff like that. The internet too and in the packet.

In this sense, there is a significant gap between *knowing* what the pill does and what the pill *actually* does.

The unpredictability of the pill creates a problem and one that is recognized by the Canadian Federation for Sexual Health and [sexualityandu.ca](http://sexualityandu.ca) websites. Both sites encourage young women to consult with doctors and other medical professionals. Similarly, participants

indicated the ways that one can conduct one's self so as to minimize potential issues surrounding the pill. Alicia observes that it is important to read the pamphlet and to take the pill regularly.

*Lisa:* What advice would you give to a friend who was thinking of going on the pill?

*Alicia:* Well, to read about it. Read the pamphlet. Also, be aware of how it works and that you really need to take it regularly. But I think it's a good idea if you don't want to get pregnant and that I've been on it for awhile and I haven't had a problem.

*Lisa:* Where would you send them for information?

*Alicia:* I think your doctor is best, she can look it up online too. I think it's important to be aware of all... like to do your own research before you go see your doctor. That way you know what you're doing for yourself, not just someone telling you, "This is what you're going to do". To have a conversation, not just getting a prescription.

Renée indicated that a young woman can talk to her doctor to know which pill will best suit her.

*Lisa:* Si t'avais une amie qui pensait à prendre la pilule, quel conseil tu lui donnerais?

*Renée:* De parler avec son médecin pour savoir quelle pilule est bonne pour elle. Parce que à un moment il y avait des problèmes avec Yasmin. Alors, peut-être aller voir laquelle ... il devrait avoir une qui convienne plus. Pis, après ça, d'attendre un mois avant d'avoir des relations sexuelles non-protégés. Et de faire attention, comme, prendre la pilule à une moment quand tu vas plus t'en rappeler. Par exemple, midi pendant que tu manges, ou le soir avant de coucher... quelque chose que tu vas toujours te rappeler. Et que, ça se peut qu'elle peut prendre du poids avec la pilule.

I will discuss more fully in the next chapter, the importance of friends for providing knowledge about their experience of the pill. For the moment, I want to draw attention to the importance that participants placed on the knowledge of doctors, despite the fact that many participants had received conflicting, incomplete and unclear information from medical experts.

The irony is that today, pharmaceutical companies are no longer really investing in developing new pharmaceutical technologies for fertility control. It is too expensive to deal with law suits (Djerassi 2001). Indeed, there have not really been any radically new fertility control devices since the pill came on the market. In spite of this, there is an ongoing tendency to privilege advances in hormonal methods over those made in relation to barrier methods and what are characterized as "natural" methods. Arguably, in the twentieth century contraceptive methods have changed in many ways; for example, the vulcanization of rubber led to better and more durable condoms and better and more accurate thermometers allow women to track ovulation with higher degrees of accuracy. However, as Djerassi (2001), Fisher (2006) and

Watkins (2011) have observed the popularity of a contraceptive device is often dependent on the support of social relationships that encourage its use as opposed to its effectiveness in relation to other methods.

Key social changes in North American society have situated contraceptive counselling as a responsibility of doctors. Most doctors in Canada will receive training in reproductive health, which includes guidelines on how to counsel patients on contraception. It is assumed that it is easy for a doctor to prescribe a pill and that it is easy for a young woman to take a pill. The “life-style” benefits of the pill serve to amplify this relationship. But this does not mean that doctors are informed about available contraceptive technologies or even comfortable describing to patients how to other available methods. For example, several participants noted asking their doctor about the IUD or the nuva-ring and were discouraged from using it without any reason provided by their doctor. However, while young women acknowledged and were aware of their lack of knowledge, none of the participants recounted being informed by a doctor about the uncertainty surrounding how the pill might affect the body. Indeed, the real trick is that doctors and pharmaceutical companies do not know all the ways that the pill might affect the body.

#### **4.5 Conclusion**

In this chapter, I explored the popular metaphor “tricking the body” in public health communications available on the Canadian Federation for Sexual Health website and [sexualityandu.ca](http://sexualityandu.ca) and data from interviews with young women about what the pill does to the body. I offered an account of what the pill does to the body. Descriptions of how the pill functions isolate the effects of taking it to the reproductive functions of the body. Further, the pill is taken to be highly innovative because it is entirely man-made or synthetic, and its “natural” components are obscured.

In public health information websites and in interviews, I found that contraceptives were classified into “natural” versus “non-natural” methods or “hormonal” versus “non-hormonal” methods. But these boundaries are social distinctions that attribute higher degrees of legitimacy to some methods over others. As Bowker and Starr (1999) observe categories contain a moral or ethical dimension that serve to direct the conduct of individuals in particular ways. Finally, as I explored informed consent structures expectations surrounding knowledge about devices and configures users and providers of pharmaceutical technologies in particular ways. The metaphor of “tricking the body” implies that knowledge about the pill is dumbed down for consumption by women and the general public. But the metaphor is part of a general uncertainty around what the pill actually does and the limitations of scientific knowledge. While participants identified doctors and medical professionals as important sources of knowledge, as I will explore in the next chapter, the young women I interviewed also drew on alternative and unconventional knowledge sources to navigate uncertainty. I now turn to the ethical work that young women engage in when getting on the pill and a focused consideration of difference.

## 5 Girls, ethics and getting on the pill

*Lise:* What I hate, you know when you go to see those advertisements for the Plan B and I think that's disgusting. Oh yeah, I think that's really not the sort of thing that should be advertised, like I don't think it's appropriate. I think as much as I'm pro-abortion if that happens, I still would feel pretty bad about that happening and about like not having seen it coming. I mean I've used two methods of contraception most of my life and I just switched to one because I thought it was reliable. And when I thought it had happened, I was really sad, like I was really disappointed in myself, for not having taken the necessary precautions. So the fact that people take it so lightly... "Oh you can just use the Plan B..." And I'm like, you know sometimes that phrase, "We've run out of condoms and like, oh I'll take the Plan B tomorrow." I think it's really something not to take lightly. And I'm not against abortion, but saying that abortion is some kind of prescription is a little bit playing with the devil. I know for students it's sometimes for that. But I think Plan B is really problematic. It's really not like a 100% either.

*Lisa:* So, for you, when you use the pill, what's the biggest benefit?

*Erin:* Um... I would say just no cramps, ever. But also, not having to worry about unplanned pregnancy, but cramps is definitely... the big one.

*Lisa:* Why is it important for you to not have cramps?

*Erin:* Um... just so my daily life isn't affected when I have my period.

*Lisa:* For you, what would you say is the biggest drawback of using the pill?

*Erin:* I don't really think there is one... once in awhile I forget to take it. But usually I remember a couple of hours later. Or just, you know, whatever amount of risk is involved with taking hormones. I think it's mostly negligible given the benefits.

*Lisa:* Do you have any concerns about using the pill long term?

*Erin:* Um... I don't know, I'm wary of using any sort of medication long term, but... not ... I don't think enough to stop me from using it.

*Lisa:* When do you think you'll stop using the pill?

*Erin:* I don't know, I would like to ... maybe when I'm a little older look into the IUD again. That's a possibility. Or otherwise once I want to have children...

*Lisa:* Do you think you want to have kids?

*Erin:* Eventually.

In this chapter I turn to the ethical work involved in getting on the pill as a young woman and the importance of difference. How is getting on the pill connected to questions of freedom for young women? Why do young women choose the pill in the context of other available options? How do other individuals figure into this decision, such as doctors, parents, friends and sexual partners? What do young women want to do with the pill? Do different identity factors play a role in this experience? This chapter engages directly with the study of ethics and care of the self in the work of Foucault (1985, 1986, 1988, 1994a, 2005, 2008), differential modes of governance in the work of Valverde (1996, 1998) and rhetorical campaigns of desire as discussed by de Courville Nicol (2013). I develop these concepts within the particular context of girls as subjects and discuss the ethical work that participants engage in in getting on the pill. This analysis

chapter draws on two data sets: the Alesse advertising campaign and interview data. In getting on the pill young women sometimes aligned with discourses of freedom such as those put forward by Alesse, but they also had different intentions and constructed their own conditions of liberty.

The Alesse advertising campaign places an emphasis on individuality, personality and self-realization consistent with contemporary formations of the self (Rose 1992; White & Hunt 2000) and employs what de Courville Nicol would identify as a rhetorical campaign of desire—or a set of discourses that aim to structure moral responses towards the pill as pleasurable (179). The Alesse advertising campaign aims to produce an association of self-esteem, empowerment and individuality with taking the pill. At the same time, the advertising campaign employs a rhetoric of fear, that aims to encourage a feeling of disgust with unplanned pregnancy and bodily functions such as menstruation. In this sense, the bodies of young women are inherently problematic as freedom is not possible without enjoying the control offered by the pill. In contrast, in young women's talk about the pill I found that freedom in relation to the pill was described in far more fluid terms. The experience of freedom was highly dependent on specific bodily experiences, changing social contexts and close intimate relationships. In this sense, getting on the pill was connected to a shifting set of tensions where the orientation to freedom was not fixed. Not all women will use the pill and even those who use it will not use it continuously. Getting on the pill may be seen as a way a young woman tries on the ideal of freedom and makes her day to day life easier, as for Erin, a 22 year old anglophone student originally from Ontario. But as Lise, a 25 year old francophone student originally from Montreal observes, taking the pill also produces ethical dilemmas that are unique to young women and the management of reproductive health and fertility. In getting on the pill, young women sometimes

aligned themselves with discourses of freedom such as those put forward by Alesse, but they also had different intentions and constructed their own conditions of liberty.

### **5.1 “You’re 16...you should probably be on the pill”**

The first dimension of ethics identified by Foucault (1985), is the determination of the ethical substance, or “the way in which the individual has to constitute this or that part of himself as the prime material of his moral conduct” (26). To understand what part of the self is being worked on when young women get on the pill I want to begin by looking at Alexandra’s story.

Alexandra was 28 years old at the time of the interview and originally came from a small town in Ontario. She was an Anglophone Caucasian and grew up in a middle-income household. She did not indicate that her parents played a significant role in her decision to take the pill. She identified as queer, and predominantly slept with women, but had also had sexual relationships with men. She had volunteered as a sexual health educator for queer youth, and compared to other participants, I found she had a very comprehensive knowledge of available contraceptive methods. Below she recounts the first instance when she got on the pill when she was sixteen. At this time she was having sex with men and women, and she also had polycystic ovaries.

*Lisa:* And the first time that you started using it, what was it that prompted you to take it?

*Alexandra:* I was diagnosed pretty early as having polycystic ovaries and I think combined with the, well you know the doctor saying, “you’re 16, you’re probably going to be sexually active, it’s a good thing to maybe consider.” It was like those two issues combined. But a lot of the way that my doctor used to sell me on it was around vanity. Like around, your skin will improve that kind of thing. I felt like I didn’t completely have, really accurate information, and they were appealing to my sense of vanity to sort of push me over the edge to accepting it. And I did feel like it was kind of coercive. I really trusted one of my doctors. But it still felt kind of different from other medical advice I would be getting on a completely different issue.

Alexandra identifies two issues that prompted her doctor to recommend the pill: contraception and treatment of polycystic ovaries. But the side-benefits of the pill, in this case, treatment of acne, also figured prominently in how the pill was presented as useful to Alexandra by her

doctor. She indicates that she was aware that her doctor was attempting to guide her conduct and indicates that she thinks his intervention was somewhat coercive.

Below Alexandra recounts what prompted her to use the pill a second time when she was twenty-five.

*Lisa:* What prompted you to take the pill this second time?

*Alexandra:* Now I'm taking it, and I'm conflicted about it, but I'm still doing it. I'm taking it to help manage the symptoms of polycystic ovaries, particularly because I have a history of osteoporosis and bone loss in my family. Polycystic ovaries if you don't have periods affects your ability to regulate iron and calcium in your system, so it's seen as a good thing to regulate, so that you don't have brittle bones. This is what I've been told and research that I've looked up has backed that up. And then really just the other symptoms, like acne, they really bug me so I don't want to have to deal with it. And when I was off the pill for about 2 years, I noticed that my skin got so much worse. And I wonder if it was because I had been on the pill for so long so it didn't work itself out of my system or something, so that really returned when I went off the pill.

In this second instance, Alexandra was no longer using the pill for contraception and identified her primary reason as for taking the pill as the treatment of polycystic ovaries. She identifies the treatment of acne as a nice benefit. In both instances she described herself as conflicted.

However, in the first instance she perceived a degree of 'coercion' on the part of her doctor.

More recently, she has changed to the progestin-only pill because of a concern over migraine headaches.

*Alexandra:* My doctor just recently switched me off of Diane-35 because I have migraines and she was concerned about that. She basically said, "You know if you are experiencing that, than Diane-35 is definitely not helping." So now I have the progestin only, which is called Micronor.

*Lisa:* Have you always had problems with migraines?

*Alexandra:* No, it was the first one. I had it maybe 2 months ago. The progestin only pill is definitely not as good at managing the symptoms of polycystic ovaries, at all.

As she mentions, the latest pill is "not as good at managing the symptoms of polycystic ovaries."

Her story illustrates how getting on the pill is a process of balancing expectations for freedom--that might have varying degrees of importance for the individual--with what the individual is willing to accept in terms of side-effects.

For many of the young women I spoke with, they got on the pill because of its contraceptive benefits; but in other cases they started using the pill to treat issues associated with

premenstrual syndrome, amount of blood flow, acne, or polycystic ovaries. Participants recounted many different reasons for getting on the pill, but all issues were described as problems specific to young heterosexual women. In this sense, taking the pill was an activity associated with the formation of the self.

To some extent what the pill is used for can be explained by governmental and industry regulations governing its use and distribution. Equally, medical professionals will have society wide standards, such as those published by the Society of Obstetricians and Gynecologists of Canada (SOGC), which establish particular devices as appropriate for particular types of patients and conditions. For example, in Canada (and the United States) the pill is generally accepted as the preferred method to offer to young patients because it allows for a high degree of error, is generally highly effective and does not require the individual to maneuver with a device. In other places in the world, other methods are preferred. For example, women in Europe and China tend to use the intra-uterine device over the pill for contraception (Djerassi, 2001). Preference for the pill can also be partly understood by the branding of particular pills by pharmaceutical companies. The brand I found participants most frequently mentioned was Alesse.

Alesse is produced by Wyeth, and is marketed as a low-dose version of the oral contraceptive pill. Anderson DDB Health & Lifestyle was the marketing agency responsible for Alesse's marketing campaign in the mid 2000's. In a profile article published in *Canadian Pharmaceutical Marketing* in 2008, the author recounts that the challenge confronting the agency was that when Alesse was launched "the market was crowded with 23 other brands" (14) which were all low-dose versions of the oral contraceptive pill. The "savvy targeted campaign, which included tie-ins with youth music channel Much Music, out-of-home ads, and guerilla

marketing on university campuses and a website, helped Alesse surpass the competition to become number one” (16).

When the generic brand became available, one of the agency’s creative directors described Anderson DDB’s strategy, “Anderson DDB opted to get more tactical, creating a name-brand recognition campaign that played on words (*i.e.* “Be realesstic” to encourage girls to continue to ask for Alesse” (*Canadian Pharmaceutical Marketing*, 2008: 16). As the company’s creative director observed, “We stopped the erosion” (*Canadian Pharmaceutical Marketing*, 2008: 16). Wyeth Canada’s Business Unit Director identifies Anderson DDB as an important partner in “staging ongoing and innovative ‘experiences’ for young women” and helping to create “a brand loyalty that continues to make Alesse the most prescribed birth control pill in Canada” (16). Pharmaceutical companies invest millions of dollars in ensuring that patients will go to their doctor and ask not just for the pill, but specifically for Alesse. In a previous publication I have examined the dynamic between normative body ideals and pharmaceutical marketing, as well as the extension of this industry into structuring everyday experiences through the internet (Smith, 2013).

In the Alesse advertising campaign the young female body is non-reproductive, periods are regulated, and acne is non-existent. While the Alesse website contributes to discourses that normalize the bodies of young women, the campaign also mobilizes dilemmas of freedom specific to young women, or as the creative director puts it, girls. One of the ads frequently mentioned by young women aired in Canadian movie theaters and on television in 2009.

[Fast-paced heavy rock music plays throughout the ad].

*First scene:* 2 young women are in a brightly colored (mostly hot pink) gym fencing. One girl in a different coloured suit (brown and pink) takes off her helmet shakes out her hair, and speaks into a wrist walkie-talkie. She says in a firm voice, “I’m on Alesse”.

*Second scene:* An Asian woman with long straight black hair is sitting cross-legged in a bright pink outfit. She also talks into her wrist walkie-talkie. She says, “I’m on Alesse”.

*Third scene:* A Black woman in a black body suit gets onto a motor bike. She also talks into her wrist walkie-talkie. She says, “I’m on Alesse”.

*Fourth scene:* A blonde woman lying on a red sofa with big shades speaks into her wrist walkie-talkie. She says in Russian, “I’m on Alesse”.

*Fifth scene:* Cuts to 4 screens with all of the women running.

*Sixth scene:* All 4 women are waiting in an elevator, with elevator music playing in the background and all 4 look bored.

*Sixth scene:* The Alesse package appears in the middle of the screen. Text appears at the bottom of the screen and is read by a woman’s voice: “Talk to your doctor. It’s your choice. Ask about Alesse”.

The Alesse advertising campaign fully embraces the notion that for a young woman, “consumption and lifestyle are key to identity,” and that “success and young femininity are connected through notions of choice, versatility, beauty and cleverness” (Harris, 2004: 22).

Marie recounted that she remembered the Alesse advertising campaign because it was related to contraception, but also because of the general focus on young women as users of that particular product.

*Lisa:* So you were familiar with the brand?

*Marie:* Umm... yes. Alesse had a big campaign going on at that time. It was really pink and for young girls and like, “Wow, you’re on Alesse! Cool!”...

*Lisa:* What do you remember most about what you saw about Alesse? Was it just the images?

*Marie:* Yeah, I feel like it was like young women, and it was fun and it was like, I feel like the ad campaign, but I feel like there were superheroes. It was fun and young, so I imagine the pharmaceutical company was really targeting girls exactly like me, who were just like, who had been watching *Sex and the City* secretly since they were 15. Who were like [making funny voice] “Oooh, sexual adventures! But got to be safe...” So it was like safe and it was like be responsible and [whispering] have sex. But I remember it was like bright pink, the commercials, and the packaging and so it was very feminine.

The Alesse advertising campaign seeks to situate decisions in relation to contraception, and health in general as central to a young woman’s identity and sense of self. In a similar vein, I found that getting on the pill was perceived by respondents as a natural step in a young heterosexual woman’s life. It was a form of conduct that was expected of her as she became a mature individual interested in acting in a responsible manner.

Participants identified the contraceptive and other benefits of the pill as highly important. But equally important was using the pill as a way to try on a mature identity through using a device that was associated with adult activities, such as engaging in responsible sexual relationships and learning to govern menstruation.

*Lisa:* And what about now? Are you in a relationship?

*Lynn:* I am not now, but now I'm also much more clear ... about what's up my end, what's up on their end, like all that stuff. Well I don't know, I'm just sort of dating someone, it's not sexual yet, so [laughs], I wouldn't say I'm in a relationship. But, yeah, I was like very stupid and embarrassed about everything. So, I think I told him once I was on it, but I wasn't like [using funny voice], "I am going to make the decision to go on the Pill. What do you think?" It wasn't like that. I think I wanted to do it because my friends were on it. And it was very important at that time not to be a loser and so yeah.

As Alexandra identified this type of behaviour is strongly attached to heterosexual expressions of femininity. Mid-way through the interview she asked me if I ask participants about their sexual orientation.

*Lisa:* Yes, but I'm also looking at people's experiences over the long-term, so it comes out usually indirectly.

*Alexandra:* Right.

*Lisa:* Why do you ask?

*Alexandra:* Oh I'm just interested, because it's not like I've felt a bit stigmatized... as a woman who identifies as queer, for taking birth control. I mean it's not something I discuss with queer people, but it feels like, when I've had conversations with people about it, and they don't understand the nuances of that. And it's almost seen as an un-queer thing to do, does that make sense?

*Lisa:* Yeah...

*Alexandra:* I guess people question my authenticity as a queer person because I'm subscribing to this, this thing that's largely considered to be in a heterosexual domain. And I think that there's also a degree of body consciousness and awareness that's also really valued in queer communities... in that, people really perceive birth control as not a good thing. All of that stuff around opening up options for women, they think it's like, the perception I've encountered is that people think it's like doing the opposite. Because you lose touch with what your body is really doing or what it's really telling you. I mean I don't think it makes me less queer because I'm taking birth control, but I also am really conscious of addressing that with doctors, like saying, "I don't need birth control, per se, I'm using the pill to manage polycystic ovaries."

As Alexandra observed, taking the pill is commonly thought of as something done by "straight women" and corresponds with negative views surrounding the intervention of the pharmaceutical industry in women's bodies. The association of the pill with straight women is connected to certain social codes that legitimate its use in this way by this population, but the young women I interviewed equally reinforced gender norms in the way they talked about the pill.

In terms of ethical work, I found participants often identified the pill as responding to certain female-related problems. Alexandra's story illustrates how getting on the pill involves various orientations to the problem of being a young woman ranging from contraception, to

management of periods, acne and polycystic ovaries and equally involves particular identity characteristics, such as being queer versus heterosexual.

The various uses of the pill are emphasized by pharmaceutical companies like Wyeth to situate Alesse as a lifestyle accessory for a young woman in control of her life. I found that participants often identified the pill as a natural and expected step for young heterosexual women. Tara, a 20 year old Caucasian anglophone student originally from Ontario, indicated that for young women, taking the pill is comparable to the way “old people take blood pressure medication all the time”. Christie, a 22 year old African anglophone student originally from Montreal, observed that the diaphragm is an “old woman’s thing”. Marie, a 26 year old Caucasian Anglophone originally from Manitoba, observed that the diaphragm is “something you would see on Seinfeld”. But the everyday quality of the pill also made it more mundane than suggested by the Alesse advertising campaign. Melanie, a 26 year old Caucasian anglophone originally from Montreal recounted that getting on the pill was “no big deal”. Alicia, a 26 year old Caucasian anglophone student originally from Ontario, identified that she got the pill and then “she had to get back to school”. Consistent with a rhetoric of desire, in the Alesse advertising campaign getting on the pill was identified as *the* access point to freedom and self-realization is implied. For participants, this designation was far more fluid and responded to the shifting ways that they used the pill. Thus, for most participants, getting on the pill was *a* way that they tried on and worked out different formulations of freedom.

## **5.2 “I’m not usually that kind of girl...”**

The second dimension of Foucault’s study of ethics is “the mode of subjection” or “the way in which the individual establishes his relation to the rule and recognizes himself as obliged to put it

into practice” (Foucault 1985, 27). Here Foucault is concerned with what rules are followed and why? To understand this second dimension I will introduce Christie’s story.

Christie identified as an anglophone African-Canadian montrealer. She was twenty-two years old and a student at the time of the interview. She started taking the pill when she was fifteen because she had very irregular periods and excessive blood flow, often bleeding through tampons and pads onto her sheets at night. But she also described her choice as motivated by the fact that she had “boyfriends” and wanted to be “extra safe to not get pregnant”. When starting a new pill pack Christie would throw up repeatedly for three to four days and she also had experienced persistent yeast infections. Below she describes her reaction to the pill as well as her general views on medications.

*Christie:* ... I was on and off with the pill, because I’ve had several partners too. My last partner that I was with, I know I stopped for like a month or two because he saw how sick I was too. And he was like, “I don’t want to see you like this...” But they’re very understanding, which is cool. And then in the morning, they’re like, “You’re still sick?” And it’s like, “Yeah”. Actually, because I used to take it in the morning, but because I would get so sick, but then I took it at lunch time, but it would do the same thing. So I decided to take it at night, like right before going to sleep. Because I didn’t mind getting up in the middle of the night to go throw up [laughs]. It’s better than throwing up at work, all of your food and like your juice. So I figured... I would take it at night. Like I don’t take it at a specific time, I know I should, but it’s hard for me to do that.

*Lisa:* ... would you say that the pill is different from other pharmaceuticals that you use?

*Christie:* What do you mean?

*Lisa:* Like other medications? Antibiotics for example.

*Christie:* Um, well... antibiotics are so bad for your body, anyways. It’s all bad for you, it’s all crap that you’re putting into your body. I mean no different, it’s all junk, it’s not good for your body. Our bodies are not made to be taking this stuff.

Like many participants, Christie identified the pill and other medications as highly toxic and undesirable. In spite of this she preferred the pill over other available methods and planned to continue using it until she wanted children.

Though Christie’s reaction to the pill was more intense than many participants, like many of the participants Christie identified her choice to use the pill as distinct from how she would make choices in other areas of her life. In this sense, the rule that prescribes the pill could be considered one of freedom through *un*freedom. While the Alesse advertising campaign presents

the pill as the best available choice, for most of the young women I interviewed, they often described taking the pill as *a* choice, but not necessarily the best one.

Hannah was of African descent, originally from Trinidad. She had immigrated to Canada with her family as a teenager. She indicated that getting the pill was easier in Trinidad than in Canada, because a prescription is not required. However, she remarked that Canadians were generally more open in discussing sexual health. She observed that her parents did not discuss sexual health or contraception openly with her. For Hannah, she described that getting on the pill is incongruous with a general ethic for valuing “natural” and “non-interventionist” approaches to health.

*Lisa:* And are there other things that worry you about taking it for a long time?

*Hannah:* I don't like to take any medicines at all. Like if I have a headache I don't take tablets, I just let it go away naturally. I don't like antibiotics and stuff like that. So just the fact that every day I'm taking a pill bothers me. Like I just don't like unnatural things in my body and that bothers me. But of course, I know why I'm taking it.

I will discuss more fully perceptions of risk and danger in using the pill in the next chapter.

Perhaps one of the most distinguishing characteristics of the pill is that it is known as *the* pill. I do not have to specify in conversations what I mean when I say “the pill.” Equally, in women's talk about contraception and sex, the pill was used as a stand in for “being safe.” Other methods, such as withdrawal or condoms were perceived as unsafe. This was the case even if participants had used various methods like condoms and withdrawal occasionally and had never experienced pregnancy as a result. Participants' understandings of safety were linked to the fact that the pill worked, they did not get pregnant. To express this participants would sometimes use percentages, such as the pill as “99% or something”. However, I found participants were more likely to point to the importance of characteristics of the pill which made it safe which had nothing to do with its actual contraceptive properties per se.

Fisher (2006) highlights that in the early part of the twentieth century women took little interest in managing contraception and left it to men. She raises the question, how did women overcome the refusal to be involved in contraception? Part of my answer would be that they did and they didn't. As Granzow (2007) also found, the young women I interviewed preferred the pill because it did not involve direct engagement with the body, beyond swallowing a pill. Methods such as the nuva-ring, the diaphragm and the intrauterine device that involved inserting a device into the vagina were often described as "weird", "scary" or "too much." Because of her severe nausea Christie had thought about exploring other options.

*Christie:* ...and then I tried the ring, and that was the biggest mistake of my life.

*Lisa:* When was that?

*Christie:* That was 2 years ago, when I had my infection. It was so strong in the sense of chemicals and everything and my body couldn't cope with it. And I got rashes and I got the biggest infection ever and oh it was just gross! That whole experience ... I actually got a misdiagnosis by the Jewish General Hospital and he's like, "Oh you have herpes or something" [whispering]. And it's like, What!!

*Lisa:* This was while you were on the ring?

*Christie:* Yeah, this was because I had an infection and they didn't know what it was. And I was crying and the guy was horrible. And he was like, "Oh it's a shame you know, you're so young and you've ruined your life. And blah, blah, blah..." And I was like, this guy is such a jerk [whispers]. You know, he's like telling me all this stuff. And we did the blood test and everything and it was just a really bad experience. And not only that, but I had to call people I had slept with and tell them you know, that I might have something. And then I get the test results back, and they were like, "No you don't have it, you just had a really bad yeast infection. You need to take care of it now." And I was taking medication and everything, and they were just like [making a silly voice], "no you just have a really bad yeast infection".

*Lisa:* They gave you medication for...

*Christie:* Herpes. Yeah!! [laughs] And then I had to call back the guys and be like, "Yeah, I don't have it." It was so embarrassing! It was really, really horrible. It was the worst infection ever, it gave me rashes and bumps. Like I said to the guy, like I throw up all the time because of how strong the pill is, like the dosages or whatever. So for me to shoot that directly in there, was like bad. My body didn't cope with it well.

*Lisa:* Was it your doctor who suggested you try it?

*Christie:* Yeah. Well because of the throwing up and everything, I mentioned it to different doctors and then afterwards when I got older, they gave me the same options again. So I thought ok, let's do it. I thought I don't have anything to lose. It kind of creeps me out, but ...

*Lisa:* What about it creeps you out?

*Christie:* Um, the fact to have something inside me and that I can just take it out whenever I want. And when you have intercourse, the fact that you can keep it on. I thought that was like... too many things in there [laughs]! I was like, the guy feel it too, it's like gross right. It's like this rubber band and the fact that it was shooting chemicals up in there, yeah it just creeps me out. And what happened afterwards just confirmed it all.

Her experience with the nuva-ring led to a misdiagnosis for herpes, but her rejection of the device was also strongly motivated by an emotional response, it “creeped” her out. The way a device was perceived or connected to certain bodily experiences was often more important than its effectiveness in comparison with the pill.

Similarly, in the Alesse advertising campaign, the effectiveness of the pill is secondary to its status as a marker of individuality. Employing a rhetoric of desire, the advertising campaign encourages the user to get on the pill as an expression of individuality and empowerment. For example, the website is not sexually suggestive at all, and in fact, sexual activity is only mentioned by allusion, such as “getting carried away”. As soon as the user enters the site, she is greeted with upbeat generic “teen” music. The user can change the music to meet her tastes. Does she prefer “Rock,” “Hard Rock,” “Urban,” “Electronica,” or “New Country”? There are links to the band websites, and free downloads are merged with a section which compares different forms of contraception. The ability to choose what type of music will be played as a backdrop is a reflection of the general message behind Alesse’s advertising campaign: that a young woman is in the process of defining who she is as a unique individual through the choices she makes. This message is also found in “Alesseisms”. These phrases are prompted by the question, “Tell us what Alesse means for you?” They are meant to indicate the range of meanings that Alesse can have for a young woman. The Alesse website fully embraces the notion that for a young woman, “consumption and lifestyle are key to identity”, and that “success and young femininity are connected through notions of choice, versatility, beauty and cleverness” (Harris, 2004: 22). For a young woman, her consumer choices are constructed as ethical choices that are implicated in the constitution of the self.

In general, the young women I interviewed stated that they used the pill because it worked *better* than other options at doing what they wanted it to, for example contraception, managing periods<sup>6</sup>, or acne control. However, many participants did not really consider other available options, often did not know whether or not other options were available or in some cases were afraid to ask doctors. For example, Serena, a Caucasian Anglophone, was 19 years old at the time of the interview. She had started taking the pill at 17 when she became sexually active. She explained to me that her reason for choosing the pill was because she did not want to use condoms and the pill was what was offered to her at the clinic.

*Lisa:* When you decided to go on the pill, you mentioned the female condom and condoms, did you think about other options?

*Serena:* Yeah, I had thought about the patch. But, it was mainly an issue like money... I know my parent's insurance covers my birth control pill, but the patch is more expensive. And I personally didn't know anyone who was on the patch and just like you have a patch stuck to you kind of thing. So I wasn't really as sure of that. And when I first went in to get my birth control, I was really nervous, so I was not going to ask about anything else. I was like, get in, get the pill, get out! It was like a drug deal!! I felt like everyone in the waiting room knew why I was there!!

Jennifer was a Caucasian anglophone, who was originally from the United States. She had moved to Montreal in order to attend university. She observed that reproductive health politics were much more complicated in the United States compared to Canada. She started taking the pill when she was 20 years old because she was in a sexual relationship and did not want to get pregnant. Jennifer recounted that she did not really consider anything else aside from the pill.

*Lisa:* When you decided to go on the pill were there other options that you considered?

*Jennifer:* Yeah, the pill was pretty much it. Yeah. I didn't consider anything else.

*Lisa:* Why was that?

*Jennifer:* I guess like I figured it's still popular and it seems to work very well. And it was the cheapest too. Yeah, I think, I was also not sure what was even available from the McGill clinic. And an IUD I didn't want to get, cause it seemed too permanent. I mean I didn't want to get ... I don't think the McGill clinic offers it. What else is there? The nuvaring, I didn't even think about it, I don't know why.

Fisher (2006) found that among women at the turn of the century in Britain there was a general lack of knowledge about contraception. In contrast, as I explored in the previous chapter, today

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<sup>6</sup> Space does not permit me to explore fully the use of the pill for menstrual suppression, but women noted using the pill to avoid periods for vacations and important events where menstruating would be an annoyance.

in Canada, there is an expectation that young women are informed. For example, the Alesse advertising campaign situates young women as if they are at the forefront of reproductive decision making. In contrast, I found participants often described going with the pill for reasons which they did not always fully understand and within a context where other available options were vague and frightening.

### 5.3 “I prefer not to tell him...”

Foucault (1985) identifies the third dimension of ethical work as “the elaboration of the ethical work” that one performs on oneself, not only in order to bring one’s conduct into compliance with a given rule, but to attempt to transform oneself into the ethical subject of one’s behaviour” (27). Here Foucault seeks to examine the relationship one has to the self and the practices one engages in to attain transformation. For example, in classical Greek society, men were expected to be guided by *enkrateia*, which refers to the capacity to avoid over indulgence in bodily pleasures. Doing so proved their right to rule over others. In this sense, care of the self is connected to the care for others (Foucault 1991b, 6). In this third dimension Foucault highlights the importance of relationships with others in structuring ethical work. To understand how participants connected ethical work to getting on the pill I want to begin with Melanie’s story.

Melanie was a 26 year old Caucasian Anglophone. She had started using the pill when she was sixteen at the suggestion of her doctor to help with cramps and acne.

*Lisa:* Did you discuss using the pill with partners you’ve been with?

*Melanie:* Well the first guy I was with when he found out I was on the pill, he didn’t want to wear condoms anymore. So, I sort of ended that, and then I started just not telling them, because, like I understand that for them, it’s like, it’s like less sensation... but they prefer not to wear a condom and then as soon as they know that the girl is on the pill... My girlfriends say the same thing, like as soon as my boyfriend is on the pill they don’t want to wear condoms anymore. And like if you’re in a really like committed relationship where you’re thinking about having children or getting a house than like it’s different. But when you’re still dating and not sure, I would rather not have that... because they’re like, “Well, why you’re not going to get pregnant?” I’m like, yeah but I don’t know if... like you could have an STD and not know it. And you could give it to me... cause I did have an HPV outbreak because a condom broke and I mean I was sick, but it happens. So, I was like, I don’t want anymore diseases. That’s like one of the less bad ones, so ...

Like Melanie, participants often excluded sexual partners from their decision to take the pill. In contrast, mothers and other female family members, doctors and friends were identified by young women as very important. Participants also noted seeking out information on their own from various internet sites. While some noted positive experiences with sex-education programs in school, these were more often experienced as “embarrassing” and were rarely identified as a key source of information.

Fisher (2006) found that in Britain, not that long ago men, not women, were primarily responsible for contraception. Further, she found that women actively sought to remain ignorant to maintain prevailing norms around gendered expectations for sexual innocence (Fisher & Szreter 2003; Fisher 2000a/b; Fisher 2006). In contrast, contemporary sexual relations for young people are characterized by multiple sexual partners, and a variety of short and long term relationships (Baker 2008). Key shifts in gender relations over the past fifty years have situated female control of contraception as a prerequisite for empowerment (Granzow 2007; Ruhl 2002).

In line with this, the Alesse advertising campaign identifies young women as the central actors in the exercise of appropriate contraception and emphasizes the individual nature of this work. While young women are at the centre of discourses of sexual empowerment, young men are largely absent. An example is an Alesse advertisement which was posted in university campus bathroom stalls, which depicted a series of girls declaring they are on “Alesse”, with the last image a guy with a puzzled look on his face saying, “What’s Alesse?” In contrast to young women, men are characterized as ignorant, unaware, and out of the loop as contraception is the exclusive domain of young women. Thus, in the Alesse advertising campaign a young woman,

not a young couple, is encouraged to take control.<sup>7</sup> The conduct of a young woman is at issue, not the conduct of young people in general.

While sexual partners were often identified as unimportant, as with many of the women I interviewed, mothers were often identified as highly influential. Tara, a 20 year old Caucasian anglophone, and Lucie, a 22 year old Caucasian francophone, were both prompted to take the pill by their mothers.

*Lisa:* And why did you start taking the pill?

*Tara:* I started having sex. [laughs] And my mother recommended it, so, that was what we did. [laughs]

*Lisa:* Pourquoi t'as commencé?

*Lucie:* Mais, dans le fond... j'étais en secondaire 4, j'avais un chum, pis ma mère a dit (making funny voice) « On va prendre un rendez-vous chez le médecin! » Ç'était pas était genre, une obligation, c'était comme naturel. « Ben-la, t'as une nouvelle relation sexuelle, fais-qu'on va prendre la pilule ».

To be clear, I am not arguing that mothers or parents in general, should not be involved in helping young women to make contraceptive decisions. Instead, I am highlighting how moral work organizes individual behaviour through specific types of accepted relationship chains—such as young female sexuality/health with mothers, not parents in general. I found parents were identified by most participants as important factors, with the exception of Hannah (originally from Trinidad) and Alexandra, who was queer.

Respondents also placed a high degree of importance on medical authority as opposed to their personal knowledge and experience with the pill. This was not necessarily because a woman trusted her doctor. While some participants noted having positive relationships with their doctors, there was often a sense that a doctor might have an ulterior motive or was not being completely honest. Women wanted to interact with doctors because they were the gatekeepers to the pill, but doctors were equally seen as “pushing” the pill and limiting available

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<sup>7</sup> For the women I interviewed, who to trust or share information with was highly gendered. While there were some exceptions, there was a general preference for female doctors, while encounters with male doctors were often described as “awkward” or “unpleasant”. Fathers were described as “out of the loop” and not “in-the-know”.

options. To counteract this, women recounted how they governed the behaviour of their doctors, through choosing not to disclose details and asking for specific brands because of the advice of friends. As Christie a 22 year old African-Canadian anglophone recounted, she was nervous for her first doctor's visit.

*Lisa:* What were you nervous about?

*Christie:* I don't know, to go the [lowers voice] CLSC for like the pill... but I had some friends who were on the pill too and so, we all kind of started everything early, and you know. But it was just like, nerve-wracking and everything. ... They were kind of like judging me a bit.

*Lisa:* In what way?

*Christie:* Well, they just looked at me like... oh, you know, you're going to go on the pill... cause you know, you sleep around. You know, prejudiced.

As she got older Christie learned that doctors are actually quite lenient and she could ask for what she wanted. The fact that Christie observed her capacity to influence doctors changed over time suggests that the prejudice she experienced was more likely due to age, as opposed to any racial bias.

*Christie:* The doctors are really like lenient. When you go to the CLSC or the clinic, especially if you've taken different pills before and you're like, I don't want this this or this. And they're like, ok do you want and they just asked me... when I went to Chateauguay, the guy was like, "Ok what do you want?" I was like, "I want Tri-Cyclen Lo."

*Lisa:* And how did you hear about it?

*Christie:* From friends. We talked, yeah it's something we talk about. And one of my friends was on Tri-Cyclen Lo and another friend too. And eventually at one point they had it and they said that it was good.

As Christie found, part of getting on the pill involved figuring out how to manage doctors and learning with time how to ask for what she wanted.

For most of the young women I interviewed, friends were very important sources of information about what worked well and what had undesirable side-effects. Participants also noted governing their friends through establishing the boundaries of acceptable sexual behaviour. For example, many of the young women I interviewed were concerned that the women around them including friends and family members were using the pill if they were sexually active. Participants often described friends who chose not to use the pill or who used it irregularly as

“irresponsible” and “careless”. Equally, the young women I interviewed noted sharing what could be done with the pill. For example, many women found out that they could use the pill for menstrual suppression because of friends rather than doctors or through doing their own research. Participants structured interactions and relationships with sexual partners, parents and medical professionals through exercising restraint in choosing what details to disclose to certain individuals.

#### **5.4 “Women have options... but good girls use the pill...”**

Foucault identifies the fourth dimension of the study of ethics as the “telos of the ethical subject” which refers to the ways that “an action is not only moral in itself, in its singularity; it is also moral in its circumstantial integration and by virtue of the place it occupies in a pattern of conduct” (Foucault 1985, 27-28). The *telos* of the ethical subject refers to the desired end point. Tara’s story is helpful in clarifying what kind of person young women want to be in getting on the pill.

Tara, a 20 year old Caucasian anglophone, was twenty years old at the time of the interview. She was a student in Montreal but had grown up in Toronto. She started taking the pill when she was sixteen because she was sexually active and did not want to get pregnant. Her mother approached her because she knew Tara was having sex and suggested that they go to the doctor together to get the pill. Tara also enjoyed the benefits of clearer skin. She feels she did not know that much about the pill when she first started using it and she did not think about or consider other options. When I asked her how she felt about using the pill today, like many of

the participants she said she was conflicted, but keeps using it anyways.

*Lisa:* Are there other things you want to add?

*Tara:* ... you know if you're prescribed blood pressure medication from your doctor... yeah sure, you don't know have to know how it works to lower your blood pressure. But if you knew how the system works, then you could use your diet or exercise or you would know there was another way to get the same effect. But that requires you to learn how capillaries work and how all those things fit together. But if you never ask those questions, you never think about alternative solutions. I mean I want to how everything works. I firmly believe that the way you eat, and the environment you live in, has a huge determining factor in your health. I don't dislike medication, that would be stupid, but there are a lot of things that can be helped with the way you live.

*Lisa:* But contraception is maybe different...

*Tara:* Yeah, I mean there's no diet for contraception [laughing]. Yeah, there's no way around it. And the pill is an exception to that rule because there's nothing as of yet. Who knows maybe there'll be some strange strand of guava.

As Tara's story emphasizes getting on the pill engages with freedom, but remains a contested issue. Tara is aware that the pill involves a complicated practice of freedom.

In contrast, the Alesse advertising campaign aims to imply that young women are empowered by the control offered by the pill. For example, the Alesse website repeats over and over again, "It's your choice". Taking the pill is presented as a rational and calculated behavior leading to individual control of the body and self. Taking the pill will result in a pleasurable outcome, not getting pregnant, shorter periods, and less acne. I will explore more fully in the next section the less desirable effects of the pill. The pill's effectiveness as a contraceptive can be affected by many factors, such as time of use and conflicts with other substances, such as antibiotics and alcohol. Even "responsible" behavior is incapable of always leading to certainty of outcomes. As Ruhl (2002) points out the control of biological processes is always complicated and contingent and autonomy is an ideal that structures the conduct of young women in relation to reproductive technologies.

The shifting ways that young women recounted their reasons for getting on the pill over time highlights that freedom figured in varying ways at different times. For example, in aiming to treat menstrual cramps and acne, Tara recognized she liked not having pain and she liked having clear skin. Yet, she indicated that she could stop using the pill and deal with the pain,

even though this was unpleasant. Alexandra, a 28 year old Caucasian anglophone who identified as queer, recognized that not having acne was “nice” or “great”. Erin, a 20 year old Caucasian anglophone, observed that regulating her period was not essential, but made her life easier nonetheless. Alexandra and Mona, a 20 year old anglophone Canadian of middle-eastern descent, were both using the pill for treatment of polycystic ovary syndrome. Mona indicated that her mother knew she was taking the pill and did not see taking the pill as inconsistent with her culture or heritage. For both Alexandra and Mona, getting on the pill was not identified as an issue of ‘choice’ because it involved treating a specific condition. Freedom was not necessarily at stake in these cases because participants either did not *have* to continue using the pill or had no choice because it was for treatment.

In contrast, when participants discussed the pill in relation to contraception there was a deeper tension in relation to freedom. In this case, taking the pill to avoid pregnancy was obvious, but equally problematic because it was a choice that was perceived as unavoidable.

Lynn, a 22 year old Caucasian Anglophone observed,

*Lisa:* This may sound like a strange question, but why is it important for you not to get pregnant?

*Lynn:* Ummm... well, I'm 22. [laughs]!!

*Lisa:* Ok. And why is that something that is important for you?

*Lynn:* Ok... well, ummm for 1, a number of people I've been with I would never want to raise a child with, for sure. Number 2, I don't want to be a parent right now... I don't know if this is really vague or...

*Lisa:* No, not at all.

*Lynn:* I've never thought about it this way. I just know that I definitely don't want kids, that I'm not ready. I'm in school and I have no money [laughs]! Yeah, don't have any money, I'm in school, I want to do a master's degree. I do want to have kids one day. I think I would really like to be a parent, but I'm not ready and I want to be the best I can be, and I'm definitely not right now. And if I want to have kids, like I want to be in control of when that happens. Yeah I'm not sure if that's what you're looking for...

*Lisa:* Yeah, don't worry, there's no right answer. Everyone laughs when I ask that question!

*Lynn:* Well, yeah. I was like “what, obviously!”

In most western countries today, there is an expected period of non-reproductive sexuality for a young heterosexual woman, which is seen as a natural part of her development. Maintaining this state is the telos of the ethical subject. In this context, taking the pill is not a choice in so far as

there is no conceivable circumstance in which she would want to be pregnant. Non-reproductive sex is thus not attached to the timing and spacing of pregnancies but ensuring the establishment of lifestyle choices, establishing one's career, building a foundation for one's future "adult" life. Getting pregnant in this instance is distinct from fears that construct moral panics around teenage pregnancy.

Grace was 28 at the time of the interview and she was originally from Turkey, yet, she had lived in many places around the world as her parents travelled extensively for work. She came to Canada to study at university and began taking the pill when she was 18 at the suggestion of her doctor.

*Lisa:* And why did you start taking it?

*Grace:* I had just moved to Canada and I was under International Insurance and was at... University. And I just went for a general check up and my GP suggested that I should start taking the pill. That was pretty much it [laughs].

Grace observed that her doctor's suggestion was not seen as coercion and the suggestion made sense to her. Further, she liked taking the pill because it meant that she did not have to worry about getting pregnant.

*Lisa:* Why is that important for you?

*Grace:* [laughs] ummm... In my life, that's just not something that I want to think about. So it's like, I can just put it away.

Grace was the only participant who was married. At 28 she indicated that she would likely stop taking the pill after she has children, but she did not indicate if this would be any time soon. The women I interviewed were in their late teens and early twenties, and only three women indicated they were interested in having children in the next couple of years.

As Ruhl (1996) observes, unplanned pregnancy is matched by a desire to control the occurrence of pregnancy more generally, such that fertility is always planned by a woman. For many participants, one of their concerns in using the pill was that in the future fertility would be desirable and potentially not possible highlighting the importance attached to pregnancy

occurring at the right time. For the young women I interviewed, choice permeated how they described their decision to use the pill, but it did not really figure into participants' perceptions of their own experiences which were described in very one-dimensional ways, "it's what I did", "I went with the pill". The importance of using the pill for young women becomes evident when those around them reach the boundaries of expected and acceptable behaviour.

*Lisa:* So, today, how do you feel about using the pill?

*Lynn:* Mmm... it's kind of just something that I do now. I don't feel great about it, because I fought pretty hard in the past to try and get off of it, but I haven't been able to find a specific reason or an alternative. I don't feel awful about it, because the one that I'm on is fine. I don't know if it's like making me have mood swings. I'm also like there could be all kinds of other factors that could make me feel blue. I feel ok about it. A friend of mine, a bunch of friends of mine don't take the Pill because they think it's toxic. And they're always telling me to get off of it and that it's toxic. And my counter-argument is like, "Ok, well you're having unprotected sex." And I'm really not going to do that. So ... I'm not going to go off of it, because it's like either celibacy or take the pill.

As Lynn expresses, women can choose to go off the pill, but because she wants to be responsible she will use the pill in spite of her misgivings.

In thinking about the fourth dimension of ethics, "what kind of person do I want to be?" the answer to this question could be varied. I may want to be free, in control of my destiny, good. According to Foucault "...an action is not only moral in itself, in its singularity; it is also moral in its circumstantial integration and by virtue of the place it occupies in a pattern of conduct" (28). The Alesse advertising campaign situates use of the pill as an expression of a woman's unique personality through choice consistent with liberal modes of self-constitution emphasizing the importance of mastering the body (and reproduction in particular) as a precondition to liberation. But at the same time the Alesse advertising campaign situates young women as incapable of fully realizing conditions of liberty even with the pill. Similarly, in young women's talk about the pill the end goal of getting on the pill is not to be free *per se*, but to create a solid foundation for future freedom as an adult. Getting on the pill is a starting point for trying on issues that come with exercising freedom, wrestling with it and figuring it out,

learning to exercise freedom appropriately. But getting on the pill also produces new dilemmas that shape the conduct of young women and other individuals who are involved in her decision.

## **5.5 Conclusion**

Irene Diamond invites us to “[question] a tenet of the contemporary feminist movement so pervasive that to scrutinize it is to seemingly question feminism itself: the assumption that a woman’s freedom lies in the right to gain control over her body and sexuality” (Diamond 1994, 3). In contemporary Canadian society, getting on the pill is in many ways an activity uniquely associated with the freedom of girls. Many of the young women I interviewed were middle or upper-class and were university students. Some of the young women I interviewed were from lower-income backgrounds and were not intending to study beyond Cégep. Participants came from diverse backgrounds and recognized that the choice to use the pill was often influenced by economic, cultural and social factors. Yet, in line with the Alesse advertising campaign, participants generally identified getting on the pill as an individual choice and one easily made if a young woman has her priorities in the right place.

Even so, many participants noted that their capacity to get on the pill was often limited due to issues beyond their individual control. For example, Serena, a 19 year old Caucasian anglophone, noted that when she was living in a small town in Ontario she did not get on the pill. In her story, there was an ongoing contrast between her life “back home” in a small town and her life in Montreal. In her first relationship, she often used withdrawal because getting to the clinic in her small town was a hassle because she did not have a car. She got the pill when she moved to Montreal to start university, but enjoyed having shorter periods and wished she had gotten

“bigger boobs” as well.

*Lisa:* And did you discuss your decision with someone?

*Serena:* Yeah, well I'd spoken to my roommate about it, because she knew that I had a boyfriend back home. And I also knew that you needed to take it for a month, for it to be considered as a proper method. So I knew that if I was going home for Thanksgiving in October, I would need to start it right away in September so that it was effective. So what happened was, when I originally started it, you know, things get wonky and I was like bleeding for like 2 weeks straight, so I called my Mom being like [making funny voice], “I'm dying!” And she was like, “What happened?” And I was like, “Well I got the pill...” And my Mom's like ok with it, like she was glad that I talked to her about it, but she was kind of embarrassingly ok with it... where she's just like, “I just wanted to know if everything is going well??” And I'm like, Mom stop... [laughs]! So my mom knows. There's been times when I've gone to her, because she took it when she was a teenager ... but she took it for cramps. But just when I first started taking it, I'm spotting and I'm not supposed to... or you know, “Are these normal symptoms?” She'd be like, “yeah, it's fine”. And so it's great, because if I have a problem or a complication I can talk to her and she made me an appointment for a gynecologist when I went home, so it was yeah.

Serena got on the pill to avoid getting pregnant, but her capacity to get on the pill was dependent on a variety of situational factors and she drew on the support and guidance of her mother, various medical professionals, and close friends.

As I mentioned in the methodology section, this sample does not allow for meaningful comparison between different identity orientations. Nevertheless, I found that identity characteristics did play a subtle role in the ways that young women understood and experienced taking the pill. I have attempted to highlight these instances, for example, Alexandra's experience as a queer woman taking the pill, and Hannah's observations about differences between Trinidad and Canada. Nevertheless, I found that it was not clear whether race played a significant role in how women recounted their reasons and experiences relating to taking the pill. Christie and Sheila were both African-Canadian anglophones, however, I found no more similarities between their experiences than those of other participants. In this study, I did not find that race and ethnicity impacted the importance that participants attached with getting on the pill. I expect this is because in choosing to take the pill young women align with a certain set of ideals about the body and self. Indeed, the Alesse advertising campaign uses multi-ethnic models in an attempt to display different kinds of women. Yet, I would argue that the Alesse

advertising campaign targets young middle and upper-class women who are more likely to have access to health care and the support of their families in making birth control choices (Harris 2004, 23). The Alesse ads also highlight the important role of age in determining appropriate conduct and behavior. For girls, “[s]uccess and failure are constructed as though they were dependent on strategic effort and good personal choices . . . However, these designations have much more to do with economic and cultural resources than personal competencies” (Harris 2004, 32). Even for middle and upper-class young women, access to the pill is still dependent on issues such as being able to get to the clinic, actually having access to a doctor/clinic, and the bureaucracy of dealing with the clinic and maintaining prescription refills. By portraying the choice to use the pill as individual, despite the fact that it is textured by social factors, young women who are not able to or who choose not to use the pill are constructed as failing to live up to the neo-liberal ideal of responsibility. Ethnographic accounts of ethical work highlight the complex ways that subjects work out freedom in the context of various limitations and within relationships with others.

While young women often identified doctors and the medical establishment as highly judgmental and coercive, I found the young women I interviewed were equally adept at evaluating their own behavior and attempting to guide the intentions of those close to them. Thus, getting on the pill is a technique of the self and the conduct of a young woman is evaluated and guided by others in subtle ways. Equally, a young woman guides the conduct of others and structures her own conditions of freedom. In the next chapter I explore the mobilization of “pill scares” in the print news media and discuss the various ways young women manage undesirable effects associated with taking the pill.

## 6 Disturbing ethics

Pierre Markarian se souvient encore de la perplexité ressentie en octobre 2007 devant la détérioration de l'état de santé de sa fille de 17 ans. «Théodora était sportive, ne fumait pas. Elle était toujours pleine de vie. Je ne comprenais pas que, du jour au lendemain, elle puisse changer comme ça», relate-t-il. Ses malaises étaient le signe avant-coureur d'une embolie pulmonaire qui l'a emportée quelques jours plus tard. Ce n'est qu'en faisant des recherches par la suite que M. Markarian s'est rendu compte d'un lien possible avec l'usage d'un contraceptif oral de troisième génération, Mercilon. La jeune femme avait commencé à l'utiliser quelques mois plus tôt à l'insu de ses parents. Théodora, dit-il, présentait une anomalie sanguine qui augmentait les risques de formation de caillots et d'embolie, mais le médecin qui a prescrit cette pilule ne l'a pas dépistée, et n'a pas cherché à le faire (LP2).

*Lisa:* Est-ce que tu te rappelles quels effets secondaires il [le docteur] a mentionné?

*Christine:* Des maux de cœur, des seins qui gonfle, que tu peux prendre du poids aussi, et j'ai eu des maux de têtes. Et moi, j'ai eu des maux de têtes parce-que j'suis très sensible aux migraines, ça ma effet particulièrement... Mais, ça c'est après, parce-que j'ai changé de pilule, je suis rendu à Diane-35 maintenant. ... La fameuse pilule qui tue des gens en France (rit).

As I was delving into my analysis, my inbox was flooded with emails from friends and family as the latest story regarding the health risks of the pill came out, as recounted in the above article from *La Presse*. They proclaimed, “**This** is what you’re fighting against!” **This** generally referred to the ongoing and nefarious profit motives of pharmaceutical companies who collude with doctors and other medical professionals to impose the pill on women. Yet, as I discussed in the previous chapter, getting on the pill is rarely imposed on young women, and is more consistent with Foucauldian accounts of self-government, wherein the government of self is realized in conjunction with the government of others. Getting on the pill is an accepted and expected behaviour for young heterosexual women and is connected to a complex practice of freedom.

In this chapter, I examine the recent Diane-35 and Yasmin pill scares, as well as more general concerns about the pill, as discussed in the print news media, Health Canada and the Society of Obstetricians and Gynecologists of Canada. The Diane-35 and Yaz/Yasmin pill scares consist of a “hazard sequence,” where current risks are read over a series of notifications in the context of existing interpretational frameworks that draw on the past and create new frameworks for future hazard notifications (Barnett & Breakwell 2003, 302). However, I extend

their analysis to consider more mundane concerns about the pill, such as loss of sex drive and environmental damage. Drawing on the work of de Courville Nicol (2013), I explore the ways that the print news media employs a rhetoric of fear, wherein the aim is to structure the moral responses of subjects to perceive the pill as potentially pain-producing and dangerous (179). However, as I will discuss the print news media equally presents scattered and inconsistent accounts that I argue serve to amplify interest in the pill and produce ethical dilemmas. I conclude with an exploration of the ways that both amplified and mundane concerns are picked up, interpreted by and/or rejected by women.

Many of the young women I interviewed had experienced or heard about women who had experienced unpleasant effects like those discussed in the media. Equally, many of the young women were using or had used Diane-35 and Yaz/Yasmin and brought up concerns they had about these drugs during the interview. In some cases these concerns were consistent with public discourses. Yet, I found that women also constructed their own frameworks within which to interpret the less desirable effects of the pill, such as drawing on close relationships and their own life and experience. The multiple ways that participants responded emphasizes the importance of actual “users” in shaping the discourse surrounding a given reproductive technology (Watkins 2011, 33). Like Christine, an 18 year old Caucasian francophone, participants were sometimes flippant about the undesirable effects of the pill, even if they were aware that it could cause death.

In talking to women I found that using the pill was less an exercise in risk-calculation than a repeated act, “tied to ambiguity” (Granzow 2007, 43) that was productive of ongoing emotional management strategies. As de Courville Nicol (2013) observes, emotion management is a fundamental part of the constitution of subjectivity through moral work. Subjectivity is

formed through the social and embodied experience of emotions of fear and desire as felt capacity or incapacity. In this sense pill scares, which are often understood as disturbing accounts of freedom, are actually part of a continuum of uncertainty which constantly circulates and incites individuals to engage in emotional work so as to position themselves in relation to devices like the pill. In doing so, young women engage with relationships of power, but equally shape their own conduct and the conduct of others.

### **6.1 Pill scares**

The negative health outcomes of the oral contraceptive pill circulate as a general theme in the news media (Potts 1991) and public health communications. Employing a rhetoric of fear, the aim in many news articles, is to associate the pill with potentially painful and unpleasant outcomes, such as blood clots, strokes and death. Barnett & Breakwell (2003) identify a “pill scare” as a period of intensification and amplification in concern surrounding the negative side-effects of the pill. They discuss the social amplification of risk perception and the hazard sequence in the October 1995 oral contraceptive pill scare in Britain. A hazard sequence involves a “series of hazard notifications, which are structurally similar” and are read by the public through “hazard templates” which are “frameworks for making sense of risk information” (Barnett & Breakwell 2003, 303). As they demonstrate, the template will change over the course of a sequence and evolve over time to take in new frameworks.

In Canada, Diane-35 and Yasmin/Yaz have both been the subject of intense media attention and public health warnings and advisories in recent years. Adverse reaction and medical device problem reporting can be completed by consumers and health professionals to the Canada Vigilance Program. An accumulation of reports will often lead to inquiries on behalf of Health Canada. In other cases, a high number of reports will sometimes prompt media interest and mount public pressure for a review by Health Canada of the safety of a particular product.

Safety reviews are also prompted by changes in the regulation of a drug by other countries. Class-action lawsuits can raise public awareness of the dangers of a particular drug and lead to increased media scrutiny. The publication of reviews by Health Canada will generally lead to a response by the Society of Obstetricians and Gynecologists of Canada, who might in turn provide their own statement. Sometimes these sequences will result in the provision of new guidelines to the Society of Obstetricians and Gynecologists of Canada for practitioners regarding how to provide contraceptive counselling and information about side-effects to patients.

Diane-35 is manufactured and produced by Bayer (previously manufactured and produced by Berlex). It contains two synthetic hormones, ethinyl estradiol (35 mg estrogen) and cyproterone acetate (2mg), which acts like a weak progesterone but primarily suppresses testosterone. While ethinyl estradiol is commonly used in many combined oral contraceptives, cyproterone acetate was originally used to treat prostate cancer in men. Because of anti-androgen properties, cyproterone acetate can be used to treat severe acne and hirsutism. In Canada, Diane-35 was first approved for use in September 1997, for treatment of severe acne “with associated symptoms of high levels of male hormone, including seborrhea (oily skin) and mild hirsutism (excessive body hair) – in women who are unresponsive to other available treatments”. Contraception is an off-label use. In September 1999-2000, sales of Diane-35 increased by 45% following a marketing campaign targeting young women and a promotional campaign encouraging physicians to prescribe Diane-35 for the off-label use of contraception (Mintzes 2004).

Shortly after it was approved, Diane-35 was the source of media controversy because of the increased risk of venous thrombosis or blood clots. In 2003 alone, there were thirty-three

reports to Health Canada of blood clots linked to Diane-35. Throughout the early 2000s there have been several periods of intense media reporting in relation to health risks and Diane-35. There have been numerous reviews and public health notifications regarding the safety of the drug by Health Canada, which are then reviewed by the SOGC. The most recent instance began in January 2013.

In late January, *La Presse*, the *Globe and Mail*, and *Le Devoir* all announced that following several deaths, France decided that Diane-35 would no longer be available for distribution. An article published on January 30, 2013 in *La Presse* announced, “Suspension des ventes de Diane 35 en France”. A similar article appeared a day later, on January 31, 2013, in the *Globe and Mail* but placed a greater emphasis on the Health Canada review. The article announced, “Health Canada to review safety information on controversial acne drug”.

Diane-35 has a long, tortuous history but nevertheless remains a popular product, especially with teenage girls concerned about acne. The drug is supposed to be prescribed only as a treatment of last resort for young women with severe acne. But it is often prescribed off-label as an oral contraceptive. Diane-35 is even packaged like birth-control pills, in a 28-pill holder and taken to coincide with a woman’s menstrual cycle, ostensibly because in young women acne breakouts are often related to menstrual cycles. Most birth-control pills help clear up acne because they stabilize hormone levels. One of the ingredients in Diane-35, cyproterone acetate, is seen as particularly potent. However, it is more likely to cause blood clots, which is why the drug should not be used as an oral contraceptive. Earlier this week, the Toronto Star reported that there were 195 reports of severe adverse effects among users of Diane-35. That number included 11 women who died, among them four teenagers (GM3).

Across articles authors highlighted the ongoing controversy surrounding Diane-35, linking it with past issues, but equally, highlighted the youth of users and the association of the drug with conditions particular to young women, such as acne.

Following the banning of the drug in France, Health Canada announced that it would conduct a review of “all available safety information on the drug Diane-35” (HC3). Health Canada reviewed if the risk of blood clots was higher in Diane-35 compared to other similar medications, meaning other combined oral contraceptive pills, and if the risks it carried

outweighed the benefits. In late February, both Health Canada and the Society of Obstetricians and Gynecologists of Canada released a position statement about Diane-35 and the risks of blood clots. The Society of Obstetricians and Gynecologists of Canada provided a comparative chart to put “combined hormonal contraceptive related deaths into perspective” (SOGC7).

	Deaths/100,000 women per yr
Smoker (35 yr)	167
Road deaths	8
Household accidents	4
Per 100,000 combined hormonal contraceptive users with Leiden V	1.9 - 4
Per 100,000 combined hormonal contraceptive users	0.5-0.9
Background risk of fatal VTE for women aged 15-44	0.6

The Society of Obstetricians and Gynecologists of Canada cautions against relying on information from the media in relation to blood clots. In the conclusion of the position statement the author writes:

Fear and confusion resulting from media coverage of rare events (death from combined hormonal contraception induced VTE of < 1/100,000) has the potential to create harm as inadvertent pregnancies are often the result of panic stopping of combined hormonal contraceptives and these pregnancies themselves carry greater risks for VTE. This situation occurred in 1995 following the publication of three articles in *The Lancet*. According to Mills, in the UK alone, there were 30,000 more conceptions in the 9 months following the “pill scare” (deliveries increased by 20-25% and abortions reached the highest level in 30 years with 10,000 more than anticipated). Mills and Edwards argued convincingly that “the constant negative drip of information from the lay press makes it impossible for the professionals and consumers to interpret true risks and benefits of drugs.” Combined hormonal contraceptives are known to reduce the risk of pelvic inflammatory disease, ectopic pregnancy, anemia, endometrial and ovarian cancer, and acne. CPA/EE, in particular, is one of the most effective and safest treatments for acne in women of reproductive age and because of its contraceptive efficacy, it does not carry the risk of teratogenesis associated with Accutane (SOGC7).

While the Society of Obstetricians and Gynecologists of Canada critiques the media for creating a “pill scare”, follow-up articles in the same newspapers reiterated the position of Health Canada and the Society of Obstetricians and Gynecologists of Canada.

For example, *La Presse* published an article entitled, “Contraceptif Diane-35: des peurs exagérées, disent les gynécologues...”, on February 27, 2013.

Les craintes pour la santé relativement au contraceptif Diane 35, qui a été associé dernièrement à quatre décès en France depuis 1987, sont exagérées. C'est ce que l'on peut conclure de la position récente de la Société des obstétriciens et gynécologues du Canada (SOGC) à la suite de la controverse soulevée en France sur ces décès et de la décision de Santé Canada d'étudier l'innocuité du médicament. L'organisme a comparé différents taux de risque de développer une thrombose veineuse ou des caillots dans le sang pouvant provoquer une embolie pulmonaire et bloquer les poumons. Selon la Dre Édith Guilbert de l'Institut national de santé publique du Québec, il est plus risqué pour une femme d'avoir une thrombose veineuse si elle est enceinte que si elle prend le contraceptif incriminé (LP1).

Several months later, on May 17, 2013, a follow-up article stated, « Pilule Diane 35: bénéfices supérieurs au risque pour «certaines patientes» ».

Contrairement à la décision de l'Agence nationale de sécurité du médicament (ANSM) de suspendre l'autorisation de mise sur le marché de Diane 35, l'agence européenne ne s'est pas prononcée dans ce sens. L'agence européenne souligne que «ces médicaments doivent être utilisés uniquement pour le traitement de l'acné modéré ou sévère (...) et/ou pour le traitement de l'hirsutisme à savoir la pilosité excessive non désirée, chez les femmes en âge de procréer». L'EMA ne se prononce pas sur l'utilisation de Diane 35 à des fins contraceptives, le laboratoire Bayer n'ayant pas obtenu d'autorisation de mise sur le marché qu'en tant que produit anti acné ou pilosité (LP35).

The Society of Obstetricians and Gynecologists of Canada situates the media as at the forefront of creating “pill panics”. Yet, news reporters also summarized and communicated the findings of regulatory health agencies. Thus, while the news media may play a part in the amplification of risk, this occurs within a “hazard sequence” wherein the dangers of pill use are mitigated over time and normalized in general.

Both the *Globe and Mail* and *La Presse* focus on the use of Diane-35 by young women for contraception, because it is also an acne treatment. Acne is a condition associated with youth. For example, in a follow-up article published in the *Globe & Mail*, published on March, 16, 2013 the author discusses “off-label” use of medications. The article features a young woman currently using Diane-35 as a contraceptive.

Six years ago, Ellyn Braun's doctor told her that the acne medication she was taking could double as birth control, even though Health Canada doesn't regulate it as a form of contraception. The drug, Diane-35, is regulated for temporary acne treatment, but Braun's been using it on a permanent basis as a birth control pill – even though it has been linked to the deaths of nine Canadians since 2000. That doesn't seem to faze Braun. “I think there's a place for it, but you just have to be careful about it,” says the 28-year-old medical student at McMaster University in Hamilton (GM1).

While urging more scrutiny of the off-label use of medications is a key point of the article, it also emphasizes the role of doctors in informing patients about the risks, and health agencies in accurately assessing the “benefit-risk” assessment of medications. As Fox (1999) reminds us, the classification of risks and hazards defines the social milieu within which they occur.

Yasmin and Yaz were approved for use as contraceptives in Canada in 2005. Both are produced by Bayer and both have been the objects of public scrutiny. They are classified as “fourth-generation” oral contraceptives, because they contain drospirenone, a synthetic form of progestin. Off-label uses include the treatment of heavy menstrual bleeding, painful menstrual cramps, irregular menstruation, acne, and premenstrual dysphoric disorder. Drospirenone has higher anti-androgen properties and is said to reduce bloating and water retention commonly associated with previous formulations of synthetic progestin; however, some studies have shown it carries a higher risk of blood clots and gall bladder disease compared to previous versions of the pill. The risk of these conditions is compared to other oral contraceptive pills or “older” generation pills, which contained levonorgestrel.

Between February 2007 and February 2013, Yasmin and Yaz were the subject of 600 adverse reaction reports and linked to the deaths of twenty-three women. Most women died of blood clots, which are a known side-effect of all oral contraceptive pills. Following the rise in reporting, several class action lawsuits were launched against Yasmin and Yaz. These lawsuits have been widely covered in the Canadian news media. At issue in these lawsuits is whether or not women were adequately informed of the *increased* risks involved in using Yasmin and Yaz. In 2011, Health Canada issued a warning that the risk of blood clots was 1.5 to three times higher with pills containing drospirenone than with other pills. To date, Health Canada has not issued a statement regarding the increased risk of gall bladder disease.

In 2011, the approval of a class-action lawsuit prompted a series of articles discussing the health risks of Yasmin and Yaz. An article published in the *Globe and Mail* on April 18, 2011 stated, “New birth control pills increase gallbladder disease risk only slightly, study finds”. The author writes:

The new generation of birth control pills - which includes popular products like Yaz and Yasmin - increases the risk of gallbladder disease only marginally, a new Canadian study concludes. The research, published in Monday’s edition of the Canadian Medical Association Journal, challenges popular wisdom on the issue. “The media has created some hysteria about this based on anecdotal reports, but our study shows the risk of gallbladder disease is pretty much the same for all oral contraceptives,” Mahyar Etminan, of the Centre for Clinical Epidemiology and Evaluation at Vancouver Coastal Health Research Institute, said in an interview. The new research involved 2.7 million women who took birth control pills for at least six months between 1997 and 2009. A total of 27,087 women in the study group underwent cholecystectomy (surgical gallbladder removal). Taking birth control pills is known to increase the risk of gallbladder disease, as does hormone replacement therapy (GM22).

A few days later another article by the same author examined if there is an increased risk of blood clots for users of Yaz and Yasmin. The vice-president of the Society of Obstetricians and Gynecologists of Canada highlights the role of the media in amplifying fear. In a *Globe and Mail* article, he states,

“Each time a new product comes out, we see this – it’s the new pill effect,” he said. “Risks and complications are always greatest in new patients, much higher than those who have used the same product for a long time.” Women choose contraceptives based on various criteria, including side effects, price and secondary benefits other than birth control. For example, products like Yaz and Yasmin are reputed to reduce the symptoms of pre-menstrual syndrome, while other formulations are said to reduce acne. Dr. Lalonde said that while blood clots can occur with all oral contraceptives, the risk is low and needs to be kept in perspective. “We can’t forget that birth control pills are taken for a reason - to prevent pregnancy. The risk of blood clots is much higher in pregnancy than from taking these products,” he said (GM21).

The article concludes with a mention of the lawsuit but notes that no allegations have been proven.

In 2013, the publication of two new studies set off another “pill scare.” On June 11, 2013, *La Presse* published an article entitled « Des contraceptifs seraient liés à la mort d’au moins 23 Canadiennes » and the *Globe and Mail* article proclaimed “No recall planned for

contraceptives Yaz and Yasmin, as gynecologists' group says drugs are safe". The *Globe and Mail* article cautions on the overemphasis that is placed on adverse reaction reports.

Two popular birth control pills linked in media reports to the deaths of 23 Canadian women will not be recalled, and a national gynecologists' group says the contraceptives, Yaz and Yasmin, are safe. Anyone can file an adverse-effect report, and it is impossible to determine from a report whether the reaction was the direct result of using the product. The reports do not attribute a death to a side effect. Health Canada provides a synopsis of reports in an online searchable database. "Adverse events are very different from attributable events, and [the latter] is the number you need," said Jennifer Blake, a gynecologist and CEO of the Society of Obstetricians and Gynaecologists of Canada, who described being bombarded with calls from concerned women after the news reports. "We are advising that there is no new data and ... that the pills are safe and effective" (June 11, 2013 Andreatta)

Around the same time, the SOGC released a position statement indicating that Yaz and Yasmin are safe and effective (SOGC7).

While recent media coverage of the risks of Diane-35, Yasmin and Yaz are in many ways an amplification of concerns, "pill scares" are not one-dimensional and multiple views and opinions are drawn on over an extended time period as multiple discourses compete in public space. Further, as I demonstrated, the print news media often would highlight statements from experts about the negative role of the media in creating panic. Articles also often contradicted earlier statements. For example, the start of a "pill panic" would usually begin with a claim of the risks of death in using the pill, while only a month later there would be a report that there is no need for concern.

The Diane-35 and Yaz/Yasmin "pill scares" are consistent with Barnett & Breakwell's (2003) discussion of a "hazard sequence", where current risks are read in the context of existing interpretational frameworks that draw on the past. Opposing positions about the pill emerge in public discourses debating the safety of the pill, but focus on young women, as opposed to women more generally, as the victim. For example, in Barbara Seaman's book from the 1970s, *The Doctor's Case Against the Pill*, the typical victim is a middle-aged mother of three children, whose husband grieves her loss. Today in Canada, the victim commonly portrayed by the print

news media is a strong, healthy teenager whose life was cut unexpectedly short. Her parents, usually her mother, are wracked with guilt for encouraging use of the pill and seek justice from pharmaceutical companies. In the previous chapter, I discussed the ways that girls are subjects where freedom is at issue. In the case of undesirable effects of the pill, the print news media generate a troubled account of individual responsibility for health risks wherein young women are unable to realize ideals of freedom.

In this sense, print news media narratives refer to the conduct of young women, but also that of parents. A similar phenomenon is observed by Connell & Hunt (2010) in relation to the Gardasil vaccination campaign where mothers were encouraged to engage in risk management activities on behalf of their daughters. In this sense, the discursive construction of the risks of the pill highlights potentially disturbing outcomes in relation to particular groups that are perceived as vulnerable, such as girls. The articles I collected also emphasized the importance attached to managing risk through engaging in responsible conduct as an individual. For example, articles encouraged women to speak to doctors, stay up-to-date on the latest health reports associated with particular brands and to read informational pamphlets.

Exploring pill scares is illustrative of “patterns of risk amplification” and Barnett & Breakwell argue that “risks become normalised” (302). However, I found pill scares were also situated within a more general concern about the side-effects of the pill that helps to explain the complicated ways in which women are positioned in the context of expectations for rational and calculated choice-making.

## 6.2 Pill concerns

While allowing that contraception has given women unprecedented control over their own fertility and reduced unwanted pregnancies and maternal deaths, the authors are concerned that women on the Pill may be choosing partners they “otherwise would not have chosen,” said author Alexandra Alvergne, an evolutionary anthropologist from the university's department of animal and plant sciences who wrote the paper with colleague Virpi Lummaa.

Women who do not take hormonal contraceptives experience “dual sexuality” over the course of their menstrual cycle, write the authors, citing earlier research. “Women prefer good genes during ovulation and good dads when they're not ovulating,” Dr. Alvergne said.

During ovulation, women prefer men with symmetrical, masculine features. These men are aggressive, compete with other men, and in some cases exhibit “creative intelligence,” write the authors. More importantly, their major histocompatibility complex genes – the ones that build our immune systems – are considerably unlike the individual woman's. According to earlier research, being attracted to a person with a different immune system is advantageous because the baby will inherit a larger arsenal to combat disease.

But during the infertile phase, women appear to prefer men who are more genetically similar to their relatives. Others opt for men who exhibit more “feminine” characteristics and have the means to invest in child rearing, Dr. Alvergne said. The researchers say this dual strategy allowed ancestral women to “maximize their reproductive success.”

To put it another way: “You fall in a long-term relationship with the caring, investing wimps and then you poach the good genes from the highest-status [masculine]guys. And the wimps hopefully make good stepdads and raise your kids,” said Geoffrey Miller, an associate professor of human sexuality and evolutionary psychology at the University of New Mexico (GM11).

### **Birth control has actually increased unintended pregnancy rates outside of marriage. How?**

The rate planet-wide is surprisingly high, given how much technology we have to control our own fertility. The unintended consequence of access to contraceptives is that you get more unintended pregnancies because social norms have evolved in a way that allow people to more freely express their sexuality. When more people have sex outside of marriage, you're bound to get more pregnancy and child birth outside of marriage (GM2).

“Pill scares” refer to an intensification in print news media reporting in conjunction with regulatory agencies. Yet, more “mundane” side-effects of the pill were also a common theme in health editorials and interview data. Both articles come from the same *Globe and Mail* reporter. The second article was published just a few months prior to the latest Yaz/Yasmin health scare. The young women I interviewed recounted being aware of many potential unpleasant risks involved in using the pill that ranged from serious to very mundane. As I discussed in Chapter 4, participants often listed off a range of potential ways in which the pill might affect the body even while admitting that they in general did not understand how the pill worked. Using the pill thus involved both the negotiation and mitigation of various degrees of risks which were more or less disturbing.

Similarly, in health editorials about the effects of the pill on the body, reporters often covered the most recent findings in terms of the effects of the pill on the body. In *La Presse*, an article entitled, “Aucun lien entre pilule contraceptive et prise de poids,” discussed the most recent research on the pill and weight gain. The author observes,

La semaine dernière, le site spécialisé ScienceDaily a fait état d’une étude - pas encore publiée -- menée par un chercheur de l’Université de Göteborg, avançant qu’il n’y aurait aucun lien entre l’utilisation de la pilule contraceptive et la prise de poids (LP20).

In the *Globe and Mail*, an article published in November 2011 discusses the relationship between the pill and decrease in sexual pleasure. The author recounts:

Hormonal contraception can stifle sexual arousal, limit lubrication and decrease the number of orgasms in women, suggests new research from Indiana University. The study of 1,101 sexually active women found those using hormonal forms of contraception including the Pill, patch, ring and shot reported experiencing less pleasure and subsequently less sex than women employing non-hormonal methods such as condoms, diaphragms and the controversial withdrawal method (GM10).

As with “pill scares” authors tended to encourage women to consult with doctors and pharmacists and highlighted the importance of more information from public health agencies, such as Health Canada and the Society of Obstetricians and Gynecologists of Canada.

Another theme was the social impact of the pill on relationships and concerns surrounding how it might result in changing dynamics between men and women. For example, the *Globe and Mail* article “Does taking the pill lead to a happier marriage” discusses studies on the impact of the pill on sexual satisfaction. The author states,

The study of 2,519 mothers, mainly from the United States and Czech Republic, found that those who met their first child’s father while on the pill were less attracted to their spouses and had greater sexual dissatisfaction over the long haul, compared with women who weren’t taking birth control pills when they met their spouse, Time reports. The upside is that the women taking oral contraceptives were happier with other aspects of the relationship – and 10-per-cent more likely to stay with their mates (GM12).

An article in the *Globe and Mail* proclaimed: “Birth control pills may make women less attracted

to study males” (Bielski, 2009). The author notes,

Women who are on the birth-control pill may be more likely to pick provider types over aggressive, masculine specimens – a course that could potentially affect the health of their children, according to a controversial new paper from the University of Sheffield. By doing away with ovulation, a woman's most fertile phase, the Pill may also make women less attractive to men, says the review paper, published in the current issue of the journal *Trends in Ecology and Evolution* (GM11).

Alexandra, a 28 year old Caucasian anglophone, noted she had similar suspicions about the impact of the pill on women’s sexuality.

*Lisa:* Why is it [the pill] different [from other forms of contraception]?

*Alexandra:* Well because ... I don’t know. See I always paired it with condoms except for with one partner who I had had for awhile. I think there was a time that I felt when I was on the Pill, that it actually made me feel more attracted to men. [laughs] But I think that was a really half-baked... like when I wasn’t on the pill I felt like my desire was more queer. But I don’t really feel that anymore. I think maybe at the time, cause I also have high testosterone, I think maybe at the time, I thought that by having more estrogen in my body that it was like making me more attracted to men... is this weird??

*Lisa:* No, not all!!

*Alexandra:* I was like [laughs]... this is a conspiracy. “If birth control wasn’t shoved down women’s throats there would be way more sexual experimentation or women would be way more comfortable recognizing their desires for bisexual sex or lesbian sex. But I mean I don’t think that anymore. [laughs] It seems kind of funny in retrospect to think that...”

In both cases the social impact of the pill emerges as a site of more general social problems.

Another common theme was environmental concerns. An article in *La Presse*, entitled “La pilule contraceptive est polluante selon le Vatican.” The author announces, “ La pilule contraceptive a «des effets dévastateurs sur l'environnement» et est en partie responsable de «l'infertilité chez l'homme», écrit samedi le journal du Vatican, l’Osservatore Romano” (LP25).

Allison, a 22 year old Caucasian anglophone, also noted that she was concerned about the environmental impact of the pill.

*Lisa:* Today, now, how do you feel about using the pill? How does it fit into your life?

*Allison:* Ummm... I feel like it’s pretty good. Sometimes I have... well, I would definitely characterize myself as an environmentalist, so the idea that I am putting hormones into my system that are than being dumped into the environment, really does bother me. And then sometimes I have to be like, well the environmental costs of a child you know... so sometimes I do feel like there is an environmental pressure. But that comes from myself, not from other people. I think maybe I should be looking at something that isn’t hormonal. But I mean non-hormonal methods I just feel like are just not very ... you can’t really depend on them. I feel like there not as... other than a condom, but just using a condom, I feel like that’s not enough.

A more recent series of articles discussed the recall of the generic oral contraceptives, Alysena and Esme. Between April and September 2013, the *Globe and Mail* published ten articles discussing various aspects of the recalls. *La Presse* and *Le Devoir* published one article each in April. The recall was due to a factory error where a row of placebo pills was placed in a row where active pills should be placed. Articles often offered a critique of various regulatory agencies and encouraged women to consult with pharmacists, as indicated below in an article from the *Globe and Mail*.

Canadians using this product should use a non-hormonal method of birth control, contact their health care provider for medical advice and return unopened packages to their pharmacist. Alysena-21, which is manufactured at the same facility, is not part of the current recall as these packages don't normally include a row of the placebo pills.

However, because the product is made in the same facility, Health Canada and Apotex are working together to verify this product as well. In the meantime, Canadians are encouraged to check to make sure their packages of Alysena-21 contain three rows of pink pills (GM34).

In the *La Presse* article, that author placed on emphasis on the risk of pregnancy if active pills had been replaced by placebos.

Selon Elaine E. Jolly, professeure à la Faculté de médecine de l'Université d'Ottawa et gynécologue, l'Alysena est l'un des contraceptifs hormonaux les «plus populaires» sur le marché. «C'est très utilisé. C'est probablement l'un des meilleurs. Et c'est un problème sérieux s'il y a plus de sept placebos», a-t-elle affirmé au cours d'une entrevue téléphonique. Comme il s'agit d'une pilule de «deuxième génération» -avec des concentrations d'hormones très basses-, le risque de tomber enceinte est réel si un seul comprimé est manqué, a expliqué la gynécologue. La communauté scientifique s'interrogeait déjà quant à savoir si sept comprimés placebos par cycle étaient un nombre trop élevé. «Plusieurs docteurs demandent à leurs patientes de prendre le placebo ou d'arrêter la pilule pendant une période de seulement quatre jours» avant de recommencer, a-t-elle ajouté. Si le débat continue sur ce point, il est certain que «si vous prenez le placebo pendant 8, 9 ou 10 jours, il y a un véritable risque de grossesse non désirée», selon Mme Jolly.

In the instance of pill recalls, responsible use by the patient is compromised as even correct use of the pill could still lead to pregnancy. As I discussed in Chapter 4, calculation rates of the effectiveness of the pill often take into account error on behalf of the individual user. However, the same calculations never take into account the possibility of errors on behalf of the manufacturer. There are many factors that can affect the effectiveness of the pill and not all of these have to do with the responsibility of an individual. Unlike “pill scares,” like those

associated with Diane-35 and Yaz/Yasmin, pill concerns reflected a more subtle current of awareness that there is uncertainty in terms of what the pill does or whether it will function as it is intended.

### 6.3 “It’s all part of the process...”

*Lisa:* You said, you like taking a break from the hormones, why is that?

*Jennifer:* I have no idea. [laughs] It’s totally psychological. Yeah. If I did it from a financial standpoint I don’t know if it would be cheaper to pay for the pills, taking them all the time. I don’t know how... I don’t know. I think I’m just used to doing it the way I do it. I mean it’s worked fine so far, so why change it.

*Lisa:* Did your doctor talk to you about any of the long-term benefits of taking the pill, like cancer prevention?

*Jennifer:* Yeah, well I’ve heard that it lowers your risk of some cancers and raises your risk of other cancers. I forget which one’s.

*Lisa:* Did it affect your decision in anyway?

*Jennifer:* No. Everything gives you cancer [laughs]! The benefits outweigh the negatives.

*Lisa:* Are there side-effects that you wouldn’t put up with?

*Jennifer:* I guess having mood swings or ... but really I’ll probably stop when I want kids.

*Lisa:* When do you think that will be?

*Jennifer:* Um... not for at least like until I’m 30.

In Chapter 5, I discussed how taking the pill involved a complex practice of freedom that was constantly changing and evolving. I found for participants, managing the various effects of the pill involved an ongoing process of bodily and emotional management. Equally, in taking the pill I found that participants managed both potential and actual disturbing effects. While in some instances this resulted in disrupted accounts of freedom, this was not always the case, and participants often developed their own techniques for managing less desirable effects of taking the pill. Equally, participants seemed to assume that less desirable effects were to be expected. As Jennifer, a 20 year old Caucasian anglophone expressed, “everything gives you cancer”.

Only three participants noted that they had experienced undesirable effects. Most participants had experienced some positive effects and some less desirable effects. For Valerie, a 27 year old anglophone of Aboriginal descent, her ability to manage side-effects was dependent

upon the relationship she had with her doctor.

*Lisa:* So when you first started taking the pill did you notice changes?

*Valerie:* Instantly, my PMS symptoms, like cramping it was gone. Eventually my periods were quite light, which was a big change ... it was a big adjustment, and recently I'm curious if a little bit of extra weight is because of the pill. So I'm curious to know what my body would be like if I went off of it, because it's been so long I don't really know what it would be like. I would get headaches instead of like bloating and cramping... and that's why after a couple of years on Alesse I changed to Marvelon. And they went away.

*Lisa:* Did you talk to your doctor about the headaches?

*Valerie:* Yeah, and the doctor thought they weren't severe enough... it could just be like period hormones, it might not have been the pill. But he changed the pill anyways. And what changed for me at that time when I got a prescription and it was a male doctor, and in the last 5 years I've been saying like a young female doctor, who's been much easier to talk to. It's not that I was that hesitant to talk to the male doctor about things, but she's much more comfortable answering my questions than the other doctor.

*Lisa:* Did you notice any changes in your emotions when you started the pill?

*Valerie:* Uh, yes [laughs]. I forgot about that one...yeah I'm an emotional person anyways. But I definitely was more prone to a burst of tears or for a little while I was crabby too. I remember feeling a little more crusty.

*Lisa:* When you switched brands, was there any changes?

*Valerie:* The periods got more, but now, since coming to the Tri-Cyclen it's been really, really good. I'm feeling like the least effected by that variety.

Mona, a 20 year old Anglophone Canadian of middle eastern descent, observed that she experienced mostly unpleasant effects after starting to take the pill.

*Lisa:* So when you first started taking the pill, the Yaz brand, did you notice any changes in your body?

*Mona:* The acne cleared up a lot faster. Um, cramps! That was something I noticed. I never used to have them, and my period was more regular and everything, but I became a little more severe with Yaz.

*Lisa:* ...

*Mona:* I definitely liked that my skin was getting clearer. ... [pause] You know what, to be honest, I think there were a lot more negatives. But I mean they're minor things, so, I can get over it, but ... for the sake of not getting pregnant. Other than that, I guess that my cycle was regular. That was huge. When I was younger it would drive me crazy and that things were all over the place. It was nice that those issues were treated.

*Lisa:* Did you notice any changes in your emotions?

*Mona:* Um, with the pill I definitely became moodier. I can actually pinpoint the days on which I'm more sad, or more irritated by things. I'm very conscious of it, so I actually make an effort to not allow that to happen and I know that it happens to people who are not on the pill.

Like Mona and Valerie, many participants were unclear if the pill was even actually the cause of a given bodily or emotional experience.

Several participants had experienced what they thought might have been a blood clot.

Two participants had experienced more severe side-effects. Below Christie, a 22 year old

African-Canadian anglophone, describes her reaction to the pill.

Christie: ... I was on and off with the pill, because I've had several partners too. My last partner that I was with, I know I stopped for like a month or two because he saw how sick I was too. And he was like, "I don't want to see you like this..." But they're very understanding, which is cool. And then in the morning, they're like, "You're still sick?" And it's like, "Yeah". Actually, because I used to take it in the morning, but because I would get so sick, but then I took it at lunch time, but it would do the same thing. So I decided to take it at night, like right before going to sleep. Because I didn't mind getting up in the middle of the night to go throw up [laughs]. It's better than throwing up at work, all of your food and like your juice. So I figured... I would take it at night. Like I don't take it at a specific time, I know I should, but it's hard for me to do that.

Serena, a 19 year old Caucasian anglophone, was originally from a small town in Ontario. She was unclear as to whether the pill had caused what might have been a really intense migraine or a stroke.

*Lisa:* And what's the biggest drawback [in taking the pill], if there is one?

*Serena:* When I had my really big migraine in September, they originally thought it was a stroke. Cause I couldn't talk and I couldn't see out my eye. And I couldn't move my hands. I was in class...[making funny noise]. I laugh about it now... and so they rushed me to the hospital and they thought I was having a stroke because my heart rate was really really high. And I had an irregular heart beat and all this stuff. Yeah, cause my mom gets migraines, but her symptoms are like nausea and sensitivity to light. Whereas I don't get sensitivity to light at all. And I don't get nauseous... I had to eat with this hand, and then they said, it could have been caused by the birth control. But they don't know because it's a low-dose and I've never had any other symptoms. But then also, 19 was the age when my Mom started getting migraines too. So they said next time I go home to ask about getting a lower dose or ... whatever. So I'll do that, so it is kind of like... [!!!]. And I haven't had one since, so on the one hand that's really good, but on the other hand if it was a stroke, cause they don't really know. They were like, oh it's probably just a migraine based on your history. You're gonna start getting them know. But was it a stroke or a migraine... so it's kind of weird. It's scary! They sent me for an MRI, they didn't see anything. They did a cat scan. They did an EKG because I had an irregular heartbeat. I can still feel it sometimes. And they said that's just something to get checked up on. But I mean I don't drink, I don't smoke, so I'm one of those people where I know my body, cause my Mom has a lot of health problems and so does my Dad. And I'm just one of those people, I feel like stress causes a lot of that. So I'm not gonna stress about it. It's all gonna work out!

*Lisa:* Do you have any concerns about using the pill for a "long" period of time?

*Serena:* Basically, just worrying about blood clots and heart issues.

The less desirable effects of the pill throw into relief the more general uncertainty that participants experienced in using a pharmaceutical device. A participant's capacity to manage undesirable effects was often dependent upon her knowledge about her health, as well as her relationship with her doctor, health care professional and even close friends and family. Taking the pill rarely involved a straight-forward practice of freedom and autonomy, but rather an ongoing negotiation of complex bodily experiences that were often beyond individual control.

Further, women saw doctors and the medical establishment as not always working in their best interests and thus worked around and modified expected “rules” of conduct for managing side-effects. Turning again to Christie, a 22 year old African-Canadian Anglophone, she was not overly concerned about taking the pill for a long period of time.

*Lisa:* Were you aware of different brands before you started using them?

*Christie:* Before, no. But later, with my friends, we were like “Oh what pill are you on.” “Oh yeah, do you like it?” “Does it make you sick, because mine makes me sick.” Just like talking generally and you kind of get the feedback from everybody else, and you kind of just interchange. Like, “Well this is not good for me and I don’t know why.” And sometimes we’d switch [laughs]. Or I’d sleep over at my friend’s house and I’d be like, “Oh I forgot my pill” and she’d say, “Oh you can take mine.” Actually my friend, she was the one who gave me the Tri-Cyclen Lo pack. She said, “Oh I have a pack that I’m not using and she was like you want to try it.” I mean it wasn’t full, but I tried it and then I knew right away that it was better.

*Lisa:* Do you remember seeing ads for the pills?

*Christie:* Yeah, I saw the Alesse ads that were like “Kill Bill” type of thing. I was like, “Hey I know what that is!” But I think, that one, I don’t know if Yaz or Yasmin came out with one, but I saw it in the news. It was actually my friend who was on Yaz and she was like, “Oh I’m not feeling too great on that pill.” And I was like, “Don’t take it it’s really bad!” Like for me personally. And then just after that we heard it on the news. And decided to change.

*Lisa:* What did you think when you heard about it in the news?

*Christie:* It didn’t surprise me. I think it was like blood clot issues or something like that. I thought, it’s about time somebody does something. Cause there’s lots of strong hormones ... I don’t know.

*Lisa:* Does it worry you?

*Christie:* I don’t know, I’m kind of blasé about it. But, I mean it can’t be that great to be taking pills so regularly. The only thing that concerns me is that when I want to get pregnant, if it ever happens, is it going to compromise my pregnancy because I took it on and off, so often and badly. And strong and then not strong. I feel like I played with that a lot and that there would be birth defects or something like that. That’d be the only thing that really concerns me.

Like Christie, several participants, noted giving advice to friends about which brands were “good” and which brands to avoid. This was sometimes based on print news media reports, but often was based on the experiences of friends.

As Fisher (2000) highlights, at the turn of the century withdrawal was a preferred method, not because other methods were not available, but because individuals were willing to live with a degree of uncertainty in relation to pregnancy. She uses oral history to challenge

prevailing views of the fertility decline as the product of conscious choice.

This image of calculating parents bears little relation to the everyday dynamics of family decision making. Oral testimony suggests that such a calculative attitude toward childbearing was not always central to respondents' considerable stress on the unpredictability of family size and pregnancy, emphasizing the casual, ill-informed, ill-considered way in which they approached family building. Above all, the vast majority of respondents denied that they were in a position to "plan" their families (Fisher, 2000: 299).

In this sense, "Birth control was used, but only with the general hope that family size would then be kept down, rather than to ensure a particular timing or spacing of births" (Fisher 2000, 300). As she observes, "The decline in fertility does not necessarily reflect the adoption of a "more calculating attitude about childbearing" (Fisher 2000, 300). In a similar vein, contemporary accounts of risk-management in relation to the use of a reproductive technology like the pill emphasized the increased importance placed on rationality and calculation in the management of health and sexuality with an acceptance for a degree of uncertainty in relation to health. As did Fisher, I found that participants recognized and were aware of risk-management activities, yet the experience of the pill in the body was still largely uncertain. In this sense, young women did not use the pill because it was the best method available out of an unlimited number of options, which they calculated between. As I explored in the last chapter, the "choice" to use the pill was heavily dependent on social networks and expectations for appropriate fertility and management of various bodily conditions.

Equally, while print news media and the SOGC encouraged women to consult doctors and other medical professionals, participants recognized that accessing doctors and clinics was not always easy. Pharmacies were often closed on holidays or too far to get to without a car. None of the young women were able to call doctors immediately and an appointment was required. Further, as Serena observed, dealing with the various discomforts associated with accessing the pill and unpleasant effects is all "part of the process" for girls. On her way to

becoming a mature woman the pill is thus an indispensable accessory for a fully empowered and responsible young woman.

#### **6.4 Conclusion**

In this chapter, I have sought to understand the various ways that women's conduct is organized in relation to discourses which construct undesirable effects of the pill as reflected in "pill scares" and more general concerns. In certain instances, the print news media produces a rhetorical campaign of fear that aims to associate the pill with danger and pain and encourages women to manage emotional responses by consulting with various experts. In this sense, the recent Yaz/Yasmin and Diane-35 "pill scares" emphasized the potential "negative" or "side" effects of the pill and would seem to offer disrupted accounts of autonomy and freedom. However, I argued that these discourses actually contribute to a broad field of uncertainty surrounding the use of reproductive and pharmaceutical technologies and prompt ongoing processes of emotion management that are productive of the constitution of the self.

I found that participants were often only moderately interested in the serious side-effects of the pill and it was actual bodily experiences of varied unpleasant effects that encouraged the management of the self. I found that while women often referred to pill scares and concerns as they appeared in the print news media and public health communications, they also constructed their own frameworks within which to interpret the side-effects of the pill, drawing on close relationships and their own lives and experiences. Further, participants perceived dealing with unpleasant effects as a natural step in a young woman's development as a mature and responsible individual. In the next chapter I offer concluding thoughts.

## Conclusion: The next generations' case against the pill

*Lisa:* How old are you?

*Jody:* I just turned twenty-seven [laughs]. Yeah...

*Lisa:* And at what age did you start using the pill?

*Jody:* I used it first when I was seventeen until I was about twenty and then I went off it for five years and then I started taking it again about a year and a half ago.

*Lisa:* When you first started using the pill, can you tell me what your reason was?

*Jody:* Ummm... first boyfriend, and it was really like my Mom was like, "This is what you're doing. You're going on the pill, you know you make your own choices and everything, but this is what you're gonna do." And I had no problem with that, I guess. I could see the value, or the importance for sure.

*Lisa:* At this time, you were using it for contraception?

*Jody:* Yup.

*Lisa:* And why was that something that was important for you, not getting pregnant?

*Jody:* I wanted to, you know, I was in Cégep, so I wanted to finish. So that was the furthest thing from what my life was like then. Even now, as I've gone through my twenties and thought about it more and you know, trying to decide whether I want to have kids at all... you know, like that's starting to be a conversation I'm having with myself. It was always like, I don't want to be pregnant, I want to finish school.

*Lisa:* Not right now.

*Jody:* Yup.

### Choosing Wisely (Birth Control Selection Tool)

With so many options available, making the right decision about contraception can be a little overwhelming. Choosing wisely is developed by professionals to help you make informed decisions. The software asks questions about your health, medical history and lifestyle, then provides choices based on your answers so you can discuss them with your doctor (SU10).

*Lisa:* When do you think you'll stop using the pill?

*Elaine:* Honestly, I can't see stopping any ... I mean maybe if I switched to a different kind of birth control at some point. I was looking at the longer term one's ... do it, have it over with, then switch it out later on. The IUD or like the implant.

*Lisa:* What do you think about those?

*Elaine:* I was looking up mostly the implant, and it seems like something that would be a viable option, but again it doesn't help with acne. So while I'm young, I'd rather stick with something that would help with acne. But maybe in the future I would get the IUD or the implant or something like that.

An idea turned into reality – that is what "Start Something with Alesse is all about! Whatever it is, we want to hear about it. And if your idea is selected as one of the winners, not only will you receive \$5,000 in prize money, but you will also be partnered with a mentor who can help guide you in achieving your goals. And for the runners-up, we are giving each a new iPad\* – to help you continue on your road to success! Great ideas come in all shapes and sizes – so tell us about yours! Flex those fingers and get typing. It's that easy to Start Something... with Alesse (A2).

At the beginning of this thesis, I emphasized that today in Canada, young heterosexual women, not women generally are the primary users of the pill. Alesse and the Society of Obstetricians and Gynecologists of Canada associate choice, reproductive rights and increased control over the body with the pill. The Alesse and the [sexualityandu.ca](http://sexualityandu.ca) websites identify girls as powerful

subjects learning to harness their sexual health and fertility, but equally as a problematic population in need of the control offered by technologies like the pill. In this sense, taking the pill is not a straightforward expression of freedom, but it is connected to social expectations of individual responsibility for sexual health and fertility control. In *A History of Contraception*, McLaren (1990) observes that fertility control remains complicated for women. Equally, issues raised by feminist health critics throughout the 1970s and 1980s about the health risks of the pill in many ways remain unresolved. This is complicated by the increasing tendency to use the pill as a “life-style” drug. Jody and Elaine want to stay on the pill for similar, but distinct reasons.

To some extent, I think it is self-evident that as social scientists we ought to study the pill. Indeed, there have been hundreds of scientific studies, and a good number of scholarly articles written about the pill. However, not all young women will use the pill. Some young women will use the pill for a very short period of time. Some young women will use it as contraception while others will aim to manage acne and menstruation. Some women will have no problem using the pill. Some women will experience unpleasant effects. What I have tried to do in this thesis is to recognize and acknowledge this diversity. I have also sought to explore the various tensions that emerge around the pill and how in using the pill young women manage sex, health and the self in various and unexpected ways. The aim in conducting such research is not to offer advice as to how a young woman ought to make choices in relation to a particular pharmaceutical technology. Instead, I am interested in sparking a dialogue, providing a space where questions can be asked and where uncertainty can be acknowledged.

Foucault identifies the four dimensions of a study of ethics as the determination of the ethical substance, the mode of subjection, the elaboration of the ethical work and the telos of the ethical subject. Foucault observes that for Greek men there were many ways that a subject could

achieve the *telos* or the end point. However, it would seem that for young women, in particular, there are very few options. Failure to be empowered, failure to be responsible, failure to optimize one's health, failure to avoid pregnancy with absolute certainty are all increasingly understood as a failure of the self to fully realize. Even so, I found that young women constructed their own ethical standards and worked around social expectations for certain types of conduct. Further, even though unpleasant effects of the pill appear to offer disrupted accounts of freedom they also produce dilemmas that are embodied by women as they use the pill on an ongoing basis. When I started this thesis I expected to find that women were duped into taking the pill by aggressive marketing campaigns, like the Alesse campaign, and were kept ignorant by doctors who cared little beyond getting them on the pill. I was surprised to find that using the pill was part of a more subtle series of changes in expectations for contraceptive behaviour and management of health and appearance through medical technologies that involved a particular practice of young heterosexual femininity and engaged particular types of relationships.

As I discussed in the introduction, Margaret Sanger is commonly identified as playing a pivotal role in pushing for the scientific research for the pill. She is often taken to be an emblem of the feminist fight for reproductive choice and rights. Indeed, what is more precious than being able to control when we do or do not have children? However, when we assume that control is possible we begin from a limited view of freedom, as any failure requires an explanation. Today, young women are the primary users of the pill in Canada and they engage in ongoing attempts to work with what is before them. It may be the case that fertility control is best managed by an individual young woman and I think there are very clear cases where such an argument can be justified. It may also be the case that a young woman's life is better and more

convenient when her schedule is not interrupted by menstrual blood and acne. But there are implications to our preferences.

After I had submitted my first draft, a friend asked me what my thesis was about. I described for him my research and gave a brief summary of my findings. He observed, “So basically what women need is more information.” I really had to think about this. Do young women just need more and better information? I had to think about how many times in a week I sign papers without reading them or pop an over-the-counter medication without fully understanding what it contains or the risks to my health. Ibuprofen is a commonly used over-the-counter analgesic (or pain killer) which I frequently take to alleviate pain associated with long hours in front of my computer. Potential side-effects are listed as follows on the package insert:

Common side effects of ibuprofen oral:

rash, dizzy, feel like throwing up, heartburn, stomach cramps

Infrequent side effects of ibuprofen oral:

ringing in the ears, itching, visible water retention, water retention, conditions of excess stomach acid secretion, indigestion, incomplete or infrequent bowel movements, loss of appetite, head pain, throwing up, gas, diarrhea, nervous, easily angered or annoyed

Rare side effects of ibuprofen oral

Depression, Yellowing of Skin or Eyes from Liver Problems, Numbness, Tingling or Pain of Hands or Feet, Double Vision, Blind Spot in the Eye, Blurred Vision, Problems with Eyesight, Pink Eye, Dry Eye, Visions Changes caused by Medications, Hearing Problem, High Blood Pressure, Heart Attack, Abnormal Heart Rhythm, Chronic Heart Failure, Stroke, Meningitis not caused by an infection, Vasculitis, Inflammation of the Nose, Vocal Cord Swelling, Brochospasm, Canker sore, Ulcers of Esophagus, Stomach ulcer, Ulcer from Stomach Acid... Chronic Trouble Sleeping, Sun-Sensitive Mouth, Fast Heartbeat, Heart Throbbing or Pounding, Anxious.

I would question the extent to which more information about the pill is actually available, and equally whether having more information would necessarily help young women to make choices about whether or not to use the pill. As Takeshita (2010) observes, “informed consent requires the patient to play the role of an ideal consenting and safe user thereby successfully enrolling [her]self in the network of discourses and practices” that establish appropriate use (47). I think in the short-term what could potentially be helpful to young women and men would be a

dispersing of expertise, such that information and devices were produced from a more egalitarian framework. Some youth-focused clinics like Head & Hands in Montreal are reflective of this type of approach. Information is created and written by youth and takes into account different sexual orientations, backgrounds etc. Equally, I think it is misleading to tell women and men that they have lots of options. There are not a lot of contraceptive options that allow for the type of control that is desirable in contemporary Canadian society. I would argue that these are some of the immediate issues.

There are also more long-term issues to consider. The pill is in many ways a Band-Aid solution for the awkwardness that still exists in Canadian society surrounding discussions about sexual education, what Fine calls the “missing discourse of desire.” As a device taken in private by a young woman there is a separation between sex and reproduction, but there is equally a social separation insofar as there is no need for negotiating contraception with partners. Yet, even young women who use the pill can still get pregnant. Even young women who use the pill can still get STDs. Even young women who use the pill can still experience sexual violence. Even young women who use the pill may not experience sexual pleasure. In the long-term, in Canadian society, I think a more radical re-envisioning of sex, health and the self is needed, such that freedom is not so strongly attached to control of fertility through a negation of the body, and this is perhaps the work of the next generation of women *and* men. That said, as I have discussed in this thesis the pill is not only a contraceptive device. It can be used by individuals for different purposes. It is important to be aware of the multiple ways that the pill is used by young women to work on the self and to explore the various relationships they engage with in taking it. In doing so, we can turn a critical eye to the standards by which girls are situated as

subjects and the ways they struggle with pharmaceutical devices in seeking to realize social and cultural ideals of freedom.

## APPENDIX A: Participant Characteristics

**Table A1: Age distribution of participants**

<b>Age</b>	<b>Number of participants</b>
18	2
19	2
20	4
22	6
24	3
25	1
26	4
27	3
28	2
<b>Total</b>	<b>27</b>

**Table A2: Language spoken by participants**

<b>Language</b>	<b>Number of participants</b>
English	16
French	9
Other	2

**Table A3: Place of Birth**

<b>Place of Birth</b>	<b>Number of participants</b>
<i>Within Canada</i>	
BC	1
Manitoba	1
New Brunswick	1
Ontario	11
Quebec	9
<i>International</i>	
Caribbean	1
United States	2
Middle East	1

**Table A4: Occupation**

<b>Language</b>	<b>Number of participants</b>
Student	17
Working	10

**Table A5: Relationship Status**

<b>Type of relationship</b>	<b>Number of participants</b>
Boyfriend	18
Single	8
Married	1

## APPENDIX B: Details on pill use

**Table B1: Age at first pill use**

Age	Number of participants
12	1
15	5
16	6
17	8
18	4
20	2
21	1

**Table B2: Reasons for pill use**

Participant	Contraception	Menstrual Regulation	Menstrual Cramps	Acne	Polycystic Ovaries
Lucie	X		X		
Melanie	X	X	X	X	
Jennifer	X	X	X		
Renée	X	X	X		
Grace	X	X			
Evelyne	X	X			
Sheila	X				
Alicia	X	X	X		
Hannah	X	X	X		
Lynn	X			X	
Marie	X				
Kim	X	X	X		
Lise	X				
Jody	X			X	
Allison	X				
Leah	X				
Nathalie	X				
Valerie	X	X	X		
Tara	X	X	X	X	
Mona	X				X
Christine	X				
Elaine	X			X	
Erin	X		X		
Serena	X			X	
Christie	X	X	X		
Laurraine	X				
Alexandra	X				X

## **Appendix C: Interview guide**

### **Background information**

Age  
Relationship status  
Family status – children, living situation  
What is your occupation?  
Where did you grow up?

### **How you came to use the pill**

At what age did you start using the pill?  
What was your primary reason for wanting to go on the pill? Why was this important to you?  
Were there secondary reasons?  
Did your reason for being on the pill ever change? How so?  
Did you discuss your decision to take the pill with someone? Ex. Partner, family member, friends, with your health care provider or someone else?  
Tell me about what you knew about the pill when you first started using it? What did you know about how it worked? Where did you get this information?  
Tell me about how you got the pill?  
Did your doctor/health care provider discuss any side-effects of using the pill? Which?  
Did your doctor/health care provider discuss any benefits aside from ‘x’ for using the pill? Which?  
Which brand of pill did your doctor/health care provider prescribe? Were you familiar with the brand? If yes, how?  
Were there other options you considered besides the pill? Why did you choose the pill over these options?  
Is the cost of the pill covered by your health care insurance?

### **Using the pill**

Did you notice changes in your body when you first started using the pill?  
Did you notice changes in your emotions when you first started using the pill?  
If using the pill for contraception, do you use a secondary method as well?  
As of today, how long have you been using the pill?  
Did you ever stop taking it? Why?  
Has your reason for using it every changed?  
When do you take the pill? Tell me about how you remember to take it?  
For you, what is the biggest benefit?  
For you, what is the biggest drawback?  
For you, what is your biggest concern?  
Today, how do you feel about using the pill?  
When do you think you’ll stop using it?

### **Ideas about the pill**

In your opinion, do you think of the pill as different from other methods of contraception?

In your opinion, is the pill different from other pharmaceuticals/medications you might take? Do you think of it as a medicine? If yes, why? If not, why not?

In your opinion, is contraception a moral issue? If yes, how so? If not, why not?

In your opinion, is contraception a matter of individual choice?

In your opinion, is reliable contraception important for good sex?

In your opinion, what do you think the pill has meant for women more generally?

What do you think of the idea of a male contraceptive pill?

If a friend was thinking of going on the pill what advice would you give them?

What 3 words or images come into your mind when I say “the pill”?

What would you hope would come out of a project like this?

Are there issues I haven't covered that you think are important?

## Appendix D: Text research index

### ALESSE

CODE	TITLE	SOURCE
A1	Alesse Website	<a href="http://www.alesse.ca">www.alesse.ca</a> (retrieved September 2009)
A2	Start something with Alesse	<a href="https://startsomethingwithalesse.ca/en/contest_details/sample_entry/">https://startsomethingwithalesse.ca/en/contest_details/sample_entry/</a> (retrieved April 2013)

### CANADIAN FEDERATION FOR SEXUAL HEALTH

CODE	TITLE	SOURCE
CFSH 1	Contraception & Safer Sex	<a href="http://www.cfsh.ca/Your_Sexual_Health/Contraception-and-Safer-Sex/">http://www.cfsh.ca/Your_Sexual_Health/Contraception-and-Safer-Sex/</a> (Retrieved September 2010)
CFSH 2	Contraception & Birth Control	<a href="http://www.cfsh.ca/Your_Sexual_Health/Contraception-and-Safer-Sex/Contraception-and-Birth-Control/">http://www.cfsh.ca/Your_Sexual_Health/Contraception-and-Safer-Sex/Contraception-and-Birth-Control/</a> (Retrieved September 2010)
CFSH 3	Birth Control Pill	<a href="http://www.cfsh.ca/Your_Sexual_Health/Contraception-and-Safer-Sex/Contraception-and-Birth-Control/Pill.aspx">http://www.cfsh.ca/Your_Sexual_Health/Contraception-and-Safer-Sex/Contraception-and-Birth-Control/Pill.aspx</a> (Retrieved September 2010)
CFSH 4	Safer sex---Protect Yourself	<a href="http://www.cfsh.ca/Your_Sexual_Health/Contraception-and-Safer-Sex/Safer-Sex/">http://www.cfsh.ca/Your_Sexual_Health/Contraception-and-Safer-Sex/Safer-Sex/</a> (Retrieved September 2010)
CFSH 5	How to talk about sex	<a href="http://www.cfsh.ca/Your_Sexual_Health/How_to_Talk_about_Sex/">http://www.cfsh.ca/Your_Sexual_Health/How_to_Talk_about_Sex/</a> (Retrieved September 2010)
CFSH 6	How to talk about sex with your teen	<a href="http://www.cfsh.ca/Your_Sexual_Health/How_to_Talk_about_Sex/with-teens.aspx">http://www.cfsh.ca/Your_Sexual_Health/How_to_Talk_about_Sex/with-teens.aspx</a> (Retrieved September 2010)
CFSH 7	How to talk about sex with your parents	<a href="http://www.cfsh.ca/Your_Sexual_Health/How_to_Talk_about_Sex/With-Parents.aspx">http://www.cfsh.ca/Your_Sexual_Health/How_to_Talk_about_Sex/With-Parents.aspx</a> (Retrieved September 2010)
CFSH 8	How to talk about sex with your sexual partners	<a href="http://www.cfsh.ca/Your_Sexual_Health/How_to_Talk_about_Sex/With-Sexual-Partners/">http://www.cfsh.ca/Your_Sexual_Health/How_to_Talk_about_Sex/With-Sexual-Partners/</a> (Retrieved September 2010)
CFSH 9	I broke the law by using birth control	Promotional Poster for Sexual and Reproductive Health Day 2009

### GLOBE AND MAIL

CODE	TITLE	AUTHOR	DATE PUBLISHED
GM1	Experts call for more scrutiny amid growing use of 'off-label' prescriptions	Jane Gerster	March 16, 2013
GM2	What do the numbers say? A cost-benefit analysis of love and sex	Zosia Bielski	February 28, 2013
GM3	Health Canada to review safety information on controversial acne drug	Andre Picard	January 31, 2013
GM4	Is the pill behind your low sex drive?	Dr. Sheila Wijayasinghe	October 23, 2012
GM5	Low-estrogen birth-control pills safer than others	Andre Picard	August 14, 2009
GM6	Slower absorption by obese women raises concerns about the Pill	Paul Taylor	July 16, 2009
GM7	Slight increase in stroke risk for women	Gene Emery	June 14, 2012

	using the Pill: Study		
GM8	I'm in my 40s and I want off the Pill. How likely am I to get pregnant?	Dr. Sheila Wijayasinghe	June 13, 2012
GM9	One step closer to a Pill for men?	Zosia Bielski	February 2, 2012
GM10	Does the Pill make sex less pleasurable?	Zosia Bielski	November 1, 2012
GM11	Birth control pills may make women less attracted to studly males	Zosia Bielski	October 8, 2009
GM12	Does taking the pill lead to a happier marriage?	Adriana Barton	October 12, 2011
GM13	Birth control pill alters women's memories: study	Wency Leung	September 12, 2011
GM14	My daughter's doctor doesn't believe in birth control	Lisa Priest	May 27, 2012
GM15	Do you put too much faith in your birth control?	Adriana Barton	April 30, 2012
GM16	Birth-Control hormones linked to easier HIV transmission	Paul Taylor	October 6, 2011
GM17	Drop the paternalism and sell the Pill over the counter	Margaret Wentz	March 20, 2011
GM18	Pelvic politics: the Republican attack on women	Judith Timson	February 23, 2012
GM19	Pfizer recalls birth control pills, says tablets may not prevent pregnancy		February 1, 2012
GM20	Yasmin, Yaz birth control pills may raise blood clot risk: Health Canada	Helen Branswell	December 6, 2011
GM21	New birth-control pills can triple the risk of blood clots	Andre Picard	April 21, 2011
GM22	New birth control pills increase gallbladder disease risk only slightly, study finds	Andre Picard	April 18, 2011
GM23	Using the Pill for years may have pitfalls, study says	Paul Taylor	January 6, 2009
GM24	Evidence of blood-clots risk builds for newer oral contraceptives	Carly Weeks	November 7, 2011
GM25	The Pill turns 50	John Allemang	May 7, 2010
GM26	Contraceptive controversy	Paul Taylor	March 12, 2010
GM27	40-something, female and sexually active? You should read this.	Paul Taylor	March 4, 2013
GM28	Why teen pregnancy is on the rise again in Canada (and spiking in these provinces)	Zosia Bielski	January 29, 2013
GM29	Why are faulty birth-control pills being treated as a minor inconvenience?	Carly Weeks	September 15, 2013
GM30	Health Canada announces third birth-control recall this year	Carly Weeks	September 5, 2013
GM31	Health Canada issues another recall of faulty birth control pills		August 28, 2013
GM32	Class action launched against maker of recalled birth control pills	Justin Fauteux	May 16, 2013
GM33	U.S. regulator warns Canadian drug maker Apotex about quality control	Carly Weeks	April 26, 2013
GM34	Birth-control recall expanded in Canada		April 13, 2013
GM35	Birth-control recall: Experts still unsatisfied with Health Canada despite investigation into delays	Carly Weeks	April 12, 2013
GM36	Minister order inquiry into delay in	Carly Weeks	April 11, 2013

	notifying public of Alysena recall		
GM37	Some women may not realize they're using recalled birth-control pill	Carly Weeks	April 10, 2013
GM38	Women not alerted immediately of Alysena 28 birth control pill recall	Erin Anderssen	April 9, 2013

### HEALTH CANADA

CODE	TITLE	SOURCE
HC1	Birth Control – What can you do?	<a href="http://www.hc-sc.gc.ca/hl-vs/sex/control/index-eng.php">http://www.hc-sc.gc.ca/hl-vs/sex/control/index-eng.php</a>
HC2	Yasmin and Yaz	Health Canada Information Update, December 5, 2011
HC3	Health Canada to Review Safety of Drug Diane-35	Health Canada Information Update, January 31, 2013
HC4	(drospirenone): Increased risk of blood clots	Health Canada Information Update, December 5, 2011
HC5	Precautionary recall of birth control product: Esme 28	Health Canada Recalls & Alerts, September 5, 2013
HC6	Esme 28 Recall	Health Canada Recalls & Alerts, September 11, 2013
HC7	Birth control product recall: Freya-28	Health Canada Recalls & Alerts, August 8, 2013
HC8	Birth control product recall: Freya-28	Health Canada Recalls & Alerts, August 27, 2013

### LA PRESSE

CODE	TITLE	AUTHOR	DATE PUBLISHED
LP1	Contraceptif Diane 35: Des peurs exagérées, disent les gynécologues		February 27, 2013
LP2	France: Des Poursuites contre des fabricants de pilules font du bruit	Marc Thibodeau	February 3, 2013
LP3	Des pilules contraceptives de Bayer au banc des accusés	Sophie Allard and Marc Thibodeau	February 3, 2013
LP4	Suspension des ventes de Diane 35 en France		January 30, 2013
LP5	Des pilules contraceptives en constante évolution		January 2, 2013
LP6	Nouvel espoir pour la pilule contraceptive masculine		August 16, 2012
LP7	Des pilules contraceptives liées à un risque de caillot sanguin		October 28, 2011
LP8	Les femmes qui prennent la pilule vivraient plus longtemps		March 14, 2010
LP9	Le décalage horaire a-t-il un effet sur la pilule?	Isabelle Audet	May 15, 2009
LP10	Pamplémousses et médicaments: des risques de caillots		April 2, 2009
LP11	Contraceptifs oraux sans prescription: les gynécologues du Québec jugent l'idée trop risquée	Ian Bussieres	January 20, 2013
LP12	L'avertissement sur certaines pilules renforcé aux États-Unis		April 11, 2012
LP13	Toronto plus conservateur sur la pilule	Mathieu Perreault	February 11, 2012
LP14	Contraception: un accommodement à l'américaine	Richard Héту	February 11, 2012

LP15	De plus en plus de femmes n'ont pas accès à la contraception		March 11, 2013
LP16	Le stérilait serait bein plus efficace que la pilule		May 24, 2012
LP17	17 filles: épidémie de bébés	Normand Provencher	March 17, 2012
LP18	Une ville autrichienne donne la pilule contraceptive à ses pigeons		May 31, 2012
LP19	Une pilule contraceptive pour homme		May 25, 2012
LP20	Aucun lien entre pilule contraceptive et prise de poids		June 15, 2011
LP21	6 vérités sur la pilule	Silvia Galipeau	May 14, 2010
LP22	Bonne fête pilule!	Silvia Galipeau	May 14, 2010
LP23	La pilule fête ses cinquante ans	Silvia Galipeau	May 12, 2010
LP24	Elle donne deux fois naissance à des jumeaux en prenant la pilule	Nadielle Kutlu	February 4, 2009
LP25	La pilule contraceptive est polluante selon le Vatican		January 3, 2009
LP26	La pilule contraceptive influencerait le choix du partenaire		August 22, 2008
LP27	Il doit sa « vie » à la pilule	Silvia Galipeau	May 18, 2010
LP28	Huit inventions qui ont changé la vie des femmes	Silvia Galipeau, Isabelle Audet, Sophie Allard	March 4, 2009
LP29	Recours collectifs contre les fabricants de contraceptifs	Katia Gagnon	March 27, 2013
LP30	Des contraceptifs seraient liés à la mort d'au moins 23 Canadiennes	Sheryl Ubelacker	June 11, 2013
LP31	La France veut limiter la prescription des pilules de 3e generation	Elisabeth Zingg and Olivier Thibault	January 11, 2013
LP32	Plus de 200 millions de femmes n'ont pas accès à la contraception	Julie Charpentrat	November 14, 2012
LP33	La pilule miraculeuse	Lysiane Gagnon	May 11, 2010
LP34	Rappel préventif du contraceptif Alysena 28	Philippe Teisceira-Lessard	April 13, 2013
LP35	Pilule Diane 35 : benefices supérieurs au risqué pour « certaines patientes »		May 17, 2013

## LE DEVOIR

CODE	TITLE	AUTHOR	DATE
LD1	Santé Canada examine les risques de la pilule Diane-35	Amélie Daoust-Boisvert	February 1, 2013
LD2	Les 50 ans de la pilule	Amélie Daoust-Boisvert	June 10, 2010
LD3	Près de 100 000 avortements par année au Canada	Hélène Buzzetti	January 26, 2013
LD4	La pilule est mise en vente au Japon		September 3, 1999
LD5	En bref – La pilule davantage accessible pour les Américaines		
LD6	Les usines d'Apotex sont sûres, dit Aglukkaq	Amélie Daoust-Boisvert	April 30, 2013

## SEXUALITYANDU.CA

CODE	TITLE	SECTION
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SU1	Birth control	
SU2	Comparing birth control methods	
SU3	Types of birth control (Contraceptive methods)	
SU4	Which Birth Control Methods is the Best Choice for me?	
SU5	Talking to your partner about birth control	
SU6	Controlling your period with birth control	
SU7	Birth Control Myths	
SU8	Birth Control Brigade	Games & Apps
SU9	S.O.S. (Stay on Schedule)	Games & Apps
SU10	Choosing Wisely: Helping you make decisions about contraception	Games & Apps
SU11	Parents—Contraception—Birth Control	

### SOCIETY OF OBSTETRICIANS AND GYNECOLOGISTS OF CANADA

CODE	TITLE	SOURCE	DATE PUBLISHED
SOGC1	SOGC Position Statement – The Birth Control Pill and Cancer	Media Centre,  <a href="http://www.sogc.org/media/guidelines-oc_e.asp">http://www.sogc.org/media/guidelines-oc_e.asp</a>	
SOGC2	Oral Contraceptives and the Risk of Venous Thromboembolism: An Update	SOGC Clinical Practice Guideline	December 2010
SOGC3	Sexual and Reproductive Health Counselling by Health Care Professionals	SOGC Policy Statement	August 2011
SOGC4	Missed Hormonal Contraceptives: New Recommendations	SOGC Committee Opinion	November 2008
SOGC5	Statement on Generic Oral Contraceptives	SOGC Policy Statement	March 2008
SOGC6	Diane-35 and Risk of Venous Thromboembolism	SOGC Position Statement	February 19, 2013
SOGC7	Hormonal Contraception and Risk of Venous Thromboembolism	SOGC Position Statement	February 19, 2013
SOGC8	Faulty generic products pose unacceptable risk to Canadian Public	SOGC Position Statement	August 28, 2013
SOGC9	Birth control pill recall: Freya-28	Media Centre	
SOGC10	Birth control recall expanded to include Esme-28	Media Centre	

## Appendix E: Yasmin Patient Package Insert

### Yasmin

(drospirenone - ethinyl estradiol (Yasmin))

#### 1 Chapter: DIN (Drug Identification Number)

02261723 YASMIN 21 TABLETS

02261731 YASMIN 28 TABLETS

#### 2 Chapter: How does Yasmin work? What will it do for me?

Drospirenone - ethinyl estradiol is a combination medication containing two ingredients: *progestin* (drospirenone) and *estrogen* (ethinyl estradiol). It is a **birth control pill used to prevent pregnancy**. This medication works by preventing *ovulation* (the release of an egg from an ovary) and by causing changes in the mucus of the cervix (that makes it difficult for sperm to penetrate into the uterus) and in the endometrium (that make it difficult for an egg to implant).

Drospirenone - ethinyl estradiol is also used to treat moderate acne for women over 16 years of age who also want birth control and have started menstruating.

**Your doctor may have suggested this medication for conditions other than the ones listed in these drug information articles.** As well, some forms of this medication may not be used for all of the conditions discussed here. If you have not discussed this with your doctor or are not sure why you are taking this medication, speak to your doctor. **Do not stop taking this medication without consulting your doctor.**

**Do not give this medication to anyone else, even if they have the same symptoms as you do.** It can be harmful for people to take this medication if their doctor has not prescribed it.

#### 3 Chapter: How should I use Yasmin?

**21-day pack:** Take 1 tablet daily for 21 days. Take no tablets for 7 days, and then begin the next pack.

**28-day pack:** Take 1 tablet daily for 21 days, then take 1 "reminder" tablet daily for 7 days, and then begin the next pack.

Talk with your doctor about the best time to start your pills. The first day of your menstrual period (bleeding) is known as "Day 1." Your doctor may have you start your pills on the first Sunday after your period starts or on Day 1 or Day 5 of your period. The pills should be taken approximately the same time every day, (e.g., with a meal or at bedtime).

It is a good idea to use a second method of birth control (e.g., latex condoms, spermicidal foam or gel) for the first 7 days of the first cycle of pill use to ensure prevention of pregnancy.

Many women experience spotting or light bleeding or may feel sick to their stomach during the first 3 months of taking the pill. **If you do feel sick, do not stop taking the pill.** The problem will usually go away. If it does not go away, check with your doctor or clinic.

If you have [vomiting](#) or [diarrhea](#), or if you take certain medications (such as antibiotics), your pills may not work as well. If you start a new medication while taking birth control pills, check with your doctor or pharmacist to make sure that it will not reduce the effectiveness of the pills. Use a backup method of birth control, such as latex condoms and spermicidal foam or gel, until you can check with your doctor or pharmacist.

Many things can affect the dose of a medication that a person needs, such as body weight, other medical conditions, and other medications. **If your doctor has recommended a dose different from the ones listed here**, do not change the way that you are taking the medication without consulting your doctor.

It is important that you take this medication exactly as prescribed by your doctor. If you miss pills at any time, the risk of becoming pregnant increases.

**If you miss one pill**, take it as soon as you remember, and take the next pill at the usual time. This means that you might take 2 pills in one day.

**If you miss 2 pills in a row during the first 2 weeks of your cycle**, take 2 pills on the day you remember and 2 pills the next day. Then take one pill a day until you finish the pack. Use a second method of birth control if you have sex in the 7 days after you miss the pills.

**If you start your pills on Sunday and you miss 2 pills in a row during the third week of your cycle or 3 or more pills in a row anytime in your cycle**, keep taking one pill a day until Sunday. On Sunday, safely discard the rest of the pack and start a new pack that day. Use another method of birth control if you have sex in the 7 days after you miss the pills. You may not have a period this month. If you miss 2 periods in a row, call your doctor or clinic.

**If you start your pills on a day other than a Sunday and you miss 2 pills in a row during the third week of your cycle or 3 or more pills at anytime during your cycle**, safely dispose of the rest of the pill pack and start a new pack that same day. You may not have a period this month. If you miss 2 periods in a row, call your doctor or clinic. Use another method of birth control if you have sex in the 7 days after you miss the pills. You may not have a period this month. If you miss 2 periods in a row, call your doctor or clinic.

**If you are taking the 28-day pack and miss any of the white pills in week 4**, safely dispose of the pills you missed and keep taking one pill each day until the pack is empty. Begin a new pack as you would normally.

See the package insert for additional information on where to start and what to do if you forget to take a pill.

Store this medication at room temperature in its original packaging and keep it out of the reach of children.

Do not dispose of medications in wastewater (e.g. down the sink or in the toilet) or in household garbage. Ask your pharmacist how to dispose of medications that are no longer needed or have expired.

#### **4 Chapter: What form(s) does Yasmin come in?**

##### **YASMIN 21** ®

Each hormone-containing yellow, round, film-coated tablet contains 3.0 mg drospirenone and 0.030 mg ethinyl estradiol. *Nonmedicinal ingredients:* cornstarch, hydroxypropylmethyl cellulose, lactose monohydrate, magnesium stearate, modified starch, polyethylene glycol, povidone, talc, titanium dioxide, and yellow ferric oxide.

##### **YASMIN 28** ®

Each hormone-containing yellow, round, film-coated tablet contains 3.0 mg drospirenone and 0.030 mg ethinyl estradiol. The white tablets are hormone-free. *Nonmedicinal ingredients for both hormone-containing and hormone-free tablets:* cornstarch, hydroxypropyl methylcellulose, lactose monohydrate, magnesium stearate, povidone, talc, and titanium dioxide; *hormone-containing tablets also contain the following nonmedicinal ingredients:* modified starch, polyethylene glycol, and yellow ferric oxide.

#### **5 Chapter: Who should NOT take Yasmin?**

**This medication should not be taken by anyone who:**

- is allergic to drospirenone, ethinyl estradiol, or to any of the ingredients of the medication
- is or may be pregnant
- has active liver disease
- has any eye damage resulting from vascular (blood vessel) disease of the eye, such as partial or complete loss of vision or defect in visual fields
- has conditions that increase the risk of high potassium (such as diseases of the kidney, liver, or adrenal glands)
- has had a heart attack
- has had jaundice (yellowing of skin) with pregnancy or with prior pill use

- has, has had, or may have an endometrial cancer (cancer of the uterus lining) or another type of tumour that needs estrogen to grow
- has, has had, or may have breast cancer
- has heart valve disease with complications
- has or has had benign or malignant liver tumours
- has or has had cerebrovascular disorders (e.g., [stroke](#)) or a condition that may be the first sign of a stroke (such as a [transient ischemic attack](#) or small reversible stroke)
- has or has had coronary artery disease (e.g., angina)
- has or has had migraines with aura
- has or has had pancreatitis associated with extremely high triglyceride levels
- has or has had thrombophlebitis or thromboembolic (blood clotting) disorders
- has reduced kidney function
- has reduced liver function
- has problems with the adrenal gland
- has severe or multiple risk factors for blood clots:
  - [diabetes](#) with blood vessel involvement
  - heavy smoking (more than 15 cigarettes per day) and over age 35
  - inherited or acquired blood clotting disorders
  - major surgery associated with an increased risk of blood clots after surgery
  - prolonged bed rest
  - severe high [blood pressure](#)
  - severe high [cholesterol](#)
- has undiagnosed abnormal vaginal bleeding

## 6 Chapter: What side effects are possible with Yasmin?

**Many medications can cause side effects.** A side effect is an unwanted response to a medication when it is taken in normal doses. Side effects can be mild or severe, temporary or permanent. The side effects listed below are not experienced by everyone who takes this medication. **If you are concerned about side effects, discuss the risks and benefits of this medication with your doctor.**

The following side effects have been reported by at least 1% of people taking this medication. Many of these side effects can be managed, and some may go away on their own over time.

**Contact your doctor if you experience these side effects and they are severe or bothersome. Your pharmacist may be able to advise you on managing side effects.**

- abdominal cramping or bloating
- acne (usually less common after 3 months of treatment, and may improve if acne already exists)
- back pain
- breast pain, tenderness, or swelling
- changes in weight
- [diarrhea](#)
- dizziness
- [nausea](#) and [vomiting](#)
- Nervousness

**Although most of the side effects listed below don't happen very often, they could lead to serious problems if you do not check with your doctor or seek medical attention.**

**Check with your doctor as soon as possible if any of the following side effects occur:**

- changes in your bleeding pattern during periods or between periods, such as:
  - breakthrough bleeding or spotting between periods
  - complete stopping of menstrual bleeding several months in a row
  - decreased bleeding during periods

- occasional stopping of menstrual bleeding
- prolonged bleeding during periods
- for women with a history of abnormalities in the breast
  - breast cancer
  - cysts in the breast
  - lumps in the breast
- increased [blood pressure](#)
- persistent sad mood or other emotional changes
- signs of a liver problem (e.g., yellow eyes or skin, abdominal pain, dark urine, pale stools, or [itchy skin](#))
- swelling of ankles and feet
- swelling, pain, or tenderness in upper abdominal area
- vaginal yeast infection with vaginal itching or irritation, or thick, white, or curd-like discharge
- worsening headaches or migraines

**Stop taking the medication and seek immediate medical attention if *any* of the following occur:**

- crushing chest pain or heavy feeling
- pain in the calf
- redness, tenderness, itching, burning, or peeling of skin
- seizures
- sharp chest pain, coughing up blood, sudden shortness of breath
- signs of an allergic reaction (e.g., difficulty breathing, hives, swelling of the face or throat)
- sudden loss of vision (partly or completely)
- sudden severe or worsening [headache](#); vomiting; dizziness; fainting; vision or speech problems; weakness or numbness in the face, arm, or leg

**Some people may experience side effects other than those listed.** Check with your doctor if you notice any symptom that worries you while you are taking this medication.

Are there any other precautions or warnings for Yasmin?

**Before you begin taking a medication, be sure to inform your doctor of any medical conditions or allergies you may have, any medications you are taking, whether you are pregnant or breast-feeding, and any other significant facts about your health. These factors may affect how you should take this medication.**

## 6.1 HEALTH CANADA ADVISORY

### 6.1.1 December 5, 2011

Health Canada has issued new information concerning the use of Yasmin®(drospirenone - ethinyl estradiol). To read the full report, visit Health Canada's website at [www.hc-sc.gc.ca](http://www.hc-sc.gc.ca).

A previous advisory on Yasmin® was issued on June 7, 2011.

To read the full Health Canada Advisory, visit Health Canada's web site at [www.hc-sc.gc.ca](http://www.hc-sc.gc.ca).

**Blood clots:** All hormonal contraceptives can increase the risk of developing blood clots. Some studies show that birth control pills containing drospirenone have a higher risk of blood clots compared to other birth control pills. Tell your doctor if you have a history of blood clots or are at risk of developing blood clots. Inform your doctor if you are planning an upcoming surgery or if you will be immobilized or inactive for a prolonged period of time (i.e., through accident or illness), as there is an increased risk of blood clot formation when using combination hormone contraceptives. If you experience crushing chest pain or heaviness, pain in the calf, sudden shortness of breath, vision or speech changes, sudden severe headache, weakness or numbness in an arm or leg, or are coughing blood, get immediate medical attention as these symptoms could indicate a possible blood clot.

**Blood pressure:** People with high blood pressure should discuss with their doctor how this medication may affect their medical condition, how their medical condition may affect the dosing and effectiveness of this medication, and whether any special monitoring is

needed. You may need to visit your doctor more frequently to have your blood pressure checked while using this medication. Occasionally, high blood pressure may develop with the use of hormone contraceptives. This may require stopping this medication.

**Cigarette smoking and heart disease:** Cigarette smoking increases the risk of serious heart disease and death. Birth control pills also increase this risk, particularly as a woman gets older. Women over 35 years of age who are heavy smokers (more than 15 cigarettes per day) should not use the birth control pill. All women are urged not to smoke while taking this medication.

Other factors that increase your risk of heart disease include [diabetes](#), high blood pressure, high [cholesterol](#) levels, or a family history of these conditions. It is unclear whether taking the birth control pill increases this risk. For women who have a low risk of heart disease and do not smoke, the benefits of using low-dose birth control pills outweigh the possible risks of heart disease, regardless of age. These women may continue to use birth control pills up to the age of menopause.

**Depression:** Women with a history of depression or other emotional problems should discuss with their doctor how this medication may affect their medical condition, how their medical condition may affect the dosing and effectiveness of this medication, and whether any special monitoring is needed. Women with a history of depression or other emotional problems may be more likely to have a recurrence while taking oral birth control medications.

**Diabetes:** Women with diabetes or those with a family history of diabetes should discuss with their doctor how this medication may affect their medical condition, how their medical condition may affect the dosing and effectiveness of this medication, and whether any special monitoring is needed. If you have diabetes, it may be necessary to test your blood sugar more often to detect any worsening of blood sugar control after starting birth control pills.

**Epilepsy:** Women with a history of epileptic seizures should speak to their doctor about the possibility of this medication increasing the numbers of epileptic seizures she may experience.

**Electrolytes:** This medication contains progesterone drospirenone, which may increase potassium levels in women who are at high risk for this condition. Women with reduced kidney or liver function or inadequate production of adrenal hormones are at increased risk. Women who receive other medications that can increase their potassium should have their potassium levels checked by their doctor when they first start this medication. Some of these medications include potassium supplements, ACE inhibitors, angiotensin-II receptor antagonists (e.g., candesartan, losartan), some diuretics, heparin, aldosterone antagonists (e.g., spironolactone), and nonsteroidal anti-inflammatory drugs (NSAIDs; e.g., ibuprofen or naproxen).

**Eye problems:** Women who are taking birth control pills may experience fluid buildup in the cornea of the eye, which may cause vision changes. This fluid buildup may also mean that your contact lenses may not fit as well as they used to, especially if you have hard contact lenses. Soft contact lenses usually do not cause problems. If your contact lenses feel uncomfortable, talk to your eye doctor.

**Fibroid tumours:** This medication may worsen fibroid tumours (noncancerous growths in the uterus), causing sudden enlargement, pain, or tenderness. If you notice these effects, contact your doctor.

**Gallbladder problems:** The use of hormonal contraceptives increases the risk of gallbladder problems. If you experience symptoms of gallbladder problems, such as severe stomach or back (between the shoulder blades) pain, nausea or vomiting, contact your doctor.

**Kidney disease:** People with kidney disease should discuss with their doctor how this medication may affect their medical condition, how their medical condition may affect the dosing and effectiveness of this medication, and whether any special monitoring is needed. You may need to have regular blood tests while taking this medication.

**Liver disease:** Although uncommon, the use of hormonal contraceptives has been associated with liver problems. See your doctor as soon as possible if you develop signs of liver problems such as yellow eyes or skin, abdominal pain, dark urine, pale stools, or [itchy skin](#).

**Migraine and headache:** Women with migraines should discuss with their doctor how this medication may affect their medical condition and whether any special monitoring is needed. You should report to your doctor if you notice the development of worsening migraine headaches or new types of headaches that are recurrent, persistent, or severe.

**Regular checkups:** You should visit your doctor yearly for a physical examination and follow-up while you are taking this medication.

**Return to fertility:** After stopping birth control therapy, you should delay pregnancy until at least one normal spontaneous menstrual cycle has occurred in order to date the pregnancy. An alternative birth control method should be used during this time. If you do not menstruate for 6 months or more after stopping birth control pills, notify your doctor.

**Risk of cancer:** The use of hormone contraceptives may increase the risk of breast and cervical cancer in women before menopause (around age 50). If you have been using hormone contraceptives for a long time (more than 8 years), started using them at an early age,

or have a family history of cancer (mother or sister), you may be at an increased risk of developing cancer. Talk to your doctor about whether any special monitoring is needed.

If you are taking birth control pills, you should learn how to do a breast self-exam. Notify your doctor anytime you detect a lump. In a few women, the use of birth control pills may speed up the growth of a breast cancer that has not yet been diagnosed. A yearly clinical breast examination is also recommended because, if breast cancer should develop, medications that contain estrogen may cause the cancer to grow quickly.

**Sexually transmitted infections (STIs):** Birth control pills do not protect against HIV/AIDS and other sexually transmitted infections (STIs; formerly known as sexually transmitted diseases or STDs). It is recommended that latex condoms be used in combination with this medication to protect against these infections.

**Pregnancy:** This medication should not be used during pregnancy. If you become pregnant while taking this medication, or think that you may be pregnant, contact your doctor as soon as possible.

**Breast-feeding:** The hormones in this medication pass into breast milk. These hormones may reduce the quantity and quality of the breast milk. Breast-feeding women should use another form of birth control until they are no longer breast-feeding. Talk to your doctor about your options.

**Children:** The safety and effectiveness of using this medication have not been established for children under 16 years of age.

## 7 Chapter: What other drugs could interact with Yasmin?

There may be an interaction between drospirenone - ethinyl estradiol and any of the following:

- › acetaminophen
- › acetylsalicylic acid (ASA)
- › alcohol
- › aminocaproic acid
- › anastrozole
- › angiotensin converting enzyme inhibitors (ACE inhibitors; e.g., ramipril, lisinopril, or enalapril)
- › angiotensin-II receptor blockers (e.g., candesartan, losartan)
- › antacids (when taken within 2 hours of the medication)
- › antibiotics (e.g., ampicillin, chloramphenicol, cotrimoxazole, erythromycin, metronidazole, penicillin, neomycin, nitrofurantoin, rifampin, sulfonamides, tetracyclines)
- › anticonvulsants (e.g., carbamazepine, ethosuximide, lamotrigine, oxcarbazepine, phenobarbital, phenytoin, primidone, topiramate)
- › antidiabetes medication (e.g., glyburide, gliclazide, glipizide)
- › antihistamines (e.g., chlorpheniramine, diphenhydramine)
- › antipyridine
- › aprepitant
- › barbiturates (e.g., phenobarbital)
- › benzodiazepines (e.g., lorazepam, diazepam, chlordiazepoxide)
- › beta-blockers (e.g., propranolol, metoprolol, atenolol)
- › caffeine
- › certain diuretics (e.g., amiloride, spironolactone, triamterene)
- › chloral hydrate
- › chlordiazepoxide
- › cholestyramine
- › clofibrate
- › clonidine
- › cyclosporine
- › folic acid
- › griseofulvin
- › guanethidine
- › heparin
- › insulin
- › isoproterenol
- › ketoconazole
- › meperidine
- › meprobamate
- › methyl dopa
- › mitotane
- › modafinil
- › nevirapine
- › nonsteroidal anti-inflammatory drugs (NSAIDs; e.g., naproxen, ibuprofen)
- › phenothiazines (e.g., chlorpromazine, perphenazine)
- › phenylbutazone
- › potassium supplements or potassium-containing salt substitutes
- › prednisone
- › ritonavir
- › St. John's wort
- › theophylline
- › tricyclic antidepressants (e.g., amitriptyline, clomipramine)
- › vitamin B12
- › vitamin E
- › warfarin

**If you are taking any of these medications, speak with your doctor or pharmacist.** Depending on your specific circumstances, your doctor may want you to:

- stop taking one of the medications,
- change one of the medications to another,
- change how you are taking one or both of the medications, or
- leave everything as is.

**An interaction between two medications does not always mean that you must stop taking one of them.** Speak to your doctor about how any drug interactions are being managed or should be managed.

**Medications other than those listed above may interact with this medication.** Tell your doctor or prescriber about all prescription, over-the-counter (non-prescription), and herbal medications you are taking. Also tell them about any supplements you take. Since caffeine, alcohol, the nicotine from cigarettes, or street drugs can affect the action of many medications, you should let your prescriber know if you use them.

## Appendix F: Diane-35 Patient Package Insert

### Diane-35

(cyproterone - ethinyl estradiol)

#### 1.1 DIN (Drug Identification Number)

02233542 DIANE-35 TABLET

How does Diane-35 work? What will it do for me?

This medication contains a combination of two ingredients: cyproterone and ethinyl estradiol. Cyproterone belongs to a group of medications known as *antiandrogens*. Ethinyl estradiol belongs to a group of medications known as *estrogens*. Together, they are used to **treat certain types of acne in women**. This medication works by regulating hormones that affect the skin.

**This medication may be available under multiple brand names and/or in several different forms.** Any specific brand name of this medication may not be available in all of the forms or approved for all of the conditions discussed here. As well, some forms of this medication may not be used for all of the conditions discussed here.

**Your doctor may have suggested this medication for conditions other than those listed in these drug information articles.** If you have not discussed this with your doctor or are not sure why you are taking this medication, speak to your doctor. **Do not stop taking this medication without consulting your doctor.**

**Do not give this medication to anyone else, even if they have the same symptoms as you do.** It can be harmful for people to take this medication if their doctor has not prescribed it.

#### 2 Chapter: How should I use Diane-35?

**This medication is taken in 28-day cycles consisting of 1 tablet daily for 21 days, followed by a 7-day interval without medication (i.e., 3 weeks on, 1 week off).** Tablets should be taken at the same time each day. Treatment is usually started on the first day of menstrual bleeding. Usually, several months of treatment are needed before improvement is seen. Once the acne has completely resolved, this medication is usually continued for another 3 or 4 cycles and then stopped. This medication may be restarted if your acne returns.

If spotting or breakthrough bleeding occurs during the 3 weeks during which this medication is being taken, continue taking this medication as the spotting or breakthrough bleeding is usually temporary. If bleeding is persistent or lasts a long time, contact your doctor.

If your menstrual period fails to occur during the 7-day tablet-free interval, do not start the next medication cycle and contact your doctor.

Many things can affect the dose of medication that a person needs, such as body weight, other medical conditions, and other medications. **If your doctor has recommended a dose different from the ones listed here,** do not change the way that you are using the medication without consulting your doctor.

It is very important to take this medication on a regular schedule as prescribed by the doctor. The medication will be less effective if you miss doses. If you miss a dose of this medication, and you remember within 12 hours, take the missed dose. If more than 12 hours have passed, discard the missed tablet and continue to take the remaining tablets in the pack at the usual time. **Do not take a double dose to make up for a missed one.**

Store this medication at room temperature and keep it out of the reach of children.

Do not dispose of medications in wastewater (e.g. down the sink or in the toilet) or in household garbage. Ask your pharmacist how to dispose of medications that are no longer needed or have expired.

### 3 Chapter: What form(s) does Diane-35 come in?

Each beige, round, biconvex, sugar-coated tablet contains cyproterone acetate 2 mg and ethinyl estradiol 0.035 mg. *Nonmedicinal ingredients:* cornstarch, lactose, magnesium stearate, povidone, and talc; *tablet coating:* calcium carbonate, ferric oxide yellow, glycerol, polyethylene glycol, povidone, sucrose, talc, titanium dioxide, and wax.

### 4 Chapter: Who should NOT take Diane-35?

**Do not take this medication if you:**

- are allergic to cyproterone, estradiol, or any ingredients of the medication
- are or may be pregnant
- have a history of *cholestatic jaundice* (yellowing of the skin, whites of the eyes caused by problems with bile flow)
- have active liver disease
- have any eye problems caused by blood vessel disease in the eye (such as partial or complete loss of vision or other vision changes)
- have existing or have had blood vessel or blood clotting disorders (including thrombophlebitis, cerebrovascular disease such as stroke, heart attack, and coronary artery disease)
- have had *otosclerosis* (abnormal bone growth in the ear) that worsened during pregnancy
- have known or suspected breast cancer
- have known or suspected tumours dependent on estrogen
- have or have had liver tumours
- have severe diabetes with blood vessel changes
- have undiagnosed abnormal vaginal bleeding

### 5 Chapter: What side effects are possible with Diane-35?

**Many medications can cause side effects.** A side effect is an unwanted response to a medication when it is taken in normal doses. Side effects can be mild or severe, temporary or permanent.

The side effects listed below are not experienced by everyone who takes this medication. **If you are concerned about side effects, discuss the risks and benefits of this medication with your doctor.**

The following side effects have been reported by at least 1% of people taking this medication. Many of these side effects can be managed, and some may go away on their own over time.

**Contact your doctor if you experience these side effects and they are severe or bothersome. Your pharmacist may be able to advise you on managing side effects.**

- breast pain, tenderness, or swelling
- brown, blotchy spots on exposed skin
- dizziness
- headache
- increased or decreased interest in sexual intercourse
- nausea
- swelling of ankles and feet
- unusual tiredness or weakness

- vomiting
- weight gain or loss

**Although most of the side effects listed below don't happen very often, they could lead to serious problems if you do not check with your doctor or seek medical attention.**

**Check with your doctor as soon as possible if any of the following side effects occur:**

- changes in the uterine bleeding pattern during or between menstrual periods (such as decreased bleeding, breakthrough bleeding or spotting between periods, prolonged bleeding, complete stopping of menstrual bleeding that occurs over several months in a row, or stopping of menstrual bleeding that only occurs sometimes)
- signs of depression (e.g., poor concentration, changes in weight, changes in sleep, decreased interest in activities, thoughts of suicide)
- *for women with diabetes:* mild increase of blood sugar, faintness, nausea, pale skin, or sweating
- *for women with a history of breast disease:* lumps in breast
- headaches or migraines (although headaches may lessen for many users, they may increase in number or become worse for others)
- increased blood pressure
- symptoms of liver problems (e.g., swelling, pain, or tenderness in upper abdominal area, yellowing of eyes or skin, skin itching)
- vaginal infection with vaginal itching or irritation, or thick, white, or curd-like discharge

**Stop taking the medication and seek immediate medical attention if *any* of the following occur:**

- abdominal or stomach pain (sudden, severe, or continuing)
- signs of blood clots (e.g., coughing up blood; pains in chest, groin, or leg - especially in calf of leg)
- signs of heart attack (e.g., sudden chest pain or pain radiating to back, down arm, jaw; sensation of fullness of the chest; nausea; vomiting; sweating; anxiety)
- signs of stroke (e.g., sudden or severe headache; sudden loss of coordination; vision changes; sudden slurring of speech; or unexplained weakness, numbness, or pain in arm or leg)
- shortness of breath

**Some people may experience side effects other than those listed.** Check with your doctor if you notice any symptom that worries you while you are taking this medication.

## **6 Chapter: Are there any other precautions or warnings for Diane-35?**

**Before you begin taking a medication, be sure to inform your doctor of any medical conditions or allergies you may have, any medications you are taking, whether you are pregnant or breast-feeding, and any other significant facts about your health. These factors may affect how you should take this medication.**

**Birth control:** This medication should not be used only for the purpose of birth control. Women should use a non-hormonal method of birth control (such as condoms) while taking this medication. Birth control pills should not be taken at the same time as cyproterone - ethinyl estradiol.

**Blood clots:** This medication appears to increase the risk of developing blood clots. This risk may be greater than that which occurs with birth control pills. These blood clots may form anywhere in the body, but are more noticeable when they occur in the large muscles, lung, brain (stroke), or heart (heart attack). If you experience pain in the chest or leg, unexplained shortness of breath, fast and irregular heartbeat, severe headache, blurred vision, or slurred speech, get immediate medical attention.

**Breast cancer:** All women who take this medication should practice breast self-examination. Ask your doctor to teach you how to do this. If you have a family history of breast cancer, you should be closely monitored by your doctor while taking this medication.

**Diabetes:** This medication can cause changes in blood sugars. If you have diabetes or a family history of diabetes, discuss with your doctor how this medication may affect your medical condition, how your medical condition may affect the dosing and effectiveness of this medication, and whether any special monitoring is needed.

**Depression:** Hormones, such as cyproterone - ethinyl estradiol have been known to cause mood swings and symptoms of depression. If you have depression or a history of depression, discuss with your doctor how this medication may affect your medical condition and whether any special monitoring is needed.

If you experience symptoms of depression such as poor concentration, changes in weight, changes in sleep, decreased interest in activities, or notice them in a family member who is taking this medication, contact your doctor as soon as possible.

**Liver function:** Like other hormones, cyproterone - ethinyl estradiol can cause decreased liver function and liver disease. If you have decreased liver function or liver disease, discuss with your doctor how this medication may affect your medical condition, how your medical condition may affect the dosing and effectiveness of this medication, and whether any special monitoring is needed. This medication should not be taken by women with severe liver disease.

If you experience symptoms of liver problems such as fatigue, feeling unwell, loss of appetite, nausea, yellowing of the skin or whites of the eyes, dark urine, pale stools, abdominal pain or swelling, and itchy skin, contact your doctor immediately.

**Medical conditions:** The combination of obesity, high blood pressure, and diabetes greatly increases the risk of side effects from this medication. If you have this combination of medical conditions, discuss with your doctor how this medication may affect your medical condition, how your medical condition may affect the dosing and effectiveness of this medication, and whether any special monitoring is needed.

This medication can cause fluid retention, which may worsen conditions such as high blood pressure, heart disease, or kidney disease.

**Migraine:** This medication may cause migraine headaches to occur. If you experience a new pattern of headaches that is severe, persistent, or recurrent, contact your doctor as soon as possible. Cyproterone - ethinyl estradiol is not recommended for people who experience migraine headaches with aura.

**Smoking:** Smoking increases the risk of serious side effects on the heart and blood vessels. This risk increases with age and heavy smoking (15 or more cigarettes per day) and is even more serious for women over 35 years of age. Women who use this medication should not smoke.

**Surgery:** Certain situations such as long-term bed confinement may make blood clots more likely. Discuss with your doctor the risks and benefits of temporarily stopping this medication. If you are scheduled for surgery, let all doctors involved in your care know that you are taking this medication.

**Vaginal bleeding:** Report any unusual vaginal bleeding to your doctor.

**Vision and contact lenses:** Like other hormones, cyproterone - ethinyl estradiol may cause changes to the shape of the eye. If your contact lenses do not seem to fit as well as they used to, consult your doctor or eye care professional. You may need to stop wearing them or be fitted for a different pair. If you experience any vision changes while taking this medication, contact your doctor.

**Pregnancy:** This medication should not be taken by pregnant women as it can cause harm to the developing baby. If you become or suspect that you may be pregnant while taking this medication, contact your doctor immediately. After stopping treatment, you should wait until at least one normal menstrual cycle has occurred before trying to get pregnant.

**Breast-feeding:** This medication passes into breast milk and can reduce the amount and quality of breast-milk produced. This medication is not recommended for women who are breast-feeding.

## 7 Chapter: What other drugs could interact with Diane-35?

There may be an interaction between cyproterone - ethinyl estradiol and any of the following:

- alcohol
- ampicillin
- amiodarone
- analgesics (painkillers; e.g., acetaminophen, codeine)
- anastrozole
- antacids
- antihistamines (e.g., chlorpheniramine, loratidine)
- antimigraine medications (e.g., dihydroergotamine)
- antipsychotic medications (e.g., haloperidol, perphenazine, olanzapine)
- antiseizure medications (e.g., carbamazepine, lamotrigine, phenobarbital, phenytoin, primidone, topiramate)
- aprepitant
- aripiprazole
- “azole” antifungals (e.g., fluconazole, ketoconazole, voriconazole)
- barbiturates (e.g., pentobarbital, secobarbital)
- beta-blockers (e.g., metoprolol, atenolol)
- bosentan
- bromazepam
- caffeine
- calcium channel blockers (e.g., diltiazem, nifedipine, verapamil)
- certain benzodiazepines (e.g., alprazolam, clonazepam)
- chloral hydrate
- cholestyramine
- clobazam
- clofibrate
- clomipramine
- clonidine
- corticosteroids (e.g., dexamethasone, prednisone)
- conivaptan
- cotrimoxazole
- cyclosporine
- dacarbazine
- dasatinib
- diabetes medications (e.g., glyburide, gliclazide)
- other estrogens
- efavirenz
- felbamate
- flutamide
- folic acid
- griseofulvin
- imatinib
- isoniazid
- levothyroxine
- macrolide antibiotics (e.g., clarithromycin, erythromycin)
- melatonin
- meperidine
- methyl dopa
- metronidazole
- mirtazapine
- modafinil
- mycophenolate
- nefazodone
- nevirapine
- nitrofurantoin
- penicillin
- phenothiazines (e.g., chlorpromazine)
- pimozide
- phenylbutazone
- protease inhibitors (e.g., ritonavir, saquinavir)
- prucalopride
- retinoic acid (Vitamin A) derivatives
- rasagiline
- rifabutin
- rifampin
- ropinirole
- selective serotonin reuptake inhibitors (e.g., citalopram, fluoxetine, paroxetine, sertraline)
- St. John's wort
- "statins" (e.g., atorvastatin, pravastatin, simvastatin)
- tetracycline
- theophyllines (e.g., aminophylline, oxtriphylline, theophylline)
- thyroid medications (e.g., levothyroxine, desiccated thyroid)
- tranexamic acid
- tricyclic antidepressants (e.g., amitriptyline, desipramine)
- warfarin
- vitamin C (ascorbic acid)

**If you are taking any of these medications, speak with your doctor or pharmacist.** Depending on your specific circumstances, your doctor may want you to:

- stop taking one of the medications,
- change one of the medications to another,
- change how you are taking one or both of the medications, or
- leave everything as is.

**An interaction between two medications does not always mean that you must stop taking one of them.** Speak to your doctor about how any drug interactions are being managed or should be managed.

**Medications other than those listed above may interact with this medication.** Tell your doctor or prescriber about all prescription, over-the-counter (non-prescription), and herbal medications you are taking. Also tell them about any supplements you take. Since caffeine, alcohol, the nicotine from cigarettes, or street drugs can affect the action of many medications, you should let your prescriber know if you use them.

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