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Normalizing Abnormality: An Exploration of Social Forces Driving Gendered Disparity in Rates of Anxiety Disorder Diagnoses

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The College of Wooster

Normalizing Abnormality: An Exploration of Social Forces Driving Gendered Disparity in Rates
of Anxiety Disorder Diagnoses

By Sara Tebeau

Presented in Partial Fulfillment of the Requirements of Senior Independent Study

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Departments of Sociology and Anthropology and Women's, Gender and Sexuality Studies
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Abstract

According to recent statistics provided by the National Institute of Mental Health (2013), American women are twice as likely as men to face diagnosis with an anxiety disorder. While there are existing bodies of sociological and feminist work theorizing both the social construction of mental illness categories and the historical pathologization of women, there is no contemporary dialogue centered on gendered disparity in anxiety diagnosis rates. In this paper, I contribute to ongoing discussion of neoliberal influence on the gendering of mental illness through an exploration of the forces contributing to disparity in rates of diagnosis with anxiety disorders. In response to themes brought to light while analyzing survey data provided by 69 college students, my work focuses on the influence personal experience has on perception, contradictions between the biological and the social, and constructions of masculinity. I conclude by arguing the necessity of an American mental health justice movement that recognizes the neoliberal state, rather than the individual, as the primary site of anxiety production.

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Chapter One

Gendered Disparity in Diagnosis

According to the National Institute of Mental Health (NIMH), “anxiety disorders affect about 40 million American adults ages 18 and older (about 18%) in a given year, causing them to be filled with fearfulness and uncertainty” (2014). These diagnoses are not only rampant; they are disproportionately distributed throughout the American population. The fifth edition of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (DSM-V) reports that American women are more than twice as likely as American men to be diagnosed with an anxiety disorder (2013:223). Research by NIMH and the Anxiety and Depression Association of America (ADAA) confirms this statistic: NIMH reports that “women are 60% more likely than men to experience an anxiety disorder over their lifetime” (2014). Prominent mental health authorities are unanimous in their assertion that American women are more than twice as likely to experience anxiety disorders by nature of their sex. How have American women come to be *doubly* susceptible to categorization as pathologically anxious?

The authoritative voices of dominant mental health institutions have created a cultural understanding that certain emotions, when experienced in excess or particular combinations, call for medical diagnosis and treatment. Yet, there are psychiatrists and social theorists—Thomas Szasz, Michel Foucault, and Robert Merton among them—who have argued that mental illness is not a natural phenomenon that was discovered by neurologists, biologists, and geneticists; rather, they suggest that it is a social construct, finding its genesis within particular social contexts

during particular moments in history. These scholars have asked how society, not biology, has determined who is mentally ill and who is not. They have highlighted the gray areas and blank spaces in psychiatric diagnostic criteria and biological research as evidence that mental disorders are interpretive, subjective, and socially defined. Epidemic rates of diagnosis with anxiety disorders suggest that now is the time for sociologists to re-investigate the role played by society in producing mental illness. The statistics demand that the epidemic rates of anxiety diagnoses and the gendered disparity within those diagnoses be thoroughly and critically examined through both a sociological *and* a feminist lens. The question I seek to answer through my thesis is this: how has the social construction of anxiety contributed to American women's disproportionate susceptibility to diagnosis?

Anxiety as an Umbrella Term

I began this project with an eye to specificity. The statistical sociologist in me—the one who has been trained to examine one specific independent variable X in relation to one specific dependent variable Y—believed that the most empirical way to answer my research question was to choose a single diagnostic category to serve as my dependent variable. However, as my familiarity with the history of American psychiatry has grown, I have observed how rigid and confining the symptomatology of discrete diagnostic categories can be. I now feel that focusing on just one disorder would make me compliant with the system I am critically examining.

As I elaborate in the coming chapters, the use of discrete diagnostic categories multiplies the need for psychiatric and psychopharmaceutical niches to accommodate them. It further medicalizes, pathologizes, and pigeonholes the gamut of human expression and emotion that falls under the “anxiety” umbrella. It perpetuates the neoliberal principles of individualization and isolation. This is why, rather than conduct a study examining just Generalized Anxiety

Disorder or Panic Disorder or any other of the multiple forms of anxiety disorders, I have chosen to instead use “anxiety disorder” as an umbrella term. In no way does my decision to treat anxiety disorders as a homogenous group of diagnostic categories mean to essentialize the experiences of those who have received diagnoses. Rather, my goal is to problematize the social climate in which these disorders are produced, diagnosed, and treated.

Positionality of the Researcher

With a project as controversial as this, it is imperative that I address my personal reasons for choosing to pursue this research. As is the case for most things we become passionate about, my decision to focus on women and anxiety disorders stems from personal experience. My mother’s lifelong battle with mental illness and the consequent social and economic obstacles she has faced have continually motivated me throughout the research process. While anxiety and depression have been her greatest struggles, my mother has been clinically diagnosed with four disorders over the past 17 years. Each doctor’s appointment left her with a new diagnosis, and each prescription left her with a new range of symptoms (and expenses) that she had not anticipated. I have always wondered whether my mother’s self-identification and coping strategies would have taken a more positive trajectory had her emotional struggles not been pathologized and medicated in the ways that they had.

In addition to my mother’s history, my own, albeit brief, encounter with diagnosis has also contributed to my interest in pursuing this project. After expressing moderate academic and social anxieties at an annual doctor’s appointment when I was sixteen, my physician determined that my emotions mirrored symptoms of Generalized Anxiety Disorder. I was promptly offered a prescription of “take as needed” anti-anxiety medication until I could get in to see a psychiatrist and receive a proper diagnosis. I rejected the prescription and the psychiatric visit. I was

unwilling to resign myself to the same dependency on medication my mother was trapped in, and I was terrified that what I had been feeling might be a biological, genetic illness rather than a normal response to the stresses of high school. That doctor's visit stuck with me and caused me to question the legitimacy of a diagnostic process so quick to diagnose and pharmaceutically treat.

Because of the intimately personal connection I have to my research, I entered into this project with a bias that, for transparency's sake, should be brought to light. Because of my experiences with my mother, I believed at the onset of my research that anxiety disorders are not biologically derived, but socially produced. Although I do not find this presupposition to be entirely problematic, I think it is important for me to take into consideration what feminist scholar Kath Weston writes about "making the familiar strange" when studying a culture one is already a part of (2004:201). Weston writes that "presumptions of a common frame of reference and shared identity can...complicate the [researcher's] task by leaving cultural notions implicit, making her work to get people to state, explain, and situate the obvious" (2004:202). In the process of writing this thesis, particularly when conducting my analysis, I have made certain that a multiplicity of perspectives have been offered in my writing. It would be counterproductive for my personal experience to allow me to dismiss other perspectives, even if what I encounter contradicts what I have learned through my own experience.

In addition to recognizing the bias that accompanies my personal experience, I have remained conscientious of my general positionality as a white woman with access to educational and economic privileges. As both sociologists and feminists have long argued, the position of researcher is inherently imbedded with privilege and power; even the sociological knowledge that there is such a thing as a social constructionist perspective towards mental illness creates a

particular power dynamic between myself and participants in my survey (see Sprague 2005 and Stoppard 2000). However, as Scott Lauria Morgensen points out, “even feminist work never entirely resolves the problem of power embedded in research” (2013:70). Acknowledging my situated power as a researcher should not prevent me from taking on important and meaningful projects, but should help keep me from inadvertently reinforcing uneven power relationships.

Overview of Thesis

As previously stated, this thesis explores through an interdisciplinary perspective how the social construction and production of anxiety disorders has contributed to gendered disparity in current rates of diagnosis. In the next chapter, “The Social Construction of Anxiety Disorders,” I will provide a history of the psychiatric evolution of mental illness, followed by a brief analysis of the categories of anxiety disorders presented in the recently published DSM-V. This will lead into a discussion of the anti-psychiatry movement of the 1960s and the influence this movement had in inspiring the emergence of a sociology of mental illness. I conclude the chapter by setting up the theoretical framework I later use to inform my analysis and discussion. Chapter Three, “The Pathologization of Women,” explores the historical pathologization of women through a review of literature that engages psychological justifications, feminist theoretical perspectives, and previous research.

I begin Chapter Four, “A Feminist Methodology,” with a discussion of the obstacles I faced in getting my research methods approved by the College of Wooster’s Human Subjects Review Committee. The latter portion of the chapter then details the development of the survey

on exposure to and attitudes towards anxiety disorders I constructed to collect my data, as well as the process by which I completed my analysis. I conclude the chapter with a brief demographic snapshot of my sample. Chapter Five, “Normalizing Abnormality,” highlights the three dominant themes that emerged from participant survey responses: exposure to anxiety disorders through interpersonal experience; contradictory beliefs about the origins of anxiety disorders; and masculinity as the supposed cause of gendered disparity in diagnosis rates. I situate the results of my data within the context of the theoretical framework set up in Chapter Two and the literature reviewed in Chapter Three. Additionally, I illuminate places where my data raises new, unanswered questions that could be used as fodder for future research.

I conclude my thesis by articulating how my research can be used in praxis in Chapter Six, “Movement Towards Mental Health Justice.” Feminist scholars Toby Jayaratne and Abigail Stewart state that “when selecting a research topic or problem, we should ask how that research has potential to help women’s lives” (2008:54). In solidarity with Jayartne’s and Stewart’s philosophy, it is my hope that this project problematizes mainstream understandings of how anxiety disorders are developed, diagnosed, and treated. Chapter Six parses the politics behind social justice activism taking place in a neoliberal context and attempts to identify how the knowledge produced by this study can be used to inspire activism for mental health justice. I conclude that beginning to understand anxiety disorders as phenomena greatly influenced by social structures could play an important role in restructuring the ways we treat and respond to those who experience them.

Chapter Two

The Social Construction of Anxiety Disorders

Since all systems of classification are made by people, it is necessary to be aware of who has made the rules and for what purpose.

—Thomas Szasz, *The Myth of Mental Illness*

At the outset of this chapter on the social construction of anxiety, I want to make it explicitly clear that my intention in applying a social constructionist perspective to the concept of mental illness is not to challenge the “realness” of the experiences of those living with diagnoses. Nor is it to disprove biological and neurological evidence that natural causes are indeed the foundation of certain mental diseases, or deny suggested correlations between neurotransmitters, genetics, and anxiety disorders. Rather, my goal is to dissect the social origins of the system of classification being used to medically diagnose anxiety through a synthesis of past work that has attempted to do the same. Many systems of classification have come to be understood as products of social construction: gender, race, and class among them. Yet this understanding does not invalidate the reality of what it means to live as a Black woman, as a Hispanic man, as working class. My objective is to uncover socially constructed elements masquerading as naturally occurring phenomena within the diagnostic framework, not the individual experiences deriving from that framework.

That being said, the goal of this chapter is to establish a social constructionist context within which I can comfortably situate the rest of my work. It will begin with a historical overview of the psychiatric field and the development of the concept of mental illness, followed by current definitions of mental illness and the most common categories of anxiety disorders

deriving from the recently published fifth edition of the DSM. After setting up a psychiatric frame of reference, the chapter will conclude with an in-depth exploration of both classical and contemporary social theories of mental illness.

This theoretical exploration will provide a synopsis of the work of Thomas Szasz and Michel Foucault, whose radical social constructionist stances on mental illness largely inspired the anti-psychiatry movement that occurred during the 1960s. Although the writing of Szasz and Foucault establishes a general social constructionist stance on mental illness, two additional theoretical perspectives have taken root within the discipline: structural strain theory and labeling, or societal reaction, theory. While classical structural strain theory in the vein of Robert Merton “locates the origins of disorder and distress in the broader organization of society [i.e., that structural inequities lead some populations to being more susceptible to diagnosis with mental illness than others,]” “the logic behind labeling theory is that people who are labeled as mentally ill, and who are treated as mentally ill, become mentally ill” (Thoits 2010:106). This chapter will explicate each of these sociological perspectives, examining structural strain theory as developed by Merton and labeling theory as developed by Thomas Scheff. Sociologist Peggy Thoits’ contemporary interpretation of these theories specifically as they pertain to mental illness will be used as an additional guide. The chapter will close with a look at two contemporary counterparts to structural strain and labeling theory, whose recent interpretation and applications are relevant to the current state of psychiatry and diagnostics and are salient to this work: Thoits’ contemporary variation on labeling theory, “self-labeling theory,” and Allan Horwitz’ book on the social construction of mental illness, *Creating Mental Illness*.

The Evolution of Psychiatry and the Concept of “Mental Illness”

The concept of mental illness was first applied to varying forms of psychosis by neurologist Jean-Martin Charcot in the late 1800s. Until the turn of the 20th century, psychiatric practice and the categorization of “mentally ill” were relegated to cases of insanity within the asylum. Then, at a turning point in psychiatric history, psychologist Sigmund Freud “transformed [the boundary...between the insane and others] by creating a new class of neurotic behaviors,” becoming the first to use the moniker of mental illness to classify a wide range of emotional and behavioral expression (Horwitz 2002:53; Szasz 1961:41). Freud determined that “the differences separating normal from abnormal behavior were only matters of degree, not kind” (Horwitz 2002:41). He admitted that his determinations were theoretically founded and were not steeped in empirical scientific discovery; within his texts, Freud advocated for a psychology, rather than a biological science, of what he saw as “abnormal” human behavior. However, Freud’s utilization of the word “illness” to categorize particular levels of severity in neuroses conflated psychology with the medicalized psychiatry already being practiced in asylums. The two became inextricable from one another, and Freud’s categorizations were adopted into the psychiatric domain (Szasz 1961:41, Horwitz 2002:45).

The model of psychiatry that emerged from Freudian thought was one in which “the basic principle...was to link neurotic with normal behavior and to classify both as variants of common development processes...[it] blurred the distinction between the normal and the neurotic but kept the distinction between the psychotic and all other behaviors” (Horwitz 2002:41). This model became known as *dynamic psychiatry*, and with its inception came the publication of the first edition of the American Psychiatric Association’s (APA) *Diagnostic and Statistical Manual of*

Mental Disorders (DSM-I) in 1952, which introduced the first formalized definition of mental illness (APA 1952).

Dynamic psychiatry was the dominant psychiatric practice between 1920 and 1970 and shaped the content of the DSM-I and DSM-II (Horwitz 2002:58). It was not until 1980 that the publication of the third *Diagnostic and Statistical Manual of Mental Disorders* birthed modern diagnostic psychiatry. As such, the system of classification being used today to categorize all that is termed “mental illness,” “mental disorder,” or “mental disease” is relatively young. Diagnostic psychiatry did not emerge gradually; rather, the restructuring of mental illnesses into discrete diagnostic categories constituted a “total reorientation of the discipline over a short period of time” (Horwitz 2002:54). The rapid formation of this discrete system of categorization served two functions: one, to discredit the work of anti-psychiatrists and social theorists who were beginning to question the proposed biological nature of mental illness; and two, to maintain psychiatric legitimacy in the face of an evolving biomedical landscape that said “real” disorders have discrete boundaries, are linked to specific underlying etiologies, and can be treated through physical means (Horwitz 2002:59). The DSM-III was greatly successful in achieving these functions, concretely framing the symptomatology of mental disorders in the same way as illnesses and diseases of the body (Horwitz 2002:58, APA 1980). Each edition since has maintained this diagnostic model, including the recently published DSM-V.

DSM-V Diagnostic Criteria for Anxiety Disorders

As Horwitz argues, “the DSM claims to be based on science rather than ideology, on medicine rather than anecdote, and on fact rather than unproven and vague entities. For its advocates, who now include virtually the entire psychiatric community, the illness categories of

the DSM provide a more accurate and valid description of clinical reality” (2002:81). The start of my research conveniently coincided with the much anticipated publication of the fifth edition of the DSM in May of 2013, the first major edition to come out since 1994. The DSM-V was put together by a collective of thirteen work groups under the direction of the “DSM-5 Task Force,” comprised of mental health “experts” from various fields. In *Creating Mental Illness*, Horwitz posits that “although diagnostic psychiatry is officially agnostic about the variety of factors that lead people to develop mental diseases, the medicalized system of classification it uses emphasizes underlying organic pathologies” (2002:3). With a nearly twenty year gap existing between the publication of the DSM-IV and the DSM-V, I was curious to see if scientific progress over the past two decades would render the diagnostic criteria for anxiety disorders biologically founded and testable. Interestingly, questions about the legitimacy of a medicalized psychiatric field, similar to those posed by Horwitz, are raised by the DSM-V itself. The introduction states: “it has been well recognized by both the APA and the broad scientific community working on mental disorders that past science was not mature enough to yield fully validated diagnoses—that is, to provide consistent, strong, and objective scientific validators of individual DSM disorders” (APA 2013:5). When an opening statement admits to multiple flaws in the current diagnostic process (and therefore the potential invalidity of diagnoses made within it), one would expect affirmation that the revised diagnostic criteria in the DSM-V have now become the “consistent, strong, and objective scientific validators” that the APA itself determined were lacking.

However, the introduction then states that “a complete description of the underlying pathological processes is not possible for most mental disorders,” therefore, “it is important to emphasize that the current diagnostic criteria are the best available description of how mental

disorders are expressed and can be recognized by trained clinicians” (2013:xli). It seems that the DSM-V would agree with Horwitz when he states that “the ascendant belief that ‘mental illnesses are brain diseases’ is due far more to the cultural belief that only biologically based illnesses are ‘real’ illnesses than to any empirical findings that the causes of mental disorder are brain based” (2002:156). Yet even in the face of these assertions by the DSM-V, the definition of mental disorder given is, word for word, the same that was used in the previous edition. The DSM definition of mental disorder is as follows:

A mental disorder is a syndrome characterized by clinically significant disturbance in an individual’s cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior (e.g. political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above. (APA 2013:15)

In addition to an unchanged definition of mental disorder, the diagnostic criteria for the major categories of anxiety disorders were transferred nearly verbatim from the DSM-IV to the DSM-V (1994:432; 2013:222). The primary diagnostic criteria in the DSM-V for a diagnosis with Generalized Anxiety Disorder (GAD) is “excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities” (2013:222). Other disorder categories, such as Social Anxiety Disorder and Agoraphobia, use the same criteria, but replace “about a number of events or activities” with a specific fear (i.e., social situations, being outside of the home alone) (2013:199, 210). What constitutes “excessive” anxiety in all cases is left up to the clinician’s judgment, leaving ample room for individualized interpretation (2013:189). To receive a diagnosis with any anxiety disorder, the person’s anxiety must not be indicative of another disorder, and “the anxiety, worry,

or physical symptoms must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning” (2013:222).

Statements made within the DSM-V text are strikingly similar to Horwitz’ critiques of diagnostic psychiatry, one of which states that “rates of the most prevalent disorders—depression, generalized anxiety, and substance abuse—all vary widely across social contexts” (Horwitz 2002:180). The diagnostic section for most anxiety disorders in the DSM-V includes a section entitled “Culture-Related Diagnostic Issues,” containing acknowledgements that certain populations are more prone to experiencing these disorders than others. For instance, the section on GAD states that “individuals of European descent tend to experience GAD more frequently than do individuals of Non-European descent. Furthermore, individuals from developed countries are more likely than individuals from non-developed countries to report that they have experience symptoms that meet criteria for GAD in their lifetime” (DSM-V 2013:223). Crucial to this study, a section entitled “Gender Differences” also exists for nearly every anxiety disorder, and generally contains a statement about women’s susceptibility to diagnosis. The sections on GAD, Phobias and Agoraphobia all specifically state that females are twice as likely as males to be diagnosed, while sections on Social Anxiety Disorder, Panic Disorder and Separation Anxiety Disorder allow that the disorder is more common in females than males (2013:192, 199, 204, 210, 219, 223).

These sorts of socialized patterns in diagnosis, in combination with the evident discrepancy between the actual construction of DSM-V diagnostic criterion and its supposed biological nature, are evidence that psychiatry is not immune to sociological critique. Before detailing the social theories that are most pertinent to an exploration of the current diagnostic

criteria for anxiety disorders, this chapter will provide a historical overview of the first major social constructionist stances towards mental illness.

The Myth of Mental Illness & Psychiatric Power

In 1961, psychiatrist Thomas Szasz published a scathing critique of the psychiatric and biomedical definition of “mental illness” in his book *The Myth of Mental Illness*. This book, as well as the larger anti-psychiatry movement that accompanied it, took what was arguably the pioneering social constructionist stance towards mental illness. Szasz, along with other prominent thinkers such as Michel Foucault, challenged the pathologization of emotion and the medicalization of psychiatric practice by shedding light on the psychosocial and ethical factors governing the diagnostic process. In *The Myth of Mental Illness*, Szasz states that “general medicine... never had to ask itself what disease is. It always knew what it meant to be ill, for both the patient and the doctor knew what pain and other forms of suffering were. Psychiatry never had such a clear criterion of illness” (Szasz 1961:34). This he attributes to a large conceptual misappropriation on the part of psychiatry. Objective medical science, he asserts, is the study of natural disease objects through the testing of their representations. Subjective psychiatric medicine, on the other hand, reverses this process: it mistakenly studies and classifies representations in an attempt to locate a natural “object.” In Szasz’s view, this is the grand failure of psychiatry as a discipline: “since he [the psychoanalyst] has failed to codify this logical distinction [between object and representation] clearly he will persist in describing his observations, and in theorizing about them, as though they were objects instead of representations” (Szasz 1961:51). This object/representation distinction is not meant to challenge altogether the existence of mental illness; he states that “representations are no less real, of

course, than real objects” (Szasz 1961:51). What it is meant to challenge is the notion that these representations are derived from real, naturally occurring objects. His thesis boldly states that “mental illness is a myth. Psychiatrists are not concerned with mental illnesses and their treatments. In actual practice they deal with personal, social, and ethical problems in living” (Szasz 1961:296). Throughout his text, Szasz describes mental illness as a cultural *protolanguage*; that is, a mode of human expression among many other alternate modes (Szasz 1961:1). The only thing Szasz believes differentiates this protolanguage from other modes of expression is that it deals with behaviors and emotions that violate society’s normative roles and rules.

Over a decade after the publication of *The Myth of Mental Illness*, Foucault’s “Psychiatric Power” course from 1973-1974 at Le College de France reignited the anti-psychiatry rhetoric that Szasz initially incited. In the course description, Foucault states that the only way the psychiatric field could transfer the power it established in the asylum to the emerging practices of psychoanalysis and psychopharmacology was through a thorough medicalization of all forms of mental pathology (Foucault 1994:49). The scientific authority that was given to doctors of the body had to be transferred to doctors of the mind for the field to progress. “The doctor is qualified, the doctor knows the diseases and the patients, he possesses a scientific knowledge that is of the same type as that of the chemist or the biologist, and that is what authorizes him to intervene and decide. So the power...[given] to the psychiatrist will have to justify itself by producing phenomena that can be integrated into medical science” (Foucault 1994:44). However, because scientific research had not discovered any determinant biological causes of mental illness, psychiatry had to find a way to make sure that “the moment of testing, when the illness appears in its truth and is fully expressed, no longer must figure in the medical process”

(Foucault 1994:46). Both Szasz and Foucault believed this was done by overemphasizing “psychogenic factors in so-called mental illness” and subsequently obscuring psychosocial factors from view (Szasz 1961:36).

Szasz and Foucault were both informed by and informants of the predominant theoretical models used by social scientists to explain mental illness, as well as other forms of societal deviance and role-adaptation. Traces of both structural strain theory, as set up by Robert Merton in his 1938 work “Social Structure and Anomie,” and Thomas Scheff’s use of labeling theory in his work *Being Mentally Ill*, are evident in their writing. “Rule-breaking” (strain theory) and “role-playing” (labeling) are central tenets of both Szasz’s and Foucault’s perspective (Szasz 1961, Foucault 1994).

Structural Strain Theory

In “Social Structure and Anomie,” Merton outlines a theoretical perspective in which societal norms, as well as deviance from said norms, are governed by two primary constructs: cultural goals and institutionalized means (1938:676). Whether or not an individual’s behavior conforms or deviates from a particular society’s understood set of norms, Merton claims, fully depends upon the individual’s access to those institutionalized means and subsequent achievement of those cultural goals. While “conformity to both cultural goals and means is the most common and widely diffused” adaptation pattern in every society, there are various ways in which nonconformity, or *deviance*, can emerge (1938:677). When an individual lacks societally sanctioned goals, means, or both, they enter into a state of “anomie,” a Durkheimian term Merton re-appropriates to “describe the gap between cultural goals and the structural means to those goals” (Thoits 2010:114). This sense of anomie leads the individual to seek out alternative

forms of cultural adaptation outside of the typical conformist route. He provides the categories of innovation, ritualism, retreatism, and rebellion as four basic ways in which deviance can manifest itself (Merton 1938:676). When structural strain theory is used to explain the derivation of mental illness, retreatism is the category most heavily drawn upon.

Merton states that “persons who ‘adjust’ in...[retreatist] fashion are, strictly speaking, *in* the society but not *of* it” (1938:677). After being denied access to the institutionalized means necessary to progress and abandoning pursuit of culturally established goals, retreatists are those that choose to “‘escape’ from the requirements of the society” by adopting deviant personas, a “psychopathological,” or mentally ill, personality being one of those (Merton 1938:678). Merton and other structural strain theorists believe that retreatism in the form of “mental illness is an adaptive response to structural strain” (Thoits 2010:115). Contemporary theorists such as Thoits have applied Merton’s explication of the retreatist response to structural inequality to mental illness even more directly than Merton himself. Thoits states that “mental illness is not randomly distributed in society; it is concentrated in several demographic groups that are socially and economically disadvantaged or low in power and influence,” further supporting Merton’s claim that mental illness is a product of adverse social circumstances (2010:119). Thoits also places great importance on *roles* in her interpretation of structural strain theory, something that Merton does not directly address. She says that “people who have few or no social roles are at a greater risk of engaging in deviant behavior” than those with multiple established positions in society (2010:118). This could easily be filtered into Merton’s framework, with social roles as simply one of many institutionalized means, the lack of which contributes to an individual resorting to retreatism in the form of mental illness.

Labeling (Societal Reaction) Theory

Unlike structural strain theory, labeling theory claims that while mental illness most certainly represents a form of deviance, its manifestation as an identity category results from an act of a certain type of conformity rather than non-conformity (Scheff 1961:436). “Labeling theory is based on one key idea: people who are labeled as deviant and treated as deviant become deviant” (Thoits 2010:120). Labeling theory operates under the premise that deviance does not arise solely from negative individual circumstances within a grander societal structure. Rather, it assumes that deviance is a product of *interaction* between society and the individual in which society determines the individual’s deviant identity and the individual conforms. Labeling theory is also often referred to as “societal reaction theory” because it is not the “various causes of primary deviance (psychological symptoms)” that concern these theorists; “what matters is how the social group reacts to an individual’s primary deviance” (2010:120). Although many labeling theorists emerged between the 1970s and early 1980s with various topical foci, I emphasize the work of Thomas Scheff due to his direct application of labeling theory to mental illness.

In his 1961 paper “The Role of the Mentally Ill and the Dynamics of Mental Disorder” and the larger work that followed, *Being Mentally Ill*, Scheff succinctly defines deviance as something that “violates the assumptive world of the group” (1961:439). However, he furthers this basic conceptualization by identifying a second kind of deviance, “the diverse kinds of deviation for which our society provides no explicit label” (1961:439). This he calls *residual deviance*. Scheff believes that most residual deviance is overlooked in a “pattern of inattention and rationalization...called ‘denial,’” and that it is only “when (and if) the primary deviance becomes an issue, and is not ignored or rationalized away, [that] labeling may create a social type, a pattern of ‘symptomatic’ behavior in conformity with the stereotyped expectations of

others” (1961:451). Towards the end of his work, Scheff concisely states what could be considered his thesis: “when a primary deviant organizes his behavior within the framework of mental disorder, and when his organization is validated by others, particularly ‘prestigious’ others such as physicians, he is ‘hooked’ and will proceed on a career of chronic deviance” (1961:450). Scheff’s application of labeling theory to mental illness is, according to Thoits, “especially valuable because it reminds us that mental illness is, to some extent, socially created and sustained and that there are risks to accepting psychiatrists’ judgments as invariably valid assessments of mental disorder” (2010:123).

Critiques & Contemporary Frameworks

The original sociological approaches towards mental illness outlined above remain highly controversial and are contested inside and outside of the field of sociology for a variety of reasons. Among structural strain and labeling theorists themselves, there is an awareness of the inherent limitations of a sociology of mental illness. Thoits reminds us that “no single approach to mental illness—biological, psychological, or sociological—can completely explain its origins” (2010:124). Even Scheff, whose work with labeling theory has often been cited as radical within the sociological field for its staunch rejection of the “conventional medical and psychological approaches,” warns against taking a one-dimensional approach towards mental illness within the discipline. He states: “just as the individual system models [i.e., structural strain theory] under-stress social processes, the [labeling theory] model presented here probably exaggerates their importance” (1961:438).

The dominant critique of structural strain theory as applied to mental illness is that “structural theorists generally do not elaborate the ways in which broad social structures and broad socioeconomic trends become actualized in the lives of specific individuals, and thus they

do not clarify how or why macro-social trends can produce psychological distress or disorder” (Thoits 2010:119). Although Merton clearly states that structural inequality is the driving force that leads to the form of deviance we call “mental illness,” “Social Structure and Anomie” does not provide more than the indication of potential causality. Merton’s structural strain theory suggests that to curb psychosomatic symptoms, all we must do is solve the problem of social inequity, without explaining what specific social factors lead individuals to exhibit certain emotional deviances and not others. Merton himself admits this flaw in his theory, saying “this statement, being brief, is also incomplete. It has not included an exhaustive treatment of the various structural elements which predispose toward one rather than another of the alternative responses open to individuals; it has neglected...the factors determining the specific incidence of these responses” (Merton 1938:682).

Similar, and possibly more extensive, critiques have been made of labeling theory, including a direct critique of Scheff’s work by one of Thoits’ first theoretical pieces, “Self-Labeling Processes in Mental Illness: The Role of Emotional Deviance.” Thoits starts the essay by stating that her modifications to traditional labeling theory are meant to address Scheff’s “limited scope of applicability” to modern diagnostic psychiatry (1985:221). “Because the majority of mental health clients, both inpatient and outpatient, seek treatment voluntarily and do not become chronically ill,” the assumption that a mentally ill identity is always externally derived does not explain most modern diagnoses (1985:222). Thoits’ work extends this critique into the construction of her own theoretical framework, promoting a unique sort of hybridization of structural strain theory, labeling theory and symbolic interactionism in the vein of George Herbert Mead. She calls this a “self-labeling theory” of mental illness that gives primacy to

individual experience, and asserts that “social control is largely a product of self-control” (1985:222).

Thoits believes that self-labeling with mental illness is a result of a four-factor associative model of emotion which all individuals are taught to operate within, consisting of situational cues, physiological sensations, expressive gestures, and cultural labels (1985:228). Within this associative model, mental illness arises when “one...inadequately or incompletely learn[s] the often subtle, complex associations between bodily sensations, situational cues, and emotional labels, and, therefore, experience[s] a discrepancy between what one should feel and what one actually feels” (1985:228). Properly learned associations are the result of a societal structure that accomplishes three main things: it produces well socialized actors who can recognize rule-breaking or the violation of normative expectations; it establishes known categories of norms, whose violations carry cultural labels (“we learn that there are appropriate times and places for appropriate degrees of emotional expression”); and it motivates individual actors to conform to these social expectations (1985:224). However, Thoits’ model, contrary to those of Merton and Scheff, allows that conforming to social expectations does not necessarily mean acting out emotional and behavioral norms. In the case that normative emotional expectations cannot be met, there are further expectations that one will take on the culturally sanctioned deviant role of “mentally ill” (1985:242). Although she maintains Merton’s view that structural strains plays a large part in preventing individuals from aligning with society’s emotional norms, she adds that multiple role occupancy and major role transitions may play equal roles in this prevention (1985:229).

Along with self-labeling theory, Allan Horwitz’s 2002 work *Creating Mental Illness* perhaps provides the most holistic, pragmatic, and applicable social theory of mental illness to

date. In many ways, he yields to biomedical progress on mental illness in a way that none of the other social theorists previously discussed have. He rationally begins his book by stating that, just as a purely biological perspective cannot explain mental illness, “a pure constructionist perspective has no extra-cultural criteria for developing a valid concept of mental illness and therefore cannot judge the adequacy of any classification of mental symptoms” (2002:10). His text contains multiple theses that mirror aspects of strain theory, labeling theory, and self-labeling theory, yet he comes across in his writing as more of a modern-day Szasz than a Merton or a Scheff. Horwitz strategically distinguishes specific claims and functions of diagnostic psychiatry, indicating gray areas where cultural and social influences have clearly played a role in shaping the current system.

Before he delves into his theoretical work, he parses apart terminology that other theorists had previously used interchangeably. *Mental diseases* are conditions where symptoms indicate underlying internal dysfunctions, are distinct from other disease conditions, and have certain universal features; *mental disorders* are all mental diseases as well as psychological dysfunctions whose overt symptoms are shaped by cultural as well as natural processes; and *mental illnesses* are whatever conditions a particular social group defines as such (2002:15). Horwitz’ principle argument is that the application of the labels *mental disease* and *mental disorder* to “common depressive, anxious and psychophysiological symptoms” is not representative of biomedical truth, but of societal determination (2002:130). He states that “the manifestations of...[these] symptoms change over time and across cultures, their symptoms blur indistinguishably into different diagnostic entities, they have no distinct past history in families or distinct prognosis among individuals, and all respond to similar types of treatments. There is little justification for treating them as discrete and natural disease entities” (2002:130). Horwitz identifies what past

social constructionists did not by indicating the specific social institutions that have a stake in labeling “psychological conditions that fluctuate with social situations” as *mental illness*: “the pervasiveness of disorders justifies advocacy efforts, the expansion of mental health services, the promotion of pharmaceuticals, the legitimacy of diagnostic psychiatry, and ultimately, the reality of these mental disorders itself” (2002:106).

Peggy Thoits and Allan Horwitz have critiqued and reenergized the sociology of mental illness, integrating and modifying structural strain theory and labeling theory in ways that reach beyond a generalized theory of “madness” to the current psychiatric climate. Their works are applicable to modern diagnostic processes and criteria in a way that Merton’s structural strain theory and Scheff’s labeling theory were not able to be. Their theoretical approaches have evolved alongside the progression of biological research. They focus on neuroses with biologically ambiguous origins rather than egregiously claiming, as past social constructionists have, that all conditions labeled as “mental illness,” including serious psychosis such as schizophrenia, are solely products of social construction. Thoits’ self-labeling theory and Horwitz’ work will be referenced consistently throughout the proceeding chapters.

Chapter Three

The Pathologization of Women

If enough people in a specific social category begin showing psychological symptoms, we [should] extend the explanatory courtesy to them that we now extend to most middle-class white men, asking: What is the matter with the category?

-Carol Tavris, *The Mismeasure of Woman*

As discussed in the opening chapter, anxiety disorders are at epidemic rates, affecting 40 million Americans each year, and American women are 60% more likely to be a part of that 40 million by virtue of their sex (NIMH). It is my conviction as a researcher that these statistics indicate enough people in the social categorization of “woman” being diagnosed with anxiety to prompt critical questioning of the current categorizations and manifestations of anxiety disorders in our society. And while the previous chapter illustrates the generally fraught history of American psychiatry and positions it within social constructionist frameworks, the gendered inequities in anxiety diagnoses cannot adequately be addressed without specifically chronicling the historical psychiatric treatment of women’s mental health. Of additional and equal importance, it is also necessary to carve out a space within existing research on the relationship between gender and mental disorders in which I can properly situate my own.

The goal of this chapter on the pathologization of women is therefore fourfold. It will begin with a brief history of psychiatry and psychology’s relationship with women. Within this history, I will take a close look at hysteria, masochism and codependency among other woman-centric diagnostic categories of the past, paying particular attention to the subtle ways in which these categories may have contributed to the structure of modern-day anxiety and depressive

disorder categorizations. This critical history will give way to a review of psychological and psychiatric studies that have attempted to uncover both biological and psychosocial causes of gendered disparity in anxiety disorders.

The final portion of this chapter will address previous feminist sociological research that has examined women's relationship to and experiences with mental illness. As of yet, no feminist sociological research has been done on women and anxiety; therefore, most of the studies I deal with concern depression. This was also an intentional decision on my part, made because of the high comorbidity rates of anxiety and depression in women (NIMH). These studies will be divided into two sections: the first providing a broad overview of existing research, and the second focusing on studies particularly salient to my own work. Because the literature I review for the first section varies greatly in theoretical perspective and methodology, I have organized it around methodological themes in an effort to maintain both coherence and inclusivity; it will begin with two theoretically-based studies, continue with qualitative research focused on the lives of women with depression, and conclude with a unique study conducted by a feminist biologist that provides further interdisciplinary insight.

The concluding section pays close attention to research that cites neoliberalism, individualism and the market economy as the principal factors responsible for the gendering of both the "social production and the social construction" of mental disorders (Walters 1993:394). This literature applies the sociological concept of self-labeling theory in a manner similar to my own intended application, but through the lens of neoliberalism. I will first look at a few feminist texts outside of the mental health arena in order to provide a cursory definition of the neoliberal, individualist and consumerist forces that encourage women to self-label in various spaces. The bulk of the literature will then consist of feminist sociological studies that have examined how

the psychopharmaceutical industry has grown to encourage women to self-label, or self-diagnose, with mental disorders. These authors conclude that this industry's effects have a potentially causal relationship to the disparity in rates of diagnoses for numerous DSM diagnostic categories. This research is most closely tied to the research I have conducted, and will provide a fluid transition into the following chapter on my methodological approach.

A History of Miscategorization & Misdiagnosis

The historicization of what feminist scholars Barbara Ehrenreich and Deirdre English aptly term “the woman question” in American mental health practice has occurred within a large body of literature across a variety of academic disciplines and among activist groups (1978). This breadth of this work suggests that the marginalization of women through arbitrarily constructed, yet societally pervasive, mental illness categories by the “experts” has not been ignored by previous scholars (1978:7). To assist in my framing of the historical pathologization of women, I have chosen to highlight three canonical feminist works. My choice of texts was due primarily to the authors' application of a feminist social constructionist lens to their historicization. Additionally, the accessibility and widespread acknowledgement of their work played a part in my selection. The works I have chosen are historians Ehrenreich and English's *For Her Own Good*, social psychologist Tavis' *The Mismeasure of Woman*, and psychologist Hannah Lerman's *Pigeonholing Women's Misery: A History and Critical Analysis of the Psychodiagnosis of Women in the Twentieth Century*. I will also turn to other feminist scholars when useful for further elaboration.

Although the pathologization of femininity surely has roots in earlier times and in different locations, the American story in particular takes shape during the 19th century.

Ehrenreich and English write that “in the mid- and late nineteenth century a curious epidemic seemed to be sweeping through the middle- and upper-class female population...in the United States;” this epidemic was “hysteria” (1978:113). Hysteria as a concept was not native to the United States. Rather, it transcended the boundaries of nation-states and oceans before it eventually ended up in the rhetoric of American doctors. Hysteria evolved from Grecian notions of the “wandering womb,” the idea that all forms of mental pathology in women could be reduced to an unsatisfied uterus that was roaming the female body in search of reproductive satisfaction (1978).

While the idea of the “wandering womb” was not used outright as an explanation for diagnoses of hysteria in the United States, American doctors still placed the blame on sexual dysfunction and thought it to be inherent to all members of the female sex. According to Ehrenreich and English, “doctors had established that women are sick, that this sickness is innate, and stems from the very possession of a uterus and ovaries” (1978:147). The belief that hysteria was sexually derived was evident in the disturbing procedures commonly used to treat hysteria, such as ovary removal, clitoridectomy, and forced clitoral stimulation (Ehrenreich & English 1978:136; Sheehan 1997:327). With the backing of well-respected psychologists such as Freud, hysteria eventually evolved into a blanket diagnosis that was used by medical authorities to explain every variation of female stress and suffering (Ehrenreich & English 1978:153).

However, it is worthwhile to note that this blanket diagnosis only encompassed *upper-class* female stress and suffering. “The theory of innate female sickness, skewed so as to account for class differences in ability to pay for medical care, meshed conveniently with the doctors’ commercial self-interest,” helping to establish American psychiatry’s medical and economic legitimacy alike (Ehrenreich & English 1978:127). As this legitimacy was garnered, more and

more affluent women not only received diagnoses of hysteria but *sought* them. With ever-increasing medical and market credentials, “the experts wooed their female constituency” (1978:7). This mass of female psychiatric patients was well established by the time the United States transitioned from its Great Depression-ravaged state into its post-World War II, industrial capitalist and consumerist identity. During this time, the already pervasive symptomatology of hysteria became conflated with the very real stresses felt by women as a result of the increasing devaluation of their domestic roles. “Industrial capitalism freed women from the endless round of household productive labor, and in one and the same gesture tore away the skills which had been the source of women’s unique dignity” (1978:17).

As the field of psychiatry expanded into the publication of the first edition of the DSM in 1952, hysteria gradually ceded its role as the catch-all diagnosis for women to a host of other woman-centric disorders. The creation of these new categories catered to the categorical specificity preferred by psychiatry and the burgeoning pharmaceutical market. More categorizations were needed to encompass *all* of the expressions of the female condition that psychiatrists had come to consider inappropriate. In the 1960s, psychotherapists began to find “‘rejection of femininity’ in frustrated or unhappy patients” (1978:300). ‘Masochism’ became the new trending diagnosis for women, otherwise known as “self-defeating personality disorder.” This new diagnosis could conveniently be applied to women who abandoned their domestic roles for the work force *or* women who denied the individualist, consumerist pull of American society and stayed put in the domestic sphere (1978:296). Whichever “nature” you denied, be it your womanly nature or the capitalist nature of society, a diagnosis of masochism could medically explain your resulting distress.

Masochism, or self-defeating personality disorder, soon had spinoff diagnoses such as “codependency disorder,” a revolutionary diagnosis that was often used to hold female victims of domestic abuse or the wives of addicts personally accountable for staying with their spouses (Tavris 1992). According to Tavris, “codependency was ‘based on the model of the normalcy of men,’” viewing the masculine traits of individualism and personal detachment as the norm that female codependents could not attain (Tavris 1992:197). It was not difficult for genuine selflessness to be warped and labeled as codependency by psychiatrists. And amongst all of these diagnostic categories pathologizing women’s mental experiences, there was an additional slew of categories pathologizing their menstrual, sexual, and reproductive bodily functions (i.e., Vaginismus, Premenstrual Syndrome, Postpartum Depression) blurring the lines between psychiatry and gynecology (Ehrenreich & English 1978).

In spite of the overt medicalization of women’s mental states throughout America’s psychiatric history, the argument that the female “nature” was fundamentally flawed (an argument that often served as the foundation of disorders like hysteria, masochism, and codependency) was eventually abandoned:

For all their talk of data, laboratory findings, and clinical trials, [the experts] turned out not to be scientists but apologists for the status quo...Within less than a decade, the entire edifice of domestic ideology-- with its foundation of biological metaphors, its pillars of Freudian dogma, its embellishments of medical paternalism-- tumbled down like an ornate Victorian mansion in the face of a hurricane (Ehrenreich & English 1978:345).

However, while hysteria has long since been abandoned as a valid diagnostic category, its successor- “histrionic personality disorder”- as well as self-defeating personality disorder and dependent personality disorder (codependency), still enjoy widespread application by clinicians (Lerman 1996:64). Until the very recent publication of the DSM-V, the three had maintained their place in the American Psychiatric Association’s manual (APA 1994).

For the most part, feminist efforts have not allowed diagnostic categories with blatant gender bias to exist unquestioned. At times, as was the case for hysteria, they have succeeded in ridding the psychiatric and psychological fields of problematic diagnostic categories all together (Ehrenreich & English 1978). Feminist psychologists such as Marcie Kaplan have also been internally maintaining checks on the system. In her 1983 piece “A Woman’s View of the DSM-III,” Kaplan states that “masculine-biased assumptions about what behaviors are healthy and what behaviors are crazy are codified in diagnostic criteria; these criteria then influence diagnosis and treatment rates and patterns” (Kaplan 1983:786). Because of activist-scholars like Kaplan, gender-neutrality now serves as mandatory criteria for those granted the responsibility of maintaining, editing and creating categories of mental disorders (APA 2013).

Psychological and Psychiatric Research

Even this brief historical context raises the question: how does our society neglect to address the disproportionate rates of anxiety diagnoses between men and women when these controversial disorders of the past were “were characterized by anxiety”? (Lerman 1996:63) Psychologists and psychiatrists have only recently begun exploring the potential causes of gendered disparity in anxiety diagnoses. The ensuing review of studies related to anxiety and depression? is not exhaustive but, as far as I am aware, encompasses most of the available methodological approaches and findings. The earliest study specifically looking at the relationship between biological sex and anxiety was published in 1986, entitled “Sex, Sex-Role Stereotyping and Agoraphobia.” The study was conducted collaboratively by psychologists Dianne Chambless and Jeanne Mason and was meant to address the statistic that agoraphobia, at the time of the study, was “four times more likely to be diagnosed in women as in men” in both clinical and community populations (1986:231).

The methods chosen by the researchers were meant to test the “sex-role stereotyping” hypothesis (among other variables less relevant to the purposes of my study), which claims that “women are taught and allowed to be fearful and to perceive themselves as incompetent and helpless without male assistance” (1986:231). The researchers hypothesized that sex-role stereotyping did indeed play a role in experiences of agoraphobia, and that those with the disorder would exhibit more stereotypically feminine traits (1986:231). Questionnaires intended to gauge participant levels of masculinity and femininity were distributed to 334 female students and 68 male students at Temple University, all who had been previously diagnosed with agoraphobia. The study operationalized masculinity in terms of “instrumentality” and femininity in terms of “expressiveness” (1986:232).

Chambless and Mason found that “the absence of masculinity” was significantly related to higher levels of psychopathology in respondents (1986:234). They concluded that “a society that does not teach women to be instrumental, competent and assertive rather than just nurturant and expressive, is one that breeds phobic women” (1986:234). They qualify this conclusion, however, by stating that it is “quite possible” that lower levels of masculinity could be one of the effects of experiencing agoraphobia rather than one of the causes of it (1986:234). This qualification is briefly mentioned and is not elaborated upon or backed with experimental evidence, demonstrating Chambless and Mason’s hesitancy to place responsibility for agoraphobia on society’s definitions of womanhood. It is also notable that both of the researchers are women; as Lerman points out, “until recently, almost all psychiatrists in the United States, particularly those with organizational power, have been male and white” (1996:102). It is interesting to speculate whether or not Chambless and Mason’s assertions were given more credibility due to their positionality as women.

The next study I have looked at on the relationship between gender and anxiety was published twelve years after Chambless and Mason's work, by Peter Lewinsohn and a cohort of three additional psychologists. In the introduction of their study, entitled "Gender Differences in Anxiety Disorders and Anxiety Symptoms in Adolescents," the researchers rightly critique the neglectful level of attention psychologists and psychiatrists have paid to rates of anxiety in women as opposed to that paid to women's rates of depression (1998:109). They build their methodology upon the premise that, "to the extent that it is possible to identify psychosocial factors that are associated with anxiety and with being female, such psychosocial variables might mediate the association between gender and anxiety" (1998:109). With a sample population of 1,507 adolescents from Oregon high schools, Lewinsohn et al. administered two sets of diagnostic interviews and questionnaires over a one year period, "assessing as many as possible of the psychosocial variables known or hypothesized to be related to depression" (1998:110). Examples of the ten total psychosocial variables assessed are self-esteem, emotional reliance, and coping skills (1998:111).

After controlling for all psychosocial variables, the results of the statistical analysis indicated that women were still vastly more likely to be diagnosed with an anxiety disorder. Yet even though there was a statistically significant correlation between what they deemed "pathological" expressions of the psychosocial variables and gender, Lewinsohn et al. concluded that the fact that gender is still related to anxiety even when psychosocial variables are removed from the analysis entirely negates the relevance of said variables (1998:113). This conclusion seems illogical, as the idea that any person can exist outside of the domain of the psychosocial is nonsensical. Thus, the idea of "controlling" for these variables cannot occur in the real world and only exists within the realm of statistical manipulation. Reminiscent of Chambless and Mason's

conclusions, Lewinsohn et al.'s positionality within a field that sees mental disorder as an organically derived phenomenon may have left them hesitant to conclude that psychosocial factors play any real role in the actual development of an anxiety disorder.

Yet another twelve years later, psychologists Carmen P. McLean and Debra A. Hope hypothesized that “socialization that encourages exposure to feared stimuli would facilitate the emotional processing of feared stimuli;” essentially, they infer that men’s socialization processes render them more competent in processing fear and therefore less likely to develop an anxiety disorder (2010:495). To test this hypothesis, McLean and Hope conducted an experiment meant to induce fear where they asked participants to approach a tarantula (2010:496). Participants were separated into two groups: one that was told that their monitored heart rate was not related to the amount of fear they experienced during the experiment, and one that was told their monitored heart rate mattered and would be used to detect whether or not they were being truthful when reporting their levels of fear (2010:496). Unsurprisingly, the results of the study did not render statistically significant results. “Neither instrumentality nor expressivity [masculinity and femininity notably operationalized in the same ways they were twenty-four years prior in Chambless’ and Mason’s study] was significantly related with anticipatory or peak anxiety ratings suggesting that gender role may be more related to fear behavior than fear reporting” (2010:501).

In spite of the lack of evidence produced by their experiment, McLean and Hope maintain their hypothesis that male privilege in the form of “learning to cope with anxiety in [a] problem-focused manner may help equip males with the instrumental traits and skills that prevent excessive fears or other anxiety disorders from developing” (2010:495). They conclude their paper with recognition of the various limitations imposed by their experimental design, and

propose ideas for how future research on gendered differences in fear reporting would be best conducted. However, it is difficult to take seriously an experiment based off of the assumption that *everyone* would feel fearful when approaching a tarantula, and that those fear responses could mimic the myriad fear-inducing stimuli that provoke anxiety disorders. When many psychological studies have shied away from citing gender socialization as a predominant factor in the development of anxiety disorders, it is disappointing to see psychologists who actually support socialization theory using such an elementary research design. Additionally, I find their rigid operationalization of masculinity and femininity to be problematic (see Sprague 2005 for further discussion).

One year later, McLean co-authored a second study, along with authors Anu Asnaani, Brett T. Litz, and Stefan G. Hofmann, entitled “Gender Differences in Anxiety Disorders: Prevalence, Course of Illness, Comorbidity and Burden of Illness.” With this publication, McLean tempers her perspective and conducts her research with an eye to both the biological and the social. The article appears in a psychiatric, rather than a psychological, publication, and attempts to unveil “basic etiologic mechanisms that are expressed differently due to gender-specific biological and environmental risk factors” in people with anxiety disorders (2011:1028). The data used in the study was taken from the NIMH Collaborative Psychiatric Epidemiology Surveys (CPES), and was evaluated using the World Health Organization Composite International Interview, “a diagnostic interview that generates DSM-IV diagnoses” (2011:1029). The sample consisted of 9282 respondents, and represents the “largest, most ethnically representative survey of the U.S. population to date” (2011:1033).

One of the primary conclusions drawn from the researchers’ analysis had to do with comorbidity rates of anxiety and depression among women. They speculate that high rates of

both anxiety and depression indicate that, “latent gender-dimorphic temperamental factors play a key role in consequent gender differences both in anxiety and depression” (2011:1032.) “In other words,” the researchers state, “genetic vulnerabilities gradually evolve into fully articulated traits through complex, bidirectional interactions with environmental factors. The nature of this genetic diathesis, including how gender affects heritability and expression, is not well understood” (2011:1032). Here, the reliance of psychiatry on biological and genetic rhetoric is finally made explicit. Although the researchers must clarify that no biological proof of “genetic diathesis” has been discovered, they still choose put forth a biologically determinant, yet subjectively attained, interpretation of their results. Rather than speculating about how gender socialization processes might have contributed to the observed differences, they immediately assume that genetic factors must be responsible.

Feminist Social Constructionist Research

Much like researchers in the fields of Psychiatry and Psychology, feminist sociologists have not yet conducted research specific on women and their experience with anxiety disorders. However, as discussed in the previous chapter, sociologists like Thoits and Horwitz have theorized extensively about the social construction of mental illness in general, following in the tradition of much earlier social constructionist scholars like Szasz and Foucault. Feminist researchers have taken this theoretical framework and applied it to a group of research studies that extensively look at women’s relationship to mental health frameworks. These studies address a wide array of questions pertaining to women’s experience with mental disorder and diagnosis. In recent years, particular attention has been paid to investigating women’s predisposition to depression. Each study takes a unique methodological approach that demonstrates innovation and diversity of perspective within the feminist sociological field. As

was explained in the introduction to this chapter, I discuss the studies in this section thematically, beginning with theoretically based texts, moving to qualitative studies, and ending with a feminist biologist perspective.

The first theoretical piece I would like to address is a paper written in 1980 by Walter Gove, a sociologist who self-identifies as a “proponent of the psychiatric perspective” (1980:349). Gove’s clear empathy towards the psychiatric cause serves as a bridge between the psychological and psychiatric literature just discussed and the feminist sociological literature I am now engaging. In general, Gove has taken a unique stance for a sociologist towards mental illness; he rejects Scheff’s (1970) labeling theory of mental illness and claims that societal perceptions of mental illness come directly from the expression of mental illness itself, not vice versa. However, in “Mental Illness and Psychiatric Treatment Among Women,” Gove asserts that, in the case of women, mental illness is more likely to be socially rather than biologically derived. After analyzing existing data about women’s relationship to psychiatry, Gove states, “My major reason for believing that the higher rates of mental illness among women are largely due to societal and not to biological factors is that they generally appear to be specific to particular societies at particular times...and, more important, women have higher rates only within specific roles” (1980:354). This work by Gove is a reminder to researchers in the fields of psychiatry and sociology alike that, whether or not you believe that mental illness is a biologically or socially derived phenomenon, you must recognize that psychiatry’s disreputable history with women requires that *any* questionable pattern of diagnosis be thoroughly investigated from a societal framework.

With Gove in mind, I begin my look at studies specifically regarding women’s relationship to depression with Denise Russell’s *Women, Madness, & Medicine*, a feminist

challenge to the current epistemological and empirical understandings of mental disorder. Russell counters the biological determinism she finds present in Psychiatry with a staunch social constructionist perspective much like that of Szasz, but with a particular focus on her conviction that mental disorder diagnosis serves as a way of tethering women to their assigned social roles. She discusses at length the “numerous psychological studies [that] have pointed out that what in the West is generally regarded as the woman’s role happens to coincide with what is regarded as mentally unhealthy” (1995:30). Additionally, she strongly asserts that the DSM-III-R (the version of the DSM in use at the time of her publication) definition of mental disorder is constructed in a way that intentionally pathologizes female experience (1995:30). While her book addresses a variety of mental disorders, including schizophrenia, premenstrual syndrome, anorexia and bulimia, and female criminality, she devotes an entire chapter to understanding depression and analyzing shifting trends in diagnosis. She argues that a diagnosis of depression has replaced hysteria as the “catch-all female diagnosis” when women exhibit a socially “inappropriate level of unhappiness” (1995:51).

Russell’s goals are to “collapse the distinction between sanity and madness,” to propose a re-conceptualization of the way we relate socially as a cure for mental distress rather than continue to accept the “harm of chemical control” through pharmaceutical treatment, and to encourage future researchers to “investigate a direction which undermines psychiatry’s prop to patriarchy” (1995:162). Her text does little to collaborate or compromise with existing psychiatric and mental health diagnostics, and the strength of the language she uses could easily alienate researchers steeped in psychiatric and psychological theory. Therefore, the likelihood of her work influencing existing power structures is very slim. However, influencing these structures was probably not Russell’s intent. Like many other radical feminist scholars, it seems

Russell desires a complete overthrow of the system rather than a reformation of the one already in place. The strength of her convictions renders this argument very compelling and puts her in a viable position to influence other researchers within her field.

The next theorist whom I wish to engage is Janet M. Stoppard, a feminist psychologist and author of the article “Why New Perspectives Are Needed for Understanding Depression in Women.” As evidenced by the frequency with which she is cited in the greater sociological and psychological communities, Stoppard is a well-known proponent of utilizing “feminist standpoint and social constructionist epistemological perspectives” to challenge and reconstruct current “realist assumptions of mainstream medicine” towards depression among women (2000:81). She critiques the positivist trajectory that clinical psychologists have taken within mainstream research on depression, stating that the end results “serve to medicalize and pathologize both women’s bodies and women’s experiences” rather than to empower them (2000:79). She utilizes a Marxist feminist perspective, frequently alluding to “the gendered division of social labour” as a key factor in the perpetuation of depressive symptoms among women (2000:86). Her conclusion calls for more researchers to utilize qualitative rather than quantitative methodologies when researching depression among women, stating: “qualitative methodologies can contribute to the goal of exploring the gendered aspects of depression by grounding knowledge in the experiences of women” (2000:86).

Stoppard uses social constructionist theory in a tangible, practical way, illustrating both the benefits, and the potential means, of adapting social constructionist and feminist standpoint perspectives in real world situations. She challenges researchers to embrace an interdisciplinary model and discover “possibilities for combining [mainstream and feminist standpoint approaches] in ways that would enrich and eventually transform each approach,” something I

aim to do in this study (2000:87). Unlike Russell, who seeks to completely re-conceptualize depression in a space parallel to the mainstream medical world, Stoppard suggests that researchers could work to incorporate social constructionism and the lived experience of women into already existing models. This suggestion has deeply influenced my methodological decision to analyze my data qualitatively, and will be discussed in further detail in the following chapter.

Seven years prior to Stoppard's work, scholar Vivienne Walters was already seeking out women's lived experiences with anxiety and depression. In her study "Stress, Anxiety and Depression: Women's Accounts of Their Health Problems," Walters' objective was not to discover whether or not women's mental disorders were biologically or socially derived; rather, she was interested simply in women's personal interpretations of their mental health problems (1993:394). Using census data from the Hamilton City Directory to obtain a random sample, Walters interviewed 356 women about their understandings of their own experiences with stress, anxiety, and depression. Walters identified three main themes in women's explanation of their own mental health problems: "the heavy workload of women, the issues of identity with which they grappled and their social legacy" (1993:397). Additionally, she notes that women's "mental health problems were seldom explained with reference to a biomedical model," indicating that women generally believed that their problems were derived from their environment rather than their genetics (1993:400). It is noteworthy that Walters' sample consisted of a high percentage of women who were both employed and married, suggesting the potential that her conclusions only speak to the realities of women in particular classes and roles (1993:394).

Walters' methodological approach privileges women's narratives of their lived experiences, a much-needed response to paternalistic psychiatric, psychological, and even sociological research that has valued institutions over the individual in the name of science and

objectivity. However, it would be a stretch to use the themes identified by Walter to explain a modern women's experience with anxiety or depression. The ever-changing structure of society requires sociologists to continuously question the relevance of studies about the "social production and social construction" of anything, including mental illness. In Walters' case, the homogeneity of her sample (predominantly white, middle-class, employed, married women) and the time that has elapsed between publication and the present suggest that her research questions should be revisited and reconceptualized.

A study undertaken by Black feminist scholar Tamara Beauboeuf-Lafontant revitalizes Walters' methods through an examination of the way intersectional identities affect depression. Beauboeuf-Lafontant's piece "Listening Past the Lies That Make Us Sick: A Voice-Centered Analysis of Strength and Depression Among Black Women," uses a methodological technique she terms "voice-centered analysis"—essentially an alternative way of framing in-depth interviews—to challenge the "prevailing notion of the distress [depression] as a white women's illness" (2008:393). Beauboeuf-Lafontant begins her piece by describing what she refers to as "The Silencing Paradigm," or the idea presented by numerous previous feminist scholars such as Stoppard (2000) that depression in women is a result of gendered inequalities in society. "Most provocatively," Beauboeuf-Lafontant claims, "the silencing paradigm refutes the conceptualization of depression as a unique and pathological state, as portrayed in the medical literature, and instead depicts it as a process and a continuum with deep roots in what are largely considered 'normative' conditions of femininity and representations of feminine goodness" (2008:392). To test whether or not this same paradigm can explain Black women's experiences with depression, she obtained a convenience sample of 58 African-American women and

conducted interviews about stereotypes of Black womanhood, beauty, and the experiential realities of depression among Black women (2010:397).

Beauboeuf-Lafontant's work indicates that Black women's experience with depression cannot be fully theorized within the context of the silencing paradigm. An additional "strength discourse," emphasizing the societal and cultural expectations of Black women to maintain composure and remain selfless and silent in the face of adversity, must be included in an intersectional theorization (2010:399). She concludes that, in reality, Black women most likely experience depression at equal or higher rates as white women, but due to pressure to perform the 'the strong Black woman' stereotype, seek help for mental health issues far less frequently than their white counterparts (2010:404). Many of the stereotypical characteristics of 'the strong Black woman' notably mirror the stereotypical assumptions of masculinity, which I previously mentioned have already been correlated to lower rates of help-seeking for, or reporting of, mental health problems.

However, the selflessness required of Black women differentiates the challenges they face from those posed by hegemonic masculinity. In Beauboeuf-Lafontant's words, "the discourse of strength leaves little room for recognizing states of need and duress among Black women because they emerge from the concerns of a 'self' that the discourse systematically discounts" (2010:404). Beauboeuf-Lafontant's work provides relevant, modern social commentary about the ways in which different populations frame mental and emotional strain. This study is an exemplar of intersectional feminism and serves as an important reminder to researchers that there should be scholarship directly addressing race and class. It also highlights the necessity of engaging in analyses of mental health paradigms that look beyond normative assumptions of masculinity and femininity.

Elizabeth Wilson (2008) presents an additional challenge to feminist sociological researchers who focus on mental health. In her essay “Organic Empathy: Feminism, Psychopharmaceuticals, and the Embodiment of Depression,” she challenges “the commonplace feminist presumption that biology and politics are separate domains and that biology is a supplement (a dangerous adjunct) to politics” (378). Wilson does something that, to the extent of my knowledge, no other feminist researcher had formerly done; she actually looks at the pharmacokinetics (the way a drug moves through the body) of antidepressants and breaks down how drugs are ingested, metabolized, and affect the body and brain of someone suffering from depression or a related mental disorder (2008:379). Wilson uses this analysis in an attempt to overcome the barriers she feels past feminist researchers have constructed between the psychological and the biological; she asserts that the power of antidepressants to thoroughly improve someone’s cognition and emotional state is clear evidence that there is “an intimate cohabitation of the biochemical and the psychological” (2008:386).

Wilson believes that to project a hardline political opposition to psychiatric and pharmaceutical definitions of depression is also to project ignorance about the inextricability of the biological from the cognitive. Although I agree that feminist scholars should be more sympathetic to existing genetic and biological evidence, Wilson neglects to address the subjectivity involved when constructing the symptomatology of diagnostic categories such as depression and the troublesome history of Psychiatry. I find this to be equally as problematic as she finds other feminist researchers’ neglect of biology. Nevertheless, this piece forces proponents of the social constructionist model to remember that our psychosocial experiences are also *embodied* experiences, to prevent us from unwittingly falling into the masculinist dualism

inherited from Descartes. As such, we must grant consideration to biology when engaging our social constructionist frameworks.

Psychopharmaceuticals and the Neoliberal Push to Self-Label

At the end of Wilson's piece, she states, "interest in the vicissitudes of serotonergic energy systems doesn't mean compliance with the rhetoric and politics of Big Pharma" (2008:390). In recent years, a number of studies about the pharmaceutical industry's effects on gendered disparity in rates of mental disorder diagnoses have emerged. Although Wilson's work exists tangentially to these studies (most of which use social constructionist theory to frame their arguments), they are all united in one crucial way: they seek to critique the influence neoliberal forces like "Big Pharma" have had on our society's approaches to mental illness. Critiques of the neoliberal model are becoming commonplace in sociological and feminist scholarship; feminist anthropologist Ellen Lewin recently cited neoliberalism as "the new patriarchy" in a talk at the 2013 American Anthropological Association conference in Chicago, Illinois. Before engaging with these studies, I would like to define neoliberalism in order to foster a better understanding of the way these authors use this political-economic shift within their analyses.

Foucault, who has already been useful to this study in historicizing the anti-psychiatry movement, offers a useful introduction to neoliberalism and its individualizing influence on society in one of his famous lectures at the College de France. This particular lecture was not made available to the public until 2001, when it was transcribed and discussed in Thomas Lemke's 2001 article "The Birth of Bio-politics': Michel Foucault's Lecture at the College de France on Neo-liberal Governmentality." Lemke interprets Foucault's definition of neoliberalism as follows: "the neo-liberal programme seeks to create neither a disciplining nor a normalizing society, but instead a society characterized by the fact that it cultivates and optimizes difference"

(Lemke 2001:200). This cultivation of difference is manifested in the discrete diagnostic categories of the DSM that have been “pigeonholing” emotional distress (Lerman 1996). Foucault believes that an individual in a neoliberal society “becomes a behavioristically manipulable being and the correlative of a governmentality which systematically changes the variables of the ‘environment’ and can count on the ‘rational choice’ of individuals” (2001:200). The authors of the articles I am about to discuss believe that the transformation of all forms of mental distress into medicalized, and therefore marketable, disorders is one such systematic change. They also posit that the pervasiveness of capitalism and consumerist culture requires that all of the ‘rational choice’ individuals are able to make must occur in the marketplace.

Feminist sociology’s interrogation of the effects of neoliberalism and consumerist ideology on the gendering of mental disorder rates began in 2004 and 2005 with Linda M. Blum’s and Nena F. Stracuzzi’s “Gender in the Prozac Nation: Popular Discourse and Productive Femininity,” and Ruth A. Chananie’s piece “Psychopharmaceutical Advertising Strategies: Empowerment in a Pill?” It has continued with Jennifer Arney’s and Rose Weitz’s very recent piece from 2012 entitled “Gendering Affective Disorders in Direct-to-Consumer Advertisements.” Collectively, these studies looked at either mass print articles in magazines or television advertisements in order to determine whether or not the advertising strategies employed by psychopharmaceutical companies can be held responsible for some of the gendered disparity in diagnosis rates for anxiety, depression, and other common mental disorders. The results from each study were a resounding “yes.” All three studies found that direct-to-consumer advertisements blatantly target women through their use of predominantly female actresses or models as well as their use of covertly gendered language. They also found that not only do the advertisements target women; they strongly encouraged viewers to self-label and self-diagnose

(Blum & Stracuzzi 2004; Chananie 2005; Arney & Weitz 2012). Chananie states that advertisements “accomplish medical legitimacy by describing disorders, symptoms, and side effects using both scientific and everyday language that relies on cultural understandings of illness in general and women’s experiences in particular” (2005:499). Blum & Stracuzzi warn readers to be wary of the “biodeterminist model” of mental illness promoted by psychopharmaceutical companies whose interests lie in accruing profit (2004:283).

All of these studies strongly support self-labeling theory, and can be easily conceptualized through a Foucauldian lens, fitting into the larger feminist conversation about the detrimental effects of neoliberalism on marginalized populations. They consider where many definitions of mental disorders are produced and how these messages are communicated to the masses. They have great potential to explain why women are predisposed to seek help for mental distress and therefore receive the majority of diagnoses with mental disorders. What they do not do, however, is measure how diffuse and internalized these messages have become. Their findings justify correlative *speculation* that the high rates of women being diagnosed with mental disorders can be attributed to psychopharmaceutical influence, but they do not show definitive causation. They do not leave space for the inclusion of other variables that have been systematically altered by the neoliberal system that could also be contributing to the imbalance in diagnostic rates. My own research builds upon this body of work by filling the gaps I have identified.

Chapter Four

A Feminist Methodology

The development of my methodology has been anything but linear. I ultimately constructed and submitted to The College of Wooster's Human Subjects Review Committee (HSRC) three different methods proposals before receiving permission to conduct the study detailed in this chapter. Although I was frustrated by the lengthy series of rejections and reinventions my methods went through before receiving approval, the process served as a catalyst for my methodological creativity. It forced me to reconsider with each application whether or not my previous ideas were truly answering my underlying research question: how has the social construction of anxiety contributed to women's disproportionate susceptibility to diagnosis? Additionally, the experience provided insight into how Institutional Review Boards (IRBs), much like Wooster's HSRC, can perpetuate many of the same institutionalized systems of knowledge that sociological and feminist researchers critique. Thus, while the primary purpose of this chapter is to explicate the methods that produced the data used in my analysis, it will also serve to document the evolution of my methodology and offer up a feminist critique of current IRB practice.

Methodological Development and the HSRC

In my previous chapters, I discussed several informational and methodological gaps that could be filled by a number of prospective methodological approaches, each with the potential to produce new knowledge about women's experience with anxiety disorders. The work of Thomas Szasz (1967) and Janet Stoppard (2000) particularly influenced which of these directions I chose

to take; feminist standpoint and social constructionist theory are guides that I have consistently followed in spite of the construction and deconstruction processes my methods have undergone. Sociologist Joey Sprague, author of *Feminist Methodologies for Critical Researchers*, provides a comprehensive overview of feminist standpoint epistemology and theory that sits harmoniously with the social constructionist theory put forward in the previous two chapters. Sprague states that standpoint theory, much like social constructionist theory, argues that “the world, including humanity, is socially constructed, which is not to say that it is not real, but rather that it is the product of human activity” (2005:51). Therefore, standpoint theory asserts that “knowledge is constructed in a specific matrix of physical location, history, culture, and interests, and that these matrices change in configuration from one location to another” (2005:41). Sprague also includes a discussion of the power that is naturally embedded in knowledge-producing research. Although she acknowledges the potentially problematic authority that derives from the privilege held by researchers, she states that this cannot prevent us from doing necessary work. As long as we live in a society that is structured to “ensure the hegemony of the dominant,” attempting to avoid hierarchal power structures altogether is untenable (2005:80). As addressed in Chapter One, it has been my aim as a feminist researcher to remain mindful throughout this work of the power and privilege I hold in relation to my research, a central praxis of feminist standpoint theory.

Sprague’s, as well as Stoppard’s, definition of feminist standpoint theory stresses that legitimate knowledge can and should be produced from a variety of perspectives and understandings, and that it is the researcher’s job to bring these perspectives to light in academic and non-academic spheres. In the case of women living with anxiety disorders, there is little literature that captures the perspectives of those who have received an actual diagnosis. Although social constructionist theory surrounding mental disorder, as well as women’s disproportionate

susceptibility to diagnoses of anxiety and depression, are becoming more widely recognized, the existing literature neglects to include the lived experience of women who have been absorbed into anxiety's medical pathologization. The urgency with which Sprague and Stoppard ask their readers to consider such voices as epistemologically valid sources struck me and left me certain that an interview-based project working to capture women's experience with anxiety disorders would be the focus of my thesis. Sociologist Beauboeuf-Lafontant's concept of voice-centered analysis also served as methodological inspiration, confirming the initial inclination I had gained from Sprague and Stoppard to conduct interview-based research. I determined that I would conduct 10-15 in-depth interviews with women who had received a clinical diagnosis of an anxiety disorder. The interviews would be semi-structured in format, with the primary intent behind each question being to gain an understanding of the way each participant conceives of her own identity before, during, and after her anxiety diagnosis. My intention was to prompt participants to map the trajectory of their own identity formation, in relation to and outside of their diagnosis. My research proposal confirmed that a number of close friends and family members with anxiety diagnoses had already expressed interest in participating, and that I intended on using snowball sampling to gather the rest of my participants. I stated that I believed a woman's participation in the study could produce the indirect benefit of having a non-clinical space in which to reflect upon her experience with anxiety.

The HSRC firmly rejected this application in an email from Brian Karazsia, head of the committee, on August 27, 2013, containing the statement:

Please know that this decision was not made lightly. Factors that went into this decision included the very sensitive population from which you are sampling, coupled with sensitive questions that could potentially increase symptoms of depression or anxiety of your participants. We were also concerned that the referral to online websites for assistance was not sufficient enough to mitigate these risks. Moreover, you are not

trained, nor will the interviews be conducted in the context of someone who is trained, to handle serious psychopathology.

I could not deny the validity of the HSRC's concern that an undergraduate student would not have enough training to handle serious psychopathology. Additionally, I realized in retrospect that referral to counseling services, rather than to online websites, would have been a more ethically sound way to ensure the safety and wellbeing of my participants. Yet I was taken aback that, according to the HSRC, the 18% of the adult American population who have been diagnosed with an anxiety disorder collectively constitute too sensitive of a population to be able to reflect upon their experiences with anxiety in a non-clinical space (NIMH). In light of the research that has been done exposing the fallibility of DSM diagnostic categories, the American psychiatric system, and the influence of neoliberal forces on diagnosis and prescription rates, it was concerning to me that the HSRC would only consider research on anxiety that would occur within the context of these systems by individuals who have received their credentials within them. This demonstrates how the same institutional structures that decide how and when to diagnose also hold the power to allow or disallow research into their practices.

Anthropologist Elizabeth Chin recently published a scathing, yet important feminist critique of IRBs, entitled "The Neoliberal Institutional Review Board, or Why Just Fixing the Rules Won't Help Feminist (Activist) Ethnographers." In it, she states:

IRBs present yet another manifestation of neoliberalism in the academy whose primary purpose is no longer to ensure ethical treatment of human subjects but rather to shrink the vistas of legitimate research to those forms that support the tenets of neoliberalism itself: the positivist, the quantitative, the experimental (2013:201).

By restricting research focused on women with anxiety to fields with access to psychological or psychiatric resources, IRBs reinforce that the positivist, "empirical" knowledge of disorders stemming from these fields hold greater legitimacy than the knowledge produced by sociologists

and feminist scholars whose work seeks to give voice to the lived experience of their research subjects. It also suggests that those who experience clinically diagnosable anxiety no longer hold enough agentic power to make the informed decision to speak to a non-clinical researcher about their experience. Their anxiety, because it has been labeled as a “disorder,” invalidates their consent, and may only be examined in clinical, monitored contexts. In Barbara Ehrenreich and Deirdre English’s (1978) words, scientific authority on mental distress is relegated to the domain of the “experts,” a domain where, as Chin states, “positivism directly delegitimizes feminist forms of knowledge production and related activist aims” (2013:202).

Despite these challenges—ones that ultimately reach far beyond my own project—the HSRC’s rejection of my initial proposal prompted me to critically reflect upon my research question and to ask myself whether the interviews I had designed would have actually helped answer it. I realized that although I am fascinated by both the social forces driving women’s high rates of anxiety diagnosis and the way that receiving a diagnosis affects women’s identity formation, each of these inquiries is individual, complex, and multifaceted. This realization led me to reorient myself methodologically. I began to brainstorm new methods focused solely on capturing women’s perspectives on the social factors that lead them to seek and/or receive anxiety disorder diagnoses. Although I wanted to keep elements of Beauboeuf-Lafontant’s voice-centered analysis in my new methodology, I was aware that interrogating lived experience with anxiety would not be approved by the HSRC and that anonymity would most likely be required. Therefore, I designed a survey that would be anonymously administered, consisting of mostly open-ended response questions that would ask participants about their exposure to, perceptions of, and experiences with anxiety disorders. This survey received HSRC approval upon its second submission, after I was asked to remove several questions regarding personal experience.

Methodology

I entitled the final survey “Exposure to and Attitudes Towards Anxiety Disorders” and sent it to a random sampling of 250 students at the College of Wooster. The sample size was kept relatively small in comparison to the overall College of Wooster student population of 2,116, due to the open-ended nature of the majority of the survey questions (The College of Wooster 2014). I estimated that my response rate would fall somewhere between 50-100 responses, and ended up obtaining a survey sample of 69 (27.6%). According to the NIMH, the majority of adults diagnosed with an anxiety disorder experience their first episode by age 21.5; this statistic, in addition to the ease with which I could access a sample of college-aged students, served as my motivation to sample from the College of Wooster student population. Potential participants were sent a recruitment email detailing the purpose of the survey, the potential for identity disclosure through demographic information, and a statement saying that consent to participate was implied once the survey link was clicked. The survey consisted of 13 questions: four gathering demographic information, six multiple-choice questions (four of which requested that participants provide an open-ended explanation of their response), and three open-ended, short answer questions (see Appendix A).

Aside from age, each demographic question was left open-ended in order to allow participants to identify their sex and gender identity, racial identity, and socio-economic status in a way that felt most comfortable to them. As Sprague states: “standardized measures of traits are premised on the assumptions that traits are stable and can be measured out of context” (2005:87). I understood that, even in leaving the demographic questions open-ended, I would eventually still need to categorize responses in order to efficiently contextualize them with the rest of my data. However, I was adamant that my survey challenge the typical census style format: one that conveys identity markers like gender and race as fixed, static, and pre-determined (Sprague

2005). This chapter will conclude with a brief demographic portrait of my sample that includes the specific wording used by each participant to identify themselves and a discussion of the way this information will be contextualized within the following analysis chapter.

After demographics, the bulk of the survey questions centered on the two themes identified in the title of the survey: exposure and attitude. Participants were asked if they were aware of anxiety disorders, what had led to their awareness, and what their first exposure to anxiety disorders looked like. They were then asked questions to gauge their basic understanding of and general attitude towards anxiety disorders, such as how they defined anxiety disorders, what factor or factors they thought caused them, and what they thought the most effective form of treatment was. The last section of the survey was meant to ascertain more specific attitudes participants held about the gender and circumstances of those with anxiety disorders. The intent of this last set of questions was to explore what college-aged students believe leads an individual to seek medical help for anxiety. Additionally, the questions were designed to further explore whether students' opinions align with Thoits' theoretical perspective that women are more likely to self-label with an anxiety disorder than men.

My goal with the survey was to achieve three principal objectives. Firstly, I wanted it to serve as a continuation and, in some ways an evaluation, of the research of Blum, Stracuzzi, Chananie, Arney and Weitz. I wanted to see if the neoliberal influence of pharmaceutical advertisements, cited by the previously listed scholars as the driving force of gendered disparity in mental disorder diagnoses, would also be cited by my participants as the source of their first exposure to anxiety disorders. Furthermore, I wanted to determine whether other social factors, such as pop culture and educational experiences, play roles similar to psychopharmaceutical advertisements in influencing students' perceptions of anxiety disorders. With so much recent

research centering on psychopharmaceutical advertisements' influence, I hypothesized that the influence of other social factors might have been overlooked or minimized by previous research. Lastly, I wanted to see if the gendered messages being circulated by pharmaceutical companies and various other social forces have become diffused in our society to the point where students accept gendered disparity as normal and expected in clinical help-seeking and actual diagnosis of anxiety disorders. To analyze and draw themes from the data within the 69 participants' surveys, I did an initial read-through of the responses to each question and wrote down abstractions of the themes I noticed. I then did two additional read-throughs and color-coded themes (such as participants' mentioning of personal experience with anxiety disorders or having taken a high school course that first educated them about anxiety disorders) within the text by highlighting key words and phrases. I created a master spreadsheet attaching the demographic information of each participant to their use of keywords or identifiers salient to each theme, as well as individual documents for each theme chronicling salient numbers and quotes to be used to enhance the explication of each theme in analysis.

Demographic Snapshot

Participants ranged in age from 18-22. When asked to identify their sex and/or gender identity, 45 (65.2%) participants identified as female, 22 (31.9%) identified as male, one identified as both male and female, and one identified as agender. The vast majority of participants (55, or 79.7%) identified as White or Caucasian. One participant identified as Black, one as Asian, one as Middle Eastern, one as Jewish, one as Hispanic, two as American, two as Multiracial, one as both Caucasian and Middle Eastern, two as both White and Hispanic, one as both Asian and White, and one as having no racial identity. When asked to identify their socio-economic status, most participants identified as either middle class (32, or 46.4%) or upper-

middle class (22, or 31.9%). Three participants identified as upper class, one as privileged, seven as lower-middle class, one as lower class, one as “upwardly mobile” lower class, and one stated “we make ends meet.”

Although Sprague does caution against using standardized measurements for identity categories like gender, race, and socioeconomic status, I must also acknowledge the warning she gives that “by building measures on the opinions of respondents, [feminist researchers run the risk of] incorporating the dominant ideology as...respondents [have] internalized it” (2005:88). It is certainly important to remain cognizant that the majority of the identifiers chosen by my participants aligned with standardized models and, consequently, with the dominant ideology. However, I believe that allowing participants to have agency over their own identifiers is still a critical feminist methodological decision. The sorts of distinctions made by participants who chose to identify their gender outside of the binary or their race as multifaceted would not be observed under standardized surveying methods. Thus, while open-ended demographic questions may reproduce the prevalent demographic categories, they also allow participants a more active role in that reproduction.

The specific demarcations of gender, race, and socioeconomic status, used in the above snapshot and taken directly from participant responses, will be maintained in the following chapter as I contextualize the positionality of my participants within the themes that emerged from their survey responses. Gender, while particularly important for the purposes of this study, is not the only culturally significant identity experienced by participants. Race and socioeconomic status also influence the way participants have been exposed to and taught about anxiety disorders, and, as discussed in Chapters Two and Three, often have disparate implications in terms of diagnosis and experience with a whole host of mental disorders.

Although previous research on racial and socioeconomic rates of diagnosis with anxiety disorders is too limited for me to fully theorize the way that intersectionality interplays with exposure to and attitudes towards anxiety disorders (nor is it the intent of my current research to do so), recognition of the intersection of identities is critical to understanding where any set of attitudes and beliefs originate.

Chapter Five

Normalizing Abnormality

The results produced through the analysis of my survey data unearthed a host of new themes and questions that have not been considered in previous literature. After completing the previous chapters of my thesis, I began my analysis presuming that most of my participants would have first encountered anxiety disorders through the marketing strategies of psychopharmaceutical companies, and that because these advertisements sell prescription drugs, participants would view anxiety disorders as solely medical phenomena. I hypothesized that the gender bias that previous research had already confirmed existed within advertisements would have led participants to believe that women were more biologically susceptible to experiencing anxiety disorders; this would neatly reflect back upon the history of the pathologization of women that I chronicled in Chapter Three.

Instead, the data generated through participant responses strongly suggests that understandings of anxiety disorders do not stem from macro-social forces, but from micro-social ones. It also asserts that articulating perceptions of anxiety disorders garnered through these micro-social forces is a difficult endeavor; participants' discussions of anxiety disorders were fragmented, disjointed, and laced with contradictions between what they had learned and what they had experienced. Throughout this chapter, I will address the three themes that occurred most often in my data: exposure to anxiety disorders predominantly through interpersonal experience; contradictory assertions about anxiety as participants defined it versus anxiety as it is developed

and experienced; and participants' view of masculinity as the driving force of gendered disparity in diagnosis rates.

The first section on exposure will consider how the prevalence of stories surrounding personal experiences and interactions contradicts previous research citing the market and the media as the primary source of individual exposure. I will discuss this theme's implication that the influence neoliberalism has on participant perceptions may be more insidious than acknowledged by previous studies. In the second section on contradiction, I will attempt to negotiate the inconsistency of participants' statements about the origins and underlying implications of anxiety disorders, as well as the paradox between the assumptions of abnormality participants attached to anxiety and the normalization of their breadth of personal experience suggests. In the final section on masculinity, I will interrogate the suggestion made by the majority of participants that the root of gendered disparity in diagnosis lies not in an over-diagnosis of women but in an *under-diagnosis* of men. I will contrast this suggestion with a discussion of how previous theory and literature all suggest otherwise, and propose avenues for future research on the subject.

Exposure

Personal experience was the social force overwhelmingly responsible for participants' first exposure to anxiety disorders. I had previously inferred that, with 18% of Americans diagnosed with some form of anxiety, sheer probability would lead some elements of personal experience to surface within my data. Even in light of that initial inference, I had not anticipated that the vast majority of my participants would have had some form of intimate connection to anxiety disorders. Nor had I predicted that a substantial segment of my sample would have been personally diagnosed. Yet the numbers speak for themselves: 51 of 69 participants (73.9%)

indicated that either they and/or a friend or family member had been diagnosed with an anxiety disorder. Of these 51, 17 participants (24.64%) had personally received an anxiety disorder diagnosis, a rate that exceeds the national average by over six percentage points (NIMH). Forty-nine participants (71.01%) knew either a friend or family member who had been diagnosed; having a friend with a diagnosis was nearly twice as common as having a family member with a diagnosis (29 versus 11 participants, respectively). Additionally notable, 46 participants (66.67%) responded that a conversation with a close friend or family member had contributed to their initial awareness. Attitudes towards anxiety disorders varied depending on the interpersonal experiences they were developed through, but participant responses made it clear that these experiences were the most formative factor in their perceptions of anxiety disorders.

Participants frequently embedded their beliefs about anxiety disorders directly into their statements about friends and family members with diagnoses. For instance, one participant highlighted the role she believes genetics play in the development of anxiety disorders through this statement about her family: “Generalized Anxiety Disorders have been a part of my knowledge for quite some time, seeing as mental illnesses along these lines are embedded in my family’s genetics.” Another recounted her experience with an ex-boyfriend who had been diagnosed by stating: “My ex had it and some of his symptoms were random outbursts of violence and then panic attacks which usually resulted in him passing out due to the lack of oxygen caused by shortness of breath.” Later on, this participant defined anxiety disorders as “more of a chemical imbalance rather than a mental thing,” a viewpoint that supports the way she frames her ex’s anxiety as a physiological rather than a mental ailment. A third participant briefly relayed a close friend’s experience with anxiety with a reference to the “dysfunctionality”

she later associates with anxiety disorders: “One of my good friends is diagnosed with anxiety, and sometimes it’s difficult for her to function and stuff like sitting through a movie in a theatre.”

Most participants, including some that had been personally diagnosed, expressed that having a close friend and/or family member with a diagnosis was a necessary precursor to an individual’s decision to seek help for anxiety. Some expressed this in the context of their own experience; one participant stated: “my friend freshman year had a severe anxiety disorder and it made me realize that I shared all the same symptoms, did some research and realized I was having panic attacks and that wasn’t just a normal thing.” Another wrote: “My sister was diagnosed with depression and admitted to a psychiatric ward when I was 13. After that time I started going to a psychologist and was diagnosed with depression and anxiety at 15.” These statements underscore the salience of interpersonal exposure in these particular participants’ decisions to seek professional help. They also bring to light a mirroring effect in individuals’ recognition of their own anxiety, where one sees themselves in the experiences of others and takes on similar labels in response (see Cooley 1902 for further discussion of mirroring.) However, although a few other participants made similar personal connections, most participants discussed the importance of friend/family influence as something generalizable that most likely applied to all who sought treatment. One participant said that “knowing someone who has an anxiety disorder” was important in any individual’s decision to seek treatment. Another said that “if they don’t know anyone who has received treatment, they’re more likely to dismiss it [their feelings of anxiety].”

In the same vein, participants also identified intervention by friends and/or family members as a critical factor in an individual’s decision to seek help. One participant stated: “Since one of the problems with anxiety disorder is that you often don’t recognize it, I think it

usually takes another person to get you to seek treatment.” Others said things like “I think that a huge factor is the concern of people close to the affected individual” and “I think surrounding friends and family are the biggest factor. It’s hard to admit there may be a serious problem to yourself, but if someone who you trust thinks you should seek help it sinks in more.” In total, 37 participants (53.62%) believed that conversation with, or intervention by, friends or family was important in motivating individuals to identify anxiety issues and seek treatment.

Although participants’ privileging of interpersonal, micro-social forces does not directly build upon the societal privileging of psychopharmaceutical companies found by other researchers, it *does* enhance the arguments made by labeling and self-labeling theorists. As previously quoted, Thoits asserts in her explication of self-labeling theory that “social control is largely a product of self-control” (1985:222). The mirroring effect displayed through participants’ accounts of personal experience, are stark examples of individuals policing their own emotions and behaviors. When, as one participant aptly stated, “a person is in such distress and does not function as society dictates they should,” a society that encourages self-labeling says the next logical step is to seek out alternate culturally sanctioned roles (i.e., the role of the mentally ill) (Thoits 1985:242). My data goes one step further in suggesting that the existence of these alternate roles, particularly the role of the mentally ill, is not an option that all individuals consider when they first recognize their emotions or behaviors as deviant. Rather, the role is generally modeled by someone close to them before they adopt it themselves.

Individuals do not just take on these labels themselves; the emphasis participants placed on family/friend intervention provides evidence in support of traditional labeling theory as well. Yet while Scheff saw “prestigious others” such as psychiatrists as responsible for labeling individuals as emotionally deviant, my data suggests otherwise (1961:450). As mentioned

previously, 37 participants expressed that common knowledge of anxiety disorders is widespread enough that the average person feels capable of assessing others' emotional state and determining whether abnormal amounts of anxiety are present. This suggests that anxiety disorders are no longer simply deviant but have become what Scheff calls a "social type" (1961:451).

The importance of personal experience in transmitting information about anxiety disorders detailed here should not be interpreted as a contradiction or invalidation of the conclusions drawn by previous research about neoliberal influence. Perceptions have to originate somewhere, and although it is possible for beliefs and attitudes to be generated at the micro-social level, the history of the American Psychiatric Association and the monopoly it has long held on mental illness frameworks suggests that our understandings of anxiety disorders have been propagated from the top down as detailed in Chapter Two. It would be impossible to track the exact genesis of how perceptions of anxiety disorders, generated at the macro-level, became diffuse enough within the population to the point where transmission through micro-social interpersonal interaction was commonplace. However, some speculation on this topic can be drawn from my data as well. In the context of my sample alone, 30 participants (43.48%) indicated that advertisements for prescription drugs like Prozac and Sarafem had played some role in developing their awareness of anxiety disorders. Perhaps messages dispelled through advertisements instigate interpersonal conversation about anxiety disorders in which individuals feel they have license to talk about anxiety as a disease, indirectly removing the blame from society and instead promoting individual responsibility for one's health.

Additionally, the large number of high school and college-aged students who are taught about anxiety disorders in an educational context could be additionally reflective of interplay

between the American education system and the American market system. Thirty-three participants (43.84%) stated that their awareness of anxiety disorders had been at least partially cultivated in an academic context. Eleven of these participants cited a college-level Psychology course as the educational medium and seven mentioned a middle or high school course. Several participants used language indicating that they were reflexive when learning about mental illness, considering the symptomatology as it pertained to their peer groups and themselves:

We discussed anxiety disorders in my high school health and wellness class, alongside other common high school age psychological issues like depression; I took a college psychology class in high school where it was mentioned and I realized that I could possibly suffer from the same disorder; I distinctly remember it being explained in a classroom setting, sometime in middle school I believe, and thinking that it sounded like something I imagined most people dealt with.

Curriculums, particularly in middle or high school settings, may be structured with the intent of educating youth to become medical consumers. This in turn could influence students to self-label with mental illnesses like anxiety disorders; self-labeling might then drive the other forms of interpersonal interactions routinely emphasized by participants (Thoits 1985). Future research should pursue more in-depth consideration of how these macro- and micro-social forces interact to shape views about anxiety in a neoliberal era.

Beliefs and Contradictions

My original hypothesis that participants would ascribe to biological determinist definitions of anxiety disorders was both affirmed and challenged throughout the responses provided to me by participants. Although medicalized language was infused throughout my data as predicted, participants continuously contradicted their learned perception that anxiety disorders are biological abnormalities with stories of personal experience and statements citing society or societal factors as the primary production site of anxiety. Biological/genetic factors

indeed trumped social/cultural factors when participants were asked about the number one cause of anxiety disorders. Twenty-seven participants chose to incorporate phrases like “chemical imbalance,” “psychological malfunction of the brain,” “hormonal misfirings,” and “biogenetics of anxiety disorders” when constructing their own definition of anxiety disorders. Physiological symptoms were also frequently mentioned in these definitions; 20 participants referenced somatic manifestations of anxiety such as “rapid heart rate,” “sleeplessness,” “inability to breathe normally,” and “anxiety attacks.”

The way participants answered questions about the influence gender has on diagnosis occasionally reflected biogenetic perspectives as well. Although the portion of my sample that believed men and women are equally likely to be diagnosed with an anxiety disorder were in the minority (27 participants, or 39.13%), the language used by participants to explain why they thought both genders would experience anxiety disorders at equal rates often coincides with the language discussed above: “just because you are male or female does not make you more likely to be mentally unstable. It is all about genetics.” Because “men and women are very biologically similar,” some participants whose perceptions aligned with biological determinist models doubted that gendered disparity could exist in rates of anxiety disorder diagnoses. As one participant succinctly stated: “if biological factors play a part, then anyone can be likely to get an anxiety disorder.” Interestingly, a few participants who were already aware that women are statistically more likely to be diagnosed with an anxiety disorder *also* used biological rhetoric to explain their response: “There [are] a plethora of differences in hormones, brain chemistry, and neural organization that contribute to women being generally more prone to anxiety than men.” One participant even mentioned body chemistry during ovulation as a reason women experience

higher rates of anxiety disorder diagnoses than men, referring to the statistic as “a product of these more vulnerable times in a woman’s life.”

Seeing biology and genetics as central to developing an anxiety disorder shows that, by and large, participants conceptualize these disorders as medical phenomena. If participants frame anxiety as genetically derived and physiologically manifested, then anxiety can be equated with bodily health, relegating it to the medical realm. This perhaps indicates participants’ acceptance of an abstraction of the “Cartesian dualism” that has been reflected in most modern medical systems, where “medical practitioners...tend to believe that their primary medical role is to diagnose and treat a patient’s illness by treating the body to the exclusion of the person who is experiencing the illness” (Switankowsky 2000:567). If abnormal levels of anxiety are produced in brains by chemicals, hormones, and genetics, it follows that they would be medically diagnosed and medically treated. This model suits the neoliberal principle of individualism, categorizing anxiety disorders as individual experiences caused by individual biology and eliminating the need to ask what society might be doing to produce them. However, this is where I reached a juncture in my analysis, and I began to notice the breadth of contradictions that came through in participant responses.

Psychological counseling, a form of treatment that addresses the mind instead of the body, was labeled the most effective form of treatment for anxiety disorders by 34 participants (49.28%); a mere nine participants believed that prescription drugs were more effective. In fact, many participants who had initially defined anxiety disorders as biological and/or genetic phenomena strongly *opposed* medication. One participant who had at first insisted that “anxiety disorders are almost purely genetic” later claimed that psychological counseling would be the most effective form of treatment “because the cause of most disorders stems from problems that

aren't dealt with and buried down, then it manifests itself as anxiety." A second participant said they would define an anxiety disorder "how it is defined medically," but later said that "drugs...only suppress the issue. Counseling works to fix the causes of these disorders." A third participant discussed "genetic factors" in their definition of anxiety, but later argued against prescription drugs, stating: "it is important to get to the root of the problem, rather than merely covering up the symptoms, which is all prescription drugs are capable of doing." This theme challenges prior conclusions about the impact psychopharmaceutical advertisements have on producing biological, bodily understandings of anxiety; it suggests that perhaps advertisements make the population amenable to a medicalized response by healthcare professionals, but not necessarily a medicated one.

Forty-four participants (63.8%) used key words or phrases connoting that anxiety disorders are derived externally rather than internally. Words like "stress," "pressure," and "triggers" appeared regularly, all three of which were generally used when discussing the influence of outside forces, like work and school, in producing anxiety. Other phrases, like "the root of the problem" and "past experiences," further suggested that many participants see anxiety disorders as incited by specific moments. One individual defined anxiety disorders as "stress that overwhelms someone caused by a particular situation, event, [or] persons;" another said that they "believe that there is almost always a trigger, however subtle, derived from social/past experience." Once again, these statements often came from the same participants who had earlier used biogenetic language to describe anxiety disorders. Although participants did not seem to view the presence of stress as any more inherent to individuals with anxiety disorders than those without them, they framed stress management as a natural "capability" that those with anxiety disorders lack. This was apparent in many of the definitions of anxiety disorders provided by

participants, such as: “they [anxiety disorders] are a set of disorders that causes a level of worry or panic above the typical for a stress level;” “anxiety disorders are a chronic issue of anxiety...beyond typical periods of stress in life;” and “it would be primarily defined as a disorder wherein an individual who is most likely hypersensitive to...stress is crippled by said sensitivity.” The idea that anxiety disorders prevent individuals from handling “normal,” albeit stressful, expectations also came through in the 38 times statements like “interference with daily living” and “inability to function” appeared.

Framing anxiety disorders as an inability to deal with “normal” levels of stress was a way that participants tried to negotiate the impasse between biological determinism and social constructionism. The framework of “abnormality” serves as a middle ground, a sort of umbrella under which both biological factors and deviance against socially sanctioned emotional and behavioral norms can fit. About half of all participants (49%) used wording or phrasing describing anxiety as an abnormality or irrationality at some point during their response. “Abnormality” and “irrationality” are generally not defined or used in the same context; however, I chose to meld them into one category because the way they were used by participants was ambiguous and disjointed. While the words “normal” and “abnormal” at first seem to hold biological implications, participants frequently paired them with statements that contradicted a purely biological interpretation. The same can be said of participants’ use of words like “irrational,” “excessive,” and “exaggerated.” Although these words are generally used to imply deviance from social norms, participants used them in the same way they used “normal” and “abnormal;” they used them to distinguish the behaviors of those with anxiety disorders from the behaviors of everybody else, without having to do much else to articulate why these behaviors were so different.

The responses I included in the statistic given above were definitions of anxiety such as “the irrational inability to calm a sense of extreme fear or nervousness;” “a profound lack of control over the running of one’s thoughts and emotions;” and “conditions which cause people to worry or be anxious more often than normal.” Although this set of words and responses convey the notion that there is a “normal” amount of anxiety one should have and a “normal” way in which to express it, they circumvent the task of deciding whether or not these norms have been defined by biology or society. However, the language is still optimizing the validity of the diagnosis while minimizing the validity of the “stress,” “pressure,” or “root of the problem” discussed previously. Hence, under this framework of “abnormality,” the medicalization of anxiety disorders appears to be just as easily rationalized as it is under a biogenetic framework.

This framework of “abnormality” presents one final contradiction in terms of participant responses. In the previous section on exposure, I mentioned that the vast majority of participants (73.9%) had either been personally diagnosed with an anxiety disorder or had a close friend or family member who had been diagnosed. Yet although it was quite common for participants in my sample to have had personal experience with anxiety disorders, nearly half of them conceptualize these disorders as a definitive abnormality. Especially surprising were the participants with personal diagnoses who placed their own experiences under this umbrella. One participant who believed that he might suffer from an anxiety disorder himself later defined the disorders as “a feeling— usually *irrational or exaggerated*— of overwhelming social pressure.” Another participant who had recently determined that she suffered from anxiety attacks stated: “Going through every day constantly worrying about things that you know are irrational is one of the most frustrating things ever.” A third participant who had been diagnosed with what she termed a “severe anxiety disorder” stated that “anxiety disorder is a generalized term for a

variety of conditions in which a person worries *excessively* about something.” Individuals certainly have the capability to recognize their own emotional behavior as irrational or excessive if it greatly differs from the emotional behavior they see exhibited by others. However, when this “irrationality” is present in the lives of 73.9% of a sample, we should begin to question how emotional normality is being defined in the first place.

Pathologizing Masculinity?

While participants’ conceptualizations of anxiety disorders were ambiguously articulated and often contradictory, participants’ opinions about how gender can play into diagnosis rates clearly stemmed from beliefs about gendered social norms and expectations. Fifty-five participants (79.71%) believed that women are more likely to seek medical and/or psychiatric help for anxiety issues; 42 (60.87%) also believed that women are more likely to be diagnosed with an anxiety disorder. Not only do these numbers reflect the gendered disparity in diagnosis rates wherein women are twice as likely as men to be diagnosed with anxiety disorders (NIMH), many of the justifications participants provided for their responses align with conclusions drawn by previous research (Ehrenreich & English 1978; Russel 1995; Walters 1993.) A number of participants (16, or 23.2%) talked about the pathologization and/or stigmatization of female emotion, and the ways in which these factors encourage women to seek help for mental strain more so than men. However, it was discussions of masculinity that emerged as the dominant theme: 44 participants (or 63.8%) stated that stereotypes about masculinity are actually *inhibiting* men from seeking help for anxiety issues. I will spend the first portion of this section illuminating pertinent connections between previous literature and the influence some participants believed constructions of femininity have on gendered disparity in anxiety disorder

diagnoses. The latter half of this section will then concentrate on the dominant theme of masculinity. Here, I will highlight how participant responses indicate a need to further interrogate the relationship between masculinity and anxiety disorder diagnoses despite the lack of previous evidence.

“It’s a sexist world out there, and there’s a rumor going around that we’re hysterical.”

This statement, made by a participant who believed that women are more likely than men to be diagnosed with an anxiety disorder, harkens back to the history of hysteria and pathologization of women documented by feminist scholars like Ehrenreich, English, Tavris and Lerman (1978; 1992; 1996). Six of the 18 participants who cited constructions of femininity as the cause of gendered disparity in rates of diagnosis made references to this history embedded with feminist underpinnings, such as: “I think women have a high tendency to be pathologized and be deemed to have something inherently wrong with them. So, patriarchy” and “there’s a whole culture and history of ‘hysteria’ that leads women to being more frequently diagnosed. The cultural assumption that women are more ‘delicate’ and ‘emotional’ also plays a part in these diagnoses.” The language of another participant even mirrored Ehrenreich and English’s discussion of the “experts” when he stated: “women are taught that 1) something is wrong with them and 2) that there are professionals to whom they should submit for care/repair.”

While these responses suggest that some participants may have been educated about the historical pathologization of women, other responses show that even participants who did not have similarly sophisticated terminology to discuss gender differences still saw these differences reflected in social norms and standards. One participant stated: “I think there is more pressure placed on women to look and feel a certain way and to fit into a category than there is on men. And women then stress to fit these social standards.” Another said they thought women were

more likely to be diagnosed “because they are stereotypically more emotional and ‘unstable’ than the typical idea of a man.” Overall, these responses, given by about one-fourth of participants, illustrated a belief that the “stress” and “pressures” participants thought trigger anxiety are placed on women more than they are on men. In light of the large amount of literature supporting this belief discussed in Chapters Two and Three, this number is strikingly low.

A much larger number of participants felt that masculinity was responsible for any disparity in rates of diagnosis of, and/or help-seeking for, anxiety. As earlier stated, 63.8% of participants specifically mentioned masculinity, referring to it as a set of norms preventing men from coming forward about their struggles with anxiety. In these descriptions, women were portrayed as emotionally liberated while men were emotionally repressed: “Culturally it’s more acceptable for women to acknowledge ‘weakness’ than it is for men. This makes it easier for women to seek help than for men.” Participants saw masculinity as a construction that mandates strength and composure, something that they did not see reflected in constructions of femininity: “Men are expected to stoically take whatever comes their way, and there’s this silly idea that to get help is to admit weakness. Women are not, and will probably be more honest about things that’re going down medically or psychologically.” It is important to note that this understanding of femininity (where “...women can be more open to the idea of talking about their problems in an effort to fix them”) may reflect that the racial makeup of my sample was 80% white; Tamara Beauboeuf-Lafontant’s work on the myth of the strong Black woman directly challenges the notion that all women feel free to express emotional struggle (Beauboeuf-Lafontant 2008).

Some participants went so far as to use language suggesting that the American culture of masculinity marginalized or stigmatized men because of the way it restricts their access to

mental health care. Participants said things along the lines of: “I think that there is a greater social stigma upon men who seek psychiatric help as being ‘weak;’” “there is a social stigma associated with men talking about their feelings, so they would be less likely to admit they have a psychiatric problem and seek treatment;” and “much of Western/American society traditionally discriminates against men who admit having weaknesses, and therefore they are less likely to seek treatment.” One participant proposed that there are other categories of dependency that men are forced into because of the stigmatization of admitting to mental strain: “men are less likely to display symptoms because of cultural reasons- they are probably more likely to turn to drugs and alcohol rather than admit they are anxious.”

This focus on the limitations of masculinity suggests a feeling among participants that women are diagnosed at rates true to “reality,” while men are severely underdiagnosed because of the restrictions that hegemonic masculinity places on male emotional expression. After detailing the problematic construction and evolution of the DSM’s symptomatology of anxiety disorders in Chapter Two and the mental pathologization women have faced throughout history in Chapter Three, it seems unlikely that this sentiment holds greater truth than the conclusion drawn by previous analyses that women are “pigeonholed” into the role of the mentally ill (Lerman 1996). The only studies I cited previously that incorporated masculinity into their discussion were psychological studies. These studies concluded that constructions of masculinity did not oppress men but allotted them *privilege* that “equip[s] males with the instrumental traits and skills that prevent excessive fears or other anxiety disorders from developing” (McLean & Hope 2010:495). In fact, these studies claimed that women were oppressed by the *absence of masculinity*, and that constructions of femininity, by “not teach[ing] women to be instrumental, competent, and assertive” instead “breeds phobic women” (Chambless & Mason 1986:234).

However, there is a body of scholarship on hegemonic masculinity asserting that, since *all* gender constructions bind and restrict, masculinity comes with its own set of oppressions just as femininity does. Scholars like R.W. Connell (2000) and Michael Kimmel (2008) have written extensively about hegemonic masculinity and the power it wields in society. While it is not within the purview of my study to provide a review of this literature, its existence alone shows that there is a viable space in which further research on the ways masculinity may repress access to mental health care can be conducted. Regardless of whether masculinity can be proven to empirically influence diagnosis rates of anxiety disorders, it constitutes a large part of the way my participants understand the intersections of gender, help-seeking, and the mental health system. This alone brings up important questions about the relationship between gender performance and help-seeking and the dynamism of gendered and emotional norms that should be addressed in future research.

Chapter Six

Movement Towards Mental Health Justice

As I conclude this complex historicization and theorization of the roots of gendered disparity in diagnosis rates of anxiety disorders, I would like to reflect upon advice given by sociologist C. Wright Mills in *The Sociological Imagination*. Mills compels the sociological researcher to “know that many personal troubles cannot be solved merely as troubles, but must be understood in terms of public issues—and in terms of the problems of history” (1959:12). Mills’ piece, published in 1959, came just before feminist Carol Hanisch declared that “the personal is political,” which eventually became a rallying slogan for second-wave feminist activist efforts. Mills’ and Hanisch’s kindred words have inspired academics and activists alike to step outside of the dominant neoliberal mindset and ask what role hegemonic systems of power have in producing the troubles of ordinary individuals’ lives. This philosophy—that personal troubles are and should be treated as social issues—has been adopted by decades of American social justice movements, from the Civil Rights movement and the Women’s and Gay Liberation movements of the 1960s to the modern manifestations of these movements today. These movements have located the origins of individual struggle in the historical construction of our social institutions; they have made gradual strides towards dismantling these institutions and rebuilding a more equitable society.

Yet while the goal of such movements may have originally been to undo the marginalizing effect social structures have on particular populations, they often ended up re-assimilating these populations into mainstream consumerist culture. Movements often hold society accountable just until social stigma is eased and economic opportunity is made viable; at

this point, a fight for human rights often becomes a fight for consumer rights, and the emphasis is once again removed from society and placed upon the individual. This is not easily identifiable by activists positioned within a society that touts a “rhetoric of universal rights for all citizens under neoliberalism,” where rights are inherently bound up in a pursuit that equates happiness with wealth (Craven 2010:121). I argue that mental health activism in the United States has, in large part, been steeped in neoliberalism, placing sole emphasis on securing individuals’ access to the healthcare marketplace; mainstream advocacy efforts have failed to frame individual mental health troubles “in terms of the problems of history” (Mills 1959:12). Before I flesh out this argument in full and propose pathways to alternate models, I would like to briefly highlight another movement that has seen a shift in focus from human rights to consumer rights for comparison’s sake.

Although political debate about what women should or should not be able to do with their bodies continues to rage throughout the world, the reproductive rights movement has in many ways been a shining example of how neoliberalism often determines the direction and outcomes of activist efforts. Feminist anthropologist Christa Craven writes about the complicated relationship between reproductive rights activism and the neoliberal marketplace in her book *Pushing For Midwives: Homebirth Mothers and the Reproductive Rights Movement*. Craven asserts that the rhetoric of “choice” used by reproductive rights activists has held both political and economic implications depending on its context (2010:127). Activists argue that individuals should have the *human right* to make autonomous reproductive choices and the *consumer right* to have access to said choices in the healthcare marketplace. However, the space in which individuals are able to enact these rights—if and when they are secured—is, by default, neoliberal. Rather than address the inequality perpetuated by a society that does not guarantee

reproductive rights and healthcare to the women constituting over 50% of its population, individuals are satiated with a range of marketplace options (2008:121). Craven summarizes this shift in reproductive rights activism in words that extend to a plethora of other activist movements: “As governments have become less interested in protecting the social, political, and economic rights of citizens, the focus for many activists has shifted to their rights as consumers to make well-informed choices to purchase commodities and services within a free market” (2010:132). In recent years, this shift has been recognized by many women of color activists and has resulted in the emergence of a separate reproductive *justice* movement that addresses “access to quality, noncoercive reproductive healthcare for [*all*] women” (2010:4). Activists like Loretta Ross and Elena R. Gutierrez, as well as activist groups like Asian Communities for Reproductive Justice, have pushed back against mainstream activist focus on consumer rights (i.e., the right to purchase birth control, an abortion, etc.) and have instead prioritized universal access to *all* forms of reproductive healthcare (see Ross and Gutierrez 2004, Asian Communities for Reproductive Justice 2005).

Mental health activism is unique in that, with the exception of the anti-psychiatry movement of the 1960s, its direction has arguably always been shaped by neoliberal institutions simply because the institution defining mental illness is a neoliberal institution itself: the American Psychiatric Association. Additionally, cultural acceptance of biological determinism (as illustrated in part by my analysis) leads to a cultural understanding that mental illness is produced within individuals and should therefore be addressed in a medical context; the rhetoric used by advocacy organizations, much like the rhetoric used in psychopharmaceutical advertisements, “reinforce[s] the medicalization process of...disorders as biologically based, and manageable (or curable) within the paradigm of Western medicine” (Chananie 2005:488).

Because of this, mainstream advocacy organizations such as the National Alliance on Mental Illness (NAMI) have focused their efforts on destigmatizing diagnosis and making healthcare readily available to consumers, affirming the authority of the neoliberal institutions defining and profiting from mental illness in the process. They demand that society provide individuals with medicalized “choices” to ensure their mental health without demanding that society acknowledge its role in producing their mental illness in the first place.

The emphasis that mental health activism places on the individual can be seen looking at the mission statement of NAMI, the aforementioned advocacy organization. Their mission statement reads:

NAMI recognizes that the key concepts of recovery, resiliency and support are essential to improving the wellness and quality of life for all persons affected by mental illness. NAMI will advocate at all levels to ensure that all persons affected by mental illness receive the services that they need and deserve, in a timely fashion. Mental illnesses should not be an obstacle to a full and meaningful life for persons who live with them (NAMI 2012).

Here, the words “recovery” and “resiliency” indicate that NAMI is concerned with ameliorating troubles in individual lives, not the social issues that may be causing them. Consistent use of the word “persons” further emphasizes that the individual is the primary target of advocacy efforts. Additionally, their focus on ensuring access to “services” shows that NAMI is compliant with the models of diagnosis and treatment set up by the dominant institutions of mental health.

This critique is not to discount the relevance or the necessity of advocacy offered by organizations like NAMI. When nearly 60 million Americans are diagnosed with some form of mental illness, stigmatization should be battled and services should be guaranteed (NAMI 2014). To do away with an organization striving to improve “the wellness and quality of life for all persons affected by mental illness” just because it is permeated by the neoliberalism that infiltrates *all* of American society would be futile. However, when two-thirds of those diagnosed

with anxiety disorders are women, and research like my own provides evidence that anxiety is perpetuated by social structures, a need for additional social justice activism becomes apparent. As Tavis so aptly stated several decades ago: “if a mental disorder reliably and stereotypically fits a narrow category of people, then we should be looking at what is wrong the conditions of people in that category, not exclusively at their individual pathologies” (1992:186).

Established in 1909, Mental Health America (MHA) is the only grassroots mental health advocacy organization that places social justice at the forefront of their mission. The first statement on their list of guiding principles asserts that “mental health is a fundamental social justice issue.” They make strides in envisioning individual troubles as issues in society (in Mills’ sense) in their second guiding principle, stating: “concern for the public’s health demands that disparities in treatment and the disproportionality of the burden of illness be eradicated.” They make further progress in their third, stating that they require “change that is commensurate to the enormous magnitude of behavioral health problems in multiple aspects of our culture, our communities, our neighborhoods and our families” (MHA 2014). MHA does not directly challenge the institutions dictating how mental illness is defined and diagnosed; they, like NAMI, still ascribe to medicalized mental illness models and advocate for consumer rights to commoditized mental health care. However, by challenging disparities in diagnosis rates as well as the magnitude of those rates, MHA does more to challenge the social forces contributing to mental illness than any other organization I found.

Yet there is still more to be done. While research on the social construction and the production of mental illness has been around for quite some time, it has not received the cultural validation that research by the dominant mental health institutions has. We have not yet seen the emergence of a mental health justice movement similar to the reproductive justice movement

spearheaded by activists like Ross and Guterrez. The American public still largely views mental illness as something produced within individual bodies; social structures are rarely held responsible for their role in producing disorders, and when they are, the demand is not that the structures change, but that the individual changes the way they navigate these structures. Mental illness categories and rates of diagnosis that disproportionately affect certain populations will not go away until these demands are reversed. It is my hope that, with further research and advocacy, social justice efforts like the MHA will someday be regarded as highly as the dominant mental health institutions. To conclude in the words of Allen Horwitz, “ultimately [those who are concerned with mental health] need to consider when restoring normality is best accomplished by changing individuals and when it is best done by transforming social conditions” (2002:229).

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Appendix A

1. What is your age?
2. What is your sex and/or gender identity?
3. How do you identify racially?
4. How would you describe your socio-economic status?
5. Are you aware of anxiety disorder (used here as an umbrella term covering several variations of anxiety disorders as they are defined by the American Psychiatric Association, such as Generalized Anxiety Disorder, Panic Disorder, etc.)?
 - Yes
 - No
6. If so, how have you become aware of it? (Check all that apply)
 - I have been diagnosed
 - Mentioned by a physician or other healthcare practitioner
 - Reference in popular culture- tv, movies, etc.
 - Discussion in a classroom setting
 - Conversation with friends/family
 - Prescription drug advertisements (i.e. Prozac, Sarafem, etc.)
 - I know someone who has been diagnosed
 - Other (please specify)
7. Building off of your response to question #6, do you remember particular details of the moment(s) that you became aware of anxiety disorder(s)? (i.e. There is a character in one of my favorite movies that has been diagnosed with anxiety; we talked about it in my Abnormal Psychology class, etc.) Provide as much detail as possible.
8. In your own words, how would you define anxiety disorder(s)?
9. What do you think causes anxiety disorder(s)? Please include all factors you think play a role, ranking their importance starting with 1 as the most important factor.
 - Biological/Genetic Factors
 - Social/Cultural Factors
 - Other (Please specify in comment field below)
10. What do you think the most effective form of treatment for an anxiety disorder is?
 - Psychological counseling
 - Prescription drugs
 - Don't know
 - Other (please specify)
11. Why do you think this form of treatment is most effective?
12. Do you think women or men are more likely to be diagnosed with an anxiety disorder?
 - Women
 - Men
 - Equally Likely
13. Please explain your response.

14. Do you think women or men are more likely to seek medical and/or psychiatric help for anxiety issues?

- Women
- Men
- Equally Likely

15. Please explain your response.

16. What factors do you think lead individuals to seek treatment for anxiety disorders? Be as specific as possible.