Stressed Out: an Analysis of the Acceptance or Denial of the Dominant Anxiety Discourse

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Stressed Out:
An Analysis of the Acceptance or Denial of the
Dominant Anxiety Discourse

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Submitted to Professor David Karp
As partial fulfillment of a BA in Sociology with Honors
at Boston College

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Abstract

The purpose of this study is to examine the way(s) that people define and perceive anxiety in light of the dominant discourses about mental illness that permeate America today. Both mental health fields, such as psychology, as well as the pharmaceutical industry have supplied the mental illness discourse that is popular today in the US. Definitions of and treatments for mental illnesses have expanded rapidly over the past several decades. The result is a mental illness discourse that allows almost anyone to be defined as mentally ill and therefore also a candidate for medication. Additionally, this dangerous discourse has been both created and embraced by the people who ordinary Americans look to as authorities on mental illness – doctors and drug companies.

The research conducted in this study is intended to address two main questions: First, what are people’s ideas about anxiety? How do they define and identify it? People’s levels of awareness about the topic in general provide insight into the influence that dominant discourses have had (or not had) upon them. Second, do people’s ideas about anxiety mirror the dominant discourse that is presented by mental health fields and the pharmaceutical industry? If the language that people use and treatment options that people seek closely mirror the language and treatment options suggested in the dominant discourse, then mental health fields and the pharmaceutical industry are having a significant influence upon the ways Americans think about mental illness.
Introduction

The historical moment that we live in is often referred to as the age of anxiety. This is primarily because over the last couple of decades the prevalence of anxiety has significantly increased (Menninger, 1996, p. 41; White, 2000, p. 14). Such sudden increases in anxiety levels in the US population are cause for concern. Are people truly more anxious? What are the possible sources of this increased anxiety? How can we eliminate or reduce its prevalence? This statistic is also complicated by the fact that anxiety is an obscure concept and all people experience anxiety. I believe that the true cause for the rapidly increasing prevalence of anxiety in the US population is the expanding definition of anxiety itself as provided by the medical profession and pharmaceutical industry.

Anxiety is a particularly interesting label because people may label themselves as having anxiety, people may label others as having anxiety, and doctors and other professionals may label others as having anxiety. Since anxiety is a subjective concept and so many different people are involved in labeling themselves and/or others, actual diagnosis and treatment of anxiety become a problem. People, often individuals with no medical background, may misdiagnose themselves before even asking their doctors’ opinions and subsequently seek treatment. Additionally, doctors may misdiagnose people based upon the use of subjective and broad medical definitions of anxiety and subsequently treat them. There is no doubt that certain people have debilitating anxiety and are in need of therapy and pharmacological treatment, but the line between “normal” and “abnormal” anxiety is becoming increasingly blurry.
The medicalization of anxiety is partially responsible for this blurring. The medicalization of anxiety essentially involves making anxiety, which in and of itself is a normal part of human functioning, into a disease. As Linley and Joseph (2004) explained, “The socially constructed illness ideology and associated traditional psychiatric diagnostic schemes, [which are] socially constructed, have led to the proliferation of ‘mental illness’ and to the pathologization of human existence” (p. 327). The commonly accepted definitions of mental illnesses that mental health professionals use have all contributed to increasing diagnoses of mental disorders.

Additionally, drug companies, in an effort to maintain increasing profits over the last few decades, have further encouraged the medicalization of anxiety and an expansion of its definition. It is in the interest of drug companies that large numbers of people are diagnosed with diseases. This provides them with the opportunity to sell increasingly large quantities and varieties of products, as more people are diagnosed with a variety of diseases and find themselves in need of medication. These people believe they need medication because mental illness has been medicalized and therefore is treated with medicine like any purely physical disease would be. Essentially, the medicalization of anxiety and mental illness in general makes it possible for drug companies to, in the eyes of doctors and patients, “legitimately” treat mental illness with their products.

The influence of the medical industry and pharmaceutical companies combined is immense. My research examines these social structures and their relationship to people’s definitions of anxiety. My goal is to understand the ways that people label themselves as having anxiety, how they define anxiety, and how they reach such definitions. On a small scale, my research conveys interesting personal accounts of the ways people answer these
questions, including specific definitions of anxiety, where they came from, and how they relate to one’s personal experiences. On a larger scale, my research explains people’s definitions of anxiety in terms of the social structures that shape them, including the medical and pharmaceutical industries.
The topic of anxiety is something with which I have a lot of experience. I have
had anxiety my entire life. It has typically manifested itself in the form of compulsions
and minor panic attacks. For a long time, I never even considered it to be a hindrance. It
made me detail-oriented, organized, and generally successful. However, during my
sophomore year of high school, at a time when I (like many girls my age) was struggling
to navigate the uncertain world of adolescence while constantly arguing with my parents,
my anxiety became a problem. I experienced uncontrollable panic attacks and regularly
had other physical symptoms of irrational and unpredictable anxiety.

Right around this time, I began seeing a therapist. I continued to attend weekly
sessions with her for the next three years until I left for Boston College. Our discussions
helped me gain incredible insight into myself and the people around me. I gradually
sorted out the major problems in my life and, in the process, learned techniques for
dealing with stress and coping with my anxiety. My therapist was a licensed clinical
social worker (LCSW) and therefore not able to prescribe medication, but she always
encouraged me to try it. Eventually, I gave in and went to a psychiatrist who officially
diagnosed me with Obsessive Compulsive Disorder (OCD) and prescribed me Lexapro. I
took it for a total of one year and, although I never got up to the dosage levels that my
psychiatrist wanted me to, I still found it helpful. I ultimately decided to stop taking the
Lexapro because I started drinking in my senior year of high school and did not want to
mix prescription drugs and alcohol.

It has now been over four years since I was on Lexapro and over three years since
I last regularly saw my therapist. Although I am a person who has been clinically
diagnosed with an anxiety disorder, I consider myself to be a highly functioning and highly successful person. I still experience anxiety on a daily basis and all of my friends joke with me about the effects of my OCD, such as my immaculately organized bedroom and symmetrical organization of place settings at the dinner table. However, I almost never feel that my anxiety is detrimental. It is this irony – my clinical diagnosis of OCD combined with the fact that I almost never feel that it is harmful – that first led me to my current research focus.

After additional consideration, I have realized that my research topic is also relevant to many other individuals. On a micro level, I expect that many people will be interested in my research because of the increasing prevalence of anxiety and mental illness, which I briefly discussed. Larger numbers of people have been labeled by themselves or others as having anxiety and therefore will hopefully be interested in my research. For these people, “mental illness continues to cast a daunting shadow on the[ir] well-being” (Synder and Lopez, 2002, p. 46). I hope that this research helps individuals reflect upon their own definitions of anxiety so that they are able to alter them if they are detrimental and/or counterproductive.

On a macro level, I expect that my research will help people to understand how social structures shape societal ideas and behaviors in concrete ways. After all, the “constructions of psychological wellness and illness… are social constructions grounded in values, not science” (Linley and Joseph, 2004, p. 321). Understanding these social structures provides insight into the workings of US society as a whole, including its strengths and weaknesses. As I already discussed, the social structures that my research
focuses on are the medical industry’s medicalization of anxiety and drug companies’ expansion of the definition of anxiety for profit.

The medicalization of anxiety has dangerous consequences that people need to be aware of. It turns normal people into victims and labels healthy people as sick. This is because “there is great uncertainty about where to draw the line that separates the healthy from the sick” (Moynihan and Cassels, 2005, p. xiii) as the result of the “expanding number of psychiatric diagnoses [and each of their expanding definitions]” (Petersen, 2008, p. 99). Medical definitions of anxiety, by nature, depict patients as victims.

Additionally, the boundaries separating people with illnesses from those without it are becoming increasingly blurry because medical definitions are unclear and have expanded over the years.

The pharmaceutical industry’s further expansion of the concept of anxiety is also important because it is responsible for the currently increasing number of prescriptions that patients are requesting and/or doctors are writing. This increase in prescription drug use affects everyone. Petersen (2008) stated, “Even those not taking medications could not escape their effects” (p. 258). For example, “Scientists have already discovered changes in the ecosystem that they believe may be caused by… pharmaceuticals flowing through the nation’s waters” (Petersen, 2008, p. 257).

Additionally, the increasing number of prescription medications that doctors prescribe influence health care and its costs for everyone living in the US. In 2008, Petersen predicted, “By 2015 Americans are expected to surrender one dollar of every five dollars they produce to the pharmaceutical industry and the rest of the nation’s medical system” (p. 317). That’s twenty percent! – And this statistic was produced before
Obama’s Health Care Reform plans, which have recently been passed into legislation. As increasing numbers of people begin to take prescription medications primarily as a result of drug companies’ promotional tactics, all of society pays (Petersen, 270). Widespread prescription drug use has an effect on the entire society in a variety of ways, not only on those people who elect to take prescription drugs.

For the people who are on prescription drugs, however, there are additional risks. Prescription drugs themselves are dangerous. Petersen (2008) claimed, “It can take a hundred years before all the risks of a medicine are known” (p. 320). This is evidenced by the “startling disclosures about the risks of heavily hyped medicines [that] have continued to come one after another” (Petersen, 2008, p. 321). Although the FDA is supposed to regulate the prescription drugs available in US markets, it is “understaffed, underfunded, and under pressure” and therefore is not effective (Abramson, 2005, p. 85). Addiction is an additional risk. It is a significant problem today, often among people who initially begin taking prescribed drugs in recommended dosages (Petersen, 2008, p. 263).

All of these important consequences of my research are discussed in more detail at the end of this paper. In order to fully understand my research and the ideas behind it, it is first necessary to examine the history of anxiety as a concept as well as a history of the drug industry and its influence. These subjects are the focus of the next section.
Literature Review

Anxiety as A Term

“Anxiety is a ubiquitous term. Coming to us from the Latin (anxietudo, anxiemtem, anxius) it has for centuries carried several meanings in colloquial English” (Pasnau, 1984, p. 81). Anxiety is a complicated topic because it encompasses a range of characteristics and levels of severity. Noyes and Hoehn-Saric (1998) explained, “Anxiety is a universal experience and, as such, is part of the human condition” (p. 1). Certain levels of anxiety are accepted as part of “a biological warning system” (Noyes and Hoehn-Saric, 1998, p. 1). However, other levels of anxiety may be considered unacceptable. Society often suggests that people who experience these levels of anxiety should seek medical treatment. Unfortunately, it is difficult to identify the people who may be at risk of developing unacceptable levels of anxiety because “It seems that biological predisposition varies from individual to individual but that practically anyone under the right conditions, can develop clinical anxiety” (White, 2000, p. 139).

In order to more clearly understand anxiety as a mental illness, many individuals and groups have attempted to define anxiety. Turner (1984) wrote generally, “Anxiety, defined in terms of behavior, is a set of responses involving some combination of cognitive and physiological reactions” (p. 53). A couple of years later, Gittleman (1986) cited a slightly more specific definition: “anxiety [is] ‘apprehension, tension or uneasiness that stems from the anticipation of danger whether internal or external… It may be focused on an object, situation or activity which is avoided or unfocused”’ (p. 73). In addition to these definitions, there are hundreds of others. Each has a slightly different focus, uses slightly different wording, and has varying levels of specificity.
The study of anxiety itself began hundreds of years ago. The beginnings of American exposure to the ideas and language of anxiety, however, began around the time of Freud in the late nineteenth century. Since then US understanding and study of anxiety has been influenced by several factors. For example, “Wars have contributed greatly to our knowledge of anxiety disorders” (Westenberg et al, 1996, p. 7). US interest in the study of anxiety has not always been strong, though. Westenberg (1996) explained, “The study of anxiety was not a high priority in the period from 1930 to 1960… This status quo gradually changed during the 1950s” (p. 14). After a decade or so of renewed focus, the topic of anxiety once again became a low priority. Finally, in the 1980s there was a new spark of “interest in pathological anxiety” (Pasnau, 1984, p. 171). At the time, “much confusion remain[ed] in both diagnosis and treatment. The epidemiology of the anxiety disorders [was] in a very rudimentary stage” (Pasnau, 1984, p. x).

Since then, US interest in anxiety as a disorder has continued to increase. Along with this increased interest and dialogue regarding anxiety have been claims of the increasing prevalence of anxiety. Pasnau (1984), who is a psychiatrist, wrote that anxiety is, “The most frequent, almost ubiquitous, clinical symptom I have encountered” (p. ix). Menninger (1996) claimed, “Anxiety disorder [is] the most common psychiatric illness in the United States” (p. ix). And yet, there is still not clear definition of anxiety. These men may be defining anxiety in very different ways. The following sections of my paper will explain the various ways that anxiety has been defined from the time of Freud up to the present. This explanation will not only outline the various ways of defining anxiety but also illuminate the ambiguities involved in studying, diagnosing, and treating anxiety. First, however, I will provide a lens through which the development of anxiety as a
concept may be viewed. This lens will be a common theme throughout the story that I will tell about anxiety in the US.

The Medicalization of Anxiety

The history and development of anxiety as a concept in the US reveals the medicalization of anxiety. Before explaining the development of anxiety, it is important to understand what is meant by the phrase medicalization of anxiety. The medicalization of anxiety is part of a larger trend of “The medicalisation of everyday life” (Gabe and Williams, 1986, p. 274). This refers to the ways that “mental health professionals have gradually pathologized almost every conceivable human problem in living” (Linley and Joseph, 2004, p. 327; Moynihan and Cassels, 2005, p. xvii and 133). Even the typical “ups and downs of daily life have become mental disorders [and] common complaints are transformed into frightening conditions” (Moynihan and Cassels, 2005, p. ix). This medicalization is characteristic not only of anxiety but of all areas of human life.

The Diagnostic and Statistical Manual of Mental Disorders (DSM), which the American Psychiatric Association first published in 1952, is the primary authority on mental disorders (Pasnau, 1984, p. 7). It provides a comprehensive list of mental illnesses, including definitions and symptoms. Since its initial publication, three revisions have been made and “each new edition of the DSM has included more and more new types of mental ‘illness’” (Compton, 2005, p. 176). Linley and Joseph (2004) concluded, “As the socially constructed boundaries of ‘mental disorder’ have expanded with each DSM revision, more relatively mundane human behaviors have become pathologized” (p. 327). Petersen (2008) even went so far as to claim, “the psychiatrists who wrote the DSM
are ‘making us all crazy’ by their continual expansion of behaviors they defined as psychiatric disorders” (p. 99).

Classification in the DSM typically involves “Terms such as symptom, disorder, pathology, illness, diagnosis, treatment, doctor, patient, clinic, clinical, and clinician” (Snyder and Lopez, 2002, p. 14). This language creates an illness ideology (Linley and Joseph, 2004, p. 321). Essentially, this means that the DSM “views psychological problems in the same way that medicine views disease” (Compton, 2005, p. 175). This disease model is the way that psychologists and other mental health professionals think about anxiety (Compton, 2005, p. 176).

Classifying anxiety as a disease has significant consequences (Linley and Joseph, 2004, p. 321). It means that minor problems are viewed as serious issues (Moynihan and Cassels, 2005, p. x). Rather than focusing on human strengths, the disease model “dictates that the focus of our attention should be disorder, dysfunction, and disease” (Linley and Joseph, 2004, p. 322). It “emphasizes abnormality over normality, poor adjustment over healthy adjustment, and sickness over health” (Linley and Joseph, 2004, p. 322). Additionally, it creates an expectation among mental health professionals that people who have anxiety disorders are helpless victims. This becomes a self-fulfilling prophecy and is detrimental to their clients.

So why is it, if this disease model is so narrow and damaging, that the model persists? Many people have offered suggestions regarding the origins and continued acceptance of the disease model and they usually all have a common theme – money. As Moynihan and Cassels (2005) explained, “there’s a lot of money to be made telling healthy people they’re sick” (p. x). If more people can be diagnosed with diseases,
doctors have more patients and make more money. This is perfectly captured in the term “disease mongering” [which occurs when] doctors… unnecessarily widen the boundaries of illness in order to see more patients” (Moynihan and Cassels, 2005, p. xvii).

Unfortunately, while doctors and drug companies may be benefitting, the general public is being brainwashed by the idea that mental illnesses are diseases.

People often do not even question this model because it is one explained to them by doctors. If people cannot trust their doctors to tell them what’s wrong with them, who can they trust? Some people, however, are frustrated and insisting upon change. Several people believe that “the illness ideology has outlived its usefulness for clinical psychology” (Linley and Joseph, 2004, p. 322). They are insisting upon a new model, claiming, “it is time for a change in the way that clinical psychology views itself” (Linley and Joseph, 2004, p. 322). Hopefully, with increasing awareness and critiques of the medicalization of anxiety, such a change will begin to occur. In the following sections, I will explain the development of the concept, definitions, diagnoses, and treatments of anxiety. This will make clearer the medicalization of anxiety and the ways that it took place in the US.

**Definitions of Anxiety**

**FREUD’S CONTRIBUTION**

Freud’s ideas about anxiety were the first that significantly influenced and interested people in the US. He brought both the concept and the language of anxiety to the American people. He observed certain, “manifestations of anxiety; and for this reason [he gave] to this complex… the name of ‘anxiety neurosis’” (Breuer and Freud, 1957, p.
Freud studied anxiety extensively. In the early years of his study, he claimed, “it arises from an accumulation of physical tension, which is itself... of sexual origin” (Breuer and Freud, 1957, p. 258). For Freud, “Anxiety resulted when the sexual drive could not be discharged in normal sexual activity” (Pasnau, 1984, p. 126). For many years, Freud explained anxiety in terms of sexual energies and dysfunctions.

However, he later amended his explanation of anxiety and disregarded his original sexual explanation for one that better aligned with his research findings. According to Gittlemen (1986), “In 1926/1959 Freud significantly revised his theory of anxiety... and dropped the concept of anxiety as transformed libido. Instead, he argued that anxiety is the response of the ego to the threat of helplessness” (p. 171; Noyes and Hoehn-Saric, 1998, p. 4). Pasnau (1984) elaborated, “Anxiety, in his view, is an internal signal anticipating... danger, experienced as an unpleasant sense of foreboding alerting the person to defend against or avoid it” (p. 34). Specifically, Freud believed that anxiety was the ego response to a threat perceived *internally* (Westenberg et al, 1996, p. 8-9).

Interestingly, Freud’s initial and final explanations of anxiety offer a “chemical explanation” and “psychological explanation” of anxiety, respectively (Breuer and Freud, 1957, xxiv). Theses two ways of framing the topic of anxiety are still used in America today.

THE BEGINNINGS OF THE DSM

However, much of Freud’s ideas about anxiety have not endured. Over the years, as definitions of anxiety have changed, Freud’s definitions have become much less generally accepted. In fact, “The science of mental illness diagnosis and its treatment has taken shape [primarily] over the last half of the 20th century” (Snyder and Lopez, 2002, p.
In the early 1950s, the American Psychiatric Association compiled its first *Diagnostic and Statistical Manual of Mental Disorders (DSM-I)*. This manual outlines a variety of mental illnesses, including anxiety. Its goal has been, “throughout its various editions… to systematically improve precision and expansion of the various classification categories [of anxiety]” (White, 2000, p. 24). Before the *DSM-I* came out, “a rather simple, psychoanalytically oriented diagnostic schema was generally accepted by most practicing psychiatrists” (Pasnau, 1984, p. 7). Each revision of the *DSM* has significantly influenced and complicated this initial definition.

*DSM-I* (1952)

The “adaption of the first edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-I)* [was] in 1952” (Pasnau, 1984, p. 7). Before the *DSM-I* was written, anxiety was typically referred to as a “neurosis.” *DSM-I*, “adopted the terminology of ‘reaction’… [and] anxiety neurosis became anxiety reaction” (Pasnau, 1984, p. 8). *DSM-I* framed the concept of anxiety in slightly different words and therefore influenced the ways people, specifically mental health professionals, understood anxiety. Most people perceived this influence as positive because the *DSM*, “allows clinicians and researchers a common language for communication” (White, 2000, 24-25). Additionally, “*DSM-I* made an important contribution to the United States and world psychiatry… [because] no other country had provided itself with an equivalent official manual of improved diagnostic terms” (Pasnau, 1984, p. 9).

*DSM-II* (1968)

Less than two decades later, the American Psychiatric Association released a second version of the *DSM*, which redefined anxiety and its subcategories. The “*DSM-II*
relied heavily on the concept of neurosis” (Pasnau, 1984, p. 9). Essentially, it reverted back to the language used pre-DSM-I but with more specific definitions and diagnostic categories. “DSM-II described ten neuroses” (Pasnau, 1984, p. 10). Additionally, it “avoided terms which carried with them implications regarding either the nature of the disorder or its causes, but was explicit about causal assumptions when they were integral to a diagnostic concept” (Pasnau, 1984, p. 9). Ultimately, “the rapid integration of psychiatry with the rest of medicine was enhanced by DSM-II, using terminology and classifications closely integrated with those of other medical specialties” (Pasnau, 1984, p. 9).


Less than fifteen years later, the American Psychiatric Association released yet another version of the DSM. The “DSM-III contains 208 classifications of which 54 involve anxiety or fear in some way” (Turner, 1984, p.2) and “represents a genuine departure from older taxonomy” (Pasnau, 1984, p. 10). For the DSM-III, “The major underlying unifying concept is that of psychiatric disorder” (Pasnau, 1984, p. 10). Anxiety, as well as the other mental illnesses categorized in DSM-III, is seen as a disorder.

Anxiety disorders are separated into “two major categories: phobic disorders and anxiety states” (Pasnau, 1984 p. 10). Each of the types of anxiety disorders that DSM-III defines falls into one of these two categories. “Phobic disorders are defined as having the essential feature of persistent and irrational fear of a specific object, activity, or situation that results in a compelling desire to avoid the dreaded object, activity, or situation” (Pasnau, 1984, p. 11). These include agoraphobia, social phobia, and simple phobia.
“Anxiety states are divided… into four basic categories” (Pasnau, 1984, p. 13). They include panic disorder, generalized anxiety disorder, obsessive-compulsive disorder, and posttraumatic stress disorder.

The definitions and language used in explaining anxiety has changed little since 1980 when the first edition of the *DSM-III* was written. The *DSM-IV*, which was first released in 1994, involves minimal refinements of the concept of anxiety. It maintains the language of “disorder” and outlines the same seven types of anxiety disorders as well as the same criteria for diagnosing each of them. For the first time in the history of anxiety in the United States, the definition and categories of anxiety have been fairly consistent for almost thirty years.

**The Tripartite Model of Anxiety**

Over the years, as definitions of anxiety have changed various researchers have attempted to conceptualize models to explain these definitions. Based upon the current definition of anxiety as a disorder, psychiatrists have developed a “tripartite model… [which] has been the dominant conceptualization for… 30 years. In this model… anxiety is conceptualized as consisting of three components: physiological [i.e. physical] responses,… a cognitive dimension, and behavioral responses” (Beidel and Turner, 2005, 18). This model helps to explain both the causes of anxiety as well as the manifestation of its symptoms. Each of these dimensions involves separate explanations for anxiety and yet these dimensions are also interrelated and as a whole help to better explain anxiety than any one individual dimension.
The cognitive aspect of anxiety involves a mental awareness of danger. It causes “attention to shift to possible signs of danger” (Mattis and Ollendick, 2002, p. 12). Everyone continually and subconsciously (sometimes consciously) perceives possible threats. This is a natural human instinct that is necessary in order for people to survive. For many people, this produces healthy levels of anxiety at times when some anxiety may be necessary. However, for others this cognitive reaction may cause severe and unnecessary anxiety. They may either perceive a threat when it does not actually exist or perceive a more severe threat than the one that exists and therefore experience unnecessarily high levels of anxiety. In either case, the person’s cognitive response can cause significant levels of anxiety in even the least threatening situations.

The physical aspect of anxiety also involves a natural reaction and may either cause healthy levels of anxiety or unnecessarily high levels of anxiety. Mattis and Ollendick explained, “The physical component of anxiety is rooted in the fight/flight response, an automatic reaction to danger or threats” (2002, p. 10). Every human being has this automatic response in particular situations. This response then, “produces several physical sensations throughout the body. These sensations help prepare the body for action in a dangerous situation” (Mattis and Ollendick, 2002, p. 11). People who have anxiety often experience physical symptoms during anxiety attacks. This anxiety, however, may not always be reasonable. Physical symptoms, “are often experienced as a panic attack when no real danger is present” (Mattis and Ollendick, 2002, p. 11).

Finally, anxiety involves a behavioral response. Behavioral responses are caused by cognitive responses to anxiety, some of which are learned. Behavioral theories “seek to explain anxiety as an event or set of events” (Turner, 1984, p. 16). Famous behavioral
Theorist Ivan Pavlov’s ideas have been particularly influential in understanding behavioral responses related to anxiety. “Pavlov (1960) saw anxiety as a conditioned response, the consequence of pairing a previously neutral stimulus with an aversive one” (Noyes and Hoehn-Saric, 1998, p. 5). Essentially, Pavlov explained anxiety as a behavioral reaction to stimuli that consistently warranted fear. This behavioral reaction often involves “Escape and avoidance… [because] they [both] have the immediate, short-term effect of reducing fear and anxiety” (Mattis and Ollendick, 2002, p. 13). Essentially, in response to a situation that seems consistently dangerous people exhibit certain behaviors in order to reduce or eliminate such danger.

**Diagnosing Anxiety**

Psychiatrists use the *DSM* definition of anxiety and the tripartite model to properly diagnose and treat anxiety. Diagnosing clinical anxiety is not a simple task. Psychiatrists may choose from a variety of methods, none of which are completely objective or foolproof. Often, psychiatrists begin with a “preliminary screening” (Turner, 1984, p. 76). This involves obtaining basic information about the person, their history, and their experiences. This is necessary partially because “Developmental and familial factors may be very important in the diagnosis of anxiety disorders” (Pasnau, 1984, p. 6). Psychiatrists then employ more specific measures, including self-report scales or self-monitoring, behavioral assessments, and/or physiological assessments (Turner, 1984, p. 252-256). Additionally, psychiatrists may “evaluate the severity of anxiety experienced by examining time and magnitude information” (Turner, 1984, p. 283).
Self-reports and self-monitoring measurement techniques are one of the most popular methods of diagnosing anxiety. Turner (1984) claimed, “Self-report inventories and rating scales are among the most widely employed assessment strategies” (p. 58). Although he was writing several years ago, his statement is still true today. Self-reports and self-monitoring techniques are just as their names imply – they are based upon a subject’s personal assessment of himself. However, the two techniques do differ slightly: “Self-monitoring is the ongoing observation of one’s own behavior” (Turner, 1984, p. 60). Self-monitoring often involves keeping a record of one’s behaviors, thoughts, etc. for a period of time. Self-reports, on the other hand, involve “Anxiety scales and inventories… [which] ask subjects how they typically feel and/or how they typically respond in a variety of situations” (Turner, 1984, p. 61). Both measures, while widely used, are also highly subjective and colored by the subject’s own biases.

Behavioral assessments are another technique that psychiatrists may use to measure anxiety. Gittleman (1986) explained, “Behavioral methods of assessment… [put] emphasis on recording behavior as actually observed… [and] attempt… to define immediately antecedent and consequence” (p. 90). They are often used in conjunction with other measurement techniques and involve “direct observation of overt behavior as it occurs in the natural [or unnatural] environment” (Turner, 1984, p. 64). Although measurement in one’s natural environment is most valid, it is also “inconvenient, inexpensive, and time-consuming” (Turner, 1984, p. 64) and therefore not often done. Behavioral avoidance tests are one example of a commonly used behavioral assessment. They involve exposing the subject to an object or situation that they are particularly fearful of and measuring the proximity of the person to the object or the amount of the
time the person was able to endure the situation (Turner, 1984, p. 67). Once again, such tests are certainly helpful but still involve significant ambiguities.

Finally, psychiatrists often measure anxiety levels based upon physiological observations. Anxiety can involve a variety of physical symptoms. Psychiatrists attempt to “measure several physiological responses. [Then the] measurements of different responses [are] combined in a summary score for each individual” (Turner, 1984, p. 71). These physiological symptoms may be based upon observation or self-reports. While it is fairly simple to detect the presence of certain physiological symptoms, it is much more difficult to measure their severity. It is also possible that such symptoms may occur as the result of variables other than anxiety.

Ultimately, the diagnostic assessments designed to test anxiety levels are inadequate. This explains why “Anxiety disorders are among those psychiatric syndromes with the lowest diagnostic agreement” (Menninger, 1996, p. 40). There is simply not enough research and widespread discussion about the development of universally acceptable diagnostic criteria for anxiety disorders. Turner (1984) pointed to the, “absence of large scale epidemiological studies of the anxiety disorders based on uniform diagnostic criteria… [as a cause for] prevent[ing] accurate determination of the prevalence and incidence of [anxiety]” (p. 249). *DSM-IV* contains the most widely accepted diagnostic criteria for anxiety and is therefore what many diagnostic assessments are based upon. However, its categories sometime overlap and are overly complex and unclear (White, 2000, p. 34). Additionally, they “neglect the individuality of those given the same diagnosis [of anxiety]” (White, 2000, p. 34).
Difficulties in Diagnosing Anxiety

Clearly the diagnosis of anxiety is both difficult and complex. Even when psychiatrists use the most popularly accepted methods of assessment, it is possible for them to misdiagnose a patient. In addition to ambiguities and shortcomings of the assessment techniques, diagnosis is also difficult because of characteristics inherent of anxiety itself. One of the primary reasons anxiety is difficult to diagnose is because of its “heterogeneous quality” (Pasnau, 1984, p. ix). There is no single definition, picture, or list of symptoms that can describe every single person with clinical anxiety: “anxious patients differ in their… symptoms and signs” (Pasnau, 1984, p. 35). This makes it difficult to ever fully conceptualize clinical anxiety and even more difficult to diagnose.

Anxiety is also often closely connected with other mental disorders. Pasnau (1984) pointed out, “the complexity of [anxiety in] clinical situations, the often overlapping nature of [its] symptoms… and the problems in treatment” (p. 27). Anxiety and depression are particularly likely to coexist (Turner, 1984, p. 192; Menninger, 1996, p. 73). In fact, “from Antiquity to the middle of the nineteenth century medicine did not [even] recognize the need for systematic distinction between anxiety and depression” (Westenberg et al, 1996, p. 4).

In addition to its coexistence with mental disorders, anxiety is also a symptom of other mental disorders. Pasnau (1984) recognized, “A major difficulty in diagnosing anxiety disorders is that anxiety can occur as a symptom in most psychiatric disorders” (p. 17). People who are diagnosed with mental disorders other than anxiety are likely to have increased levels of anxiety and therefore experience symptoms typically associated with anxiety. In addition, people with physical illnesses are also more likely to
experience anxiety: “Anxiety is present… in [both] psychiatric and physical illnesses” (Pasnau, 1984, p. 27).

Finally, anxiety is difficult to identify because it is closely related to addiction. This is true for two reasons: First, many “individuals… self-medicate for the treatment of anxiety” (Pasnau, 1984, p. 18). Second, “Most alcohol users [and other addicts] tend to have a significant amount of… anxiety” (Pasnau, 1984, p. 18). This makes it difficult to determine whether the person’s primary problem is that of addiction or anxiety. Such a determination cannot be made objectively. Ultimately, while measures of anxiety may provide insight into a subject’s levels of anxiety, it is nearly impossible to definitively diagnose a person’s level of anxiety and need for treatment.

**Treating Anxiety**

Despite the aforementioned difficulties in diagnosing clinical anxiety, hundreds of people are currently being diagnosed and treated for anxiety every day. Beidel and Turner even (2005) asserted, “Diagnostic assessments, self-report measures, and self-monitoring data all may assist in… suggesting the appropriate intervention strategy” (p. 184). Nevertheless, the accuracy of diagnostic assessments in selecting treatment plans is questionable and psychiatrists certainly rely on such assessments to develop their treatment approaches with individual patients. There are numerous approaches that may be selected for treating a patient with anxiety disorder. However, the most common forms of treatment fall into one of two broad categories—psychological treatments and pharmacological treatments (Noyes and Hoehn-Saric, 1998).
Psychological treatments involve various types of psychotherapy, including psychoanalysis and behavioral therapy. It may take place in a number of settings including individual therapy sessions as well as group therapy sessions (White, 2000, p. 47). Depending upon an individual’s specific type of anxiety disorder, different approaches may be used. In the mid-1970s, “systematic [treatment] programs were developed for specific disorders” (Pasnau, 1984, p. 199). Therefore the selection of a psychological treatment method is often directly related to an individual’s diagnosis.

Psychoanalysis, a common psychological treatment method, involves mental and emotional reflection upon one’s own thoughts. Examples of psychoanalysis include thought-stopping and cognitive restructuring. Thought stopping involves, “preventing thoughts from occurring [as] a learned response” (Turner, 1984, p. 303). Cognitive restructuring is, “aim[ed] at… altering the undesirable thoughts themselves, instead of stifling or blocking them out” (Turner, 1984, p. 304). Each of these specific treatment approaches involves a psychological reorientation of one’s thoughts and therefore influences one’s level of anxiety.

Behavioral therapy is a second commonly practiced psychological treatment method. One of its most popular applications is somatic-behavioral therapy, which focuses on physical exposure to objects or situations that a subject is fearful of. It involves “arranging contact with fear-eliciting stimuli in real-life situations” (Turner, 1984, p. 160). Such exposure is intended to encourage the subject to “adopt… coping behaviors that will allow the anxiety experience to be eliminated” (Turner, 1984, p. 296). This method is commonly used with people who have phobic disorders. They are “expos[ed] to the phobic stimulus” (Pasnau, 1984, p. 167) in order to lessen their fear of
it. Additional applications of somatic behavioral therapy exist, but this is by far the most common.

In addition to psychological treatments, people with clinical anxiety are also typically treated pharmacologically. Drug treatments are often difficult to properly implement because people respond differently to drugs and experience different side effects. It is also true that “drugs with many different pharmacological actions lower anxiety levels” (Pasnau, 1984, p. 57). Drugs ranging from antidepressants to tranquilizers have been used in the treatment of anxiety (Pasnau, 1984, p. 4). With the wide range of drugs to select as a treatment option, it is difficult to consistently select the correct one. Additionally, there is an issue with dependence. Should people be taking medications their entire lives or only for a period of time? Pasnau (1984) found that “Many [people] suffer relapses after the medication treatment is stopped” (p. 169). The topic of pharmacological treatment is ultimately a complicated and controversial topic but remains one of the primarily methods of treating anxiety disorders today.

The History of Drugs in the US

In order to properly understand pharmacological treatment and the issues surrounding it, we must first examine its beginnings and understand how it came to be such a prevalent treatment method for anxiety. Drug treatments for mental disorders are a relatively new phenomenon. They first appeared at “The beginning of the twentieth century, [which] witnessed the rapid development of ‘mood-altering’ chemicals” (Gabe and Williams, 1986, p. 4). Throughout the next several decades, a variety of drugs gained popularity for a short time until the next blockbuster drug hit the market. These drugs
included opium and bromides in the early 1900s, barbiturates in the 1930s, meprobamate in the 1950s, and benzodiazepines like Valium in the 1960s (Gabe and Williams, 1986, p. 4).

Valium was a particularly influential drug. It first became popular as a treatment for depression among housewives who felt stressed, underappreciated, and generally dissatisfied with their lives. Essentially it helped keep these women complacent. Gabe and Williams (1986) discovered, “many of the [women they studied] saw tranquillising drugs as helping to maintain them in the traditional female role of wife and homemaker” (p. 231). Soon after tranquilizers became popular among women, men began to take them as well. Men typically reported needing drugs like Valium in order to deal with “work stress or new strains brought on by a change in jobs” (Gabe and Williams, 1986, p. 237). The men taking these drugs often struggled to cope with societal expectations of males as “men of the house” who provide for their families.

Although other blockbuster drugs have since replaced Valium to some extent, it remains the most influential drug in the advancement of the pharmacological treatment of mental disorders. Ever since the renewed interest in anxiety in the 1980s, pharmacological treatments for clinical anxiety have been common. In fact, “Drug consumption is continually increasing in Western countries” (Gabe and Williams, 1986, p. 78). Even by the mid-1980s it was clear that drug prevalence and prescriptions were on the rise. This may be partially because drug companies were continuously creating new products: “The popularity of drugs is often short: the average market life of a drug – from its time of introduction to its withdrawal from the market – is only five years… in the USA” (Gabe and Williams, 1986, p. 79).
If these drugs were so effective, then why would drug companies be creating new ones every five years on average? And if these drugs are so new and their efficacy has yet to be proven, why are people in the US increasingly taking them? Exactly how effective are these drugs at relieving anxiety and how necessary are they? Gabe and Williams suggested, “in order to understand the function served by these drugs it is necessary to look beyond the medical model of disease to the structural factors creating the stresses which bring many to the attention of the health care system” (p. 240). The following sections will outline the health care system, specifically drug companies and their interactions with doctors and consumers, in order to examine its influence on the notion of anxiety.

**The Development of the Pharmaceutical Industry**

Drug manufacturing is a relatively new industry. Drug companies only “began to emerge as a major industry” in the 1930s (Pharmaceutical Manufacturer’s Association, 1980, ch. 2). Soon after the industry’s rise, “a comparatively small number of firms of comparable size [gained] control of a relatively significant output of the total market” (Pradhan, 1983, p. 250). The pharmaceutical market really began booming in the 1980s and 1990s (Moss, 2007, p. 135). Drug companies focused on blockbuster products, which would become extremely popular and deliver monumental profits (Moss, 2007, p. 11). However, towards the end of the 1990s and the beginning of the twenty-first century, “As companies have merged, blockbusters have had to get bigger just to deliver historical rates of sales growth” (Moss, 2007, p. 11).
Additionally, “Health care reform, political pressure on prices, fewer new products entrants, and other factors have conspired to reduce margins” (Smith, 1996, p. 77). The combination of these factors as well as the legalization of direct-to-consumer advertising in 1997 (Moss, 2007, p. 115) has caused the pharmaceutical industry’s consumer to “change dramatically” (Smith, 1996, p. 70). The “shift in the locus of product selection from individual physicians to managed-care organizations” has forced drug companies to target “not only… physicians but also… consumers, hospitals, and increasingly, third-party payers” (Schweitzer, 1997, p. 45). At the same time, “control over clinical research changed” (Abramson, 2005, p. 95). Many research organizations became privately funded and independent. This has allowed the wealthy pharmaceutical industry to have a great deal of influence over what gets studied as well as what studies are released for publication.

Drug companies find that it is well worth their money to fund US research that benefits their own products because the US pharmaceutical industry is extremely lucrative. In fact, the US is “the epicenter of… selling” for drug companies (Moynihan and Cassels, 2005, p. x). In 2005 Moynihan and Cassells asserted, “With less than 5 percent of the world’s population, the U.S. already makes up almost 50 percent of the global market in prescription drugs” (p. xi). Petersen (2008) identified pharmaceuticals as “America’s most powerful industry” (p. 5). In fact, even during a recession the drug companies continue to increase profits while other Fortune 500 companies’ profits fall (Geyman, 2004, p. 78). Abramson (2005) estimated that “the pharmaceutical industry [has] profits [of] more than three times the average of other Fortune 500 industries” (p. xvii). Unfortunately, the pharmaceutical industry’s profit motives often manifest
themselves in dangerous ways. The following section reveals how drug companies have significantly influenced the US understanding of mental disorders for their own benefit.

**The Pharmaceutical Industry’s Focus on Profits**

Pharmaceuticals are “an odd business [because] disease mean[s] money. Suffering brings profit” (Petersen, 2008, p. 17). For this reason, the medicalization of mental illness actually benefits drug companies by providing them with new markets for their products. In fact, along with the medical profession, drug companies have been accused of “fostering the creation’ of medical disorders” (Moynihan and Cassels, 2005, p. xi) and “mak[ing] ‘natural processes’ into medical conditions” (Moynihan and Cassels, 2005, p. xii). The more disorders that the drug companies create and expand, the more products they are able to sell. Anxiety is specifically vulnerable to this “condition branding [because since] mental disorders are rarely based on measurable physical symptoms… they are ‘open to conceptual definition’” (Petersen, 2008, p. 22).

This does not mean that the concept of anxiety as a mental disorder is purely a creation of the pharmaceutical industry. As I explained, the medical industry has had a great deal of influence upon the definitions, diagnoses, and treatments of anxiety, particularly in its earlier stages. Around the early 1980s, when blockbuster drugs became more difficult to produce and profit margins slipped as a result of political change and regulation, the pharmaceutical industry began to mold the concept of anxiety through the media and pharmaceutical research. This significantly influenced the perception of anxiety for both the medical industry as well as consumers.
Drug companies may use a variety of methods to influence perceptions of anxiety. In fact, “Most of the information available... about the diagnosis and treatment of common medical problems comes from the drug... companies themselves” (Abramson, 2005, p. 149). Often, “With a little help from a headline-hungry media, the latest condition is... portrayed as widespread, severe and, above all, treatable with drugs” (Moynihan and Cassels, 2005, p. xiv). Typically such headlines “market fear” in order to reach individual consumers (Moynihan and Cassels, 2005, p. xv). Additionally, drug companies have, “assumed an ever-larger role in funding clinical trials” (Abramson, 2005, p. 95). These trials as well as other articles influenced by drug companies are often a major source of information for medical health professionals.

Drug companies spend ridiculous amounts of money in order to reach these mental health professionals and individual consumers because their primary goal is to maximize profits. In fact, in explaining drug companies’ marketing techniques, Keller and Smith (1969) suggested that the primary goal was to “earn profits” (p. 44). This is particularly dangerous today when the marketing of drug companies is more disguised and pervasive than ever. Their ultimate goal is “to expand markets for drugs” (Moynihan and Cassels, 2005, p. xvi). Pharmaceutical companies cannot remain competitive without an ever-expanding market for medication. Moynihan and Cassels (2005) explained, “the ability to ‘create new disease markets’ is bringing untold billions in soaring drug sales” (p. xii).

If the drug companies are purely for profit companies, however, should they really be allowed to have such a strong influence over sources of information for mental health professionals? These are the people who are supposed to be the authorities of
illness and its treatments and yet their ideas and learning are strongly impacted by drug company propaganda. Should drug companies be allowed to use fear-tactics to convince consumers that they have an anxiety disorder and are in need of medication?

Pathak, Escovitz, and Kucukarslan (1992) suggested that the primary objective of information produced by pharmaceutical companies is “to inform” (p. 1). Keller and Smith (1969) wrote that the goal of the pharmaceutical industry should be “to speed the progress of medicine” (p. 20). However, these idealistic and elevated goals hardly describe the actual functions of drug companies today. In order to more fully understand drug companies and their actual influence on the medical community and consumers, we must examine the effectiveness of their advertising techniques. The following section will provide a brief overview of these techniques including their cost, their specific goals and the information they convey.

**Marketing and Advertising in the Pharmaceutical Industry**

Drug companies devote a great deal of resources to promoting their products. They “spend… exorbitant amounts on market research and advertising” (Dorgan, 2006, p. 108). In fact, they even spend more money promoting their products than they do developing them. Currently, “marketing expenditures by drug companies far exceed their R&D [research and development] expenditures” (Geyman, 2004, p. 84). Angell (2000) agrees, “The marketing budgets of the drug industry are enormous — much larger than the research and development costs” (p. 1902). The following graph shows the amount of money top pharmaceutical firms spent on marketing (the top bar) versus research and development (the bottom bar) for the year 2001:
This money is spent in a variety of ways. It supports immense staffs: “A report released in December 2001 found that brand-name drug makers in the U.S. employ 81 percent more people in marketing than in research” (Mahan, 2002, p. 13). Additionally, drug companies pay to have their advertisements in various media. They also fund a significant amount of research. For this reason, “medical knowledge grows in the
direction that maximizes corporate profits” (Abramson, 2005, p. 96). Essentially, “The drug companies’ funding buys them the right to set the research agenda” (Abramson, 2005, p. 96).

Despite assertions about pharmaceutical marketing and advertising spending, exact dollar amounts relating to such expenditures are difficult to obtain. This is “in part because marketing and administrative expenses are often folded together and in part because some of the research and development budget is for marketing research” (Angell, 2000, p. 1902). Nevertheless, it is clear that expenditures are high and consistently increasing. Mahan (2002) found, “marketing staffs increased by 59 percent between 1995 and 2000, while research staffs declined by 2 percent” (p. 13). The following chart shows how rapidly marketing and advertising expenses grew between 1996 and 2000:

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<tbody>
<tr>
<td>Total promotional spending</td>
<td>9,200</td>
<td>11,000</td>
<td>12,500</td>
<td>13,900</td>
<td>15,700</td>
</tr>
<tr>
<td>on prescription drugs</td>
<td></td>
<td></td>
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<tr>
<td>Total direct-to-consumer</td>
<td>791</td>
<td>1,065</td>
<td>1,317</td>
<td>1,848</td>
<td>2,467</td>
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<td>advertising</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Number of marketing staff</td>
<td>60,539</td>
<td>67,392</td>
<td>71,374</td>
<td>81,296</td>
<td>87,810</td>
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The money drug companies spend on marketing and advertising is aimed at promoting the “effective communication of information designed to encourage the purchase of merchandise” (Keller and Smith, 1969, p. 132). Pharmaceutical companies
accomplish this in a variety of ways. To increase sales in general, each company tries to establish a “brand [that] has an existence in both doctors’ and patients’ minds, which goes beyond the product itself” (Moss, 2007, p. 14). In addition, to increase sales of specific products, drug companies follow the “maxim ‘prepare the product, prepare the company, and prepare the market’” (Moss, 2007, p. 67). Preparing the product and the company are primarily internal tasks. However, preparing the market is where promotion becomes essential.

Pharmaceutical companies prepare the market by gaining the support of doctors and consumers. Schweitzer (1997) agreed that one of the main “purpose[s] of advertising is to affect doctors’ prescribing habits” (p. 46). In fact, “ImpactRx, a Mount Laurel, New Jersey, firm that surveys the marketing of pharmaceutical products, estimates that $30 billion is spent annually by the pharmaceutical manufacturers on influencing physicians to prescribe certain drugs” (Hemphill, 2006, p. 325). This spending to advertise specifically to physicians has been increasing in recent years: “pharmaceutical manufacturers increased spending on marketing to physicians by 74 percent between 1997 and 2001” (Hemphill, 2006, p. 325). In addition, “to fully implement direct-to-physician marketing activities, the pharmaceutical industry employed 87,892 sales representatives in 2001, an increase of 110 percent from the 41,855 employed in 1996” (Hemphill, 2006, p. 325).

Many drug companies also advertise more specifically to hospital physicians in training because they often “establish prescribing patterns… that are then transferred to the community when th[e] physician completes his… residency” (Smith, 1996, p. 123). Currently, pharmaceutical companies persist in their attempts to influence doctors. In fact

The most popular way pharmaceutical companies attempt to reach physicians, however, is to provide them with gifts. Hemphill (2006) explained, “In recent years, intense pharmaceutical industry competition has prompted questions about the propriety of… gifts, and inevitably, about conflicts of interest” (p. 325). He referred specifically to “lavish gifts to physicians, ranging from frequent flyer miles to cash and trips to luxury resorts” (p. 325). Zuger (2004) additionally mentions, “the free pens and flashlights, the free lunches, the expensive dinners, [and] the occasional all-expense-paid jaunt to a balmy resort to participate in a focus group.” It is clear that pharmaceutical companies provide doctors with a variety of financial incentives to prescribe specific drugs. (In the early 1990s the American Medical Association did attempt to establish ethical guidelines for such practices, but they are often unenforced (Hemphill, 2006, p. 325).)

The pharmaceutical industry also recently began promoting its products directly to consumers when, in 1997, direct-to-consumer advertising (DTCa) became legal in the United States (Moss, 2007, p. 117). Consumers are a particularly vulnerable group because they have limited knowledge about illness and may be highly influenced by their emotions. Drug advertisements are often the source of their knowledge of various illnesses (Moss, 2007, p. 117). As with other pharmaceutical advertising, DTCa is regulated by the FDA. However, the FDA’s rules and enforcement policies are questionable and not necessarily effective. Ultimately, there are still many questions about the appropriateness of DTCa. In fact, it “is banned pretty much everywhere else in the world [outside of the US]” (Moss, 2007, p. 117).
Typically these pharmaceutical promotions involve “marketing a disease” (Abramson, 2005, p. 62). This marketing may contain a variety of information and occur in many ways. Schweitzer (1997) provided one example: “Since the late 1980s pharmaceutical companies have attempted to use the various media – including television and newspapers and magazines – to publicize new results from drug research” (p. 53). As mentioned, this drug research is typically funded by pharmaceutical companies and therefore supports the validity of the companies’ drugs and the illnesses they are intended to treat. Drug companies also promote their products by preparing “key opinion leaders… and global or local advisory boards” to support their newly developed drugs (Moss, 2007, p. 66-67).

While these practices and others may be creative and reach wide audiences, there are still many questions regarding the information drug companies convey while promoting their drugs. Keller and Smith pointed out that while drug advertising “is a useful device, capable of reminding, stimulating, or aiding the physician, it can carry a very limited amount of information” (1969, p. 129). This is especially concerning if physicians are basing treatment decisions primarily upon information provided by drug companies – either directly or indirectly. Additionally, “from a medical point of view, the quality of drug advertisements is often questionable” (Gabe and Williams, 1986, p. 80). This is potentially confusing for both doctors and consumers. Although the FDA regulates these advertisements, they may still be misleading, confusing, and/or detrimental to the study and treatment of many medical and mental illnesses, including anxiety. In order to understand the negative consequences of these promotions, we must examine the influence that these tactics actually have upon doctors and consumers.
The Influence of Drug Companies’ Propaganda on Physicians

Doctors have a particularly influential role in the treatment process of anxiety and other mental illnesses. They are one of “the most significant deciders of what is eventually prescribed” (Moss, 2007, p. 119). This is why drug companies spend so much time and energy advertising to them. What factors actually influence their prescription choices, though? Gabe and Williams (1986) pointed out, “doctors are in such a key-position it is worth studying the factors which affect their prescribing habits” (p. 78). This is particularly important today as there is an increase in the number and types of drugs available, making it necessary for doctors to constantly keep up with new developments and information (Menninger, 1996, p. 85).

Based upon numerous studies, it seems that physicians do, in fact, use “commercial sources of information [as] a major, and probably a predominant, part of the [their] means of keeping informed about new drugs” (Keller and Smith, 1969, p. 37). Drug companies primarily control or influence most of these commercial sources of information. So ironically, the way that physicians maintain their knowledge about new drugs and their effectiveness is through information directly from the pharmaceutical companies. Additionally, “Physicians seldom are aware of the source of [this] information” (Keller and Smith, 1969, p. 128).

Nevertheless, physicians often decide to prescribe certain drugs as a result of this information. Keller and Smith (1969) found that information produced by drug companies was “both [doctors’] first source of information about a drug and the source that convince[d] them to prescribe” (p. 40). This information includes both general ideas
about specific illnesses as well as advertisements for specific drugs. Promotional tactics used for specific drugs are clearly effective at selling the product. Pathak, Escovitz, and Kucukarslan (1992) claimed, “significant numbers of physicians favor the use of certain heavily promoted drugs” (p. 51). Another study revealed a spike in diagnosis of a type of mental illness and prescriptions to treat that illness after “a drug manufacturer began supplying physicians with service materials… which… facilitated diagnosis” (Keller and Smith, 1969, p. 132).

Additional studies have confirmed that the gifts that pharmaceutical companies provide to doctors also influence their prescribing practices. Although “many physicians believe that all-expense paid trips and other gifts will not influence them… studies show that there is a statistically significant difference between prescribing patterns before and after such trips” (Orlowski, 1992). Often physicians justify participating in such trips because they convince themselves that they will not be influenced by the information provided to them. Obviously such an assumption is unrealistic. Zuger (2004) reported, “In one clever 1992 study published in the journal Chest, Cleveland researchers surreptitiously tracked doctors' use of two drugs before and after all-expense paid educational jaunts to sunny resorts. They found that drug prescriptions more than tripled, an effect that persisted for more than a year, while the use of equivalent drugs remained stable”. Such findings suggest that some physicians’ prescription habits may not necessarily favor the most effective drugs.

It is obvious that there are concerning issues related to the influence of drug companies over doctors’ prescribing practices (Schweitzer, 1997, p. 47). Even for those doctors who attempt to be unbiased and are concerned with the origin of the information
they obtain, it is extremely difficult to separate promotional and non-promotional
scientific information (Pathak, Escovitz, and Kucukarslan, 1992, p. 2). The
overwhelming amount of information thrown at doctors combined with the rapidly
increasing number of prescription medicines available makes it increasingly likely that
doctors will resort to less rational forms of decision-making. Moss (2007) explained,
“emotion can be a powerful part of the decision making process for physicians, especially
when it is making up for knowledge gaps in complex situations” (p. 10). In addition, “It
has been suggested that too little time for each patient might make doctors write more
prescriptions” (Gabe and Williams, 1986, p. 83). People should be increasingly
concerned with the number of prescriptions doctors are writing, the ways drug companies
are influencing such decisions, and the effects that both activities are having on society.

The Influence of Direct-to-Consumer Advertising

Many consumers, however, seem to be the opposite of concerned. They too are
the targets of the drug companies. They too are being fed information about diseases that
they need medication for. Alarmingly, this direct-to-consumer advertising (DTCa) is
working! “A Kaiser Family Foundation survey says 30 percent of respondents said they
had talked to their doctor about an advertised medicine” (Dorgan, 2006, p. 109).
Essentially, DTCa makes consumers feel as if they have little need for doctors. They self-
diagnose themselves based upon symptoms outlined in advertisements – symptoms,
which, are often subjective and symptoms that nearly everyone experiences at one time or
another (White, 2000, p. 35). Abramson (2005), a retired physician, expressed concern because
many of my patients were being drawn in by the growing number of drug ads and medical news stories; patients were increasingly arriving for their visits with a firm (if not fixed) idea of the outcome they wanted instead of the expectation that the best medical care would emerge from an open discussion of their symptoms, concerns, and exam, and then mutual consideration of the options (p. xvi).

This result of DTCa is distressing. DTCa “is not an effective or suitable means for communicating detailed information on the use of medicines” (Smith, 1996, p. 35). It exploits people’s emotions and fears and does not adequately explain illnesses or drugs. In fact, DTCa’s entire purpose is suspect: “the public [is] to be educated about a new condition by a campaign whose primary goal [is] to maximize sales of a drug” (Moynihan and Cassels, 2005, p. 121). Such a motive cannot possibly result in the unbiased, accurate communication of information to consumers.

As a result of the shortcomings of DTCa, many people have been extremely critical of it. Dorgan sarcastically wrote, “Who needs to see a doctor? Just watch the early morning television shows. The commercial will tell you [your diagnosis and treatment]” (Dorgan, 2006, p. 108). He is commenting on the absurdity of the idea that people are able to self-diagnose based upon a two minute commercial created by a drug company. He then, again in his biting tone, asked an important question: “Would it be so bad to put the decision-making process back in the hands of the patient and the doctor instead of the patient and a New York advertising director?” (Dorgan, 2006, p. 109). Dorgan is not alone in his critique or his concerns. As a result of the many people who are concerned with drug companies’ influence and profit motives – not only as they relate to consumers but to doctors as well – there has been a backlash against the medical model of mental illness and the current approach to treating it.
Alternative Approaches to the Medical Model

There have been many critiques of the current methods for approaching and treating mental illnesses like anxiety, specifically pharmacological approaches. Often the suggestions that grow out of these critiques involve a reorientation of the way that the medical industry and consumers perceive disorders like anxiety. The drug companies would like people to perceive those with anxiety as victims in need of help that only drugs can provide. The medicalization of anxiety also encourages this idea.

Increasing numbers of people are claiming, however, that a pharmacological approach to anxiety is not always constructive or accurate: “Actually, little evidence exists that problems such as depression or anxiety operate like diseases” (Compton, 2005, p. 176). Additionally, the medical model “locates human adjustment and maladjustment inside the person rather than in the person’s interactions with the environment and encounters with sociocultural values and societal institutions” (Linley and Joseph, 2004, p. 322). The medicalization of mental illness ignores one’s environment and assumes that there is something inherently wrong with the individual that must be fixed. Rather than empowering people with clinical anxiety, this only makes them feel worse.

This victimization of people with mental disorders is a product of both the medical industry and drug companies. Recent studies show that psychiatrists are prescribing increasing amounts of drugs (Psychiatrists prescribing more drugs than therapy for patients, 2008). However, they are not responsible for prescribing the majority of drugs for anxiety. Surprisingly, general practitioners are prescribing 59 percent of psychotropic drugs, including 62 percent of anti-depressants (the drugs most often used to treat anxiety disorders) (GPs, not psychiatrists, prescribe most
psychotropics, 2009). This is problematic because while psychiatrists and therapists are trying to treat their patients with psychotherapy, prescription medications, or some combination of both, general practitioners are simply throwing medications at their patients without requiring them to participate in psychotherapy.

General practitioners prescribing medications in this way is particularly tragic because psychotherapy treatments are often rather effective. Glass (1977) concludes, “On the average, the typical therapy client is better off than 75 percent of untreated individuals.” A more recent study conducted in 1995 by Consumer Reports discovered, “patients benefited very substantially from psychotherapy… Furthermore, no specific modality of psychotherapy did better than any other for any disorder; psychologists, psychiatrists, and social workers did not differ in their effectiveness as treaters; and all did better than marriage counselors and long-term family doctoring” (American Psychologist, 1995). By throwing medication at patients rather than recommending them to a therapist or psychiatrist, general practitioners are actually doing their patients a disservice rather helping to treat them.

What is perhaps most frightening, however, is the ineffectiveness of the drug treatments that the doctors prescribe and that drug companies so heavily promote. In fact, “ironically, the much-hyped medicines sometimes cause the very harm they are supposed to prevent” (Moynihan and Cassels, 2005, p. xv). Treating people who have only minor problems with drugs often makes their problems worse in the long run (Moynihan and Cassels, 2005, p. 133). At some point in a person’s treatment it might actually be the drug that is causing their anxiety rather than their anxiety itself (Moynihan and Cassels, 2005, p. 124). Unfortunately, doctors continue to prescribe these drugs and drug companies
continue to promote them, partially because “there is no profit to be made from…
nondrug approaches” (Abramson, 2005, p. 17). It is important, however, that drug critics
continue to push their research agendas of evaluating the ways in which mental health
professionals may use alternatives to drugs in order to ensure that people are being
treated as effectively as possible (Gabe and Williams, 1986, p. 300).

POSITIVE PSYCHOLOGY

Growing numbers of people who are strongly pushing back against the
medicalization of mental illness and the generally negative approach to the treatment of
disorders like anxiety are known as positive psychologists. Positive psychology is “a new
direction and new experience for psychology” (Compton, 2005, p. 3). They believe that
“it is time to abandon the illness ideology and replace it with a positive clinical
psychology grounded in… [an] ideology of health, happiness, and human strengths”
(Linley and Joseph, 2004, p. 322). Its focus is not treating disorders but rather “promoting
mental health” (Linley and Joseph, 2004, p. 331) and “understand[ing] the positive, the
adaptive, the creative, and the emotionally fulfilling elements of human behavior”
(Compton, 2005, p. 3).

Instead of a narrow concentration on negative emotions and experiences, positive
psychologists look at the bigger picture. They attempt to understand the purpose of both
negative and positive experiences and the ways that they complement each other. Ong
and Dulman (2007) described the “important dynamic relationships between positive and
negative affective experiences” (p. 498). Positive psychologists perceive life as involving
“two parallel processes... one that is positive, guiding our approach with promise and
hope, and another that is negative, informing us about risk of harm” (Ong and Dulman,
2007, p. 498). Instead of trying to eliminate negative emotions altogether, positive psychologists try to understand and appreciate the balance of positive and negative.

The idea of positive psychology is a particularly constructive way of approaching anxiety. Positive psychologists claim, “even people who are… plagued with debilitating anxiety can still exhibit amazing courage, resilience, fortitude, and compassion” (Compton, 2005, p. 176). In fact, anxiety may even benefit a person in certain situations. Noyes and Hoehn-Saric (1998) pointed out, “Anxiety forces a person to develop strategies for dealing with threats” (p. 28). Additionally, anxiety can “heighten social cohesiveness and emotional bonding” (Noyes and Hoehn-Saric, 1998, p. 27) as well as improve performance (Noyes and Hoehn-Saric, 1998, p. 25). Anxiety might also be a symptom of positive decisions, such as setting challenging goals for oneself (Compton, 2005, p. 244).

Nevertheless, clinical anxiety is still a problem that people must learn to cope with. One technique that positive psychologists employ is positive therapy. This “is an approach to treatment that is built on the enhancement of positive traits, the building of strengths, and helping clients find untapped resources for positive change” (Compton, 2005, p. 182). Instead of seeing clients as victims like many doctors do, “In positive psychotherapy… therapists see clients as ‘active seekers of health’” (Compton, 2005, p. 182). Therapists nurture every individual’s skills in order to help the patient cope with anxiety in positive, empowering ways.

Although the field of positive psychology is relatively new, its future seems bright. Its theoretical approach and application of positive psychology will hopefully become the standard someday soon. While “the utility of a positive approach to the
diagnosis and treatment of mental health remains an unrealized tool.” (Snyder and Lopez, 2002, p. 45) “its popularity appears to be growing rapidly” (Compton, 2005, p. 20). What is exciting about this growing popularity is that “positive psychologists do not wish to limit the topics of study but rather to expand the topics to include aspects of human flourishing” (Compton, 2005, p. 12). Hopefully the field of positive psychology, along with research similar to the kind that I am conducting, will more clearly illuminate the medicalization and capital motives behind the current definitions of mental illnesses like anxiety and encourage people to reject such definitions thereby forcing methods of diagnosis and treatment to change.
The Influence of Dominant Discourses

In the previous sections I provided a detailed history of the concept of anxiety in terms of its definitions, diagnoses, treatments, and the involvement of the mental health and pharmaceutical industries. The goal of including such a detailed description of these various topics is to present a clear picture of the current discourse about anxiety and the way that this discourse has developed. The anxiety narrative that permeates society today is one that broadly defines anxiety, victimizes those who have anxiety, and endorses professional help as a means of dealing with anxiety. As a result of this discourse, the rhetoric used to describe anxiety often has a negative connotation.

The current discourse about anxiety is one that has been created and transmitted by mental health professionals and the pharmaceutical industry. The goal of my research is to understand the influence of this narrative. Do people really adopt the discourse about anxiety that I have presented? If so, what is the effect of this acceptance? If not, what factors have prevented people from accepting this discourse?

Discourses and Their Importance

In today’s society, there are many discourses about a variety of topics. These discourses are important because, once accepted by a powerful group in society, they often determine societal values. There is a “mutually constituting relationship between discourses and the social systems in which they function” (Howarth, 2000, p. 4). Mumby (1993) more specifically pointed out the “role of symbolism and language in producing a shared version of reality and moral order in specific social groups” (p. 100). Brummett (1991) agreed, “all definitions and formulations of rhetoric have social and political
implications” (p. xiii). For these reasons, “The concept of discourse [has] play[ed] an increasingly significant role in contemporary social science” (Howarth, 2000, p. 1).

Lucaites et al (1999) also asserted, “The meaning and significance of life in all of its social dimensions require the recognition of its narrative structure” (p. 267).

Despite its significant influence upon societal values, discourse was not originally regarded as its own area of study. It “originat[ed] in disciplines such as linguistics and semiotics (Howarth, 2000, p. 1). More recently, however, it “has been extended to many branches of the human and social sciences” (Howarth, 2000, p. 1). Howarth (2000) explained the implications of this extension: “as the concept of discourse has been employed in the social sciences, it has acquired greater technical and theoretical sophistication, while accruing additional meanings and connotations” (p. 2-3). While there are various meanings that one might attribute to the word discourse, the one that will be used in this paper, “critically engages with… Marxist traditions of thinking” (Howarth, 2000, p. 10).

**Defining Discourse, Narrative, and Rhetoric**

Generally, “discourse to refers to historically specific systems of meaning which form the identities of subjects and objects” (Howarth, 2000, p. 9). More concretely, discourse is “‘the conscious strategic efforts by groups of people to fashion shared understandings of the world and of themselves that legitimate and motivate collective action’” (Howarth, 2000, p. 3). In the case of the anxiety discourse previously mentioned, mental health professionals and the pharmaceutical industry want to motivate people to seek pharmaceutical and therapeutic treatment. Although discourse was previously used
to describe a limited number of subjects, “in the wake of the growing centrality of structuralism, post-structuralism, hermeneutics, and Marxism in the social sciences during the 1960s and 1970s, the concept of discourse has been extended to a wider set of social practices and phenomena” (Howarth, 2000, p. 7). Several decades ago, the term discourse may not have been used to describe a topic like anxiety, but today such a description is considered entirely appropriate.

Two terms closely related to discourse are narrative and rhetoric. McCabe & Bliss (2003) explained, “narrative [is what] enables us to make sense of our experience” (p. 5). Although it is similar to discourse, it more closely relates to individuals and the various ways they understand a concept and use it to understand their own personal experiences. Brummett (1991) defined rhetoric as, “the art of verbal influence” (p. xi). Rhetoric describes one’s ability to persuade. Powerful individuals and groups use rhetoric in order to establish a discourse that others can understand as a narrative that applies in some way to their own lives and experiences.

**Presentation of Discourses**

Discourses are particularly influential today because of the ways that they are presented. Increasingly, various media sources allow for more direct and frequent interactions with people. Brummett (1991) observed, “the place and time of rhetoric are moving inexorably from specific locales in which issues are debated, into the more general context of popular culture” (p. xii). This means that discourses can be more easily transmitted throughout society. The danger and difficulty of this is that “rhetoric as a distinct social practice carried out during concentrated periods of speaking and listening,
or reading and writing, is dissipating into a noisy environment teeming with messages” (Brummett, 1991, p. xii). It is difficult for people to properly understand and evaluate discourses in such an environment. This may lead to either a conscious or sub-conscious acceptance of discourses that one has not had the time or focus to properly evaluate.

Along with expanding discourse presentation in the media, discourse presentation is also increasingly centered on market objectives. Young (2006) claimed there has been a “restructuring of discourse based on a market model where things are bought and sold. The result is that information… is presented not for communicative purposes but for strategic ones… the purpose [is] to get people to act, to buy products” (Young, 2006, p. 263). He continued, “the discourse of advertisement has colonized much of public discourse in general” (p. 290). The assertion that discourse is primarily presented through advertisements and motivated by the market is concerning. If Young is correct, the effects on society are potentially disastrous.

The Influence of Discourses

In order to evaluate the influence of a discourse, however, it is important to understand how people process the information included during its presentation. The presentation of a discourse often involves visualizations: “Visualizations are instigated mainly by acting, by showing pictures, and by language (producing words of a lower level of abstraction) which leads to forming mental images in the language user’s mind” (Janicki, 2010, p. 202). In commercials for anxiety medications, for example, pharmaceutical companies present visualizations by showing actors who are unhappy and stressed and using simple words to describe their situations and symptoms.
In understanding a discourse, Janicki (2010) also pointed to the “crucial role of experience in generating meaning” (p. 43). He continued, people “learn new words and what the social agreements about them are in a similar way – through all kinds of experience” (p. 33). For example, people may understand the social agreements surrounding anxiety through their experiences watching television and seeing portrayals of anxiety in television shows or commercials.

Janicki (2010) also warned, however, “We certainly do not learn very many words through direct experience with the referents” (p. 33). Instead, “Words impart experience which had been mapped onto them by language users” (Janicki, 2010, p. 51). This means that if an individual is not familiar with a term, he will learn its meaning by the way the person using the word presents it. Therefore, it is possible for pharmaceutical companies to present the term “anxiety” to the general public in any way they choose and thereby shape the meaning of the word.

Such calculation and manipulation occurs often and is intentional. Mumby (1993) explained, “the construction of social reality is not spontaneous and consensual but is the product of the complex relations among narrative, power, and culture” (p. 6-7). He then elaborated, “the social construction of meaning does not take place in a political vacuum but rather is a product of the various constellations of power and political interests that make up the relationships among different social groups” (p. 6). The various discourses presented to society primarily through advertisements are often conscious creations of powerful people. These creations then socially construct the meaning of many aspects of society today: “narratives function to construct the social reality that constitutes the lived world of social actors” (Mumby, 1993, p. 5).
Discourses influence societal values and realities in clever ways. For example, “the special kinds of vocabulary in which narratives tend to be told – the names ideas are given – impart values in subtle ways” (Mumby, 1993, p. 109). The result of this is that “narratives covertly impart values that channel attention toward certain elements in the stream of events and away from others” (Mumby, 1993, p. 109). The ability of the powerful to “channel attention” is particularly concerning because “Through narrative discourse, speakers can make strongly persuasive assertions that are masked from examination and challenge… because of the cognitive and psychological effects of stories on listeners” (Mumby, 1993, p. 105). Not only are powerful people and institutions able to carefully construct discourses, they are also able to do so in a way that is extremely compelling.

Nevertheless, it is possible for some or all people to reject certain discourses. McCabe & Bliss (2003) explained, “Coherence is a judgment we make, formally or informally, about how well put together a piece of discourse is” (p. 5). If people do not feel there is coherence in a discourse, they will not buy into the narrative. Additionally, “Actions that may succeed with one audience (e.g., solidification of the membership) may alienate others (e.g., provocation of a backlash)” (Lucaites et al, 1999, p. 385). A particular discourse may appeal to certain groups of people, while offending others.

**Discourse Analysis**

In order to determine the effectiveness of a discourse, one may perform discourse analysis. Generally, “the task of discourse analysis is to measure how effective [various discourses] are in bringing about certain ends” (Howarth, 2000, p. 3). Those who use
Marxists define discourse analysis more specifically as “expos[ing] the way in which language and meaning are used by the powerful to deceive and oppress the dominated” (Howarth, 2000, p. 4). Ultimately, discourse analysis involves understanding the influence discourses have upon certain people and their ideas.

Unfortunately, there are “no general accounts of the way in which the theories and methods of discourse analysis can be applied to this domain of study and research” (Howarth, 2000, p. 2). In social sciences, discourse analysis is rather vague. Nevertheless, “the concepts and methods of discourse analysis can be ‘operationalized’ in meaningful ways” (Howarth, 2000, p. 2). Many different sources may be examined in performing discourse analysis: “discourse analysts treat a wide range of linguistic and non-linguistic material… as ‘tests’ or ‘writings’ that enable subjects to experience the world of objects, words and practices” (Howarth, 2000, p. 10).

**Anxiety Discourse and My Research Goals**

The goal of my research is to understand the pervasiveness of the discourse I described earlier pertaining to anxiety. I am interested in how successful the mental health and pharmaceutical industries have been in transmitting the discourse that they have jointly created. I am assuming that this discourse must be somewhat prevalent considering both industries are currently booming and considering that both industries spend a great deal of money to further promote this discourse. In order to evaluate the pervasiveness of this discourse, I am conducting interviews in which I ask people about their own perceptions regarding anxiety. In analyzing my data, I will present the
commonalities that I find among my interviews and then analyze these commonalities in terms of the anxiety narrative in order to determine the narrative’s pervasiveness.
The first step in conducting my research is specifying the areas of inquiry that I want to focus on during my interviews. Anxiety is an extremely broad topic and therefore there are dozens of questions that I could ask relating to it. In order to maintain a focus on the goals of my research, I need to identify a few broad categories that are relevant. These categories are anxiety in oneself, anxiety in others, and anxiety in the media. In each of my interviews, I asked questions entirely from one category and then moved onto the next category. I began with questions about anxiety in oneself, then proceeded to questions about anxiety in others, and ended with questions about anxiety in the media.

The category relating to anxiety in oneself is by far the category with the most questions and the category that generated the most discussion in my interviews. This category addresses such complex issues that I have divided it into subcategories based upon different variables. The first variable relating to anxiety in oneself is self-perception. This relates to the ways in which people view themselves in relation to various aspects of anxiety. I measure this based upon similarities and differences in the language people use in describing and defining their anxiety, its symptoms, and their feelings about it. Questions that address this variable include:

- How did you decide you have anxiety?
- What do you consider to be the symptoms of your anxiety?
- How has being labeled with anxiety affected the ways you now perceive yourself and/or your behaviors?

Each of these questions addresses the subject’s perceptions about their anxiety.
The second variable relating to anxiety in oneself is the selection of treatment methods. After gathering sufficient information about how the subject perceives anxiety in himself, I inquired about the various treatment methods that he saw as being available to him, those that he elected to try, and the various influences involved in such decisions. I measure this based upon the number and variety of treatment methods that people describe, the various ways people decide to seek treatment, their positive and/or negative evaluations of such treatment, and their expectations of length/intensity of treatment in the future. Questions that address this variable include:

- Have you sought any sort of treatment for your anxiety? If so, what kind(s)?
- How did you reach the decision to seek treatment?
- What other available treatment options would you try and which would you not try? Why?

Each of these questions attempts to gain insight into the subject’s treatment choices, reasons for his treatment choices, and his evaluations of them.

The third variable relating to anxiety in oneself is the level of social acceptance that the subject feels. Once I have an overview of my subject’s personal thoughts on anxiety and its treatments, I want to understand how the subject feels that he is perceived by society as a whole and to what degree he feels his anxiety is socially accepted. I measure this based upon the degree to which people feel they can be open about anxiety, the degree to which people feel they have had positive and/or negative experiences with people after admitting they have anxiety, and the degree to which they feel ostracized or accepted after admitting they have anxiety. Questions that I asked to address this variable include:
• How open do you feel that you can be about the fact that you have anxiety?

• In what situations is it appropriate to discuss that you have anxiety and in which situations is it not appropriate to discuss?

• Have you ever been treated differently (positively or negatively) once someone found out you have anxiety? How?

These questions all address the ways the subject feels he will be perceived after admitting he has anxiety and the ways he feels he has been treated as a result of such an admission.

After completing questions relating to anxiety in oneself, I then move on to questions about anxiety in others. In addition to understanding how a subject feels about his own anxiety, I want to know how he perceives anxiety in others. I measure this based upon similarities and differences in the language subjects use in describing others’ anxiety and its symptoms. Questions that address this category include:

• What percentage of your friends would you categorize as having anxiety? Why would you label them as having anxiety?

• What percentage of your friends do you think would categorize themselves as having anxiety? What do you think makes them label themselves as having anxiety?

Each of these questions addresses the subject’s perceptions about anxiety in others.

Finally, I ask about my final category – anxiety in the media. I want to know how a subject feels anxiety is depicted in the media. This is likely to relate to many, if not all, of the other variables I am interested in. I measure this based upon the degree to which people recognize anxiety in movies and television and the words people use in describing
media depictions of people with anxiety. Questions that I ask to address these issues include:

- Have you noticed discussion of anxiety in movies and television shows? If so, where and how often?
- In general, can you describe the stereotypical media depiction of a person with anxiety?

Each of these questions asks the subject to consider the ways that he notices media depictions of anxiety and the connotations that he feels they have.

These three broad categories and more specific subcategories encompass the content of my interviews. The bulleted questions in this section, however, only represent a portion of the questions I asked in interviews. (See Appendix A for the complete interview guide.) Please note that even my interview guide is only a loose representation of exactly how my interviews were conducted. It is important to let the interviewee guide the conversation to some extent and therefore sometimes questions were asked out of order. Additionally, although I did not recite the questions from the interview guide verbatim, I was always cautious to phrase my questions neutrally so as to not bias the interviewee’s answer. In the next section I discuss in further detail the subjects of my study who were asked to answer the questions presented above.
The subjects of my research are primarily college-aged, upper-middle and upper class men and women. Most of the subjects are people who label themselves as having anxiety. (There are, however, two men who I interview who do not label themselves as having anxiety. These men are different from the majority of the research subjects and will be discussed later in more detail.) This group is half male and half female. At the outset of my research I had no reason to believe that either men or women are particularly more or less affected by the medical and pharmaceutical industries’ definitions of anxiety. Nevertheless, in order to produce research findings that are most generalizable, men and women are equally represented.

I elected to focus on people who are college-aged for two main reasons. The first is that the medicalized definition of anxiety as it exists today was established a few years before this group was born. (The DSM-III first released this definition in 1980.) This means that for their entire lives, the medicalization of mental illness has existed much in the same way it does today.

The second reason for my selecting this age group is that, more than any other group of people, they grew up with drug companies expanding definitions of mental illnesses in order to sell drugs. The late 1980s and early 1990s was the time during which drug companies began to merge, the political landscape for drug companies changed (including the management of health care), and profit margins were slipping. It was during this time that drug companies began to expand the definitions of certain illnesses in order to remain competitive. By the time the subjects of my research were ten years old, DTCa had been legalized and drug companies were advertising directly to...
consumers. Overall, I believe that this group has a unique perspective on mental illness and anxiety because of their unique historical perspective.

My sample also consists of primarily upper-middle and upper class people. These are people particularly affected by the expansions in definitions of mental illness because these people are under unique pressures. Additionally, they have the resources to seek psychiatric and pharmacological treatments whenever they feel that they are necessary. Today’s upper-middle and upper class young adults are the first generation that may be less successful than their parents.

This prospect, combined with the increasing competitiveness of our society and pressure to succeed, is stressful. Kegan described the possible “burden [that] we must bear if the demands made of us are over our heads” (Kegan, 1994, p. 34). Unfortunately, the stress from this burden can often be “misunderstood by those adults whose expectations they are disappointing” (Kegan, 1994, p. 38). Adults in upper-middle and upper class families often perceive this disappointing behavior as “‘misbehavior’ or ‘illness’” (Kegan, 1994, p. 38). Often, particularly for people who have the resources, mental disorders may be used as a crutch to explain poor performance or behavior and as a way to justify taking medications that may even enhance performance.

The final criterion for those participating in my study is that all interviewees label themselves as having an anxiety disorder. This may be based upon their own judgments or based upon a clinical diagnosis. My entire study is about how people come to see themselves as having an anxiety disorder, so the simple fact that someone has not been clinically diagnosed is not relevant. I try to exclude from my interviews anyone with what may be considered debilitating anxiety.
The concept of debilitating anxiety is difficult to define, as there are so many definitions of anxiety and ways that it may manifest itself. I define debilitating anxiety based upon a combination of two different definitions of anxiety. Evans (2007) claims there are “three clinical features [that define] pathological anxiety:… distress, dysfunction… [and] symptomatic inflexibility” (p. 162). By “symptomatic inflexibility” Evans means the inability to be free of anxiety in situations in which one’s stressor is absent. Symptomatic inflexibility exists if the person with anxiety is unable to move past his anxiety even after the stressor is gone. Frank (2008) provides a more simplistic definition of anxiety as a “chronic illness that has a significant impact on your daily function and may rob you of any joy in your life”.

Based upon these definitions, for the purposes of my study debilitating anxiety is defined by an inability to function or participate in situations that are necessary for one’s survival and/or that the majority of one’s peers typically participate in. This occurs when the distress, dysfunction, and inflexibility that Evans (2007) describes become so overwhelming that they not only impact one’s capacity to function effectively in everyday life (Frank, 2008), but actually eliminate their capacity to function in one or more ways. For example, I would consider consistent inability to attend classes or work as a result of anxiety to be debilitating anxiety. People with such debilitating anxiety are generally not included in my research because these people may truly be in need of serious medical intervention in addition to psychotherapy. Some of the research subjects did experience what maybe categorized as debilitating anxiety in their past, but at the time of the interviews none fell into this category.

Two of my sixteen interviewees, however, did not necessarily consider
themselves to have anxiety at all. As a result of my difficulties in obtaining male interviewees, I was forced to slightly amend the criteria that I used to obtain my last two male subjects. Instead of solely interviewing males who consider themselves to have anxiety, I interviewed two males who I know personally and who I thought would admit to having at least some level of anxiety, but who completely denied having anxiety at all and/or were unwilling to discuss their own anxiety.

After realizing that men seem to be more reluctant to talk about and admit to having anxiety, I decided it would be beneficial to attempt to further understand these specifically male stigmas. In order to secure all eight male interviewees, I therefore interviewed two males about stigmas surrounding anxiety and why they don’t like to talk about anxiety. Fortunately, although I was forced to amend my initial research criteria, these two male interviewees allowed me to gain further insight into the reasons that it was difficult to secure interviews with males and helped to confirm my preliminary research findings.
Finding a sample of sixteen people – eight men and eight women – was certainly a challenge. I selected primarily Boston College students because I have the most access to this group. I believe that this is justified because Boston College students are likely to fit the criteria I am looking for, which I described in the previous section. In order to find people willing to participate in my research, I spoke to fourteen different Boston College classes. (See Appendix B for a copy of the flyers I passed out to these classes.) I chose classes whose topics seemed either relevant to anxiety or that I thought would have students who were likely to be self-reflective and willing to be open about a private issue like anxiety. Many of these classes were sociology and psychology classes. One teacher even offered her students extra credit for speaking with me.

After I secured volunteers from these methods, I had planned to secure the rest of my respondents via snowball sampling. I was simply going to ask the people who volunteered for interviews if they could pass my name along to any of their friends who might meet the criteria of my study (Gray, 2007, p. 117). This snowball sampling, however, proved to be entirely unsuccessful. As a result, I was forced to ask friends if they considered themselves to qualify. Several of my interviewees are people who I know on some personal level. (For statistics on the exact make-up of my sample based on age, grade, college, and home state, see Appendix C.)

Once I secured subjects willing to be a part of my research, I conducted intensive interviews with each of them individually. I used a nonschedule standardized interview approach, making sure to ask each interviewee all the same questions, but sometimes asking them out of order or in different ways (Gray, 2007, p. 161). I asked my questions
in clear, explicit ways and defined any ambiguous terms I may have been using. I also asked interviewees to clearly define ambiguous terms they may have used, such as the term “panic attack”.

In order to conduct an effective interview, it is important that the tone of the interview is appropriate. At the beginning of the interview, I attempted to build a certain level of trust with the respondent through my speech and body language. I built rapport without establishing overrapport by remaining friendly yet professional and neutral in response to answers (Gray, 2007, p. 170-171). Additionally, I ensured that all my interviews were conversational so that the respondents had the opportunity to elaborate on subjects they felt were particularly important and mention ideas I may have neglected to ask about. However, I sometimes also needed to use certain preemptive techniques to direct the conversation in ways that were productive for my research (Gray, 2007, p. 170). Finally, I conducted each of my interviews in a quiet, neutral setting so that the respondent was not distracted and did not feel intimidated or uncomfortable in any way. Often, this was a professor’s unused office.
Weaknesses of My Research Methodology

Despite the aforementioned considerations, there are still weaknesses in my sampling and data collection methodology. First and most important, my sample is not random and therefore is extremely difficult to draw broad conclusion from. I solicited students from classes that I believed would be most likely to have people who were willing to open up about anxiety. These classes were primarily psychology and sociology classes, which creates a sampling bias in itself. Furthermore, in a few of the classes teachers offered extra credit for students willing to speak to me, which creates a second source of bias. After exhausting those sampling techniques, I began to ask friends and acquaintances if they would be willing to sit down for an interview. Interviewing a large number of people who I know personally creates a third bias. Clearly these sampling techniques allow for multiple sources of potential bias. In addition, intensive interview studies are difficult to generalize (Gray, 2007, p. 172). Their data is extremely subjective and difficult to categorize in concrete ways.

Many of the weaknesses in my research methodology also stem from the unique challenges that I faced because of the sensitive subject matter of my research. It is difficult to get people to talk openly about a private issue like anxiety. Although all people’s experiences with anxiety are unique, they are all similar in that they involve people’s intensely private struggles and thoughts. Convincing people to share their innermost thoughts about a subject that many of them feel embarrassed about was a difficult feat.

Initially, I planned on interviewing twenty people in total – ten men and ten women. Unfortunately, I struggled to obtain even sixteen interviewees. I believe that this
is largely because many people do not feel comfortable talking openly about their anxiety—especially to a stranger. It was particularly difficult to obtain male interviewees. I think that the reason for this is twofold. First, males seemed less willing to open up about their anxiety even if they consider themselves to have it. Second, on average the males I encountered seemed to consider themselves to have anxiety less often than females. This is an interesting phenomenon that I will discuss further in the data analysis section.

My difficulties in obtaining male interviewees create yet another bias in my research. Since I interviewed two men who did not want to talk about their own anxiety (either because they did not feel comfortable or because they did not think it existed), I only have six male interviews in which I asked about personal struggles with anxiety. My goal was to obtain eight interviews in which the men would be willing to talk about their personal struggles with anxiety. However, the two males who were unwilling to discuss such struggles, combined with the six others, comprise my total eight male interviews. This creates a gender bias because I only interviewed six males about their struggles with anxiety, while I interviewed eight females about the same subject.

Finally, even after obtaining interviewees, in many of the interviews people were hesitant to share their entire stories. Many times, I found it necessary to ask follow-up questions to tease more information out of the interviewees. Even after doing so, I am sure that some people still did not divulge all of the details of their experiences by the end of our interviews. There is also the possibility that some respondents may have felt shame or embarrassment about their anxiety and therefore were not be completely honest when answering questions. Each of these possible sources of bias, while legitimate, were out of my control. Therefore, I have taken all possible precautions to eliminate bias while
understanding that bias is inherent in my research approach and research question. As I present my data results and analysis, it is important to be conscious of these biases while still appreciating the validity of my research findings.
Data Analysis

In conducting my interviews, I asked a variety of questions in order to understand people’s ideas about anxiety and, more specifically, whether they bought into the anxiety discourse I presented earlier. Generally, based upon their responses to these questions, I found that the interviewees fell into one of two groups.

The first group, which I call the Tough Guys, buys into the anxiety discourse only to an extent. They perceive anxiety primarily as a weakness, but do not consider drugs or therapy as treatment options. I believe the reason for this is because this group (aside from one female) is entirely male. Stereotypically, males are expected to be strong and handle their problems on their own. Once these males have bought into the discourse to the extent that anxiety is a weakness, they are less likely to admit to having anxiety and also less likely to consider treatment for their anxiety, which would further suggest their inability to handle it on their own. (I believe this also explains why it was more difficult for me to find males who considered themselves to have anxiety and who were willing to talk about it for my interviews.)

The second group, which I call the Believers, buys into the anxiety discourse much more fully. They perceive anxiety as a weakness (although not nearly to the extent that that Tough Guys do) and see therapy and/or drugs as a means of treating it. This group is entirely female. For this reason, it is more socially acceptable for them to be open about their weaknesses and emotional struggles. It is also more socially acceptable for them to seek outside help since women are stereotypically seen as more emotional and more fragile than men. Therefore, despite the negative connotations surrounding anxiety, they are still convinced to seek some sort of treatment.
In the following sections, I present the detailed findings of my research. In each of these sections, I will present the data from the Tough Guys and the Believers separately. I begin by discussing the ways the interviewees defined and identified anxiety. This is fairly similar for both Tough Guys and the Believers. I then discuss the connotations that each group attributed to anxiety. While both groups have generally negative perceptions of anxiety, the Tough Guys’ negative perceptions were more apparent. Next, I discuss the groups’ opinions on various treatment options. These opinions differ significantly. I then present each group’s feelings about anxiety in the media. In general, both groups have fairly negative feelings about direct-to-consumer advertising and media portrayals of anxiety. Finally, I explain in further detail the reasons for differences between the two groups.

**Defining and Identifying Anxiety**

DEFINITIONS OF ANXIETY

At the end of my interviews, I asked each of the subjects to define anxiety in their own terms. In attempting to understand the ways people define and identify anxiety, it seems only appropriate to begin with some of these definitions. Although they all differ to some extent, they all involve either a *loss of control* or *fear*. Interestingly, these two categories are directly related to the two types of anxiety disorders contained in the *DSM IV* – anxiety states, which involve loss of control, and phobic disorders, which involve fear (Pasnau, 1984 p. 10).
The Tough Guys

Many of the Tough Guys identified an inability to control one’s feelings or thoughts as the defining feature of anxiety:

I would define anxiety as an emotion or feeling that becomes overwhelming where the person loses control of the situation and can’t focus or address the situation. I really think that’s what it comes down to… That they just can’t address the stresses that have led to the anxiety that they currently have or that they feel. (Alfred, 22-year-old Senior)

I just think it’s something that we can’t necessarily control and that it’s just part of who we are as human beings. (Jack, 21-year-old Senior)

The way I’ve described it to other people before is thinking too much… It’s just this worrying motor of thoughts that you can’t quite stop and it’s very difficult to deal with. (Mr. F, 21-year-old Senior)

[I think anxiety is] intrusive internal stimuli. Like when you can’t stop thinking about something that’s intruding with your thoughts… Or when you’re trying to focus on one task, but you’re thinking about another task. (Ernesto, 28-year-old Grad student)

Although each of these definitions involves slightly different issues with control, they are all strikingly similar.

Others identified fear as the defining feature of anxiety:

I think anxiety is kind of a fear of failure… I think anxiety is being like – I mean I took psychology so I know the definition, but I think anxiety to me is being nervous about upcoming events or something that in the near future you think is a big deciding factor in how things go for you in life. (Dale Earnhardt Jr., 19-year-old Freshman)

I think anxiety is being nervous and scared in situations that most people wouldn’t. (Jasmine, 21-year-old Senior)

Each of these subjects described a similar way of defining and identifying anxiety.

The Believers

The Believers also provided similar definitions of anxiety. Several Believers focused on control as the central element of anxiety:

I would define anxiety as the intense feeling of loss of control. So when I’m anxious I just don’t feel like I can control what I’m thinking about. I can’t monitor my thought process. I can’t control my breathing. It’s just a lack of management on my part. And it just makes me feel completely powerless and helpless. (Amy, 20-year-old Junior)
Anxiety is] like a constant, ongoing, underlying worry – like unrealistic worry about the way you perceive things. I mean in my own basic terms, not being able to turn off my brain when I should. (Molly, 21-year-old Senior)

I’d say [anxiety is] being obsessed with controlling all aspects of your life and when that’s not achieved, basically freaking out to an extreme about it. (Anne, 19-year-old Sophomore)

The Believers’ definitions involving control include mentions of inability to control one’s feelings and thoughts, similar to the definitions provided by the Tough Guys.

Some of the Believers described fear, instead of lack of control, as the central element of anxiety:

I would just say [anxiety is] overwhelming and irrational feelings of fear and loss of self-control that can affect you on a day-to-day or on a event-to-event basis. (Alexis, 21-year-old Senior)

I think for me [anxiety is] just this fear and terror of being hurt or judged or thought of as different. (Marie, 22-year-old Junior)

Once again, these definitions are similar to those of the Tough Guys. Ultimately, both groups defined anxiety in remarkably similar ways.

INITIAL TRIGGERS OF ANXIETY

The two groups did not, however, perceive the initial triggers of their anxiety in similar ways. Many of the interviewees from both groups reported that a particular experience or personal issue was the initial cause of their anxiety. These interviewees often discussed in great detail their recollection of their earliest experiences of anxiety. The Tough Guys’ experiences involve internal causes. The Believers’ experiences involve external causes. This is consistent with each group’s overall acceptance or denial of the anxiety discourse. The Tough Guys see the initial causes of their anxiety as internal and therefore something they can control without outside intervention, while the
Believers see the initial causes of their anxiety as external and therefore something they have less control over and need help coping with.

The Tough Guys

One of the initial sources of anxiety the Tough Guys reported was related to internal reflection:

I had like a panic attack when I was like eleven. It was vaguely related to religious stuff. Because I was thinking about – I was in church and I was thinking about afterlife and all this stuff and I was thinking – I mean it sounds so weird to say it. [Laughs awkwardly.] I dunno. I was thinking about like when you die, you go to heaven, and I was just like wow that sounds boring and it just kinda stretches out forever and that’s just kinda a terrifying thought. (Mr. F, 21-year-old Senior)

Recently I’ve kind of tried to live a more intentional life, but that’s kind of caused me to think about what I’m doing. If I’m doing things right or if I’m being the person I want to be. And that’s probably the thing that gives me the most anxiety. (Jack, 21-year-old Senior)

These Tough Guys made a conscious decision to reflect upon issues like religion and living an intentional life and therefore still remain in control of their anxiety to a certain extent.

Another initial source of anxiety one of the Tough Guys reported was related to self-confidence issues:

I think [my anxiety] kinda stems from me not being okay with the way I look. Like in eighth grade, that’s when people started hanging out with boys more and stuff. And I always just felt inadequate against my friends. Like I wasn’t as cute, or I wasn’t as skinny. (Jasmine, 21-year-old Senior)

Once again, this issue relates to an internal struggle that this Tough Guy must learn to control on her own.

The Believers

The Believers, on the other hand, attributed the beginnings of their anxiety to more concrete situations that were outside of their control. One Believer discussed the family issues that triggered her anxiety:
Several other Believers pointed to social and academic situations as the triggers of their anxiety:

I played soccer throughout all high school and during one game everybody was like screaming my name and was like, oh get the ball. It was a really tough game and I just froze and I thought I was having an asthma attack, but I was really having a panic attack – like an anxiety attack. (Tanya, 20-year-old Junior)

I had a really bad middle school experience and now even today if I see someone from my middle school, I’ll have a panic attack. Like I can’t handle seeing anyone. Or even like if I see them from afar I run the other way. I’ve walked into stores and seen them and turned around and left. (Anne, 19-year-old Sophomore)

[My anxiety is] definitely academic-based that I’m like – maybe it’s because I got deferred from BC and I’m always thinking I’m not smart enough to be here. So like I have to prove to myself that I’m just as intelligent as everyone else. (Kitty, 21-year-old Senior)

These family, social, and academic situations that the Believers described as their initial sources of anxiety are all fairly external and therefore something that Believers have only limited control over.

ONGOING SOURCES OF ANXIETY

In addition to explaining the initial triggers of their anxiety, I asked the interviewees to describe the ongoing sources of their anxiety. In doing so, the Tough Guys and Believers described both similar and different sources of anxiety. Many of the Tough Guys spoke more generally about ongoing sources of anxiety as well as general concerns about social situations and the future. The Believers pointed to social situations as an ongoing cause of anxiety as well, but spoke more specifically about their relationships. Both groups also spoke about performance-related stresses. I believe that the Tough Guys spoke more generally about current sources of their anxiety partially
because men (who comprise nearly the entire group) simply aren’t as detail oriented as women and partially because the Tough Guys are less willing to address current and ongoing sources of anxiety in their lives.

**The Tough Guys**

When asked about ongoing sources of anxiety, several of the Tough Guys provided vague responses about concern over things they can’t control:

My anxiety’s about things that I can’t control. (Jack, 21-year-old Senior)

A lotta times I feel like anxiety can come from lack of control over your own thoughts. (Lefty, 21-year-old Senior)

Anxiety’s just like all these things that are really like outside my realm of control. (Ernesto, 28-year-old Grad student)

These answers, rather than really addressing specific sources of anxiety, only reiterated the ways many of the interviewees *defined* anxiety.

Other Tough Guys discussed a combination of anxieties about the future and social situations:

I think the two [ongoing causes of anxiety] I would say would be social situations… and then any situation where you’re forced to think about your future in terms of relationships. (Mr. F, 21-year-old Senior)

I think it’s mostly social and mostly future. (Jack, 21-year-old Senior)

These responses, while technically answering the question, only provide limited insight into the Tough Guys’ sources of anxiety because they are so vague.

A couple Tough Guys did, however, discuss specific performance-related stressors:

I get anxiety when I have a lotta work to do and not a lotta time to do it. Like if I have a week of school where I have like a big game and a big test and a paper due and I just realize I have all that to do this week, I just become overwhelmed by it and I get anxiety about it. (Dale Earnhardt Jr., 19-year-old Freshman)
It’s more like work-related. Like a lotta times I would get anxiety about not getting enough done at work or not spending as much time on something that I should be doing. (Pablo, 20-year-old Sophomore)

I always had high anxiety before games like I’d get really nervous – even like games that weren’t really big, so that’s probly where a lot of my anxiety is. (Dale Earnhardt Jr., 19-year-old Freshman)

These performance-related anxieties about academics and sports are ones that may be common among the Tough Guys, but that most did not specifically identify.

The Believers

The Believers, on the other hand, provided very specific examples of the ongoing sources of their anxiety. One discussed specific relationship anxieties:

For the most part, it’s mostly centered around people I care about and their well-being. (Amy, 20-year-old Junior)

I have a panic about being left. So like I think the reason I worry about people I love is if they die they’re leaving me, if they get hurt they’re leaving me. Like my dad was gonna leave me. Like that was always very hard for me to deal with. (Amy, 20-year-old Junior)

This Believer was able to identify exact causes of her anxieties in her social relationships.

An overwhelming number of Believers also spoke about performance-related anxieties, specifically relating to their parents’ expectations:

I come from a family where it’s just sort of expected that we do really well. So it’s just expected that I excel and do really well. (Alexis, 21-year-old Senior)

I literally just had to be like the perfect daughter that got straight As and did three sports and ballet and hung out with her grandma. (Kitty, 21-year-old Senior)

[My parents] were really disappointed in me first semester even though I did pretty well. So I kicked it into high gear second semester and like last semester’s the first semester I got a 4.0 and that’s the first time I felt like they were proud of me and they expressed it, whereas other times they’ll be like oh, yeah, that’s great and then move on. (Anne, 19-year-old Sophomore)

[The sources of my anxiety are] just school and like pretty much just figuring out what I wanna do. I came into school as a pre-med, bio major and I changed to sociology last year. And I was having a lot of anxiety and getting really anxious. (Tanya, 20-year-old Junior)
I think may anxiety has to do with proving that my intelligence level and my work ethic is just as strong as everyone else’s. (Kitty, 21-year-old Senior)

It seems logical that both Tough Guys and Believers would both have these sorts of pressures and family expectations. However, Tough Guys did not identify them like the Believers did. The Believers as a group are more aware of and/or more willing to admit the specific sources of their anxieties.

**SYMPTOMS OF ANXIETY**

The dominant model used to conceptualize anxiety today is the tripartite model, which is explained in detail on page 20. This model separates symptoms of anxiety into three realms: the physical, the cognitive, and the behavioral (Beidel and Turner, 2005, 18). Each person who has anxiety is likely have at least *some* symptoms in each of these realms. Interestingly, when asked about manifestations of their anxiety, the Tough Guys identified almost solely physical symptoms, while the Believers identified symptoms in all realms. I believe this is because the Tough Guys are primarily men and men are expected to be more concrete and less emotional, so the men’s answers are about concrete facts rather than emotional thoughts and behaviors.

**The Tough Guys**

A couple of the tough guys described difficulties breathing, an escalated heart rate, and an upset stomach:

I just get like – I can feel my breathing get heavy and my heart starts racing. (Jasmine, 21-year-old Senior)

I also get like really nervous inside. I get like butterflies. I feel like there’s a pit in my stomach sometimes. ‘Cuz there’s something there that I really can’t control and fix right away. (Jack, 21-year-old Senior)

Others described an inability to fall asleep and difficulty sleeping through the night:
I couldn’t sleep. I would lie in bed at night and I could hear and feel my heart beating really fast – palpitations is the term they gave me when I went in to get it checked out. And just the typical things like your hands would sweat and you’d feel cold or hot. (Mr. F, 21-year-old Senior)

That’s the biggest thing I think is sleep. ‘Cuz I love sleeping. I used to be able to sleep like nine, ten hours straight. And now it’s like I sleep, I wake up at two in the morning, I wake up again at five in the morning, then I get up to go to work at like eight. (Ernesto, 28-year-old Grad student)

In each of these scenarios, the subject described physical symptoms of his anxiety.

Only one subject described a cognitive effect of anxiety, but he did so in a rather terse and general way:

People who have anxiety are nervous or really dwelling on something. (Dale Earnhardt Jr., 19-year-old Freshman)

Although this Tough Guy does recognize the cognitive aspect of anxiety, he does not even speak about it in the first person. Instead, he generalizes it by speaking about “people” and therefore is not even necessarily acknowledging that it is a symptom of his own anxiety.

The Believers

The Believers, like the Tough Guys, identified a plethora of physical symptoms as the result of their anxiety:

My hands and feet go numb when I get a panic attack. (Amy, 20-year-old Junior)

It’s like a nervous stomach, knot, butterfly feeling in your stomach. I get that a lot. (Kitty, 21-year-old Senior)

I didn’t sleep. I started having trouble breathing. That was – that was my biggest physical symptom: breathing. I felt like I was always wheezing. (Molly, 21-year-old Senior)

Sometimes I feel like I can’t breathe or I’m about to cry or there’s something like pressing down on my chest. (Tanya, 20-year-old Junior)

It’s like this vortex of everything that could possibly go wrong is about to go wrong, so what are you gonna do about it. So physically I get dizzy and headachy and my heart starts beating so fast I think I’m gonna pass out. And it’s just this overwhelming feeling of terror. (Marie, 22-year-old Junior)
My face turns bright red like a tomato. Just like sweaty palms. I completely break out in sweat. (Anne, 19-year-old Sophomore)

One Believer even reported having such intense physical symptoms that she sought immediate medical help:

There was once that we went to the hospital. And I think it was the first serious panic attack I ever had. (Amy, 20-year-old Junior)

This Believer went to the hospital, only to realize that her physical ailments were the result of an anxiety attack.

The Believers also, unlike the Tough Guys, reported many cognitive symptoms as consequences of their anxiety:

It was like I would repeat something that was bothering me over and over in my head and I couldn’t like halt that. And so I would just hear over and over like this is a problem, this is what’s happening. And like I couldn’t tell myself to stop thinking about it. (Amy, 20-year-old Junior)

Very – almost one track mind. So my eyes just get really wide and I have like a mission. And if someone were talking to me I wouldn’t hear that. If someone were to try and stop me, they couldn’t. Just like freaking out in a sense of getting on that one-track mind of doing everything possible to change the situation – to get in that control again. (Anne, 19-year-old Sophomore)

It’s like a constant worry. Not being able to just turn it off. I think that’s the biggest thing. (Molly, 21-year-old Senior)

I have certain – just worries at the forefront of my mind all the time about things that if you were to take a step back you’d be like what are you doing? (Anne, 19-year-old Sophomore)

In each of these descriptions, the Believer recounted the constant state of worry she feels and her inability to control her thoughts.

Finally, a couple of the Believers mentioned the effect of their anxiety on their behaviors:

I’m a very emotional person. I cry when I’m mad, I cry when I’m happy, I cry when I’m sad. (Marie, 22-year-old Junior)

I just really, really want to be in control of everything. Like control of grades, that’s huge. Like I freak out at the tiniest little blimp in a grade and I do everything that’s humanly
possible to like try and get the A. (Anne, 19-year-old Sophomore)

Each of the previous accounts of the ways that anxiety has influenced thoughts and behaviors may suggest to an outsider that these Believers are weak or unstable. While these judgments are unfair and not necessarily accurate, they explain the reason that the Tough Guys did not mention these symptoms, as they wanted to maintain a strong, tough appearance.

THE LABEL OF ANXIETY

The final element necessary to understand both the Tough Guys’ and the Believers’ thoughts on anxiety is their reactions to being labeled as having anxiety – either by themselves or by others. Interestingly, the Tough Guys felt that the label was primarily helpful, while the Believers had mixed feelings about the label. Some felt it helped improve their understanding of their symptoms, while it made others feel quite helpless. I believe that this is because the Tough Guys often labeled themselves as having anxiety, while doctors often labeled the Believers as having anxiety. Therefore, the Tough Guys had more power and control over the label than the Believers. Identifying anxiety also made it easier for the Tough Guys to then deal with their anxiety on their own.

The Tough Guys

Several of the Tough Guys reported that finally identifying themselves as having anxiety provided them with greater insight and the ability to better handle its symptoms:

It made it easier. See if you know that you have something wrong with you that makes it more easy to explain away for yourself. (Mr. F, 21-year-old Senior)

When I started to get more and more aware of it, like I’ll catch myself sometimes and be like why do you care about this? It doesn’t matter. (Ernesto, 28-year-old Grad student)
Some Tough Guys even claimed that identifying their anxiety helped them to develop better coping mechanisms for it:

I think the fact that I recognize it and when I know I’m in a situation now that I am anxious, I just try to take a chill pill, try to take ten seconds, fifteen seconds to be like alright Jack you’re anxious about this, but put it to the side or confront it completely. (Jack, 21-year-old Senior)

Now I know that just having that written rule in my head now that says oh this is how I usually handle anxiety, it’s just a rule of thumb for me now. And I know that anxiety’s about how and why I think about certain things that bother me. (Lefty, 21-year-old Senior)

In general, these men see the identification of their anxiety as empowering because it enables them to more effectively handle it on their own.

The Believers

Some of the Believers also felt optimistic about identifying their symptoms as anxiety:

Once we labeled it I felt like I could understand it. (Alexis, 21-year-old Senior)

I started to do research on my own and I was like that’s why I don’t sleep, that’s why I feel like this, that’s why my heart rate…, this, this, this and everything came together… but it took a while for me to accept the fact that that was what is was. (Molly, 21-year-old Senior)

They, too, sometimes felt that its identification helped them to develop better coping mechanisms:

Like now I can – when I have an anxiety attack, I have chest pain. So I know that that’s what’s happening. So I just figure out that I need to think about something else or just relax and it will go away. (Tanya, 20-year-old Junior)

However, other Believers felt that being labeled with anxiety was intimidating and discouraging:

I mean I think [the label] made it almost feel more daunting. Like I just decided it was something I couldn’t fix. (Amy, 20-year-old Junior)
After I was labeled I really realized like I’m definitely like an odd duck. I don’t like to drink. I don’t like to go out. I haven’t really had the college experience that most people have. ‘Cuz I like to be quiet. I like to go read a book. (Marie, 22-year-old Junior)

For these Believers, the label of anxiety made them feel worse. This is not surprising, since the Believers are the group that buys into the discourse about the powerlessness of people who have anxiety and their need for outside intervention. This group is inevitably somewhat discouraged by the label because to them it denies them the opportunity to be empowered.

Perceptions of Anxiety

NEGATIVE CONNOTATIONS

Naturally, many of the subjects’ descriptions of anxiety, which were discussed in the previous section, are inherently related to societal perceptions of anxiety. Unfortunately, the primary connotation of the label anxiety is typically a negative one. Both the Tough Guys and the Believers commented on the negative connotations surrounding anxiety. Not surprisingly, however, the Tough Guys spoke much more often about the negative connotation of having anxiety. Most importantly, the Tough Guys and the Believers mentioned all of the same negative connotations about anxiety except for one: The Tough Guys frequently alluded to the assumption that someone with anxiety is weak, while the Believers did not mention it at all. This is because for the Tough Guys, being perceived as weak is the ultimate tragedy. Additionally, the Tough Guys often talk about the negative connotations of anxiety as if they believe them as well, while the Believers speak about negative connotations of anxiety as originating from people who do not have anxiety themselves.
The Tough Guys

The Tough Guys were very clear about the fact that society (and often they themselves) perceives anxiety as something that is a negative:

Anxiety is all negative. Anxiety is just – it’s so big already that you wanna get it down to... the point where you can handle it. (Lefty, 21-year-old Senior)

Anxiety’s such a strong word that no one wants to really admit to saying that they have it. I think some people are more open about it in general. (Alfred, 22-year-old Senior)

It’s a weakness. Like you’re not gonna talk about something – like if you’re talking about baseball or something, you’re not gonna talk about something and be like yeah I’m so bad at that and just keep talking about something or some problem you have or something you’re bad at. (Fred, 22-year-old Senior)

In this last comment, a Tough Guy even compared having anxiety to being bad at a sport.

One Tough Guy continuously referred to anxiety as something that is not normal or something that a normal person would not have:

Like I’ve always been nervous like every day – not every day but just like times when I knew normal people wouldn’t be nervous, I’d be nervous. (Jasmine, 21-year-old Senior)

I was like okay that’s not normal – and that’s kinda what made me realize I had anxiety, I think. (Jasmine, 21-year-old Senior)

These feelings of abnormality reveal that this Tough Guy feels isolated and different. She does not feel that she meets society’s standards.

Other Tough Guys described a person with anxiety as someone who is considered crazy:

I feel like people who are depressed or have anxiety are just made out to look like crazy. And I feel like in today’s world you have to look so perfect and you have to have the perfect life and it’s like people try to hide things like you do have mental illness. (Jasmine, 21-year-old Senior)

I think it’s stigmatized… If you say you have anxiety you associate anxiety with anxiety attack and anxiety attack means that someone thinks you’re crazy. (Lefty, 21-year-old Senior)
Additionally, one Tough Guy repeatedly explained that he perceived the stereotypical person with anxiety as someone who is unstable and lives a chaotic life:

I think they’re disorganized. A lotta people that I know that have anxiety have very chaotic lives, very disorganized. They’re not very stable. (Alfred, 22-year-old Senior)

Most of the people that I know that have anxiety are very disorganized. Their life is very chaotic. There’s not enough structure to have stability. (Alfred, 22-year-old Senior)

I think these people with anxiety – they’re so fragile when it comes to their involvement with life, with standard, typical, daily actions. (Alfred, 22-year-old Senior)

Finally, the Tough Guys consistently mentioned or suggested that people with anxiety are weak and/or should be able to overcome their anxiety:

I mean people have always said like worrying gets you nowhere. It’s like being in a rocking chair. Like it does nothing for you in the end. So that’s part of the reason I don’t get anxiety is because I just don’t freak out about what’s going on. (Alfred, 22-year-old Senior)

I think you might be more susceptible to having anxiety, but you needa be able to overcome that and you needa be able to fix it. Like if the reason why is because you’re freaking out over the problem, then don’t worry about the problem nearly as much. (Alfred, 22-year-old Senior)

People who are anxious, in society people just look at them like why can’t you just deal with your problems, why can’t you just get through it? (Jack, 21-year-old Senior)

I kinda felt like a wuss or something [when I was diagnosed with anxiety]. (Mr. F, 21-year-old Senior)

I do think in general in society, people who have anxiety are treated or thought of as someone who’s a weak individual. (Jack, 21-year-old Senior)

These Tough Guys, while all except for Alfred considers himself to have anxiety, seem to have little sympathy for people with anxiety. This seems ironic, but these men are only holding others to the same standard they hold themselves to. They expect that they should be able to deal with and fix their anxiety in a strong, non-emotional way.

The result of these negative perceptions of people with anxiety is ultimately embarrassment. Nearly all of the Tough Guys expressed some sort of shame about their anxiety and/or its symptoms:
Like freshman year I didn’t tell anyone about my anxiety because I was embarrassed and I thought it was weird. (Jasmine, 21-year-old Senior)

If everybody knew [about my anxiety], then I’d feel embarrassed and ashamed about it. (Jasmine, 21-year-old Senior)

I would definitely feel embarrassed and ashamed if I had anxiety. (Alfred, 22-year-old Senior)

You don’t wanna feel stigmatized, you feel weak, you feel ashamed. You don’t wanna be seen as deficient. (Mr. F, 21-year-old Senior)

I think I did feel embarrassed about my anxiety. Because I keep thinking back to the high school years when I didn’t have anxiety – or at least I didn’t think I had anxiety and I didn’t cope with it, and I’m like why am I not like used to be. But I think I’m the same person. (Jack, 21-year-old Senior)

If I’m in public, I’ll try not to let my anxiety show. Like I’ll just hold it in and keep it to myself – because again, you don’t wanna be judged by others. (Pablo, 20-year-old Sophomore)

So if I think I’m having anxiety I might not do something to come off as being anxious. A lotta times I hold myself back from saying stuff. (Pablo, 20-year-old Sophomore)

Often, because of this embarrassment and the possibility of appearing weak, these men do not feel comfortable being open about their anxiety.

**The Believers**

In contrast, while the Believers expressed many of the same ideas about connotations of anxiety, they expressed them much less frequently and made no mention of weakness at all. The Believers expressed that those without anxiety or those not yet diagnosed with anxiety had negative perceptions of it:

I feel like anxiety is like frowned upon by people. (Kitty, 21-year-old Senior)

Someone came in and was like look we think you had an anxiety attack. I was like – I was so offended. I was like NO. I was like no I have something physically wrong with me. I like couldn’t breath like legit. And they were like no, you have anxiety. (Molly, 21-year-old Senior)

In the second comment, the Believer describes her reaction when the doctor first told her she had anxiety. Before she was a Believer, even she did not want to accept the label.
The Believers, like the Tough Guys, also used language that implied that anxiety is not considered normal:

I would say that I have anxiety because it can control my life and prevent me from doing normal behavior – you know like prevent normal functioning. (Alexis, 21-year-old Senior)

I just would get nervous about something and couldn’t cope with it normally. (Amy, 20-year-old Junior)

I constantly find myself trying to act normal if people know [about my anxiety]. (Marie, 22-year-old Junior)

A couple other Believers alluded to the fact that anxiety implies craziness and instability:

Like I’m just now noticing how crazy I am about things. (Kitty, 21-year-old Senior)

I had to tell my parents that the doctors diagnosed me with anxiety and they were like no, no, no. They were like no way – because I’m like a very stable person. (Molly, 21-year-old Senior)

These Believers, unlike the Tough Guys, seem to talk about these stereotypes more in terms of other people’s thoughts rather than their own judgments of people with anxiety.

Perhaps it is for this reason that the Believers spoke much less about embarrassment. The only person who admitted to being embarrassed was not embarrassed about the fact that she has anxiety, but rather about the numerous treatments she has tried:

I feel embarrassed about the extent of what my treatments are. But it’s kinda like a societal norm now that people take medication. (Marie, 22-year-old Junior)

The Believers seem much less embarrassed about their anxiety because they feel that the people who have negative opinions are those who do not have anxiety and therefore do not understand it. They are also less embarrassed than the Tough Guys because it is not as important for them to appear strong and unemotional.
POSITIVE PERCEPTIONS

Despite all of the negative connotations associated with anxiety, there are some people who see anxiety as serving a positive function. Surprisingly, in my research these people were primarily the Tough Guys. Although the Tough Guys were most likely to discuss and agree with negative connotations about anxiety, they were also committed to handling their anxiety on their own rather than seeking treatment to fix it. For a few of the Tough Guys, this meant seeing the benefits of it in order to better cope with it on their own.

The Tough Guys

A couple of the Tough Guys discussed several ways that they thought anxiety had a positive influence on their lives and activities:

I feel like anxiety kinda pushes me to do well. Like before games if I’m not really nervous about things, I generally don’t play as well. And I see that in our team too. (Dale Earnhardt Jr., 19-year-old Freshman)

But I think that anxiety pushes me. You just have to know which way to go about it. (Dale Earnhardt Jr., 19-year-old Freshman)

Anxiety, in a lot of ways, is fear of not doing well on something. And that can produce a lot of anxiety. And if you don’t have that fear, I think you might become lazy and not so worried about what’s coming up and you might just forget about it and not achieve as much. (Dale Earnhardt Jr., 19-year-old Freshman)

I think my anxiety is a positive thing in a way because it’s helping me manage my time… I don’t think that’s a bad anxiety because it helps me manage my time and at the end of the day I get everything done. So in a way it’s positive. (Pablo, 20-year-old Sophomore)

Both of these men see anxiety as a force that pushes them to excel and work harder. For Pablo, it also prevents laziness and encourages better time-management. These two Tough Guys have both dealt with their anxiety on their own and perceiving it as a positive influence is one of things that makes it easier for them to deal with.
The Believers

The Believers, on the other hand, did not report many ways that they saw anxiety as being something positive. One woman said that as a result of her anxiety:

I’m very – like I’m always like up on things. I’m always sorta ahead on like people’s birthdays and stuff like that. So I think in that sense I’m really grateful towards [my anxiety] and I think it’s been a positive thing. (Alexis, 21-year-old Senior)

Other than this single comment, however, none of the other Believers reported any positive results of their anxiety. This is because the Believers believe the discourse that anxiety is a problem that must be fixed with the help of professionals. The reason that they do not personally accept the negative connotations about anxiety is because they see those judgments as originating from people who have not experienced anxiety and therefore they do not consider them valid.

OPENNESS ABOUT ANXIETY

As a result of the various connotations and perceptions about anxiety, people exhibit varying levels of openness about the fact that they have anxiety. As expected, the Tough Guys don’t discuss their anxiety with others. The Believers, while they acknowledge that it is difficult to talk about, are still willing to open up about it and see it as something far more socially acceptable than the Tough Guys. This, once again, relates to males stereotypes of strength and their resulting unwillingness to discuss something that may be perceived as a weakness.

The Tough Guys

When asked about whether or not they are open about the fact that they have anxiety, most tough guys did not directly answer the question and instead explained why they would not talk about it:
I don’t want people to treat me differently… I feel like a lotta times, you just gotta deal with it yourself… And I don’t want people to look at my as like oh he has anxiety that’s why he gets mad or he’s got anxiety that’s why he gets worried before games. I just would rather people look at me for who I am rather than someone with anxiety. (Dale Earnhardt Jr., 19-year-old Freshman)

My family isn’t really supportive in that regard. Like I wouldn’t say oh hey I’m having anxiety or something because I just don’t think they’d have any idea what to say. So I wouldn’t bother. (Ernesto, 28-year-old Grad student)

The Tough Guys are not willing to discuss their anxiety with others partially because they do not want to be perceived differently and partially because they have convinced themselves that it is not important to talk about.

**The Believers**

The Believers, while more willing to discuss their anxiety, nevertheless recognized that doing so involves significant difficulties:

I think for [my dad] it was a little hard just because like my dad doesn’t believe in therapy. ‘Cuz I don’t think my dad really believes in like thinking about what bothers him… He’s just not that emotional. (Amy, 20-year-old Junior)

It’s hard telling someone about your anxiety without thinking they’re gonna judge you. (Alexis, 21-year-old Senior)

Coming from Brazil where anxiety’s not really known very much, [my mom] kinda said to me one day – she was getting really frustrated about me being upset all the time – and she just said if you were in Brazil and said that you had anxiety, they would just like give you a gun to shoot yourself. And I was like oh, thanks [laughs]. Culturally it’s not acceptable. (Tanya, 20-year-old Junior)

These Believers expressed a number of reasons that it is difficult to discuss their anxiety with others including fear of judgment and cultural differences.

The Believer were, however, more optimistic than the Tough Guys about the option of talking about their anxiety and the social acceptability of doing so:

I think that therapy and medication are both pretty socially acceptable by now. (Anne, 19-year-old Sophomore)

I just feel like it’s such a new epidemic of so many people having so much anxiety and depression. (Molly, 21-year-old Senior)
Both of these Believers saw the increasing prevalence of anxiety, therapy, and medication as a sign that discussing one’s anxiety is becoming increasingly acceptable. This does not mean that judgments about people with anxiety have disappeared entirely, but for the Believers the fact that it is becoming more prevalent is a step in the right direction.

REACTIONS TO OPENNESS ABOUT ANXIETY

Despite differing feelings between the two groups about openly discussing one’s anxiety, what is perhaps even more important is the way that people are actually treated after sharing that they have anxiety. One Tough Guy expresses her concern regarding this issue:

I’m still worried that I’ll be judged by my friends for having anxiety. (Jasmine, 21-year-old Senior)

Based upon my research, it seems that people have one of two reactions after learning that someone has anxiety: Either the person is judgmental and rude or the person is accepting and overly cautious. There are indications that this would occur with both the Tough Guys and the Believers. However, since only one of the Tough Guys ever opened up about his anxiety, it is difficult to be entirely positive.

The Tough Guys

The one Tough Guy who reported opening up to someone about his anxiety had an extremely negative experience:

I told my advisor – kinda, I didn’t get into great depth about it… And she just kinda looked at me like – it was weird. She was not supportive at all, which is weird ‘cuz she’s my advisor in the program. She gave me this kinda look. She like sat back in her chair and gave me this look – I dunno it was the bizarrest reaction… And after that – after I told her that, the rest of the semester, I would say things in class and even if they were right, even if it was something completely on topic, she’d just be like oh, yeah, well anyway. And she’d call on someone else. (Ernesto, 28-year-old Grad student)
Ernesto felt that his teacher judged him after he told her about his anxiety and from that point on she looked down upon him.

Another Tough Guy suggested that, rather than being treated maliciously, if he admitted to having anxiety he might be treated more carefully. He explained why he did not want to discuss his anxiety with others:

I just want people to look at me as a person rather than someone they have to change their actions and be careful around. (Dale Earnhardt Jr., 19-year-old Freshman)

This Tough Guy assumed that in response to his admission of having anxiety, people would change their behavior and treat him more carefully. Although this may be true, it important to note that no Tough Guys reported actually experiencing this response. It is possible that most Tough Guys who admitted to having anxiety would be judged because of the societal expectations that men be strong and unemotional.

The Believers

The Believers reported similar responses to their openness about having anxiety.

One had a negative experience after talking about her anxiety with a friend:

I had one friend in middle school and I told her that I had gone to a therapist about anxiety. And I remember her thinking it was like really weird. And she was really freaked out and judgmental about it. So I have had people be a little weird about my anxiety. (Amy, 20-year-old Junior)

This Believer was surprised and hurt that her friend judged her for having anxiety and seeking treatment.

A few other Believers reported that people were more gentle and cautious with them after they revealed that they had anxiety:

They’re a lot more gentle with me and like really cautious. And that’s usually when they first find out. But as our relationship progresses they’ll figure out that they don’t have to be so gentle and so quiet. It’s just a part of me. Even them being gentle and quiet could still trip something. (Marie, 22-year-old Junior)
I remember last year I was getting involved in like a lotta clubs. And I was getting overwhelmed and I had to write e-mails and be like I’m just getting to stressed out right now, I can’t do this right now. They were just kinda like –they didn’t make me do a lotta things anymore. They were just like do what you can. I appreciated it to some extent, but I also didn’t want them to feel like I wasn’t responsible or that I couldn’t take care of myself or that I couldn’t get things done. (Tanya, 20-year-old Junior)

These subjects, while they appreciated the concern that people showed for them, also felt somewhat isolated and negatively labeled when they were treated so carefully.

Additionally, because the Believers are females, people who learn that they have anxiety are more likely to treat them as unstable than they are the Tough Guys.

**Treatment Options**

**PSYCHOLOGICAL TREATMENT**

Next we will turn to a topic that is, for the purposes of this study, perhaps more important than people’s definitions and perceptions of anxiety: people’s ideas about treatment. This is where the opinions of the Tough Guys and the opinions of the Believers really start to diverge. This is, in fact, the factor that essentially determines whether someone is a Tough Guy or a Believer. When asked about psychological treatments, the Tough Guys expressed negative feelings towards them and did not seem to think it would be effective. The Believers, on the other hand, were extremely optimistic about therapy and every one of them had gone to therapy at one time or another. They did, however, still express feeling uncomfortable about going because of the stigmas surrounding therapy.

**The Tough Guys**

The Tough Guys felt that there is most definitely a judgment of people who go to therapy:
Like if people found out I was goin’ to see a psychiatrist, they would think it’s weird… They’d be like oh like she’s a freak ‘cuz she goes to see a psychiatrist. (Jasmine, 21-year-old Senior)

I’m not tryin’ to say I look down on people who go get help and stuff like that or anything like that, but I think for me I kinda look down on myself when I just dwell on my own problems. (Dale Earnhardt Jr., 19-year-old Freshman)

Their interviews suggested that they perceived an extremely negative connotation relating to therapy:

I think there is a stigma to therapy and medication. Because people are very judgmental and depending on who you tell, they’d be like oh that’s kinda weird. You know, why is he going to that? So they might look at you differently. (Pablo, 20-year-old Sophomore)

I have some fear of being stigmatized – or not stigmatized but you know feeling like I need someone else to made me okay. (Mr. F, 21-year-old Senior)

I think what I would do [if my anxiety got a lot worse] is I would take these conversations first to – I mean if you wanna call it therapy, go for it – but I think it would be someone on BC’s campus (if I was still here and wanted to do it) who’s like kind of a professional. I don’t know if I could consider him or her a doctor… So think yeah I think maybe therapy in a sense, but I don’t know if I would go make an appointment with a psychiatrist or something like that. And maybe that’s just me being like I don’t need that. (Jack, 21-year-old Senior)

This last Tough Guy is barely even willing to label his hypothetical decision as therapy. Although that’s essentially what it is, he clearly feels such a stigma about therapy that he cannot ever consider himself participating in it.

As a result of these negative feelings and stigmas regarding therapy, the Tough Guys are generally unwilling to even consider participating in it. One Tough Guy explained that she found therapy ineffective:

I mean I was really like – I really didn’t get anything out of it. I don’t think she got anything out of me. I was very anti going and I didn’t try. (Jasmine, 21-year-old Senior)

Another expressed that he did not feel that therapy would be worth spending his money on:

I mean I don’t see myself spending the money ‘cuz I’m too cheap to pay for that. And I don’t see myself going and talking to someone who I’ve never met before just for like an
hour a week or whatever. I just don’t see how that would affect me. (Fred, 22-year-old Senior)

What this Tough Guy is really implying, however, is that he does not believe that therapy would work. The Tough Guys as a group are simply not convinced that therapy is necessary or would even be helpful in dealing with their anxiety.

The Believers

The Believers, on the other hand, are the complete opposite. The entire group had experience with therapy. Many of them had several therapists and formed bonds with them:

I saw someone here for a while. I saw a psychiatrist here. I’ve seen a social worker in Coolidge Corner. I didn’t like her so then I switched to someone in Newton Center. And that was all in college. And besides college I would see this doctor. I saw him eighth grade, freshman year. (Alexis, 21-year-old Senior)

I’ve always had close relationships with medical doctors. (Marie, 22-year-old Junior)

The Believers often reported seeing several therapists throughout their lives and some even saw them as friends.

Not surprisingly, the Believers consistently expressed that they felt therapy was effective and some even said that they enjoyed it:

Therapy’s been really effective to the point that I make it effective. (Marie, 22-year-old Junior)

I actually went to therapy this summer... And I found that really helpful. (Amy, 20-year-old Junior)

I like loved going to therapy. I think in my life I like to play therapist for other people, so it was kinda a time where we could just talk about me. So I really enjoyed it. I never disliked going. (Alexis, 21-year-old Senior)

I’ve been seeing [names doctor] who’s like my Santa Claus. He looks like the stereotypical psychiatrist who gets in his big leather chair with his slippers on and he’s got this big Santa beard and asks you what’s wrong. He’s the best. You know, I probly wouldn’t still be around if it weren’t for him. He’s the one who prescribes me my medications. (Marie, 22-year-old Junior)
One day I just called counseling and was like, you know I needa see somebody right now. They put me in touch with the psychologist on call. And I thought that she was really helpful, so I’m still seeing the same person. That was the beginning of second semester sophomore year. (Tanya, 20-year-old Junior)

The Believers felt that therapy really helped them to better manage their anxiety.

Nevertheless, many of the Believers still expressed feeling uncomfortable or awkward about going to therapy:

I felt so awkward when I went. I got pit stains every single time that I went to counseling. I got so nervous. Every single time. I got so nervous, like I’d literally be dripping in sweat. Like I just feel so uncomfortable talking about my feelings. It’s so awkward. (Kitty, 21-year-old Senior)

I was so embarrassed to walk into that room ‘cuz it was right in Campion and right where all of the classrooms are. And I’d be like just sitting in the waiting room like please call my name so I can just go in the door… I would literally have to sit there and convince myself like okay, if someone comes in the office they’re here because they literally have the same thing that you have and they’re not gonna judge you because they’re probably thinking you have the same thing as they have. So I’d like have to talk myself down from being so creeped out of being at the office. (Kitty, 21-year-old Senior)

It was very much my choice to go. Like I was the one who told my mom I think I need this. But then I would always get really nervous. Like hands sweaty, but the chills at the same time. And just really, really uncomfortable and that’s why I stopped going. I definitely talked. I opened up a lot and I said a lot of things, but I was still very uncomfortable about it. (Anne, 19-year-old Sophomore)

I did talk to my mom about going back to therapy and she suggested that I talk to someone here, but I again just pushed that to the side kind of. So it is – yeah, I don’t think I should have stopped going in the first place probably. I think that I just felt uncomfortable. (Anne, 19-year-old Sophomore)

I was nervous at first. I didn’t want anybody to know I was going to see a psychologist, but you can’t really hide it ‘cuz it’s on campus. And I was also kind of worried that it wouldn’t help me at all or that I was just going and talking to this person and that’s it and it wouldn’t be helpful. So I had my doubts at first. But I kept going. And sometimes you know I’d be like I don’t wanna go because I feel fine today. But then the next day I’d feel really bad. Right now I’m doing like once a week… I think right now that just talking to a psychologist is helpful. (Tanya, 20-year-old Junior)

These Believers all felt nervous about going to therapy for one reason or another. Some were concerned about being judged:

I also have this really bad stigma – I think it comes from my dad that I think counselors are for freaks – and I’m like embarrassed to go to a counselor and it took me almost six months to even tell my mom that I was going to a counselor. Like I think it’s really weird
and freakish and I would completely lie about it if someone asked about it. (Kitty, 21-year-old Senior)

Others felt uncomfortable opening up about their emotions. The fact that most of the Believers continued to go to therapy despite these feelings of uneasiness truly reveals how essential they consider therapy to be.

PHARMACOLOGICAL TREATMENT

The Tough Guys’ and Believers’ opinions of pharmacological treatments were somewhat similar to their opinions of therapy. However, both groups seemed to be slightly more apprehensive about medication as a treatment option. The Tough Guys were extremely critical of it and often expressed that they did not view it as a real solution, but rather saw it as a crutch or a copout. While many of the Believers were at one time on medication, they also saw its as potentially dangerous. Some Believers even expressed that they would not be willing to take medication themselves, but were clear that they would not judge others for doing so.

The Tough Guys

The Tough Guys expressed negative feelings about medication as a treatment for anxiety. They also often mentioned the stigma of taking medication for a mental illness:

The stigma like oh you’re on meds, like you’re crazy. Like that kinda thing. I think that has a stigma. And if people found out that I took like antianxiety meds or antidepressant meds I just think that would make my anxiety worse. (Jasmine, 21-year-old Senior)

I do think there’s a stigma behind going on medication for anxiety… When someone’s on medication for anxiety, I’m kinda like – like I do think why can’t they deal with that on their own? (Jack, 21-year-old Senior)

I just think that like the majority of just the general population would think oh she’s crazy if she’s on medication. (Jasmine, 21-year-old Senior)
These Tough Guys would never even consider medication as a treatment option for their anxiety because of the judgments that would be made about them.

Additionally, many Tough Guys expressed that they did not feel medication is an appropriate way of handling anxiety:

I think that’s a temporary solution to a permanent problem. (Alfred, 22-year-old Senior)

I don’t really take any drugs for anything like that and I just don’t think it would be good. (Fred, 22-year-old Senior)

But I don’t think I would seek any medical – like taking any medicine for it or stuff like that. I’m the type of person that doesn’t really rely a lot on medicine for stuff like that. (Pablo, 20-year-old Sophomore)

I dunno it’s hard to tell if meds are working. Like when I have a headache – some people are just like oh give me a bunch of Tylenol, I don’t even think of that. I just don’t really think of drugs as a solution. It doesn’t just come to my mind. (Fred, 22-year-old Senior)

Since we’ve gotten more into psychology and since that’s generally a new topic, I think people have gotten really caught up on like always trying to have anxiety pills and for if you get a little depressed. (Dale Earnhardt Jr., 19-year-old Freshman)

Several Tough Guys expressed a general aversion to medication as a way of handling problems. To them, medication cannot and should not be used to deal with one’s anxiety.

A large part of the reason that the Tough Guys are particularly against medication is their concern about feeling or seeming weak. The Tough Guys often viewed people who take mediation as not being able to handle their problems and instead looking for an easy way out:

I don’t feel comfortable with [medication] and I feel like it’s kinda a crutch. (Mr. F, 21-year-old Senior)

The thing is I think once you’re on it sometimes people are afraid to go off it. It becomes almost like a crutch. I think that rather than finding other ways to manage anxiety, they just stay on the meds. (Ernesto, 28-year-old Grad student)

I just feel like sometimes it’s a copout. It’s like a crutch that people use and they really should just try to tough it out and try to just get in touch with themselves… I just feel like there’s too much out there and people just run to it. (Jack, 21-year-old Senior)
If someone had the exact same problems that I did and they were like taking meds just to make themselves feel better, I’d be like that’s kind of weak. (Mr. F, 21-year-old Senior)

And that’s kinda where maybe my stigma comes from – that, okay I’m really sad and I’m not happy with my life and maybe I’m anxious, let me just take this medication and I’ll be fine. They don’t have steps in between and then that’s the last thing that they do because they can’t do anything else. (Jack, 21-year-old Senior)

For the Tough Guys it is extremely important to feel strong and able to handle things on their own. To them, going on medication implies weakness and therefore it is not something they would ever consider.

The Believers

For the Believers, on the other hand, it is a different story. Some of the Believers strongly advocated their openness to and use of medication:

I’m game for everything. I mean if it could help me I’m down for it. (Marie, 22-year-old Junior)

I’m a huge like – I’m a pill popper. I just wanna take a pill and I think it’ll work. (Alexis, 21-year-old Senior)

No one can convince me that it’s a bad thing to be on medicine. (Alexis, 21-year-old Senior)

Unlike the Tough Guys who judged people for taking medication, they perceived taking drugs as something that is increasingly becoming socially acceptable:

I feel like taking pills has become a society norm. But even then you have to be on that pill so you don’t have those crazy anxiety bouts or whatever. (Marie, 22-year-old Junior)

I mean I think it’s really normal to be prescribed on something these days. I think that if you were to be like I’m on these meds someone would be like okay. (Molly, 21-year-old Senior)

Not surprisingly, many of the Believers themselves were on various medications for varying lengths of time:

I talked to my physician’s assistant that I usually go to. And she was like why not try meds – like why not? (Molly, 21-year-old Senior)
My mom prescribed me Elavil, which is an antidepressant, which is actually like used for functional dyspepsia, which is what I developed. But I think it was all a result of my anxiety. (Alexis, 21-year-old Senior)

They put me on Klonopin and I’ve been on that since I was in second grade until now. And I go off and on it. (Marie, 22-year-old Junior)

I’ve been on Celexa since fifth grade, but on some sort of anti-depression medication since second grade. I take it consistently. I’ve tried to get off it and that’s when trouble happens, so they’re just leaving me on it ‘til I get out of college. (Marie, 22-year-old Junior)

I got on probably two months [of] Celexa, which is an antidepressant but it works for anxiety. So I started on like a really low dose of that. I took that probably for two months before I went abroad. Took it the whole time I was abroad. (Molly, 21-year-old Senior)

These Believers saw medication as a helpful and necessary part of their coping with anxiety. They did not perceive their taking prescription medications for anxiety as an earth-shattering event, but rather as a typical way of treating their anxiety.

Other Believers, however, did not feel as comfortable with taking medication:

Nevertheless, they always expressed an openness to others taking medication:

Having experienced some really bad anxiety, like if it was constant in the way that I have felt it, I would definitely try just about anything to get rid of that. So I have no judgment if people wanna take meds. (Amy, 20-year-old Junior)

I was raised with the mindset that pills are for crazy people. Which like if someone else takes them I don’t think that’s weird. Like I don’t frown – I don’t look down upon people for taking like an anti-anxiety medication and sometimes like that really works, but if I ever considered taking it I’d be like – like if someone asks me if I’m on medication I wanna be able to say no. (Kitty, 21-year-old Senior)

So I wouldn’t frown upon medication for others – just not for myself. But I think it does – like from experience – I definitely think it does help. (Kitty, 21-year-old Senior)

I think if that’s something that you want to do and that you have to get permission from your doctor for anyway, go for it. (Kitty, 21-year-old Senior)

Even if they themselves did not feel that medication was right for them, these Believers by no means felt that medication was inappropriate for others to take.

The Believers did, however, recognize possible dangers of taking medication:
I’m actually trying to wean myself off my Elavil right now… I worry that when I come off it I won’t be able to function because I’m able to function so well on it. (Alexis, 21-year-old Senior)

I get really nervous ‘cuz they’ve told me that I’ve stopped producing serotonin on my own. Which makes me terrified ‘cuz that means I won’t be able to live without medication. (Marie, 22-year-old Junior)

I worry that there’s an overmedication of society and that we can’t deal with just what should be normal human problems and that we’re just reaching for medication way too fast. (Marie, 22-year-old Junior)

While these Believers expressed concern about being addicted to prescription medications and about a general overmedication, they both continue to take prescription medications themselves. So, although they realize the possible ramifications of widespread medication for anxiety, those ramifications are not so concerning that they affect their willingness to take drugs.

OTHER COPING MECHANISMS

In addition to psychological and pharmacological treatments, many interviewees described other coping mechanisms that they use to manage their anxiety. For the Tough Guys, these coping mechanisms were often alternatives to therapy and drugs – some good and some bad. For the Believers, these coping mechanisms were often complements to therapy and/or drugs. This is not surprising since the Tough Guys are opposed to therapy and drugs and try to find their own ways of managing their anxiety, while the Believers accept therapy and/or drugs as treatments for their anxiety.

The Tough Guys

The Tough Guys often feel the need to find their own ways of dealing with their anxiety. One Tough Guys explained:
You need to have the philosophy of let’s not dwell on the negative. Let’s focus on the positive. Let’s focus on how we can address it, how we can fix it. (Alfred, 22-year-old Senior)

For one Tough Guy, managing his anxiety involved talking to people about it and asking for advice:

So just doin’ things like speaking to advisors and stuff like that when you do feel overwhelmed. (Lefty, 21-year-old Senior)

Many other Tough Guys reported practicing relaxation techniques or trying to reflect by looking inside themselves for explanations of their anxiety:

A lotta times I like to meditate. (Jack, 21-year-old Senior)

I would never consider like pharmaceutical treatments ‘cuz I don’t think it’s – maybe just relaxation therapy or something. Like meditation or something like that. (Ernesto, 28-year-old Grad student)

Before I go to bed at night, I watch relaxation videos on YouTube sometimes. It’s just like meditation-type stuff. (Ernesto, 28-year-old Grad student)

I used to… go to the ceramic room and throw ‘cuz that would calm me down. That was like my stress relief for my anxiety. That’s how I would control my anxiety. So I believe in those types of treatments before medicine treatments. (Pablo, 20-year-old Sophomore)

Speaking to others and reflecting on sources of one’s anxiety are both positive ways of addressing one’s anxiety.

Some Tough Guys, however, reported less constructive ways of dealing with their stress. One described how he handles his anxiety while flying:

I do drink on flights and stuff to relax. (Mr. F, 21-year-old Senior)

Others admitted that sometimes they do not feel it is necessary to deal with their anxiety at all. Instead they find distractions:

I think the biggest thing is when I’m anxious I like to surround myself with people because I can’t sit and be alone. (Jack, 21-year-old Senior)

Most people can just ignore it or do something else. Like when they’re nervous about something or anxious about something, they can do some other form of activity. (Fred, 22-year-old Senior)
When you have anxiety, just relax or do something else and just ignore it. (Fred, 22-year-old Senior)

Ignoring one’s anxiety is obviously not an effective way of managing it in the long term. However, some of the Tough Guys continue to do so because they do not want to address their anxiety at all.

The Believers

The Believers described coping mechanisms that often accompanied their psychological and/or pharmacological treatments. Many women described making lists in order to manage their stress:

And like when I get anxious, my coping mechanism is to make lists of like everything – things that I do or things that I wanna do in my life or like whatever – whatever it is. I will make a list to like calm myself. (Amy, 20-year-old Junior)

I write things down – like I make lists. And I love being organized. I think that allows me to take control. (Alexis, 21-year-old Senior)

I have to make lists about everything and if I don’t make lists I freak out… it’s like one of my highs during the day to cross out something on the list. I thoroughly enjoy it. (Kitty, 21-year-old Senior)

Only one described also trying relaxation techniques in order to not be as affected by her anxiety at night:

Like before bed I write, I listen to the like the same soundtrack music every single night just to get myself ready to like turn off my brain, stop worrying, and go to bed. I don’t know I think that a lot of people find a lot of things de-stressing like working out and I know that when I’m working out and eating healthy I’m less stressed out like I’m less anxious already like I feel good like when my body feels good I feel good. (Molly, 21-year-old Senior)

In general, the Believers have less of a variety of coping mechanisms because they see therapy and drugs as a large part of treating their anxiety. They also are more willing to constructively address their anxiety than the Tough Guys who sometimes reported either ignoring it or using alcohol in order to deal with it.
WHY TOUGH GUYS DON’T SEEK TREATMENT

It is clear based upon the data presented about opinions of various treatments that the Tough Guys do not feel that their anxiety requires external intervention. The logical question, then, is why? Why is it that the Tough Guys do not buy into the discourse that professionals must treat their anxiety? The Tough Guys provided two main answers to this question. The first is that they simply do not feel that their anxiety is bad enough that it requires treatment. The second is that they do not really consider any anxiety to be bad enough to warrant treatment.

The Tough Guys

Some Tough Guys claimed that they did not perceive their anxieties as being bad enough to warrant therapy or drugs:

I know like I have anxiety that I definitely alters my day-to-day life, but I don’t think it alters it enough that it’s like I need help for it. (Jasmine, 21-year-old Senior)

I still wouldn’t consider seeing a therapist for it just because it’s like okay, yeah I do have a lot on my plate. It’s not abnormal to feel like this. (Ernesto, 28-year-old Grad student)

As a result, these Tough Guys felt that they could and should handle their anxiety on their own:

It’s just one of those things that I think I can tackle it head on and it’s fine with me. I mean I think more recently it’s been more overwhelming, but it’s never been to the point where I’m being completely taken over and I need to do something to fix it. I feel like I can deal with it on a day-to-day basis with certain aids. (Jack, 21-year-old Senior)

I kinda just like to heal myself and deal with it on my own with a lotta things in my life. (Jack, 21-year-old Senior)

If I don’t deal with it through myself I think that I might be taking an easy way out and I just think that generally in life the easy way out is not the best way. (Dale Earnhardt Jr., 19-year-old Freshman)

Another Tough Guys felt that anxiety is something that is overemphasized as a problem in our culture when in fact it is a natural instinct that need not be treated:
To me, anxiety and depression and all that stuff is just kind of life. I feel like probly like a hundred years ago when there was no such thing – like when they didn’t really study psychology and didn’t think of anxiety really – they just thought, oh I’m nervous because I have to perform. (Dale Earnhardt Jr., 19-year-old Freshman)

I feel like anxiety and depression and all that stuff are like an instinct an animal would have. (Dale Earnhardt Jr., 19-year-old Freshman)

This Tough Guy even felt that there were positive consequences of handling anxiety on his own:

Learning through those experiences is what builds your character up and makes you the person that you are. (Dale Earnhardt Jr., 19-year-old Freshman)

Overall, the Tough Guys simply do not buy into the anxiety discourse that suggests they need therapy or drugs to manage their anxiety. Instead, they see it as something they themselves can and should manage.

**Anxiety in the Media**

**ANXIETY STEREOTYPES**

Based upon the data in the previous sections, it is clear that the Tough Guys do not buy into the anxiety discourse presented earlier, while the Believers do. In light of this establishment, I would now like to examine the two groups’ thoughts and observations about anxiety in the media. Examining anxiety in the media is only logical based upon the ways the anxiety discourse is often presented through direct-to-consumer advertising and other propaganda. Therefore, the following sections will be dedicated to understanding the Tough Guys’ and Believers’ thoughts and observations about certain media and media sources.

One Tough Guy reiterates:

I think the media influences like pretty much eighty percent of what we perceive. I dunno it’s just like all around us all the time – like the Internet, the TV, like everything. So yeah
I feel like it gave the stigma of people who have a mental illness or have anxiety that they’re just like not normal and that’s not okay and they’re like crazy people. (Jasmine, 21-year-old Senior)

In general, both groups seem to have a fairly negative opinion of the stereotypical portrayal of anxiety in the media. Both groups mentioned that portrayals of anxiety in the media are inaccurate and often depict primarily women. Nevertheless, these media stereotypes are consistent with the perceptions and connotations about anxiety presented earlier.

The Tough Guys

When asked about stereotypical portrayals of people with anxiety in the media, one Tough Guy responded:

*MTV True Life: I Have OCD* is what first came to mind, but it’s not really an accurate depiction. Just because they choose the people that have the worst OCD to show. (Pablo, 20-year-old Sophomore)

Another Tough Guy observed:

I feel like media depictions are probly just generally negative. Or maybe, you know, like I said about the weakness – maybe kinda feminizing. (Mr. F, 21-year-old Senior)

These Tough Guys perceived anxiety in the media to be inaccurately depicted and portrayed as something that is only acceptable for women.

The Believers

Interviewees in the Believers described stereotypical media depictions of anxiety in the exact same way. A couple Believers pointed out how anxiety in the media is exaggerated and unrealistic:

I guess I’d have to say that I don’t think the media in general does a good job of portraying just like regular anxiety, or anxiety like mine like I would say mild to moderate where it comes in waves. (Alexis, 21-year-old Senior)

Like the media really doesn’t make it seem so much like a normal person going through a normal day will be struggling with anxiety internally and not showing it externally. So I
definitely think they do show it but it’s kind of distorted a lot of the time. (Molly, 21-year-old Senior)

A third Believer pointed out the tendency of media depictions of anxiety to involve women:

Usually, especially on commercials, they depict women as being anxious and having depression. I know that they target a lot of women. (Tanya, 20-year-old Junior)

It seems rather apparent that this stereotypical media depiction of anxiety is certainly influencing perceptions of anxiety. This portrayal of anxiety helps to explain the generally negative connotations about anxiety as well as the Tough Guys’ extreme negative perceptions of anxiety. Tough Guys are not willing to admit to having anxiety or willing to seek treatment when it is perceived as a generally female issue.

TELEVISION SHOWS AND MOVIES

Interestingly, despite strong ideas about media stereotypes of anxiety, both groups struggled to identify examples of anxiety in television shows and movies. While the Believers had no explanation for this, the Tough Guys offered a logical explanation that is consistent with their perceptions of anxiety.

The Tough Guys

The majority of people, both Tough Guys and Believers, were unable to think of specific examples of anxiety on television shows or in movies. When asked, many of them responded by answering:

No. No I can’t like thinking anything off the top of my head. (Jasmine, 21-year-old Senior)
Many Tough Guys, however, elaborated on such an answer. They suggested that the reason that anxiety is not prevalent in television shows and movies is related to its stigma. They claimed that people don’t want to watch shows involving anxiety:

I mean I feel like traditional TV shows don’t really show anxiety and I feel like they do that for a purpose. They try to make it – it’s not portrayed as oh it’s cool that I have anxiety. They’re not gonna show that kinda stuff. And it makes people feel uncomfortable to watch – to see people with anxiety. I feel like that’s why they wouldn’t do it. (Alfred, 22-year-old Senior)

Obviously in our society, we glorify like the hero – the person that has everything all together. People just don’t see anxiety as a strong part of who we are. You know, we just kind of push that away. If we kinda just push anxiety away, it’ll probably be easier for people to not have to confront it like when they’re watching TV. That’s probably not like something that you wanna have to deal with when you’re trying to relax or hang out. (Jack, 21-year-old Senior)

One Tough Guy even pointed out:

Well like the shows anxiety is in sorta use anxiety as comedy. Like in Seinfeld, they’ll say like picture the audience naked or something like that. I mean like Monk the whole show is based on how he’s crazy and does funny things. So I think if it is there, it’s more of like portrayed in like a funny light or something. (Fred, 22-year-old Senior)

The Tough Guys recognized that the reason they were not able to identify anxiety in shows used for entertainment purposes is because anxiety is not entertaining – unless it is made fun of and used in a comedic way.

PHARMACEUTICAL COMPANIES

So if television shows and movies are not influencing people’s thoughts about anxiety, then what is? What is the source of the anxiety discourse that the Believers buy into and that provides the Tough Guys with the idea that anxiety is a weakness? Of course there is no single answer to this question, but one of the first logical explanations is direct-to-consumer advertising (DTCa). Pharmaceutical companies are the source of DTCa. Therefore, in order to understand the Tough Guys’ and the Believers’ opinions of
DTCa, it is first important to understand conceptions about the pharmaceutical industry in general.

Neither the Tough Guys nor the Believers have a very positive opinion of drug companies. The reasons for this are complex and are beyond the scope of this study. What is important in determining the influence of the anxiety discourse is understanding the opinions that the interviewees do have about pharmaceutical firms. Both the Tough Guys and the Believers perceive drug companies as being profit-driven, unconcerned with helping people, and selling drugs at all costs.

The Tough Guys

The Tough Guys claimed that drug companies are solely concerned with money:

I feel like they just wanna sell their product and they’re maybe not so concerned with like actually like helping the people who take it. (Jasmine, 21-year-old Senior)

They obviously wanna make money. They obviously need to make money. So they’re gonna do what they need to do to get people to use their drugs. (Jack, 21-year-old Senior)

As a result, Tough Guys did not perceive drug companies as being interested in truly helping people:

I feel like it’s become too much of a marketed thing. Like it’s supposed to be for helping people and I feel like it’s more of a business now. (Jasmine, 21-year-old Senior)

They want you to become addicted to meds because they still want you to buy their product. That’s how they make their money. (Pablo, 20-year-old Sophomore)

The Tough Guys felt that as a result of their profit-driven decisions, drug companies attempt to push drugs blindly without regard for who they are selling them to:

They’re makin’ so much money off of people who probly don’t need it… and these drugs knowingly having side effects that people really aren’t aware of. (Lefty, 21-year-old Senior)

It just seems like those companies just charge ridiculous rates and provide incentives for doctors to overprescribe medications to patients who don’t need them. I’m very cynical about that kinda stuff. (Mr. F, 21-year-old Senior)
The Tough Guys see the pharmaceutical industry as highly opportunistic and therefore unconcerned with the ethics or integrity, which are so important in an industry providing people with medicine that alters their physical and psychological states.

**The Believers**

The Believers expressed sentiments fairly similar to the Tough Guys. One Believer asserted:

They obviously try to target particular people and try to make them think that they need their product because they need money. And I don’t think that’s right. You can’t just promote something just because you need money and profit. You need to think about the greater good and helping people. And they may think that they’re helping individuals and maybe they are, but most of the time they’re not. (Tanya, 20-year-old Junior)

Another Believer questioned whether the industry ever actually focused on helping people:

I think a lot of drug companies are for profit and I think one of the biggest problems in the pharmaceutical industry is that instead of looking for cures or solutions, they look for things just to suppress because they’re gonna make more money if you need to be on medication the rest of your life just suppressing something instead of doctors looking for actual cures for things. (Anne, 19-year-old Sophomore)

Yet another Believer expressed her belief that drug companies are only concerned with increasing the amount of drugs they sell:

I think they’re pretty corrupt. I’m not a huge fan. Just because there’s often not a lot of testing done. I’ve read a couple books – from a lot of things I’ve read obviously it’s not all bad, but I just think there’s a lot of overmedication going on and it concerns me. (Amy, 20-year-old Junior)

Although the Believers were not as relentless in their criticisms of the pharmaceutical industry as the Tough Guys, both groups obviously have an extremely negative opinion of pharmaceutical companies. Neither group seems to trust drug companies and both groups described drug companies as being corrupt. These notions about drug companies inevitably influence the ways people perceive direct-to-consumer advertising.
DIRECT-TO-CONSUMER ADVERTISING

Based upon the interviewees’ general perceptions of drug companies, one would not expect perceptions of direct-to-consumer advertising (DTCa) to be very positive. Drug companies fund this advertising in order to sell their products and most consumers with intellect and observation skills are aware of this. When asked about DTCa, both the Tough Guys and the Believers discussed its negative influence. However, the Tough Guys talked about the dangers of DTCa in a language that placed the blame for such dangers on drug companies. Believers recognized the possibility that DTCa may have negative consequences, but spoke more generally and did not place blame.

**The Tough Guys**

The Tough Guys recognized that DTCa is on television all the time and noticed it often:

There’s like so many drug companies that have commercials running, running, running and you don’t realize how much of it you’re watching, but there are a lot. There are a lot of ‘em. A lot. If you took the time to count how many you’ve seen in a day you’d probly come up with thirty commercials. (Lefty, 21-year-old Senior)

I mean they’re on all the time – all the drug commercials, so they kinda just blend to together, especially when they talk about the trillion warnings at the end. (Fred, 22-year-old Senior)

Although the Tough Guys could not provide specific examples of DTCa, they were certainly aware of its existence and prevalence.

They were also able to articulate specific criticisms they had of DTCa. Many related to the fact that the criteria used in DTCa to determine whether someone has anxiety is extremely broad and therefore the drug companies may be targeting people who should not be taking the drugs:
Like they just kinda make it too broad so I think a lotta people who necessarily don’t have a problem could make themselves believe that they have a problem after seeing commercials. (Jasmine, 21-year-old Senior)

I think a lotta people – it’s easy to mold them to what they think the symptoms are. Like oh yeah I was not happy yesterday when it was raining and I sat in bed. Why don’t I go talk to my doctor and get some drugs easily so I can be happier or do fun things like that? (Fred, 22-year-old Senior)

[DTCa is] ineffective in the sense that you are prescribing pills for some people who don’t need them. (Lefty, 21-year-old Senior)

So I think that the media definitely tries to prey on – someone’s always having some sort of problem and I definitely think they’re trying to prey on that. I think they’re trying to prey on your weaknesses rather than they genuinely wanna help you. (Dale Earnhardt Jr., 19-year-old Freshman)

This last Tough Guys uses incredibly strong language when he suggests that DTCa “preys” on people’s weaknesses.

In addition to those who noticed DTCa and had criticisms of it, there were also Tough Guys who claimed that they barely pay attention to DTCa:

I have noticed commercials for drugs, but I don’t necessarily pay one hundred percent attention to them… because I know I don’t need them, I don’t really retain the information that’s said on the commercial. (Alfred, 22-year-old Senior)

Sometimes I do notice them. I just notice all the medicine that say the “side effects may cause.” Those are the only parts I notice, but I don’t really pay any attention to the medicine commercials… because I’m not in the market for that stuff for anxiety. (Pablo, 20-year-old Sophomore)

These Tough Guys have little to say about DTCa specifically because when these advertisements are on they largely ignore them. This is because they are not interested in drugs for anxiety and therefore do not listen when they are on. The Tough Guys’ reactions of either criticizing or ignoring DTCa are perfectly in line with their denial of drugs as a treatment option for anxiety.

The Believers

Surprisingly, the Believers also had criticisms when asked about DTCa. Despite their willingness to take medication and their support of others who take medication, the
Believers are still skeptical of DTCa. A few recognized that the broad criteria for anxiety defined in DTCa could potentially reach people who don’t need drugs:

I think [DTCa are] inappropriate because I think there’s a certain degree to which everyone has those down days and everyone has those terrible moments where their world is gonna end. (Marie, 22-year-old Junior)

If you’re sitting at home and you’re watching TV and you feel depressed and this commercial comes on, you’re gonna think that you need that medication. You’ll be like there’s something wrong with me. I need that. And you’re gonna go to your doctor and persuade him that you need it. (Tanya, 20-year-old Junior)

This last Believer, if placing the blame on anyone, seems to actually blame the individual for “persuading” her doctor to prescribe her medications she might not need. In general, despite concerns about DTCa, the Believers were much more neutral and made fewer critical comments about DTCa than the Tough Guys. Additionally, none of the Believers reported ignoring DTCa when it came on or not paying attention to it as the Tough Guys did.

MEDIA INFLUENCES ON BELIEVERS

Despite criticism of DTCa, the Believers seem to almost entirely accept the illness ideology described earlier. This discourse is communicated through various media sources, including DTCa. DTCa and other media use a very specific language when describing anxiety and mental illness. Those who either consciously or subconsciously accept this message not only see therapy and medication as a means of handling anxiety, but also use a similar language when describing anxiety. Tough Guys do not see drugs and therapy as a means of dealing with anxiety, nor do they use the language of illness ideology to discuss their anxiety. Believers, on the other hand, both perceive therapy and
drugs as a treatment for anxiety and also use the language of illness ideology in describing their own anxiety.

The Believers

The anxiety discourse is based on *disorder* and *illness*. Several Believers used this language when describing their anxiety or anxiety they observed in others:

My grandma has really bad anxiety, but with her I don’t know if it’s so much a disorder or her life. (Amy, 20-year-old Junior)

I feel like a lot of the times people don’t think anxiety is it’s own kind of disorder. (Marie, 22-year-old Junior)

Anxiety and mental illness, you’re gonna have them for life. (Alexis, 21-year-old Senior)

The anxiety discourse then begins with *symptoms*. Since this discourse describes anxiety as an illness, symptoms are its first signs. Many Believers described the attributes of their anxiety as symptoms:

I feel like unless you feel like you need to talk to someone about it, you probly don’t have symptoms that are severe enough to be medicated. (Amy, 20-year-old Junior)

So I think at this point, all the anxiety that I had it was just being exacerbated and it was coming out in physiological symptoms. (Alexis, 21-year-old Senior)

My anxiety came through as completely physical symptoms. (Molly, 21-year-old Senior)

My mom couldn’t understand why I was stressed or having those symptoms. (Tanya, 20-year-old Junior)

In the illness ideology, once symptoms have been identified, the next step is seeing a *doctor*. Several Believers described going to doctors or speaking with doctors about their anxiety:

I went to the doctor and they were like no I think she’s having a panic attack. (Amy, 20-year-old Junior)

I think [drugs and therapy are] just something between you and your doctor. (Alexis, 21-year-old Senior)

[DTCa] might be a good way to open the door so kids can go to their doctor. (Kitty, 21-year-old Senior)
My doctor was like you need to go see a therapist or psychiatrist who would then prescribe me meds. (Molly, 21-year-old Senior)

My doctor did think that I had depression. And I’ve been seeing a counselor here at BC to find out if it’s depression or if it’s just anxiety attacks. (Tanya, 20-year-old Junior)

Once a patient sees a doctor, the doctor’s role is to then diagnose the patient with anxiety:

[My psychiatrist] diagnosed me first with depression, then later with anxiety. (Marie, 22-year-old Junior)

My roommate’s actually diagnosed with severe anxiety. (Molly, 21-year-old Senior)

The doctor can then suggest a treatment to manage the patient’s anxiety:

I got treatment during my first a panic attack. (Amy, 20-year-old Junior)

The final and, perhaps most essential feature of the illness ideology, is that is victimizes people who have anxiety. This is what allows pharmaceutical companies and doctors to convince people that they need therapy and drugs. Several Believers described themselves and others as passively suffering from anxiety:

I was like why am I suffering from this? (Molly, 21-year-old Senior)

I feel like someone suffering from really bad anxiety is going to talk to a therapist. (Amy, 20-year-old Junior)

My Aunt Winky actually suffers really bad from anxiety. (Marie, 22-year-old Junior)

I definitely think knowing I had anxiety initially, it put more stress on me because I was like why am I suffering from this? (Molly, 21-year-old Senior)

This description of one’s experiences with anxiety further confirms that the Believers completely accept the anxiety discourse presented by the pharmaceutical and mental health industries.
Tough Guys v. Believers: Explaining the Division

The Tough Guys, on the other hand, not only deny the anxiety discourse presented in DTCa and other media, but to a certain extent they also judge those who accept the anxiety discourse. This section will address the reasons for the differences between the Tough Guys and the Believers. These differences are primarily a result of gender role expectations. I asked both the Tough Guys and the Believers about the factors that differentiated males with anxiety from females with anxiety. Nearly all interviewees reported that they would expect men to internalize and not discuss it, while they would expect women to speak more openly about it. Both groups attributed these gender differences to expectations that men are less emotional and therefore more closed about their feelings.

The Tough Guys

After struggling to secure all of my male interviews, I began to ask the men I interviewed about possible explanations for my difficulty. One Tough Guy acknowledged that men are less likely to admit to having anxiety:

I’m sure a lot of men just don’t think they have it because they don’t wanna think of themselves in that negative way or like think of themselves differently. (Fred, 22-year-old Senior)

Another suggested that men and women do not, in fact, have anxiety as frequently. When asked about his friends and family members who he considered to have anxiety, he reported that they were:

Majority women, but I’d say that there are – I know a couple of guys. But I primarily think – most of the cases that I’ve known within my family have been women. (Alfred, 22-year-old Senior)
These Tough Guys offer the two of the plausible explanations for my difficulty in securing males to interview. The first is that men are simply in denial about their anxiety. The second is that men simply have less anxiety than women.

The third possible reason that it was difficult to obtain male interviewees is that men are less willing to open up about their anxiety. Some Tough Guys discussed how it is more socially acceptable for women to be emotional:

[If I had two friends – one male and one female with anxiety] I wouldn’t outwardly treat them differently or try to, but I think generally I’d be more accepting of the woman than the guy. ‘Cuz I just feel like it’s more acceptable for women to have anxiety ‘cuz they’re perceived to be more emotional and stuff anyways. (Fred, 22-year-old Senior)

It’s more socially acceptable for girls to have anxiety and like always be worrying about things as like mothers and stuff like that. It’s like their role in society. Like their role in society throughout history was to be the mother and like raise the children and I just feel like that carries with it more worry and stuff so maybe that’s why it’s perceived as more acceptable – and I think they’re just thought of as more emotional and stuff like that, too. (Fred, 22-year-old Senior)

Other Tough Guys described how women are perceived as being more sensitive and constantly worried:

Girls are constantly thinking about how other people are judging them. I don’t think guys are nearly as neurotic about that type of stuff. Guys just don’t let it get to them. (Alfred, 22-year-old Senior)

Girls are more sensitive about certain things and I feel like a lotta times they’re more willing to open up about it and bein’ open about what you’re goin’ through. (Lefty, 21-year-old Senior)

These perceptions and stereotypes make it even more acceptable for women to be open about anxiety because they are already perceived as emotional worriers.

For men, however, this is not acceptable. Men are expected to be strong and tough. Several Tough Guys explained that men are not expected to show emotion as women are:
There aren’t too many portrayals in the media that show that men suffer from anxiety because it’s stigmatized for men to show emotion for certain things. (Lefty, 21-year-old Senior)

I feel like historically men are not supposed to show the stress. And the like leave a good impression for their children and be like the stronger one of the family. (Fred, 22-year-old Senior)

I feel like there’s a difference between guys and girls with anxiety… He’s gonna wanna keep up that macho façade where if somebody asks what’s wrong he’s gonna be reluctant to say... You may see it in his actions and his chemistry at the time is just off, but he may be reluctant to say it ‘cause he’s just keepin’ up that façade. (Lefty, 21-year-old Senior)

And I feel like in most things in life, the more successful people just deal with the things that come at them without having to go to – I mean I know a lotta people go to therapy, but I feel like for me – just for me the best way to deal with it is by myself. It just makes me feel like I’m more tough about things. (Dale Earnhardt Jr., 19-year-old Freshman)

This pressure on men not to show emotion and to be tough and deal with problems on their own explains their rejection of the anxiety discourse. The stigmas about anxiety that suggest it is weak and emotional are precisely the stigmas that the Tough Guys are most interested in avoiding. Therefore, the Tough Guys would not even consider therapy and medication as ways of coping with their anxiety.

The Tough Guys also recognized that women are generally more open about their anxiety:

My closest five to ten guy friends are very open about it. And then I feel like I have a lot of friends that are girls that I’m not as close with, but they’ll open up to me about it. And I’ll be like I don’t really know you that well, but that’s cool I’m happy you’re opening up about it. But I know a lotta guys a lot better than you that would never ever have this conversation with me. (Jack, 21-year-old Senior)

I think girls have it – it’s way right or way left because they’re more open with their emotions and things like that, but at the same time their level of anxiety probably would be higher for girls than guys, but they’re more willing to share. (Lefty, 21-year-old Senior)

This further reinforces gender stereotypes as the reason that Tough Guys reject the anxiety discourse, while Believers accept it.
The Believers

The Believers as a whole, although they did not have quite as much insight on the issue, seemed to agree with the Tough Guys about gender stereotypes influencing one’s willingness to discuss anxiety. One Believer claimed that women are simply more open about their emotions than men:

I know especially men don’t like to talk about their problems. They resolve it themselves. Whereas women, they’re more likely to seek help for those problems. So I mean, to me I feel that talking about it is better than messing up your system. But that’s just me. (Tanya, 20-year-old Junior)

One Believer’s mention of gender stereotypes often came up in discussions of her anxiety in relations to male family members. She explained how she felt she was perceived as much more emotional because she is a woman:

I would never tell my brothers [about my anxiety]. That’s weird… I’m probably closer to Brian than I am to Rick. But Brian has no idea either because he would think it’s weird. They both think I’m like emotionally crazy. ‘Cuz they’re like guys. They don’t cry. They don’t have any feelings. (Kitty, 21-year-old Senior)

This same Believer continued by discussing her father’s inability to express emotions. Her father strongly suggested she seek therapeutic treatment, but was entirely unwilling to do so himself:

He [my dad] wanted me to go to therapy to talk to someone, but he didn’t wanna talk to someone. ‘Cuz he thinks that I’m like not sharing my feelings with anyone and he doesn’t think he has any feelings. But I’m the one with like all these bottled up emotions that I’m not telling anyone, so I actually had to speak to someone. (Kitty, 21-year-old Senior)

Such a request is the ultimate affirmation that the gender stereotypes the Tough Guys described are accurate. The fact that the Tough Guys are primarily men and the Believers are all women is no coincidence. These groups reject or accept the anxiety discourse that is consistent with their gender stereotypes and that is most socially acceptable for them.
Conclusion

Based upon my research I have concluded that typically women accept the discourse about anxiety, while men reject it. All the subjects that qualified as Believers were women and nearly all the subjects that qualified as Tough Guys were men. The reasons that the women accepted and the men rejected the dominant discourse were primarily related to gender stereotypes and expectations.

Obviously, however, not every single woman accepts this discourse. For this reason, one out of the eight women I interviewed was as a Tough Guy rather than a Believer. Interestingly, none of the men I interviewed qualified as a Believer. This is because it is much more likely that a woman will deny the anxiety discourse than it is that a man will accept it. This is not to say that there are not men who accept the anxiety discourse, but it seems likely that fewer men buy into the discourse than women who deny it. Ultimately, because of connotations of weakness and the expectation that one seek treatment, it is easier to deny the anxiety discourse than to convince someone to accept it. This explains why, out of the sixteen subjects I interviewed, nine were Tough Guys and only seven were Believers.

The Tough Guys completely rejected the anxiety discourse. This is primarily because they had incredibly negative perceptions of anxiety and repeatedly mentioned perceiving it as a weakness. They even described anxiety in the media as being feminized. As a result, they were entirely unwilling to consider psychological or pharmacological treatments and even seemed judgmental towards those who did consider such treatments. The Tough Guys were also extremely critical of DTCa.
The Tough Guys’ refusal to consider treatment is related to the way they perceived anxiety. They considered anxiety as having internal causes and therefore saw it as something they themselves needed to control. In fact, many of the Tough Guys even felt empowered when they finally labeled their anxiety because it explained their symptoms and made them more able to manage it on their own. Interestingly, the Tough Guys also reported practicing meditation and reflection, which involved only themselves and was therefore a “tougher” way of managing their anxiety because they did it on their own.

The fact that the Tough Guys perceived anxiety as internal combined with the expectation that men not show their emotions caused the Tough Guys to be embarrassed about their anxiety. Nearly all of the Tough Guys were unwilling to talk about it with others and the one Tough Guy who did open up about it felt immediately judged. The Tough Guys maintained that their anxiety was not bad enough to warrant outside help and therefore they never sought any. They each continued to manage it on their own.

The Believers, on the other hand, accepted almost the entire anxiety discourse. They initially felt helpless about their anxiety. When first labeled, many had negative reactions or felt overwhelmed. They saw their anxiety as having external causes, yet needing to be fixed rather than managed. This was overwhelming because they knew they had limited control over external sources of their anxiety. In order to attempt to fix their anxiety, the Believers went to therapy and/or took medications. Generally they seemed to think their treatment(s) were effective. While they recognized the dangers of widespread medication use and DTCa, many also continued to take drugs and all expressed an acceptance for those taking drugs.
The Believers were also more open and expressed fewer negative perceptions about anxiety. They were more willing to talk about their experiences with anxiety and typically people’s reactions to such openness were positive. Perhaps this openness was either a result of women feeling more comfortable discussing sensitive information or a result of women having thought more carefully about their emotions. The Believers were also more matter of fact about their anxiety. They mentioned fewer negative perceptions of it and typically saw negative connotations as originating from people who did not have anxiety themselves. Therefore, those connotations did not seem to significantly affect their decisions. This is perhaps another reason why it was easier for the Believers to be open about their anxiety than it was for the Tough Guys.

It is also important to consider gender differences when analyzing each group’s answers, as some differences may result partially from the different tendencies of men and women rather than being specifically related to their experiences with anxiety. For example, the Believers often provided more detailed descriptions of their anxiety than the Tough Guys. This may be because women in general are more detail-oriented than men. These differences, while still valuable and warranting analysis, may not be entirely the result of the subjects’ feelings about anxiety, but rather a mixture of their feelings and their gender tendencies.

The final question, then, is which group is better off? Has accepting the anxiety discourse negatively influenced the Believers in a significant way? Has rejecting the anxiety discourse positively influenced the Tough Guys in a significant way? These are difficult questions to answer. Both groups have their faults. The Tough Guys may be unwilling to discuss their anxiety to an unhealthy extent. The Believers, on the other
hand, may be more likely to accept psychological and pharmacological treatment when they do not need it. And both groups seem to believe that their acceptance or rejection of the anxiety discourse is best.

While this study provides an overview that helps the reader to understand why people reject or accept the anxiety discourse and to what degree that affects their actions, further research is warranted in order to answer questions regarding which group is better off. Additional research on the specific sources of information about the anxiety discourse is one way to help answer these questions. This involves asking people where their definitions of anxiety originated, where they first remember hearing about therapy and medication, and how they first formed their opinions about therapy and medication.

A related study should investigate the effectiveness of therapy and drug treatments and compare such results to the effectiveness of managing anxiety on one’s own. This would involve establishing objective criteria for evaluating the effectiveness of the different approaches to managing anxiety. This would also allow for a better understanding of the implications of each of the approaches.

A final study that would be an interesting corollary to the findings I presented would be to solely interview men who are Believers and women who are Tough Guys. Studying the people who are the outliers would further the research and conclusions that I have presented. Doing so would provide an even clearer understanding of how and why different people accept or reject the discourse on anxiety.

Based upon my research, I cannot definitively say that one group’s opinions, choices, and behaviors are better than the other’s. Further research on a variety of related topics is necessary to form such a judgment. Rather, I can only conclude that men are
more likely to accept the discourse, while women are more likely to reject it and that as a result, men are less likely to see treatment as necessary and women are more likely to seek treatment. These findings, in and of themselves, are both valuable and significant and, when combined with future research, can only become more informative.

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Appendix A: Interview Guide

General

- Can you state your name and a name you would like me to use as your alias? (If you don’t have one, I will pick one for you – I will not use your real name.)
- Where are you from?
- How old are you?
- What grade are you in?

Self

General

- How did you decide you have anxiety?
  - How does it manifest itself?
  - Specific situations when you experienced anxiety?
  - Periods/times when you’re more likely to experience anxiety?
- What does having anxiety mean to you? How has it affected the ways you perceive yourself or your behaviors?
- Do you think you had anxiety your whole life or did it develop?

Treatments

- Have you sought any sort of treatment for your anxiety? What kind?
- How long ago did you start treatment?
- How did you decide to seek such treatment?
- How did you feel about such treatment at the time you were being treated?
- If so, do you think the treatment was effective? / How do you feel about the treatment now?
- What other treatment options do you see as being available to you?
- Would you try them? Why or why not?

Perceptions/Values

- Do you feel that you can be open about the fact that you have anxiety?
- In what situations is it appropriate to discuss and in which situations is it not appropriate to discuss?
- Do you feel certain types of treatments are more accepted than other as being “okay” or “normal”?

- Has anyone ever ostracized you because of your anxiety or your treatment selection?
- Have you ever told someone about your anxiety or its treatment and felt that they treated you differently (either positively or negatively)?

- Have you ever felt shameful about having an anxiety disorder?
- Was there a time during which you were in denial about your anxiety?

- Did your family always encourage you to be open/seek treatment for your anxiety?

Others

- What percentage of your friends and family would you consider to have anxiety? (your opinion)
- What percentage of your friends and family would describe themselves as having anxiety? (their opinion)

- What factors do you use to determine whether someone has anxiety?

- What situations make your friends/family experience anxiety?
- Have you noticed periods in people’s lives in which people generally have more anxiety?

- Do you think certain treatment options are never appropriate?

Media

- Have you noticed discussions of anxiety in movies/TV shows? If so, where and how often?
- Have you ever noticed direct-to-consumer advertising? If so, do you remember the details of any DTC advertisements/which ones stand out to you?

- Do you pay attention to the prescription drug commercials on TV and talk to your doctor about them?

- In general, can you describe the stereotypical media depiction of a person with anxiety?
- Do you feel that the media portrays people with anxiety positively or negatively? Why?
Final

- Now that we’ve been discussing anxiety for almost an hour, how would you define anxiety?

- Is there anything else you would like to say about anxiety (in yourself, others, the media, etc.) that we did not get to discuss already?
Do You Have ANXIETY?

I want to hear about the experience of anxiety from your perspective.

Please e-mail me if you would like to meet for an hour to talk.

(Completely confidential – I am here to listen.)

Thank you in advance!!!

Lindsey Avedisian
avedisia@bc.edu

(I am an undergraduate senior writing a thesis on the topic of anxiety.)
Appendix C: Sampling Distribution Data

Age Distribution

Class Distribution
College Attendance

- BC: 88%
- Gettysburg: 6%
- Cape Cod Community College: 6%

State Distribution

- MA: 5
- CA: 2
- CT, IL, LA, MD, NJ, NY, WA: 1

# of Subjects