8. Cosmologies of Fear: The Medicalization of Anxiety in Contemporary Britain

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Rates of anxiety within the UK have been found to be on the increase, with the UK government's Adult Psychiatric Morbidity Survey revealing that 9% of individuals experience mixed depression and anxiety and 4.4% generalized anxiety disorder (NHS IC, 2009). Increasingly these levels of anxiety have been attributed to living in more anxious times, other authors having investigated what has made the times we live in more anxious and why we should respond to these in the way in which we do (Furedi, 2007; Wilkinson, 2001). These approaches view anxiety as a social 'problem' in opposition to the wealth of medical and psychological literature on the subject that views anxiety as an individual defect. The understanding of anxiety may be further developed however by taking an approach that links the social with the individual, relating this also to the to the medicalization of the experience of anxiety-through looking at anxiety, and the medicalization of anxiety, cosmologically. Within this approach, anxiety is viewed as a specific cultural response that relates to, and expresses, Euro-American cosmological ideas about the self and its existential relationship to the cosmos. This is influenced strongly by social and historical developments within Euro-American society, and subsequently results in the medicalization of anxiety as a cultural response to the experience. Such an approach attempts to further the understanding of anxiety as a Euro-American experience, but furthermore, in placing anxiety in its cultural and historical context, may also contribute to our understanding of notions of cosmology and individual response within Britain and other Euro-American societies.

Research undertaken for the Mental Health Foundation suggests that as a nation, the UK is becoming more fearful; individuals perceive the world to be more frightening, and in turn feel more frightened (Mental Health Foundation 2009:3). This survey found that 37% of adults believed they get anxious or frightened more frequently than they used to, 77% believed people in general are more anxious or frightened than they used to be and 77% believed that in the last 10 years the world has become a more frightening place (Mental Health Foundation 2009:5). The survey reported that those interviewed were most anxious about the current financial situation (recession) (66%), money/finances/debt (49%), death of loved ones (45%), crime/the threat of crime (35%), the welfare of their children (34%), developing a serious illness or disease (33%), getting old (27%), the state of the environment (18%) and the threat of war (14%) (Mental Health Foundation 2009:21). Such concerns reflect the social environment and period of time in which the survey was conducted and reveal the how fears may be embedded within a social context. A cycle of fear and risk aversion was also found by this survey, with perceived fear leading to risk aversion leading to actual fear (Mental Health Foundation 2009:33). This report therefore links the increase in fear within the UK to increased numbers of individuals with clinical anxiety; if fear levels in the general public are high then more people will experience mental illness, and particularly the most common mental illnesses; depression, anxiety and anxiety disorders (Mental Health Foundation 2009:1).

If levels of fear are related to levels of medical anxiety in the UK, medical anxiety would appear to reflect social and cultural aspects of living in the UK today. Furthermore, the examination of anxiety and its medicalization within the UK provides an example of how social experience and social distress may be taken on and experienced within the individual as personal distress, *and* how this is then dealt with

culturally through medicalization of this individual experience. Such investigation into the cultural experience of anxiety also begs the question of explanations for the levels of anxiety and fear within the UK. This is particularly interesting as levels of anxiety have risen despite the fact that individuals live in statistically safer times than previous generations, for example the fear of crime is still rising despite the fact that levels of crime have decreased in the last decade (Mental Health Foundation 2009:3). What are we then talking about when we speak about fear and anxiety in the UK? How might these experiences be situated within the British context?

The Nature of Anxiety

Anxiety, as we know, is part of everyday experience. However anxiety is also viewed as a clinical problem; the experience of anxiety is culturally transformed into symptoms when a particular point on the anxiety continuum is reached. The point at which clinical anxiety is sectioned off from "normal" anxiety is difficult to define but for some authors, this is where anxiety is obstructive in day-to-day life and where clinical intervention would be beneficial (Gale and Davidson 2007). A range of explanations and approaches have attempted to understand (and treat) anxiety of a clinical level. The evolutionist idea that anxiety results from a 'fight or flight' response has been picked up by some psychologists such as Michelle Craske who, like other psychologists, views anxiety as due to maladaptive thinking, resulting from inappropriate upbringing and socialization. She notes that individuals with generalized anxiety disorder (GAD) for example continually detect and interpret possible threats, over-estimating the probability of the threats and seeing themselves

as ineffective at managing these. A cycle is then created, a negative personal view is then seen as evidence of individual ineffectiveness, leading to increased pessimism (Craske 2003). Increasingly popular psychological treatments fit with this idea, including techniques such as cognitive behavioural therapy (CBT) which aim to address the problem of anxiety through altering this maladaptive thinking process within the individual so that they are again able to operate within society. Freud also wrote much about anxiety, with his views on what he termed 'anxiety neurosis' changing over his lifetime, from a problem of transformed libido to a reaction to trauma (Freud 1993 [1925]). These ideas, and the treatment of anxiety through psychoanalysis, have influenced psychiatric understanding of anxiety, although pharmacological interventions are also offered for anxiety disorders and reflect biomedical ideas of anxiety as having an underlying biological cause (Trimble 1996; Rees, Lipsedge and Ball 1997). Psychological, biological and psychoanalytic ideas mix within psychiatry but all such approaches focus on anxiety within the clinically 'ill' individual rather wider contributing causes, as the result of individual deficit. This is in stark contrast to socio-cultural approaches which focus on anxiety as problematic in wider society rather than located solely within the individual.

Socio-cultural approaches to the problem of anxiety remind us that anxiety and fear are socially constructed and culturally conditioned responses, aspects to anxiety that are less visible in medical conceptualizations. What we fear and the strength of that fear depends on conceptions of the world, the perilous forces that reside within it and our options for protection against these (Svendsen 2008:24). While cross-cultural approaches to emotion vary (Milton and Svašek 2005) few anthropologists would contest that our cultural perspective constructs what we view as fearful or anxiety-promoting and that this same cultural view may then promote the

extent to which we fear and express this fear and anxiety. The cultural and social impact on fear is also suggested by the temporal quality of many fears. Both Svendsen and the historian Joanna Bourke suggest that all time periods have their fears but that *what* is feared changes over time (Svendsen 2008; Bourke 2005). This is clearly visible in the films and literature of science fiction within the UK over changing time periods; Mary Shelley's Frankenstein was created at the time of, and arguably reflected the fears of, the industrial revolution for example, while a proliferation of books about nuclear war emerged during the period of the Cold War (Susan Sontag's essay 'The Imagination of Disaster' (1965) also deals with changing fears expressed in Japanese and American science fiction films). Within Western culture today, what Svendsen terms a 'low intensity fear' (2008:46) or 'constant weak "grumbling"' (2008:76) exists as the dominant form of fear and provides a background to our experience and the way in which we interpret the world. Consequently this 'grumbling' can be seen as more of a mood than an emotion (Svendsen 2008:46), and this culture of fear is emblematic of our period in time and a metaphor through which we view our experiences (Furedi 2007). In line with Furedi, Svendsen contends that Euro-American cultures consider nearly all phenomena from a perspective of fear despite living in a more secure position than we ever have before in history (2008:7).

Although intimately related, anxiety can be conceptually separated from fear in relation to personal experience. Both Bourke (2005) and Svendsen (2008) suggest that fear refers to an immediate, 'objective' threat. Anxiety, however, is an anticipated 'subjective' threat; anxiety comes from within and is more generalized (Bourke 2005), lacking a specific object with a nature of 'indefiniteness' (Svendsen 2008:35)-the 'constant weak grumbling' Svendsen mentions above rather than a direct threat. Anxiety is therefore 'deep', whereas fear is 'shallow' (Svendsen 2008:9).

Furthermore, in fear, individuals are able to assess the situation and neutralize or flee the problem, however those subjectively experiencing anxiety are unable to act (Bourke, 2005). For the sociologist Iain Wilkinson, anxiety leaves individuals searching for cultural forms which adequately express the true origins and identity of the anxiety (Wilkinson 2001). Wilkinson proposes that where individuals remain entwined by anxiety therefore, culture has not provided a means by which the feeling of being overwhelmed by the uncertainty of the future can be dealt with (Wilkinson, 2001:131). Wilkinson and Furedi thus link the growth of anxiety and fear to modernity and the growth of the risk society within Euro-American culture.

As well as what might create anxiety changing over time and being connected to cultural and social circumstances, how anxiety is expressed may also differ cross-culturally. Responses to distress differ across cultures and the expression of anxiety that has been medicalized by biomedicine might be seen as a particularly Euro-American presentation. Research on the many examples of what were formally termed 'culture-bound syndromes' demonstrates different expressions of distress located particularly within different societies. This term has largely been dropped due to its suggestion of a restrictive, fixed and bounded nature of such expressions and research has come to view these presentations as culturally specific collections of symptoms and culturally constituted means of displaying distress, or 'idioms of distress' (Nichter 1981). Littlewood further suggests these might be seen as 'stylized expressive traditional behaviours' which have moderately similar presentation, can be time-limited and while going against everyday 'normal' behaviour are condoned within the culture as an expression of distress (2002). Such idioms may not necessarily be pathologized by these cultures however. Work on '*ataque de nervious*', a cultural expression of distress found in Puerto Rico (and in Spanish-Caribbean

individuals elsewhere) describes *ataque* as '*an experience accessible to certain groups when bad things happen*' which is understood to result from a cultural context in which a gender-based expectation of social control exists (Lewis-Fernández, Guarnaccia, Martìnez, Salmán, Schmidt and Liebowitz 2009). *Ataque* can be seen an expression of distress best understood within its cultural context. Such a response can be compared to the 'laments' described by Wilce in Bangladesh where individuals express their distress through wept singing, a very different form of expressing distress but one in which Wilce argues individual identities can be constructed and resistance to power expressed (Wilce 1998). Both laments and *ataque* are culturally condoned forms that may be used to express the anxieties encountered in life. Although there is not space here for a full discussion of the 'symptoms' of Euro-American anxiety, placing anxiety in Euro-American cultures in the context of high modernity, where the self is viewed in an alternative cosmological way to the past, anxiety symptoms perhaps express physically these Euro-American notions of self and disconnectedness as well as other Euro-American cultural notions of the body itself.

The dominance of Euro-American medicine and of medical categories has made cultural differences peculiar to these cultures easy to miss. Given that the majority of these categories were first described in Euro-American cultures based on their own populations, Euro-American idioms of distress have been incorporated into such definitions, and held up as a standard form, from which other cultural expressions deviate in exotic fashions. Placing the medical categories of psychiatry in their cultural and historical context highlights the Euro-American cultural specificity of these labels however, not only of the 'pathologies of the West' such as anorexia nervosa and multiple personality disorder described by Littlewood (2002), but also

more common mental health problems such as depression (Kleinman and Good 1985; Skultans 1979; Showalter 1987). The symptoms of Euro-American anxiety can be seen as culturally sanctioned responses, idioms of distress that 'make sense' culturally- they are a cultural response both in the sense that they respond to socio-cultural circumstances *and* in the cultural patterning of how that anxiety is expressed. For Euro-American cultures to therefore medicalize anxiety, to construct a diagnosis and label these experiences as in need of medical treatment, is a further cultural response to these cultural responses, indicative of the status of biomedicine and how experiences become incorporated into the medical sphere. Euro-American culture has dealt with this increased anxiety through medicalization and it is the medicalization of anxiety that I now move on to discuss.

The Medicalization of Anxiety

Littlewood suggests that in Western countries, in general distress is medicalized: it is 'seen through a lens which encourages us to experience and indeed shape, individual concerns in medical ways', the illness comes from outside, with a cause, pattern and perhaps a cure (2002:1). Anxiety also fits this notion; the symptoms of anxiety are culturally recognized as a 'medical' problem with individuals seeking assistance from primary care general practitioners (family doctors) rather that the priests who would have been more commonly consulted for anxiety in previous times (Bourke 2005).

The interconnection between healing and religion are evident in many cultures and were once more explicitly linked within Euro-American societies. Religious orders previously took a central role in caring for the sick however modernity

promoted a split between the religious and medical domains, improvements in science developing the medical understanding of the human body and its treatment, and power moving from the unproven and unquestioning belief of religion (already unsettled through the Reformation), to the demonstrable evidence and rational thinking of science during the Enlightenment. In addition to the movement away from religious personnel to medical personnel in care and treatment from the sick, wider concerns that refer to suffering and salvation, previously the domain of the church- concerns that Good terms 'soteriological issues' (1994)- also moved to the domain of medicine. Good argues that moral and soteriological issues are 'fused' with medical issues and that medicine mediates the 'physiological' and the 'soteriological', illness having both physical and existential dimensions as it reveals the infirmity of the body and human suffering. For Good, cultures are organized around a soteriological view through which the nature of suffering is understood and salvation is achieved. In Euro-American cultures, medicine is 'the core of our soteriological vision' (Good 1994:70), perhaps also reflecting the reduced power and influence of the church in Western culture. Additionally however, as argued above, these 'soteriological issues', how we suffer, live, die, make sense of life are the very stuff of Euro-American anxiety, perhaps making anxiety particularly susceptible to being placed under the frame of medicine.

Latour and Woolgar tell us that scientific 'facts' are socially constructed (1979), but furthermore, such facts and medical labels are also culturally produced. Previous anthropological work by authors such as Young (1995) and Littlewood (2002) have considered the medicalization of experience into illness, illness categories in Euro-American culture and the effects and consequences for those involved. Through such work, experience is seen to be translated into 'symptoms' and

behaviour into 'pathology', the 'abnormal' sectioned off from everyday experience into the pathological realm. Books such as Young's work on PTSD have illustrated how medical labels may be brought about for particular social or political purposes, such as the construction of the category of railway spine for insurance claimants (Young 1995) as well as the use of and creation of medical labels by drug companies to develop new pharmaceutical markets (Lakoff 2008; Watters 2011). Such labels can also legitimize behaviour and create or reduce positions of power, and Bourke claims that fear itself sorts individuals into hierarchical social positions. She gives the example of 'school-phobia' being used for middle-class children (working class children given the label of 'truancy') and states that fear, but we may also add medical labels around fear and anxiety, can be related to the distribution of power (Bourke 2005). The power exerted by medicine, both through the power of medicalization and by the moralizing aspect of medicine is further illustrated in Showalter's consideration of 'hysteria' in the British context. She suggests that medicine took a moralistic role in controlling female sexuality and actions; suffragettes and 'modern' women desiring to work or divorce their husbands having previously been among those diagnosed with 'hysteria', rendering them as 'mad' and in need of (medical) control. Medical management is therefore a way of containing women's suffering without confronting its causes (Showalter 1987) and Furedi notes the re-orientation of social problems into individual emotional problems in contemporary 'therapy culture' (2004). The great advantage of this relocation is, of course, that it is the problem within the individual that becomes the focus of treatment and wider social issues do not need to be addressed, and this may be even more the case for a society such as the UK where there has been a strong drive toward an individual responsibility for health. Moralizing aspects of medicine can also be found

in recent debates around individual responsibility for health and obesity, smoking and the promotion of 'health behaviours' to support a 'healthy lifestyle'. These prescriptions on how to live again may be seen to be reminiscent of the moralizing discourses and position of moral guides previously held by the Christian church in earlier history. In adding to other discussions on medicalization which focus on the medical system and its positioning and power to medicalize, in this chapter I take a slightly different perspective on the medicalization of anxiety. I situate anxiety in its cultural and historical context and consider how changes to concepts of self and the role of the church impacted on both experiences of anxiety and the development of medicine. This is therefore a discussion of medicalization that focuses on the cosmological and how cosmological concerns have become viewed as part of the realm of medicine.

Cosmological Approaches to Anxiety

Rather than focusing specifically on arguments around medicine therefore, I turn my attention to understandings of Euro-American (and in particular, British) cultural changes over time and how cosmological understandings of the world, the individual within it and perceptions of risk and control, might have led not only to increased anxiety but also to its medicalization. Sociological and broader social theory approaches to anxiety view levels of anxiety found in [Euro-American] society as largely resulting from the current period of late/high modernity (Wilkinson 2001; Giddens 1991) and it is this relationship that I want to go on to examine in more depth.

The relationship of modernity to notions of risk is seen as fundamental to this largely sociological approach and both Anthony Giddens (1991) and Ulrich Beck (1992) have considered risk itself as central to late modernity, '*fundamental to the way both actors and technical specialists organize the social world*' (Giddens 1991:3). This suggests that modernity produces a 'risk society' or 'risk culture', where public knowledge and debates about risk and the riskiness of everyday life as well as the introduction of new types of risk previous generations have not faced (such as nuclear war and environmental breakdown) are present in the everyday life of the individual. Despite the actual overall reduction in life-threatening events for the individual (Lupton 1999), this greater knowledge of risk, Giddens and Beck argue, increase our insecurity about our individual position in society, our ability to live in safety and make us more anxious about the future ahead of us.

In addition to greater awareness of perceived risk and the related insecurity this brings, risk society is also about not only what *has* happened, but what *could* happen, and where no one is out of danger (Svendsen 2008:48-50). In fact, Pat Caplan argues that whereas previously the past was used to determine the present, the future, as this is seen through various risk scenarios, is now used to determine the present, history being of little significance (Caplan 2000). Such a focus on risk and future risk is also, by its very nature, related to uncertainty and attempts to control. Svendsen suggests that uncertainty is a basic element of human life and argues that [Euro-American culture] is dominated by the 'precautionary principle' as a response to dealing with such uncertainty (2008:67). Such a principle constructs a world where the future is made up of dangers rather than possibilities (Svendsen 2008:71). Svendsen cites the British Medical Journal's decision to forbid the use of the word 'accident' it its pages as symptomatic of the view that the world is completely

controllable (2008:64). Here it is also perhaps worth noting that this article occurs in a medical journal; not only the world is viewed as controllable but medicine in particular is portrayed as fully understanding the world. Science now guides that individual rather than religion (Furedi 2007; Svendsen 2008, Bourke 2005) and authors such as Giddens (1991) argue that the process of modernity decreased the role of the church and promoted a scientific and rational worldview. But as the historian Bourke notes, science has dispelled superstitions but has also delivered new fears and new risks (Bourke 2005) including risks beyond individual human control such as those related to the environmental and the political sphere.

How dangers are conceptualized and dealt with has changed through modernity, not only through notions of risk but also through increased individualization. Individualism was also seen to rise at the same time as the growth of risk (within modernity) and with it, what Caplan calls an 'ongoing search for morality' (2000:6) where individuals look to control and improve themselves rather than the social environment. In fact, the very position of the individual in relation to the world around them has changed through modernity, with the individual located as the seat of power rather than external forces. As suggested by Lupton, individuals in Euro-American cultures feel they maintain a high level of control over danger and exposure to danger, risk is therefore viewed as the responsibility of humans rather than notions of fate or destiny (Lupton 1999), and therefore the church has no role in contributing to this. Individuals thus bear greater responsibility but, stripped of the support and guidance previously afforded by the church, are also more vulnerable and alone to deal with the risks they are increasingly aware of. Risks are not only practical and related to the social environment but also relate to the security of the individual, producing existential anxiety.

Taking these understandings of risk society and modernity further therefore, anxiety can also be interpreted as existential angst, a situation where individuals struggle to create meaning in their lives from the uncertain world that surrounds them (May 1996). This idea has also been considered by Anthony Giddens who links anxiety and the notion of 'ontological insecurity' in relation to the process of modernity. The concept of ontological insecurity was developed previously by R.D. Laing who saw the ontologically secure person as one who is able to meet life's problems *'from a centrally firm sense of his own and other people's reality and identity'* (1990 [1960]:39). Ontological security gives the individual the experience of self and the relation of the self to the world around the individual, a world that the individual organizes through what Giddens terms 'basic trust' (1991:38). This trust, developed through the individual's upbringing and socialization, is connected to the individual's identity and is the 'protective cocoon' that individuals carry with them to allow them to continue with the activities of everyday life (1991:40). It is argued therefore that the process of modernity contributes to feelings of ontological *in*security, which in turn brings about feelings of anxiety. This anxiety also creates further feelings of insecurity by impeding the awareness of a sense of self as it challenges the confidence of the relationship between self and outside world (Giddens 1991).

The precursor and an explanation for the historical development of 'ontological insecurity' in Western culture can be related to the argument of Eric Fromm in his work Escape from Freedom[i]. Fromm takes an existential psychological position that argues that all humans have a need to feel related or connected to the outside world; humans have a need to avoid isolation and that therefore individual freedom from the bounds tying the individual to the world are important. Religion and

other belief systems give protection from 'aloneness' and security, without which life lacks meaning (Fromm 1994). For Fromm, individuals in Euro-American cultures have become 'more free' (including existentially free), but without the religious hold that previously gave security. This process started with the breakdown of the feudal society of medieval society which gave individual freedom from previous economic and political ties but also freedom from the ties which gave a feeling of belonging and of security. Before this breakdown, Fromm argues, there was no notion of the individual 'self', people were part of a family, a village, the construction of the universe was simple and the relationship with God based on confidence and love. Afterwards, the individual was free but anxious and alone, seeing others as potential competitors, existentially threatened and with a view of God that was also less secure. Luther's theology gave expression to this experience and offered a solution; moving away from church authority to an individual relationship with God but in so doing, the individual needed to accept their own insignificance and powerlessness, and leave behind the notion that humans had salvation and instead view life as being about being productive economically. Protestantism therefore helped the individual deal with their anxiety, re-orientating the individual to this novel world and developing an individualistic worldview as ties from others were lost and the individual faced God on their own. Unlike Weber's otherwise similar view of Protestantism, Weber saw time as developing a novel cultural spirit and economic behaviour (Weber 1992 [1930]) while Fromm suggests that society moulded a particular social character within the individual which formed the basis of new cultural ideas (Fromm 1994).

For Fromm then, the individual self and its connection to society became uncertain and thrown into doubt through historic changes in the medieval period, but the anxiety this generated was coped with through religious attachment and the drive

to work. Such ideas are a useful grounding for theories of modernity that have considered the changing role of the church after this period, the increased secularism and individualism pursued through the process of modernity and the increased vulnerability of the individual self. For example Wilkinson suggests that anxiety may be a modern term for an age-old feeling, part of the very nature and psychology of being human (2001:45). In such a secular culture he suggests, psychological language has replaced religious language in the way we explain our experiences;

> When it comes to discussing matters of feeling, we now prefer to speak with deference to the authority of experts in the fields of human science rather than the (more doubtful) wisdom of those who would explain our problem in terms of our relationship toward God. However in taking up the language of anxiety, perhaps we have not only come to explain ourselves differently, but further, we may also have begun to modify the way we feel (Wilkinson 2001:45).

Anxiety can thus be linked to cultural experiences of modernity not only through the process of modernity resulting in greater awareness of risk, individualization and ontologically insecurity, but also through increased secularization. The diminishing role of the church as well as cultural changes which altered understandings of self, others and the divine meant that those experiences of everyday life which were formally the domain of churches became increasingly the realm of medicine and psychology. These changes suggest cosmological shifts in how the world was understood to operate;

cosmological issues moving from being questions for churches to deal with to questions for medicine and psychology.

The Psychologization of Self and Ontological Insecurity

Problems of the self are not only discussed in psychological language in Euro-American cultures, but are also psychologized; Fabrega for example suggests that mental illnesses themselves are 'disturbances of the self' (Fabrega 1992:100). The self, placed within the individual body through individualism, is thus expressed through the body and it is interesting to note that one of the 'symptoms' of anxiety, and a number of other mental illnesses, is a feeling of 'depersonalization'; the individual feels detached from the self and an outside observer of what they are doing and thinking (American Psychiatric Association 2000). The relationship between anxiety and a sense of self can also be seen in the historical use of lobotomies to treat anxiety and fear; Bourke notes that these procedures were successful as they destroyed a sense of self (2005). Changes over time in the view of the self and the move from religious assistance to psychological help has also been noted by Bourke in her historical review; whereas in the past the anxious individual might have turned to the church for comfort, as the self was then located within the body through the twentieth century, anxiety was more individualized and treated through therapy or self-help (2005). For Furedi, this therapy has become a strong influence in Euro-American culture, a 'cultural phenomenon rather than a clinical technique' (2004:22) which demonstrates Euro-American culture's new focus on the importance of emotion and how this domain is dealt with (2004).

Furedi argues that within Euro-American 'therapy culture', therapy is linked to identity, a 'therapeutic script' used to understand the self. Furthermore, therapy culture itself has cultivated emotional vulnerability through the endorsement of a position where the self is seen as limited and fragile, in need of ongoing therapeutic intervention, without emotional resources to cope with adverse circumstances; a vulnerable self (2004). Interestingly, Furedi also points out that theologians are now 'therapists' (2004) as the growing literature and development of the field of pastoral psychology are testament to. This also represents an opportunity for religious figures to re-engage with individuals suffering from anxiety, albeit using techniques and approaches developed from more clinical interventions which therefore keep anxiety within a medicalized framework.

As Fromm notes, historical social changes within Western culture have placed the site of control within the individual self. This is reinforced by the scientific worldview, for example through the psychological notion of the 'locus of control'[ii], the level to which the individual feels personal control of their actions and the world around them. Having a high internal locus of control is viewed as more positive than having a high external locus of control, with the latter previously been seen as more prevalent in poorer populations and thus an explanation for poorer health in these areas (Poortinga, Dunstan and Fone 2007). This individual locus of control situated in the self is related by Littlewood to experiences such as anxiety. He suggests that anxiety, as well as other expressions and emotions, communicate a representation of the self that has lost self will and control, a loss that can be short-term or permanent, partial or complete (2002:185). The content of such experiences, the framework, expectations and responses around these, organize individual narratives which also illustrate what Littlewood terms 'the experiential reality of our local cosmology'

(2002:186). Through the process of modernity therefore, there has been a psychologization of self and the site of control has been situated within the individual; the self is discussed in psychological language, disturbances of the self have been pathologized and self-control has become to be seen as a psychological trait.

Research within medicine and psychology have also examined, and found a place for, ontological security (including through religious faith) in alleviating anxiety, research which also demonstrates how these concepts have themselves become part of psychology. Antonovsky's (1979, 1987) notion of our 'sense of coherence' (SOC), the way in which human beings make sense of the world and use the required resources to respond to it can be viewed as strikingly similar to the notions of ontological security and cosmological understandings. Studies that have investigated SOC have found a negative correlation with anxiety and depression and a positive correlation with optimism and self-esteem (Hart, Hittner and Paras 1991). Some psychiatrists and psychologists recognize that spirituality and religiosity emphasize the depth of meaning and purpose in life and that religion is a coping strategy for dealing with life events (Dein, Cook, Powell and Eagger 2010) and note that many religions also hold a 'just world hypothesis' (Hogg, Adelman and Blagg 2010); good things happen to good people, bad things happen to bad people and in this way, the world has method, consistency and purpose. Furthermore a 2009 study found that when conducting tasks measuring uncertainty, participants with greater religiosity and a stronger belief in God had a reduced reaction in the cortical system involved in self-regulation of anxiety. The authors concluded that religious conviction [and the ontological security it is connected to], act as a buffer against anxiety and provide a framework for action and understanding of the environment (Inzlicht, McGregor, Hirsh and Nash 2009). Anxiety and ontological insecurity have therefore

also become part of medical and psychological studies, but as these studies demonstrate, so has religious faith itself. Attempts to understand religious faith from within medicine have focused on psychological benefits, such as security and support, which emerge from religious faith; an approach which then rationalizes the religious within a scientific worldview. Rather than being thought of as 'ignorance' of scientific 'knowledge'[iii], religiosity and religious experiences are, from this perspective, thought of as fulfilling a psychological need (or symptomatic of psychiatric disorder) and resulting in the religious domain remaining subordinate to the medical field.

Within the medical field, psychiatry itself has been seen as lower status and less 'medical' than other specialties, psychiatry and mental health services typically receiving less funding and focus than other areas. Psychiatry has been viewed, and is still viewed by those within medicine and outside, as less scientific that other medical disciplines. Dealing as it does with illnesses that are often less obviously attributed to a solely biological base and without biological tests (both of great importance within a medical worldview), the psychiatrist works more prominently in an uncertain world- another strike against it from the certainty-loving scientists. The need to make psychiatry more allied to science and thus more 'medical' and therefore more distant from religion, may mean that psychiatrists in particular psychologize cosmological understandings of anxiety, ontological insecurity and religion more broadly, focusing on the need for a medical 'cure'. This also relates to research findings where a substantial difference exists between the religiosity of the American population and American psychiatrists (psychiatrists being far less religious) (Lukoff, Lu and Turner 1992) but also why psychiatrists have been found to be less likely to be religious in general that other medical disciplines (Curlin, Odell, Lawrence, Chin, Lantos, Meador

and Koenig 2007). These findings link to ongoing debates about the role of religion in psychiatry and the 'religiosity gap' between psychiatrists (and other mental health clinicians) and mental health patients (Dein, Cook, Powell and Eagger 2010; Lukoff, Lu and Turner 1992). In Curlin, Odell, Lawrence et al's study, religious physicians were also found to be less willing than nonreligious physicians to refer patients to psychiatrists (Curlin, Odell, Lawrence et al 2007). Lukoff, Lu and Turner note the historical tensions between religion and psychiatry which they attribute to the close links between psychiatry and psychoanalysis and therefore to Freud's anti-religious stance (Lukoff, Lu and Turner 1992). The ability to 'explain away' religion as a coping method by psychology and psychiatry may also be added as a possible contributor, as demonstrated in Hogg, Adelman and Blagg's notion of the 'Uncertainty-Identity Theory' to 'account' for religiousness[iv].

Religiosity and cosmological ideas have over time therefore become part of psychology, transformed into testable and quantifiable concepts to be measured scientifically. As noted above, science has given Euro-American cultures a worldview based on certainty, a cosmology founded on rationality. This view also privileges the power of 'evidence'. Through a scientific worldview, a God cannot exist as there is no [scientific] 'evidence', as Dawkins' book, The God Delusion, tells us (Dawkins 2006). Evidence replaces and de-values experience, taking it out of the personal realm to be treated as a separate, and often measurable, 'thing' of its own, a disease with the possibility of 'cure'. Anxiety therefore can move from being an experience to being a diagnosis. Its changing nature and cultural embeddedness is stripped away through this process as its components and its diagnostic label should be discrete and objective, able to be applied to any body in any place at any time so that treatment can be instigated. The foggy and unstable boundaries of anxiety have, however, caused

problems for the classification of anxiety and in this last section, I focus on some of the ways medicine has tried to deal with anxiety within medicine.

Medicine Deals with Anxiety

Once biomedicine had staked a claim to anxiety, it then had to find a place for it within wider medical categories. The scientific approach of defining illness categories, creating order from disorder, is particularly difficult in the case of anxiety. Like many other mental illnesses, definitive medical 'tests' are unavailable to ascertain the presence or not of the disorder and, as previously noted, the key areas about which individuals worry change over time and can depend on the individual as well as social circumstances e.g. economic recession bringing fears related to finance and financial stress (Mental Health Foundation 2009). How these are interpreted in a scientific framework, in which Latour and Woolgar suggest 'social' factors 'disappear once a fact is established' (1979:23), is challenging and may contribute to the changing descriptions of medical anxiety over the years.

To try to deal with some of the range of presentation and concerns within the broad category of anxiety, biomedicine has created sub-categories within the broader classification of "anxiety", different symptoms indicating different subgroups of the disease and suggesting different treatment plans. However, separating these different groups, and distinguishing anxiety from other conditions such as depression has not been straightforward. The National Institute for Health and Clinical Excellence (NICE) guidelines produced for clinical practitioners in the UK notes the difficulty in distinguishing the anxiety disorder 'sub-types' from each other, and indeed some

differences in categorization exist between the categories given by NICE, the contemporary version of the World Health Organization's International Classification of Disorders (ICD-10) and the contemporary version of the American Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (National Institute for Health and Clinical Excellence 2004; World Health Organization 1992; American Psychiatric Association 2013) These differences relate largely to the emphasis placed on different symptoms and the number of symptoms needed to be present to make a diagnosis (Gale and Davidson 2007), and illustrate that this category is not immutable even by medical standards.

Before 1980, those with severe feelings of anxiety would have been diagnosed with 'anxiety neurosis' (Barlow and Wincze 1998), a condition first described by Freud in 1895 (Freud 1993 [1925]). This connection to Freud and his method of psychoanalysis remained linked to the condition of anxiety until the publication of the Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM-III) which introduced the separation of anxiety disorders under the wider category of anxiety. This also brought anxiety more firmly into the realm of medicine, and clinical care of anxiety was initiated by research which suggested a more medical basis to one of the anxiety disorders. The anthropologist Byron Good, who advised on the development of the DSM III, notes the excitement around the category of panic disorder at this time (Good 2002) as recently published articles had found that patients with panic disorder responded to anti-depressants, unlike patients with generalized anxiety disorder (GAD), and that panic attacks could appear 'unprovoked…out of the blue'. These factors suggested a biological basis for what had previously been viewed as a 'psychological disturbance and the strong hold of psychoanalysis' (Good 2002). Jackie Orr suggests in her book on the history (and personal experience) of panic

disorder that the new DSM was based on empirical and observable symptoms, categorizations and diagnoses based on tests and techniques which 'became central to psychiatric thinking'. Through these changes, psychiatric researchers then overtook clinicians as the 'most powerful force in the profession' in comparison, claims from psychoanalysis were viewed to be un-provable and less relevant (Orr 2006:225). The historical (and cultural) situatedness of the DSM and the diagnostic categories it puts forward is further illustrated through the discussion of proposed amendments to the category of GAD in the fifth version of the DSM (DSM-5) (Lewis-Fernàndez, personal communication 2010). Again such changes illustrate the difficulties in placing anxiety in a rigid medical framework.

Biomedical categories are of course created through research and over time and are not 'naturally' occurring. Latour and Woolgar remind us that scientists attempt to produce order, struggling to impose a framework that reduces 'background noise' giving an apparently logical and coherent outcome (1979:36-7). Uncertainty is not welcomed by science or by Western medicine (as the banning of the word 'accident' in the British Medical Journal is testament to (Davis and Pless 2001) and part of the scientist's role is to create the order our worldview requires, 'order is the rule...disorder should be eliminated wherever possible' (Latour and Woolgar 1979:251). Through setting up categories, uncertainty can be lessoned as the world is set in order, as convincingly argued by Douglas (2002 [1966]). This creation of order from disorder arguably was also previously the realm of formal religion and the church in separating the sacred from the secular and promoting a divine ordering through which the individual understands personal experience. The very basis of anxiety is uncertainty and disorder however, and therefore it is not surprising that historical changes to the dominant framework through which the world is ordered by

society has resulted in changes to the social institution that deals with the problem of anxiety. Both of these institutions, the church and medicine, have wielded great power at different time periods to interpret individual experience (not least the experience of anxiety) in their own terms. With the reduced positing of the church, the growth of medicine and the fields of psychiatry and psychology and changes to understandings of the cosmological, anxiety might be seen as particularly ripe for medicalization.

On these bases, how might the data on increased anxiety at the start of this chapter be understood? Are we actually becoming more anxious or might rates of clinical anxiety merely point to increased *diagnosis* of anxiety? More frequent diagnosis might also be attributed to changes in expressions of anxiety, clinical definitions, wider attitudes towards mental illness, knowledge of clinicians and even the actions of drug companies looking to act on new markets. Furthermore, can we assume that all existential angst has been medicalized, or that that the psychological and medical realm has full dominance over cosmological understandings? For many patients for example, medicine and the scientific perspective do not explain everything. Medicine may explain why two individuals had a heart attack, but cannot always explain why one died and other didn't, it may explain the 'how' of a situation, but not necessarily the why. These understandings can be linked to *umbaga*, the 'second spear' found in Evans Pritchard's study of the Azande (1976 [1937]); while, in his famous example, it was understood that the granary fell because it was being eaten by termites, *umbaga* provides the explanation as to why it fell on those people at that particular time. These understandings can be found too in UK ethnographic work on 'lay' perspectives of illness, for example in Davison, Frankel and Davey Smith's study on explanations for illness in a Welsh village (Davison, Frankel and Davey Smith 1992). Here, health promotion messages were counteracted by stories of

'Uncle Norman' who had smoked and drunk all his life only to die in his late 90s (while another individual who had been healthy all their life had died suddenly, at a young age). Notions of 'luck' and 'fate' were used to complement more medical perspectives, explanations that have not been completely removed through the increasing power of scientism. These notions of 'luck' and 'fate' attribute cause to an external agency, perhaps not surprising given the tradition of viewing a God as 'up there' unlike traditions elsewhere such as the Yolmo, where cosmological ideas are represented in the individual body and in society as well as in the cosmos (Desjarlais 1992). This is not incompatible with ideas of individualism, Heelas (1981, cited in Littlewood 2002:184) suggests that in cases of a strong emphasis on the autonomous self, deviations from what we wish to occur are attributed to a discrete agency which is external to the self. Perhaps therefore, anxiety has become medicalized but is also not entirely resolved by medicalization; people's cosmological worlds are not entirely taken over by a medicalizing force and nor are they entirely passive agents to biomedicine's increasing dominance.

Through taking a cosmological perspective of anxiety, the reasons for the medicalization are perhaps therefore not surprising given the increased role of science and medicine over the previously dominant religious structure that has resulted through the process of Euro-American modernity. Euro-American culture and the process of modernity may contribute not only to increasing anxiety therefore, but are also involved in creating a particular type of Euro-American anxiety linked with Euro-American notions of the self and the cosmological position of the self in relation to the world around it. Culturally, again in response to changes stimulated by the process of modernity in these societies, anxiety is handed to clinicians as part of the domain of medicine. This is not to say, of course, that other cultures do not

experience anxiety as certainly they do, but that there is something *particularly* Euro-American about the pattern of distress expressed through clinical anxiety and how this is then dealt with through medicalization. Through this perspective, anxiety emerges as a cultural response; profoundly affected by culturally specific actions and reactions and linked inexorably to the Western process of modernity in its construction, experience and resolution. I have sought to draw out how changing cosmological understandings might emerge from wider cultural shifts, and how these in turn might result in changing cultural responses. This is not just a discussion about anxiety and medicalization therefore, but seeks to contribute another means by which examination of the cosmological might reveal something about mental illness.

Notes

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i Escape from Fear was published with the title 'Fear of Freedom' within the UK in 1941.

ii The psychological notion of 'locus of control' was developed from Rotter's 1954 concept of social learning theory which suggests that expectations about the future are developed from previous experience (cited in Poortinga, Dunstan and Fone 2007).

iii Good (1994) makes the point that lay health understandings have typically been termed 'beliefs' and contrasted with scientific 'knowledge' to emphasize the validity of scientific vs. non-scientific understandings of the world.

iv Hogg, Adelman and Blagg's 'Uncertainty-Identity Theory' suggests that religions have attributes that make them well suited to reduce feeling of self-uncertainty as individuals are able to lessen feelings of self-uncertainty through identification with groups. While all groups provide belief systems and normative prescriptions, they argue, religions also address the nature of existence and provide a moral compass, making religious affiliation of particular attractiveness in uncertain times (Hogg, Adelman and Blagg 2010). Such a theory is similar to Fromm's argument regarding the appeal of religion, both also accepting that self-uncertainty can be related to ontological certainty.

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