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ARTICLE

Distorted Thinking or Distorted Realities? The Social Construction of Anxiety for Women in Neoliberal Late-Stage Capitalism

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Abstract

Anxiety disorders are one of the most prevalent mental disorders globally, and 63% of those diagnoses are of women. Although widely acknowledged across health disciplines and news and social media outlets, the majority of attention has left assumptions underlying women's anxiety in the twenty-first century unquestioned. Drawing on my own experiences of anxiety, I will the explore both concept and diagnosis in the Western world. Reflecting on my own experiences through a critical feminist lens, I will investigate the construction of anxiety as mental disorder in the context of neoliberal late-stage capitalism, heteropatriarchy, and biomedical psychiatry. Tracing the postpositivistic foundations of anxiety, as well as the historical and ongoing medicalization and pathologization of women, I will critically consider the sociopolitical implications of constructing anxiety as biomedical disorder. Assumptions underlying mental health will be explored within the context of the construction, experience, and operationalization of gender and the way gender intersects with diverse positionalities, power, knowledge, and neoliberal governance. Weaving the voices of women poets with the biomedical language of disorder, this critical-realist inquiry will explore my anxiety as it relates to the epidemic levels of anxiety among other women, and the late-stage capitalist world within which anxiety flourishes.

Prologue

I was in the tunnel, stuck in traffic somewhere in western Canada, listening to the Senate Judiciary Committee's questioning of Brett Kavanaugh. I had felt overwhelmed for months, maybe years, a great weight slowly pushing me further into the earth. That day in traffic I felt deep-seated fear, the other cars filled with men, malevolent taillights blinking. Despite Kavanaugh's hearing happening in a completely different country, the tendrils of fear passed easily through the airways and across the border. Within the month I would take medical leave from work, terror reducing possibilities to just sleep, to just leave the house. I was eventually diagnosed with Generalized Anxiety Disorder, and through a combination of medication and counseling have kept the anxiety largely at bay.

Introduction

Today anxiety disorders are one of the most prevalent mental illnesses in the world (Dowbiggin 2009). Globally, women represent an estimated 63% of those diagnosed with anxiety disorders (Global Burden of Disease Collaborative Network 2018). As its prevalence has "been ominously mounting" (Dowbiggin 2009), increased attention has resulted in widespread advocacy to reduce social stigma and increase treatment accessibility (Gronholm et al. 2017; Kendrick 2018). Though important, the majority of this attention has left the assumptions shaping our understandings of women and anxiety in the twenty-first century unquestioned. Using a feminist critical-realist lens, and building on the work of feminist psychiatrists and critical scholars (Chesler 2005/2018; Ussher 2011), I will explore the postpositivistic foundations of anxiety as a construct, and the sociopolitical implications of this dominant framing for women. I explore assumptions underlying mental health and disorder within the context of neoliberal late-stage capitalism, and the complex ways that gender is constructed, experienced, and operationalized through a pragmatic exploration of power, privilege, and productivity. Weaving the voices of woman poets who practice the art of the Great Refusal, "breaking the spell of things that are" (Marcuse 1991, 68), with the biomedical language of mental illness, this tightrope talk (McKenzie-Mohr and LaFrance 2011) aims to balance agency and blame while I explore my anxiety, other women's anxiety, and the world where it occurs. When the radio broadcasts the weak explanations of a serial rapist as he ascends to the Supreme Court of the United States, and where being a woman is framed as a risk factor for violence, disease, and disorder, what power hierarchies and assumptions underlie the pathologization and medicalization of women's misery and distress? I hope to explore the systems and structures our understanding and treatment of anxiety upholds, how refocusing on the governance systems underlying the construction of anxiety (Marcuse 1991), and the potential for therapy without governance (Pupavac 2001) for feminist killjoys and other women who worry (Ahmed 2017), can point to the possibility of knowledge-building as an act of freedom.

A Brief History of Anxiety

An estimated 3.4% of the global population has some form of anxiety disorder, with rates increasing to 4.1% for women globally (Ritchie and Roser 2018). Where I live, in Canada, a reported 8.7% of Canadians aged fifteen and older, approximately 2.4 million people, reported symptoms consistent with Generalized Anxiety Disorder in 2012 (Pelletier et al. 2017), and 25% of Canadians will have at least one anxiety disorder in their lifetime (Statistics Canada 2013). Fifty-three percent of all Canadians and 59% of young adults aged eighteen to thirty-four consider anxiety and depression as "epidemic" (Canadian Mental Health Association 2018). There is a strong gendered imbalance, wherein women are roughly twice as likely as men to be diagnosed with an anxiety disorder (Canadian Mental Health Association 2013; Anxiety and Depression Association of America 2020), and although this is well recognized, it is often understood as inherent, due to essential neurobiological and psychosocial factors (McLean and Anderson 2009; Bahrami and Yousefi 2011; Bandelow and Michaelis 2015; Mulvey et al. 2018), or gendered differences in accessing mental health services (Ussher 2011). Is my female sex a risk factor for anxiety and depression, alongside trauma and having a chronic disease? And what does the connection between risk and female sex organs uncover about how sex and gender are understood and operationalized in biomedical psychiatry?

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The *Diagnostic and Statistical Manual of Mental Disorders, 5th ed.* (DSM-V) defines anxiety as intense and prolonged feelings of worry and distress that occur out of proportion to the actual threat or danger, and that interfere with daily life (APA 2013). This definition is housed within a larger understanding of anxiety as disorder, "not merely an expected response to common stressors and losses" (APA 2013).[1] The causes of anxiety are known to be complex and interrelated, including chemical imbalances in the brain, environmental factors, and risk factors, which can include trauma, genetics, and individual personality traits (Rector et al. 2008). Treatment is therefore often multifaceted, including prescribed mediation, psychotherapy, and a number of individual-level behaviors, including exercise, healthy diet, meditation, and an avoidance of alcohol (Rector et al. 2008; Katzman et al. 2014; Bandelow et al. 2015).

> I had a terror since September, I could tell to none; and so I sing, as the boy does by the burying ground, because I am afraid.
> Emily Dickinson, 1862

Reports of anxiety stretch back to antiquity, although anxious feelings were considered a normal and manageable part of life (Dowbiggin 2009). The shift toward pathology began in the early nineteenth century (Bound 2004; Hickinbottom-Brawn 2013) as technological and industrial competition restricted the idea of the self to consumer and productive citizen (Zeldin 1981; Cushman 1990; Dowbiggin 2009; Pearson 2009). In the early twentieth century, Sigmund Freud built upon the earlier psychological concept of panophobia, "a state of vague but permanent anxiety," to described anxiety neurosis, a "tendency to anticipate disaster" linked to psychological and sexual repression (Freud 1920/2010, 11). The publication of the first DSM in 1952 built upon Freudian neurosis to provide a modern nosology to capture the "emotional morbidity" of war veterans (Crocq 2017; Starkstein 2018). Subsequent editions moved away from psychoanalytic neurosis, drawing increasingly on essentialist biomedical psychiatry (Mayes and Horwitz 2005; Dowbiggin 2009; Frances 2013; APA 2019). Today, anxiety exists as a group of disorders, including social anxiety, Generalized Anxiety Disorder (GAD), and posttraumatic stress disorder. For GAD, the unhappy acronym that follows me around, a specific focus on worry strengthens emphasis on symptomatology and cognitive functioning in the prefrontal cortex, placing my anxiety firmly in my individual brain.

Each edition of the DSM purports to be atheoretical, "producing classifications analogous to those found in the natural sciences" (Cooper 2004; Broome and Bortolotti 2009; Ussher 2011; Starkstein 2018). Mental disorder is thus described as the "failure of an internal mechanism to perform one of the functions for which it is naturally designed" (Üstün, Chatterji, and Andrews 2002, 31). This has resulted in an assumed objectivity, which is complicated by the invisibility of psychological symptoms and a reliance on standardized tools as a means to create empirical data from subjective accounts (Ussher 2011): an erasure of personhood, history, trauma, strength, and collectivity. Potential biases within the development and standardization of diagnostic instruments have been explored elsewhere, including racial and ethnic biases (Parkerson et al. 2015), and feminist critics have highlighted gender biases across diagnostic and standardized tools (Ussher 2011). Across contexts, standardized measures focus on the individual, erasing collective experiences within and across groups. Additionally, despite ongoing claims of objectivity, 100% of the experts involved in the development of DSM-V diagnostic categories for anxiety disorders had explicit

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financial ties to pharmaceutical companies (Cosgrove et al. 2006; Cosgrove and Krimsky 2012), and reports of industry ties increased 14% for DSM-V experts (Ussher 2011). I do tend to overthink, but these financial ties and the discovery of 265 new psychological problems directly ahead of the release of the DMS-III does seem suspicious (Ussher 2011). Capitalism thus obscures the collective and sociopolitical aspects of mental illness and treatment, narrowing our focus to the individual and enabling the status quo to prevail.

> There was also valium in the drink, placed there by two other people / you had, effectively, drugged me, but / what I saw on the drug was true / you put acid in my drink without telling me, so / I would loosen up and be fun for you / but what I saw was that the historical portraits / of fat wigged men were alive.
>
> Alice Notley, 2001

It was not until the 1980s that the prevalence of anxiety began to increase for women (Crocq 2017), and the development of pharmaceutical treatments in the 1950s irreparably altered the landscape within which this disproportion flourished (Speaker 1997). Mood enhancers were often marketed explicitly to women, ranging from Valium's colloquial framing as "mother's little helper" (Gupta 2015), to the "superwomanism" promised by Prozac (Zita 1998; Hansen 2008). As women entered the paid workforce in increasing numbers, pharmaceutical aids supported productivity across labor-market and domestic domains (Blum and Stracuzzi 2004; Chananie 2005; Arney 2012). Today, Selective Serotonin Reuptake Inhibitors (SSRIs) have become among the most widely prescribed medications in the world, with efficacy shown across anxiety, depression, and range of additional mental disorders (Ferguson 2001; Cipriani et al. 2018). Although SSRIs offer relief from distress, drastic rates of negative side effects, including elevated risk of suicide (Liebert and Gavey 2008; Silverman 2017), incredibly high rates of placebo efficiency and unclear medical understanding of SSRI pharmacodynamics and pharmacokinetics (Andrews 2001) have been used as fodder for calls for more biomedical research and pharmacological testing to find the next new wonder drug. SSRIs helped me crawl out from under the blankets, but they disrupt my appetite and cause rampant insomnia. Will the next drug be better? This is what we are told to hope for, given that all our society's eggs are in that one mental health basket.

The Medicalization of Women

> A woman knows very well that, though a wit sends her his poems, praises her judgment, solicits her criticism, and drinks her tea, this by no means signifies that he respects her opinions or admires her understanding.
>
> Virginia Woolf, 1928

Woven alongside the development of anxiety as mental disorder is the medicalization and pathologization of women. The construction of the dangerous woman stretches across Western history, from Eve's original sin, to the burning of witches, hysteria, and beyond (Ehrenreich and English 1973; Chesler 2005/2018; Ussher 2011). As biomedical postpositivism became increasingly entrenched in the norms of industrialization, women were continually constructed as a "repository of powerful fears and fantasies generated by the relegation of emotion as outside the modern imperial, bounded, autonomous and rational subject" (Bondi & Burman 2001, 8). As objective (white cis-male) biomedical knowledge gained increasing "control" over the natural

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world through empiricism, women were purposefully positioned as closer to nature, subjective, and irrational. This coding of womanhood supported the creation and ongoing maintenance of the illusion that women require domestication and separation from systems of economic and political determination. This illusion was intended to create further distance between women and places of decision-making, a complex tool of political oppression that supported the ongoing pathologization of women's political protest and emancipatory knowledge-building, and the individualization of women's distress.

> Because her body is winter inside a cave / because someone built / fire there and forgot to put it out / because bedtime is a castle / she's building inside herself / with a moat / and portcullis / and buckets full of mist.
> Melissa Studdard, 2015

Hysteria was first conceptualized in ancient Greece as madness born from female reproductive organs, and quickly became a catch-all for "every known human ill" in the nineteenth century (Smith-Rosenberg 1972, 662). Symptoms of hysteria were far-reaching, including women's "unnatural" desire for privacy and independence and an intractable "craving for sympathy" (Ussher 2011). Treatment was wide-ranging and horrific. Acts of protest embodied in the personal and private spheres of women's lives were quietly reframed as illness. Although hysteria was removed from the DSM in 1980, a new cultural script emerged, constructing anxiety and depression as the new "palatable way to be disordered" (Neufeld and Foy 2006, 459; Ussher 2011). Other mental illnesses continue to be violently othered and criminalized, but anxiety is largely framed as safe and within the bounds of productive society. New language and policies have been developed to support the ongoing criminalization and incarceration of women on the margins—for instance, the criminalization of sex work and poverty, and the high rates of arrest and incarceration for women who report intimate-partner violence. As the carceral state continues to oppress and keep many at the margins, anxiety provides a label for those doing the "good" work of capitalism. The historical silencing of women continues today, evolving and shifting, but ensuring that the palatability of anxiety (and its close sibling, depression) serves the wider structure of patriarchy and capitalism over the diverse lived and breathing worlds of women in distress. Police shootings of people with mental illnesses continue at a horrific pace in both Canada and the US, mental health supports remain un- and underfunded across Euro-Western society as policing and incarceration take the place of care and support. And through this violent oppression, anxiety remains neat, tidy, and relatively quiet. The risk we—(white, middle-class) anxious people—pose to the status quo is relatively minor, and the cost to society is minimal. Medication and counseling are things I can either afford or I can't. My benefits will cover them, or they won't. The state apparatus is left to focus elsewhere. And while the things-worth-feeling-anxious-over continue around the world, anxiety provides a Band-Aid, a label to grasp for dear life while systemic roots remain safely buried and bearing rotten fruit. And thus the criminalization and pathologization of women continues, with racialized, disabled, and other oppressed women bearing the greatest burden and harm across these systems and processes.

> And while we're on the subject of diversity, Asia is not one big race, and there's not one big country called "The Islands," and no, I am not from there. There are a hundred ways to slip between the cracks of our not so credible cultural

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> assumptions about race and religion. Most people are surprised that my father is Chinese. Like there's some kind of preconditioned look for the half-Chinese, lesbian poet who used to be Catholic, but now believes in dreams.
>
> Staceyann Chin, 2007

The development of women's mental disorders and corresponding feminist critiques of the biomedical system have been constructed around assumptions of women as white, heterosexual, cisgendered, able-bodied, and middle- to upper-class, a positioning of women as patients that "meshed conveniently with the doctors' commercial self-interest" and the legitimization of psychiatric biomedicine and economics (Ehrenreich and English 1978/2005, 217). This construction is created and sustained through the interweaving of white supremacy, ableism, and classism. Biomedicine has grown from white maleness as the ideal and the norm, with medical treatments and processes designed with cis-white men in mind. It was only as women's rights movements gained traction that women were seen as worthy of medical attention, with whiteness still the norm. This continues today through narratives of anxiety and productivity and stress, wherein the white, stay-at-home mom feels stress and the white boss-lady feels overwhelmed. As recently as 2016, nearly half of medical students in a study believed that Black patients have "thicker skin" and "less sensitive nerve endings" than white patients (Sabin 2020). Although pain and anxiety are, of course, different, the idea that Black people's distress is inherent, and white people's distress is in need of remediation, runs deeply throughout our systems. Treatment is needed to support white productivity and sustain white supremacy and the colonial status quo. Black and Indigenous women, women of color, and women with disabilities have long critiqued the use of medical systems and the construction of mental illness as tools of oppression (Collins 1998; Nicki 2001; Lux 2016; Jones and Harris 2019). Second-wave feminists criticized the mental health model in the 1970s, decrying psychoanalysis as a violation of women's lives (Firestone 1970; Millett 1970; Daly 1979), but the erasure of systemic marginalization that overburdens women who experience racialization, heterosexism, transphobia, ableism, and other intersecting positionalities has continued unabated. Anxiety is framed as apolitical, and therefore in no way related to the ongoing onslaught of racism, colonialism, and violence that racialized and criminalized women face.

> I have been woman / for a long time / beware my smile / I am treacherous with old magic / and the noon's new fury / with all your wide futures / promised / I am / woman / and not white.
>
> Audre Lorde, 1997

The early twentieth century saw the rise of the self-help movement, first books and later talk-shows providing opportunities "for millions of people to recognize their psychological symptoms" (Dowbiggin 2009, 433; Salerno 2006;) and access the advice of successful personalities (for a modest fee). This continues today, through the increasing monetization of self-care (Elyse Gordon 2019; Squire and Nicolazzo 2019). For instance, meditation and yoga for mental health are widely supported—how many quotes about yoga in front of a picture of a sunset have you seen today?— with promising yet emergent biomedical evidence supporting its benefits (Butterfield et al. 2017; Macy et al. 2018). But yoga is not free, financial security and the luxury of time are required, and assumptions about the types of bodies invited to partake create barriers

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to accessibility and safety (Kauer 2016; Page 2016; Berger 2018) and can support appropriative practices (Johnson and Ahuja 2016). The influx of healing crystals across the West, without awareness of the human rights violations and environmental injustice underlying the market for them, highlights the deep problems furthered through non-critical self-care practices (Atkin 2018). To be both clear and honest, I do yoga, and the time I take to stretch, to move, and to be still is an important component of my well-being. But when self-care gets rebranded into $180/month yoga memberships, the wider sociopolitical, historical, environmental, and economic systems and structures remain hidden. And as yoga becomes another line item in a busy, productive schedule, the rampant overwhelmingness of capitalism remains untouched. Without critical reflection and an understanding of the self as political, "the 19th century rest cure [will remain] supplanted by scented candles and pastel yoga mats" (Becker 2010, 29), and social norms about who deserves to be cared for, and who deserves to do the caring, remain classist, racist, ableist, and foundationally neoliberal.

Discussion (Or, Over-Thinking Even Though My Doctor Tells Me Not To)

> These are my hands / My knees. / I may be skin and bone, / Nevertheless, I am the same, identical woman. / The first time it happened I was ten. It was an accident. / The second time I meant / To last it out and not come back at all. / I rocked shut. / As a seashell. / They had to call and call / And pick the worms off me like sticky pears. / Dying / Is an art, like everything else.
>
> Sylvia Plath, 1965

The operationalization of anxiety as diagnosis and treatment provides a window into the historical and ongoing construction of mental illness. Mental disorder *as mental* is not often unpacked (Brülde and Radovic 2006; Graham 2013a; 2013b), though a great deal of philosophical thought has explored the boundaries of the mind, framing human mentality as "perceiving, remembering, inferring, and a wide variety of motivational states" (Murphy 2006, 63; Olson 1998). This state of being, drawing on the empirical psychology of Franz Brentano (Brentano 1874), "begins and ends with consciousness and intentionality" (Graham, Horgan, and Tienson 2007). My consciousness crafts my understanding about the world through my engagement with the world. Brentano saw a person's intentionality as the mind's power to represent the aboutness of things; a painting of an apple is about an apple (but is not an apple); my fear is about something, an aboutness that represents nature. But when my mind starts to overzealously release adrenaline into my brain, the aboutness of my anxiety becomes misdirected. The world is safe and comfortable. My anxiety distorts perception. Yet, although my mental illness is functionally apparent, my mental health is hard to define, though—in looking at the media available to me—definitely available for purchase.

Anxiety as both *mental* and *disorder* conceptualizes the mind as knowable, an allegiance to both postpositivism and the funding targeted to biomedical research and practice; "physical diseases are the bedrock reality of medical sciences, [thus,] in order to be scientifically valid, histrionic personality disorders and schizophrenia have to be understood as physical disease" (Zachar 2000, 233). Anxiety and its brethren are reduced to their discrete, biological essence (Broome and Bortolotti 2009), a focus on chemical imbalances and psychosocial stressors. So Big Pharma churns out more chemicals to treat anxiety. But anxiety is not *really* a disease in the brain. My brain is functionally healthy. My anxiety is a dysfunction, not of my brain-as-organ but of my mind, my very personhood, something disordered about the complex and unbounded concepts

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of thought, autonomy, agency, and the self. Is pharmacology, then, the best way to treat my personhood? Mental illness becomes an individual and dysfunctional relationship with reality, a misplaced and unnatural aboutness. So then, my increasing anxiety when listening to Brett Kavanaugh and Lindsay Graham act like petulant children is abnormal, a problem with my consciousness and intentionality wherein the lens through which I see the world is broken. But, given all that is happening in the world, "is close cognitive contact with reality [really] a benchmark of mental health" (Graham 2013b, 221)? Is peeking behind the curtain of late-stage capitalism not an excellent reason to feel distress? Perhaps, then, mental health is a result of positive illusions about reality and mental disorder is "depressive realism" (221). I know many women who would agree. I know many women who wish they could feel more optimistic, perhaps even more naïve. However, if "psychotherapy is not a synonym for truth-seeking" (Levy 2007, 111), then what is the relationship between anxiety and reality? And how does the knowledge I engage with and share related to anxiety interact with the lived reality of myself and other women?

Mental Health in An Unwell Time

> We alone can devalue gold / by not caring / if it falls or rises / in the marketplace. Wherever there is gold there is a chain, you know, / and if your chain / is gold / so much the worse for you.
>
> Alice Walker, 1991

The neoliberal world constructs the individual as rational, productive, and responsible. This responsible person partakes in a self-governance model where freedom of choice and democratic ideals empower them to control their economic fate, while work, health, and illness are quietly depoliticized around them (Marcuse 1991; Hickinbottom-Brawn 2013; Esposito and Perez 2014). This governance is internal, a form of control and disciplinary power that Foucault has traced back to the regulation of the Church (Foucault 1965/1988; 1975/1995). This shift from "moral-religious to a secular and medical approach to the production and evaluation of individual experience" (Bondi and Burman 2001, 7; Rose 1998) shapes the possibilities available to women over time, a historical ontology (Foucault 1984) wherein anxiety disorders and their historic predecessors are "ontologically emergent, simultaneously real and historical" (Sugarman 2009, 7). The expanding pathology of women's emotions provides normative means for the "conduct of conduct . . . not just to control, subdue, discipline, normalize, or reform them, but also to make them more intelligent, wise, happy, virtuous, healthy, productive, docile, enterprising, fulfilled, self-esteeming, empowered or whatever" (Rose 1998, 12). Anxiety as diagnosis reduces the complex interweaving of individual, collective, and political stressors and responsibilities to something wrong with my mind. It tells me that my fight-or-flight response is damaged, and that there is no real reason to feel afraid. It takes the outward-lookingness of fear and turns it inwards, depoliticizing the experience of feeling anxious and letting things stay the way they are. Neoliberal late-stage capitalism therefore remains unchallenged as (relative) well-being via self-care becomes increasingly available: "we submit to the peaceful production of the means of destruction" as late-stage capitalism makes "servitude palatable and perhaps even unnoticeable" (Marcuse 1991, xli, 29). This "mentality of government" (Rose 1998, 153) provides boundaries around acceptable behavior, a comfortable social control that Marcuse sees as a productive apparatus wherein we are "pre-conditioned so that the satisfying

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goods also include thoughts, feelings and aspirations" creating a "smooth, reasonable, democratic unfreedom" (Marcuse 1991, 1) where we do not need to think critically or imagine alternatives. This is true not just of anxiety, but of other mental illnesses deemed acceptable to the state (for example, depression); for anxiety, the overthinking of what has, what could, and what will go wrong and how to stop it, is pressed down into a mold of unhealthy rumination. The collectivization potential has its wings clipped as we are all told to take deep breaths and try aromatherapy. This therapeutic governance positions women's emotional maintenance as "the responsibilities of citizenship" (Pupavac 2001, 361). Citizenship is the production and consumption of knowledge, the stories I tell myself about why I feel the way I feel, whose fault that is (often mine) and whose responsibility it is to improve those feelings (always mine). In the context of anxiety, the diagnosis of the disorder remains in tension with the overall ideal of the very busy, very productive citizen. "I'm busy" has become a common response to "how are you?" To be calm and without a full schedule is to be not living life to its fullest. There are energy drinks and apps and other things sold to help us in our busy-ness, and then when the overwhelmingness tips too far, anxiety is there to catch us as we fall. This individualized understanding of stress, distress, and worry privileges rational over relational and productivity over compassion, thus constructing purposefully gendered qualities of citizenship and consumerism that fit the status quo narrative of gender and role. In this context, the embodied misery and distress of women living within patriarchal late-stage capitalism become psychosomatic disorders amenable to a depoliticized biomedical cure. Environmental factors are accounted for, but they remain framed as an individual woman's inability to behave normally or to cope with the inherent stressors of a fruitful and productive life. Panic attacks in tunnels are disordered; the experiences and embodied histories of the things that happen to women in dark confined spaces are not relevant. Things were worse in the past, alternatives are utopian, you are safe. Be rational, be productive.

Women Worry (AKA: The World Is Worrisome)

This seems like a good time to explain what I mean by *women*. Gender, often treated "as an invisible concept" across health disciplines (Payne, Swami, and Stanistreet 2008) becomes reified with disorder "impos[ing] artificial dualisms between culture and biology" (Cosgrove 2000, 248). As evidenced by the ongoing confusion around the terms *sex* and *gender* within the literature, biomedicine continues to forget (or not listen) that "gender is something we 'do' rather than something we 'are'," a "stylized repetition of acts" that exist within particular social, cultural, political, and historical contexts (Butler 1990, 140). This has consequences as epidemiological gender differences in anxiety-prevalence assume that "categories are immutable and unproblematic" (Ussher 2011). The assumed objectivity of quantitative data in turn legitimizes definitions of illness and disorder, sustaining norms around behaviors and actions, and interweaving gendered assumptions about what is normal, what is not, and who gets to decide.

> Imagine the boys:
> They will help me carry grocery bags but then will whistle / whisper,
> crook finger in my daughter's direction / and she may flip her hair, and she
> may buck her hip / and she may accept their invitation to chill
> behind paint-chipped staircase.
> Elizabeth Acevedo, 2014

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The development of biomedicine has supported the reduction of immense suffering in the world, and many women, including myself, have benefited from these scientific advances. However, framing anxiety as mental disorder narrows the focus of research and policy development on psychopathology, leaving many social, political, and historical parts of life worth worrying about unacknowledged. These distressing things include (but are unfortunately not limited to): the ongoing tendency for women in heterosexual relationships to perform the majority of household and emotional labor (Riggs and Bartholomaeus 2018; Sullivan 2018); the ongoing pay gap (Koskinen Sandberg 2018; Fortin 2019); the stigmatization of child-bearing women in labor-market conditions (Trump-Steele et al. 2016); the moral outrage against women who choose not to have children (Ashburn-Nardo 2017); the hypercriticism of women's bodies, ranging from reproductive rights (Marston, Renedo, and Nyaaba 2018; Unnithan and de Zordo 2018) to physical appearance (Dunn, Hood, and Owens 2019; Sherlock and Wagstaff 2019), and, of course; the rise of the Incel movement and the ongoing normalization of gendered violence (wherein a third of women globally experience gendered violence at some point in their lives) (WHO 2017; Scott 2019). Given all that, maybe panic attacks are a very rational thing indeed. Add to all of this the intersectional oppression and violence meted out to the bodies of Indigenous, Black and other racialized women, sexual minorities, trans women and gender-nonconforming persons, women who are not able-bodied, and the many other diverse ways of being in the world that don't fit nicely into, or worse, get in the way of, extractive late-stage capitalism.

> Sister of ocean and sand / Can you see our glaciers groaning / with the weight of the world's heat? / I wait for you, here, / on the land of my ancestors, heart heavy with a thirst / as I watch this land / change / while the World remains silent.
>
> Kathy Jetñil-Kijiner and Aka Niviâna, 2018

Therapy without Governance

Anxiety treatments remain focused largely on maintaining comfort and productivity, but maybe not in that order. The authoritarian control of late industrial societies creates choices for happiness, available for purchase, and to ensure the one-dimensional, positive (noncritical) mentality of the masses, wherein the protests of the past are canonized and romanticized, whereas contemporary protest reduces itself into "ceremonial behaviors," "harmless negation quickly digested by the status quo" (Marcuse 1991, 14). A protest, as "intellectual and emotional refusal 'to go along' appears neurotic," protestors are hypocrites, deluded, naïve (9). Mental health within Cartesian dualism enables the rational mind to become a tool of oppression. This "psychiatric imperialism" (Chesler 2005/2018, 7) has resulted in invisible power structures within biomedical-neoliberal late-stage capitalism that maintains systems of therapeutic governance across society. Women are constructed as risky and/or as at-risk of mental illness. We are vulnerable. We are emotional. It's for own good. The ice baths, clitoridectomies, and carceral asylums are still being used, and are disproportionately enacted on the nonconsenting bodies of racialized women, women with disabilities, and others seen as outside of whiteness and (re)productivity. These violent acts are also being replaced, slowly, and more so in white and middle-class society, with color-coordinated Nestle advertisements reminding me to drink more water; Fitbits that collect my health data to help me be the best I can be; day-planners to help me organize the overwhelming

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list of things I'm supposed to do to be a good citizen/employee/consumer; and pharmacies with SSRIs always in stock and covered by my health care plan. The systemic and political aspects of women's diverse experiences of distress are hidden, functionalized, and individualized into personal discontent, erasing structural inequities and stabilizing the productive whole. The woman-as-consumer has freedom to choose an array of self-care products, an internalized governance that supports positive illusions about reality. These rose-colored glasses are "self-enhancements" (Dufner et al. 2019), neoliberal managerialism enacted through consumer choice; protest made irrational through the whittling down of critical imagination; distress individualized to ensure that the power resting in our similarities and differences remains unrealized (Ali 2002). Distress, also, is a badge of honor, when kept in check, as are daytimers with "I'm So Busy" emblazoned in glitter on the front; the notion is that if you aren't drowning in work, you're not working hard enough. Ongoing meditation retreats, aromatherapy candles, and daily meditation breaks at work keep you sane and support acceptance of the way things are and reduce the dreaming of alternatives. The ideal citizen is overworked, exhausted, and has definitely earned an evening of Netflix and wine at the end of the work day.

> I won't tell you where the place is, the dark mesh of the woods / meeting the unmarked strip of light—/ ghost-ridden crossroads, leafmold paradise: I know already who wants to buy it, sell it, make it disappear. / And I won't tell you where it is, so why do I tell you / anything? Because you still listen, because in times like these / to have you listen at all, it's necessary / to talk about trees.
>
> Adrienne Rich, 2016

My therapist is understanding, compassionate, and funny. She provides thoughtful insights, helping me to reframe the aboutness that I can get stuck in, wheels spinning, heart racing. She makes me laugh. The majority of therapists and other psy-professionals are women (Ussher 2011), and I imagine that the vast majority of them approach their work with kindness and a desire to help. Women should have access to free, skilled counseling and psychological support: the mind exists, healing is possible. But the sole focus on the individual negates the potential for systems change. Narrowing the treatment of mental distress to Cognitive Behavioral Therapy, SSRIs, and self-care practices reduces opportunities to acknowledge the power hierarchies and extractive apparatus of neoliberal society. If I assume there is something wrong with me, my fear turns inward, and I continue to pay into a system that leaves the way things are unquestioned and unchanged. Knowledge-building through this treatment begins and ends with recognizing my personal warning signs, developing coping mechanisms and trying to keep me (just me) well enough to go to work. Perhaps treatment of anxiety should not be treatment at all. What if treatment for anxiety were political and relational ways of being that account for wider systems and structures? What if knowledge-building involved many anxious women naming oppressive systems and dreaming of different ways of being? What if psychiatric knowledge were collective, founded in lived experience and revolutionary (Ali 2002)? The current options can be helpful, even vital. I can attest to this. But they remain only a "practical necessity" (Wilkinson 2001, 66), a way of getting by, of making do—securing your own oxygen mask without necessarily wondering why the plane has been going down for many decades. For me, once I openly acknowledged that my anxiety "is more code than chemistry" (Hornstein 2009, xix), the experience of distress was politicized.

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> "i do not want to have you / to fill the empty parts of me / i want to be full on my own / i want to be so complete i could light a whole city.
> Rupi Kaur, 2015

Self-care can be a political act, women taking care of themselves and one another, finding strength in their shared experiences, replacing fear with anger (Michaeli 2017). For "madness need not be all breakdown. It may also be breakthrough. It is potentially liberation and renewal as well as enslavement and existential death" (Laing 1967, 47). As Sarah Ahmed argues, women need "to recognize the weight of the world, the heaviness of happiness," and that "it is from difficult experiences, of being bruised by structures that are not even revealed to others, that we gain the energy to rebel . . . our bodies become our tools, our rage becomes sickness" (Ahmed 2017, 255–56). Women—in all the diversity that that term encompasses—as outsiders and outcasts provide opportunities for many-dimensional thought, shattering the positive totalitarianism of consumerism. The weight of history gets heavier and "we snap under the weight; things break" (255). That breaking provides opportunities to imagine beyond the way things are: that breaking can become a manifesto, an opportunity to find a community of other bruised women, to be together, "shattering as the beginning of another story" (266). This breaking is knowledge-creation. An act of power, though perhaps a wounded one. Diagnosis can provide comfort, can remove feelings of blame and responsibility: this is not your fault. My brain is tired. Some neural bridges are broken. This pill will help. Exercise and diet can also help (if you have the time and money): feed your body, feed your soul. Tell your story, share your shattering, and carry one another. The distress of women is real. The world is *really* distressing. And the structures of power, extraction, and production are large and impenetrable and seemingly unstoppable. But what if my fear turned into anger and then resolve? If I remembered that tunnels are a great place to have panic attacks because of violence, because of memories of dark spaces, because of Senate Judiciary hearings and the idling of cars and their chemicals and the climate. Maybe through creativity and art I can see my anxiety as something less vulnerable and more brave. A Great Refusal, where I join my voice with other women, naming things that we need, imagining alternatives (Ussher 2011).

Epilogue

I still tend to overthink. I am learning to breathe. I have a circle of women around me who hold me up, who celebrate, cry, rage, or otherwise, depending on the day, hour, minute. I still have a bottle of SSRIs. Sometimes I wean myself off, finding that anger at the state of Big Pharma keeps the sadness at bay, sometimes. The term *anxiety* used to help me feel validated, normal, but I've stopped calling it that. I'm not disordered; it's external. It's the climate crisis. It's rape culture. It's colonialism. It's white supremacy. It's living in a concrete jungle. And other women choose other paths, and those paths are perfect. I will keep drafting my manifesto as I meet other women and learn ways to support their Great Refusal, in whatever forms are available to them.

> There's a thing . . . called a uterus. / It sheds itself every 28 days or so / or in my case every 23 days (I've always been a rule breaker). I digress. That's the anatomy part. The feminist politic part is that women / know how to let things go, / How to

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let a dying thing leave the body, / How to become new, How to regenerate / How to wax and wane not unlike the moon and tides.
Dominique Christina, 2014.

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Note

1 DSM-V defines a mental disorder as a behavioral or psychological syndrome or pattern that occurs in an individual, which reflects an underlying psychobiological dysfunction, and results in clinically significant distress or disability.

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