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A Qualitative exploration of how anxiety is constructed in the UK and possible implications of constructions using Semi-Structured interviews and Foucauldian Discourse Analysis.

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A Qualitative exploration of how anxiety is constructed in the UK and possible implications of constructions using Semi-Structured interviews and Foucauldian Discourse Analysis.

ABSTRACT

The present study provides insight into how anxiety is constructed within the UK. In doing so, this study adopted a social constructionist approach to critiquing and employed Foucauldian discourse analysis. Data was collected from six British participants through semi-structured interviews. Three constructions of anxiety were identified within the discourse. A medical construction of anxiety was identified suggesting that anxiety is an illness. Previous theoretically based literature supports the suggestion of mental health being constructed medically (Szasz, 1960; 2010; Gergen, 2001a; 2007). Furthermore, the medical construction of mental health was suggested to produce stigmatisation of 'sufferers', thus supporting previous literature claims (Williams and Collins, 2002; Bardaro, 2016). However, alternative constructions of anxiety were identified which included a psychological construction of anxiety as a trait. In addition, anxiety was constructed as an emotion which was linked to evolutionary survival. The present research provides empirical accounts of how anxiety is constructed within the UK alongside potential impacts of constructions. Recommendation for future research suggest an investigation into additional constructions of anxiety, how to reduce stigmatisation of 'sufferers', and difference between anxiety and anxiousness.

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|-------------------|-------------------------------|----------------|----------------------|---------------------------------------|-----------------------|
| KEY WORDS: | SOCIAL CONSTRUCTIONISM | ANXIETY | MENTAL HEALTH | FOUCAULDIAN DISCOURSE ANALYSIS | UNITED KINGDOM |
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Introduction

Social constructionism (CS) takes a critical stance on assumptions made within society. The discipline of psychology assumes there is 'content' within a person (Burr, 2015). For example, personality theories, such as the Big 5 (Costa and McCrea, 1992), claims to provide a scientific framework to describe human behaviour. Although it is suggested the Big 5 is reductionist by reducing personality into 5 domains (Goldberg, 1993). SC would argue it is reductionist to reduce behaviour into a framework altogether, for SC is anti-Essentialism and concerned not with the explanation of behaviour but how an individual explains, describes and accounts for the world (Gergen, 1986; 2001a). Due to the previous distinction of sociology and psychology, critiques offered by SC have only recently been applied to psychological constructions (Craib, 1997). SC takes a critical stance upon assumptions in society, yet the lack of definition may explain the absence of the application to psychological assumptions.

SC has been critiqued for a lack of clear definition suggesting to explain the absence of application within psychology. Gergen (1985) outlined 4 key assumptions in SC. Firstly, SC questions the existence of taken-for-granted assumptions and categories within society. Secondly, SC opposes positive, empirical and epistemological positions that characterise 'hard' science. SC suggests that constructions are historically and culturally specific. Finally, SC opposes the concept of knowledge is obtained through observation suggesting knowledge is obtained and sustained through social interactions. Gergen (1985) assumption allows for research upon taken-for-granted assumptions or categories made within society to be conducted; for the critique offered by SC has the potential for marginalised populations to be recognised (Gergen, 2001b).

Gender is suggested to be a social construction and through the creation of gender-roles within cultures prejudices are proposed to be felt. Connell (1995) suggested that gender is a social construction which produces gender roles. When adopted, gender roles are suggested to help explain the behaviour of others and ourselves within society (Connell, 1995). Skrla (2000) found that female superintendents reported prejudice in the workplace due to societal gender roles. However, Skrla (2000) qualitative data was only collected from 3 women within the same US state thus generalisability of findings are questioned. Additional empirical support suggests that gender roles are culturally specific hence suggesting gender is a social construction. Nierman et al (2007) found participants in Chile had more 'traditional' views of gender roles than US participants. In addition, Nierman et al (2007) found that those with more 'traditional' gender roles positively correlated with increase prejudice views towards homosexual relationships. Thus, Nierman et al (2007) findings suggest gender is a social construction and these constructions may influence our beliefs. However, Nierman et al (2007) findings were only correlational therefore we cannot conclude causation. Therefore, gender is suggested to be a social construction with the role of the female suggested to be marginalised, thus other categories may cause similar marginalisation.

Pathology is one of the most heavily researched areas within psychology, however, mental illness itself is suggested to be a social construction. Szasz (1960, 2010) rejected the terms mental illness and mental disease due to its reductionist view of a

person. Mental health cannot be a disease, the definition of disease in pathology refers to the body, as a physical object, being responsible for the 'disordered' behaviour (Szasz 1960; 2010). Szasz (1960, 2010) states that mental illness is simply behaviour that is believed by others to be disturbed or different. Furthermore, Szasz (1960, 2010) rejects the construction of patients that accompanies the mental illness construction, due to the perception of them being helplessness and victims of their pathology. Yet, Szasz (1960) definition of disease has been criticised as there is not a universal definition of disease (Kendal, 2004). The definition offered by Szasz is suggested to eliminate current diseases recognised within the scientific community such as migraines (Kendal, 2004). Furthermore, Kendal (2004) suggests that if we take the same view as Szasz the suffering of patients will be overlooked. However, Kendal identifies as a practicing clinical psychologist. Thus, the place taken by Kendal has the potential to be biased, for the introduction of Szasz's ideas critiques the role of psychiatrists and psychologists within the treatment of mental health. Pathology is therefore critiqued with the suggestion of mental illness being a social construction.

Natural science's application to mental health is questioned by SC in reference to knowledge. Gergen (2001a) states natural sciences' assumption that knowledge is found through cause and effect relationship brushed away the role of language and society in the treatment of disease. Furthermore, SC challenged natural sciences' view that experimental methods are superior (Gergen, 2001a). The increase in the quantity of research is suggested to legitimise a biological explanation of mental health (Hoff, 1995). An example of this is the DSM (American Psychiatric Association, 1952), for the first edition contained 60 disorders. In comparison, the DSM-V (American Psychiatric Association, 2013) contains 297 disorders. The increase in number of diseases' may legitimise and are perceived to refine our understanding of mental health, thus the construct of mental health as an illness may become reality. Natural science is critiqued due to the lack of acknowledgement of language and society and through legitimisation, the reality of mental illness is suggested to be formed.

The construction of mental health medically has been suggested to benefit those within the field of medicine. Gergen (2007) suggests that the uphill spiralling of mental illness has been influenced by the psychopharmacological industry and care management programmes. The introduction of drugs within psychiatry has been suggested to be another avenue in which to market a product and generate profit (Gergen, 2007). Gergen (2007) further suggests that the use of drugs to treat 'unhappiness' is equally favoured by the management care movement in hospital administration, for the ability to give someone drug-centred treatment is more economical than therapist time. Society seeing mental health as an illness enforces the concept of them being a 'patient' which demands a particular drug based treatment, thus benefiting psychopharmacology and care management (Parker, 1995). Therefore, it has been suggested that external forces may benefit from society constructing mental health as an illness.

SC argues that social interaction, through language, is where truth is created. Gergen (2007) suggests that when psychological or psychiatric 'knowledge' is exposed to the public it becomes true within their concept of reality. SC suggests that psychological knowledge obtains meaning and significance through social

interaction opposed to hard sciences' previous claims of cause and effect relationships (Gergen, 2001b; 2007). Wittgenstein (1953) supports the suggestion that psychological terminology obtains meaning through social interaction. Thus, social interaction accompanied with claims of legitimatisation (Hoff, 1995) is suggested to produce an individual's reality of mental health. Therefore, through language exposure, via social interaction, the construction of mental health as an illness is produced.

Prejudice and stigmatisation have been suggested to stem from the medical construction of mental health. SC can broaden the way we are viewing mental health, and identify what the implications are for such constructions of reality. Gergen (2001a) questions who is being helped with the categorisation of pathology. A diagnosis of schizophrenia is suggested to alter a person's feelings of self-agency, isolation, stigmatisation, and rejection (Bardaro, 2016). Williams and Collins (2002) found that a diagnosis of schizophrenia altered patient's ideas of their self-worth within society. In addition, viewing schizophrenia biologically was found to positively correlate with stigmatisation of 'sufferers' (Williams and Collins, 2002). Williams and Collins (2000) suggested that stigmatisation was due to viewing schizophrenia as a biological construction, for it was perceived to be harder for patients to change. Although it has been suggested that medical labels of mental health may have been intended with innocence, used to distinguish behaviour within the medical field, these labels then exposed to the public became emotionally charged (Parker et al, 1995). Constructing mental health biologically is suggested to increase stigmatisation to those defined as patients.

The power medicine has over western cultures is suggested to be responsible for the construction of mental health. Parker et al (1995) suggest that the medical constructions of mental health have such influence upon our views and beliefs due to the power possessed by medicine. Evidence suggests that western cultures view a mental health diagnosis with fear (Johannsen, 1969; Rabkin, 1974; Link et al, 1987; Pen et al., 1995). Within this historical time, mental health professionals are suggested to hold the power over our constructions of mental health (Parker et al, 1995; Gergen, 2007). Foucault (1980) additionally suggests that we are all, in some degree, caught up in circulation, for power relations permeate all levels of social life. Our construction of mental health is suggested to be determined by where power is placed within society.

SC suggests that anxiety is a social construction, yet majority of literature is theoretical and US based. Anxiety is suggested to be one of the fastest growing mental health 'problems' within the 21st century (Dowbiggin, 2009). Dowbiggin (2009) suggested the rapid increase of prevalence of anxiety is due to historically significant events that occurred during the 20th century, for example World War 2 and the development of nuclear weapons, thus increasing the exposure of anxiety in the public domain. Furthermore, Smail (1987) suggests that anxiety is a position that people obtain after awareness supporting the suggestion of anxiety being a social construction. Anxiety being a social construct is additionally supported by cross-cultural research. Ansaani et al (2010) found higher rates of anxiety being reported in certain cultures. However, the extent to Ansaani et al (2010) data providing an insight into cross cultural construction of anxiety is questionable due to all participants being from the US. For, Gergen (2001a) suggests that constructions are

obtained through language and it is unknown if Ansaani et al (2010) participants originated from the US and what language they were exposed to. Anxiety is suggested to be a social construction with emphasis on historical and cultural specificity, yet the majority of theoretical and empirical evidence is conducted within the US.

Although it is suggested that constructing mental health as an illness has implications such as stigmatisation, there is evidence for a diagnosis of anxiety being useful within other medical conditions. Puleo and Kendall (2010) suggest that children with symptoms of autism spectrum disorder (ASD) treated for anxiety, through family cognitive behaviour therapy, reduced the child's symptoms of both anxiety and ASD. When a child is diagnosed with anxiety, the therapy provided is suggested to improve their quality of life. Furthermore, anxiety is suggested to be a significant contributor to the prediction of pain in older adults (Feeney, 2004). Through the techniques learned in the treatment of anxiety, pain experienced in older adults is suggested to decrease (Feeney, 2004). Therefore, although anxiety has been suggested to be a social construction it is suggested through anxiety treatments, a diagnosis of anxiety can improve an individual's lives.

Anxiety is suggested to be one of the largest growing diagnoses in the UK, yet there is limited research regarding anxiety as a social construction. Anxiety is one of the most common mental health diagnosis in the UK with 8.2 million cases in 2013 (Mental health foundation, 2016). However, thus far it has been suggested that mental health is a social construction and through the obtainment of this construction comes implications (Parker et al., 1995; Gergen, 2001a). However, there is little research on how anxiety is constructed in the UK, for a literature search on PsychArticles, PsychINFO, Wiley Online Library, and Elsevier Psychology Collection, searching for "social constructionism" and "anxiety", produced no published results in April 2018. Therefore, although there is literature suggesting mental health, and therefore anxiety, is a social construction (Gergen, 1985; 2001a; 2001b; 2007; Parker et al, 1995) they are mainly theoretically based. Furthermore, empirical evidence suggesting anxiety is a social construction is predominantly based in the US thus an investigation is needed to apply in the UK, for SC suggests constructions are culturally and historically specific.

This research will investigate how people in the UK construct anxiety. Previous literature is primarily theoretical with little empirical research on the UK's constructions of anxiety. Through the analysis of language, this research will aim to identify the UK's constructions of anxiety. Furthermore, challenging anxiety using SC is suggested to uncover any groups that may be marginalised (Gergen, 2007). This research aims to provide insight into the UK's construction of anxiety and any possible implications of these constructions.

Methodology

Design

This research used qualitative methods which allowed the collection of rich, varied and personal data surrounding the topic of anxiety (Marshall and Rossman, 2016). Six face-to-face semi-structured interviews were conducted giving the opportunity for

several pre-determined topics, inspired by previous literature, and new topics to spontaneously arise in discussion (Jones, 1995; Rubin and Rubin, 1995). In contrast to a structured-interview, in semi-structured interviews participants may produce unexpected avenues of meaning surrounding the subject of anxiety that was not considered by the researcher (Noor, 2008). Within this research, there were 8 pre-written questions (Appendix-1), for example “How would you characterise anxiety?”, this ensured the topic was covered and allowed room for further expansion. Thus the qualitative methodology of the semi-structured interview was deemed appropriate for the investigation of the construction of anxiety and their potential impacts.

Participants

Participants were recruited through opportunity sampling; participants were obtained through responses to a poster (Appendix-2). In total six participants were interviewed ageing between 20 to 24. All participants originated and lived in the UK. This ensured the data collected was from one culture, as social constructions are suggested to be culturally specific (Gergen, 1985). Participants who were uncomfortable with the discussion of mental health, due to ethical reasons, did not participate in the study, for example those within a clinical population. Due to the participants being British it was assumed that they had prior knowledge of anxiety. Participants chose a pseudonym to endure anonymity and gave them a reference to withdraw their data.

Procedure

This research was carried out in line with the British Psychological Society ethical guidelines (2009) and reviewed by the Department of Psychology Ethics panel. Approval was granted by the Faculty of Health and Social Care Research Ethics Committee at Manchester Metropolitan University (Appendix-3). Interviews took place in various public locations which allowed for a degree of privacy, for example a café. Familiar locations to the participants were favoured, for it is suggested that familiarity ensured the participants felt comfortable which increased the production of reliable data (Howitt, 2016). The participants were presented with the participant information sheet (Appendix-4) reiterating the aims of the research. Next, the participants were informed of their right to withdraw during and after, up to two weeks, provided they presented their chosen pseudonym. After which, the participants gave consent through actively reading and signing the consent form (Appendix-5).

The interviews took place within a period of a few weeks and lasted between 15 to 36 minutes long. Although it has been suggested that a 3-hour minimum is required to produce sufficient data (Wood et al., 2012) after conducting the analysis it was felt that, in terms of quality, enough data was collected. However, this is not dismissing the suggestion that if more interviews were conducted they would provide additional insight.

Once the interviews took place the participants were presented with the debrief sheet (Appendix-6) which included contact information of professional organisations if the participants wished to seek psychological help. All audio data was collected via a Dictaphone ensuring effective and accurate data collection (Norwood, 2012). Later,

all interviews were transcribed incorporating aspects of the Jefferson transcription method (Jefferson, 2004) (see Appendix-7). The data was stored on a password protected storage device and audio files were destroyed after completion of transcription for safeguarding reasons.

Analytical Technique

Foucauldian discourse analysis (FDA) was chosen as the most appropriate analytical method for identifying the UK's constructions of anxiety. FDA is concerned with the role of language in the construction of social and psychological life (Willig, 2014). FDA suggests that the availability of discursive material, within a culture, has implications for our versions of reality (Willig, 2014). FDA focuses not if discursive objects exist but the meaning that is produced (Foucault, 1972). The question is not if discursive objects exist but how they limit certain ways of thinking and therefore our use of language (Parker et al, 1995). Furthermore, Foucault (1980) argues that power relations permeate all levels of social existence thus power and knowledge are linked. The question of the application and effectiveness of power or knowledge was deemed more important than the question of 'truth' in FDA (Wetherall et al, 2001). Through the analysis of language, the source of knowledge and power is suggested to be uncovered. Therefore, by conducting an FDA the source of power in the participants' knowledge of anxiety will be uncovered.

Conducting an FDA was outlined by Willig (2014) who detailed a step-by-step guide. All interview transcriptions were analysed individually, using Willig (2014), allowing for different constructions and differences between the constructions to be identified. The action orientation allowed for closer examination of the discursive contexts within differing constructions and what the participants obtain from constructing in such a way. Subject positioning provided insight into which positions were made available. Alongside the practice which suggests how certain constructions limit what language participants produced. The final stage of Willig (2014) framework was the examination of what potential consequences occur through the uptake of subject positions. Concerns over what is felt, thought and experienced were identified in various subject positions. The constructions produced were compared to providing insight into how the UK constructs anxiety.

Analysis and Discussion

Three constructions of anxiety were identified through FDA using the framework provided by Willig (2014). Firstly, a medical construction of anxiety was identified suggesting anxiety is a physical illness. The psychological construction of anxiety suggests that anxiety is a trait. Finally, anxiety was constructed as an emotion linked to survival. FDA allowed for the identification of the three constructions of anxiety in addition to possible implications, for the action orientation, positioning, and practice being explored.

The medical construct of anxiety

Anxiety was suggested to be constructed biologically, for anxiety is identified as an illness. This is demonstrated by the use of traditional medical terms:

Kate: "...people can get anxiety medication. So clearly it is something extreme..." (Line: 20)

James: "People who suffer from anxiety will struggle to do things because it is inside of them, they can't help it." (Line: 71-72)

James: "Like they [people with anxiety] get a lot of symptoms such as over thinking things." (Line: 91)

Participants refer to medical terms, associated with the medical model, when discussing anxiety. For example "suffer", "medication" and "symptoms" have medical connotations suggesting participants are constructing anxiety a similar way to medical disorders. These findings support previous literature, such as Szasz (1960; 2010), suggesting that mental health is constructed medically. Anxiety is suggested to be constructed medically with the identification of 'sufferers' to their pathology.

The medical construction is suggested to place anxiety within a person, for suggested to dehumanise 'sufferers' and stigmatisation.

James: "Mostly it's [anxiety] in your mind." (Line: 93)

Kate: "...you have a chemical imbalance which is causing that mental health problem..." (Line: 118)

The use of "... In your mind." and "...you have a..." suggest that participants position anxiety within a person. The positioning of anxiety within the person has potential to dehumanise 'sufferers', for 'sufferers' are viewed as victims of their pathology. The concept of dehumanisation supports Szasz (1960;2010) claims of a medical construction of mental health causing the view of 'sufferers'. The construction of 'sufferers' is suggested to have potential implication on how a person is perceived and treated within society. Williams and Collins (2002) found that those who constructed schizophrenia biologically had increased stigmatisation. Additionally, Parker et al (1995) suggested when labels become emotionally charged they produce stigma towards those identified as 'sufferers'. Therefore constructing anxiety medically suggests potential stigmatisation of 'sufferers' due to the illness being placed within the person.

Participants constructing anxiety medically are suggested to distance themselves from the construction. The pronouns used by James suggest distancing "someone who worries"(Line 5), "someone could hide anxiety" (Line 14), and "I'm not sure how these people get anxiety" (Line: 40-41). The participant never associates himself with anxiety, for he projects the construction onto another when discussing. Continually demonstrated by:

Kate: "It's hard to explain when you've not suffered it [anxiety]." (Line: 6)

Again, the participant rejects identification with anxiety. In addition, Kate further shuts down the opportunity for further discussion. Shutting down the discussion indicates that Kate does not feel she is able to describe such construction without having had direct identification. Isolation may derive in those identified with anxiety, for other feel unable to discuss. The meta-contrast principle, within social identity theory, may explain categorisation behaviour. The meta-contrast principle states that individuals capture similarities within a group and differences between groups (Turner, 1985). Distancing suggests anxiety may be considered as a category differentiating them from a clinical population. The medical construction of anxiety distances individuals, for it is suggested there is an unwillingness to identify with the construction.

Through constructing anxiety medically, social isolation of those identified with anxiety is suggested, for participants displayed resistance to the discussion of mental health.

Kate: "...you are more likely [to phone in sick to work] to just say you are poorly and avoid mentioning your mental health." (Line: 143-144)

James: "...I'm not going to ask, it's not something you do as it'll just make it worse wouldn't it?" (Line: 56-57)

Kate: "...it's not something that can just change by your own input." (Line: 115-116)

It is suggested that anxiety is not something people can discuss. Limitations of social interaction of 'sufferers' may be applied due to others perceptions of anxiety. The unwillingness to discuss the topic of anxiety is highlighted by James: "...it's not something you do." Suggesting that the participant has a preconceived conception surrounding the discussion of mental health. Social isolation of 'sufferers' is suggested to be due to mental health being constructed medically (Szasz, 1960; 2010). Continually, due to the suggestion of a lack of discussion surrounding anxiety, reliance may be placed on psychological or psychiatric knowledge to define mental health (Hoff, 1995). The medical construction of anxiety is therefore suggested to isolate 'sufferers'.

Power is suggested to be placed in medicine when participants construct anxiety as an illness.

Kate: "...people can get anxiety medication. So clearly it is something extreme..." (Line: 20)

Kate: "...it's not something that can just change by your own input." (Line: 115-116)

James: "...I'm not going to ask, it's not something you do as it'll just make it worse wouldn't it?" (Line: 56-57)

The use of medication in treatment and the rejection of self-healing suggested that participants place power in medicine. Participants placing power in medicine supports previous literature, such as Parker et al (1995), for as a society we are suggested to place power within medicine which influences how we view mental health. An explanation offered by Gergen (2007) suggests that participants placing power within medicine benefits external sources such as the psychopharmaceutic companies for they are able to sell more products due to society viewing drugs as a viable treatment for mental health 'issues'. Therefore, power is suggested to be placed in medicine when constructing anxiety as an illness.

Psychological construction

Anxiety is additionally constructed as a psychological trait used to describe and rationalise behaviour.

Dan: "trait anxiety, so it would probably take you longer to react to something." (Line: 54-55)

Emma: "...if you had to categorise it I would have trait anxiety but not clinical." (Line: 69)

Emma: "I can see it [anxiety] in other people now too." (Line: 63-64)

Anxiety is described as a trait within a person with a clear distinction between a clinical construction, "trait anxiety but not clinical" (Emma: Line-69), and that of a trait. Anxiety as a trait is suggested to be established, within the culture, due to the

participants' lack of definition. Trait anxiety is defined, within psychology, as a stable individual difference characteristic used to rationalise behaviour (Zhang et al, 2009). Thus trait anxiety supports the suggestion that anxiety is a social construction, as the exposure to psychological knowledge is suggested to influence our formation of reality (Gergen, 2007). Therefore, trait anxiety is suggested to be a social construction, as it is formed from exposure to psychological knowledge.

Constructing anxiety as a trait is suggested to allow participants to be placed within their constructions of anxiety.

Emma: "I am a person who is an over worrier...I would be like 'oh you have anxiety over this'..." (Line: 53-56)

Emma: "I wouldn't say I am a sufferer because I can talk myself out of it and I can pick myself up." (Line: 68)

The participant put herself within the discourse. It is implied there is a clear distinction between trait and clinical constructions, for the participant does not identify as a "sufferer", suggesting that dehumanisation may not be applied to those positioned within trait anxiety. Furthermore, when positioned within the construction of trait anxiety the participant is suggested to be in control, illustrated by: "I can talk myself out of it." (Emma: Line-68), suggesting external help is not needed supporting the suggestion of trait anxiety may not be dehumanising 'sufferers'. Thus supporting psychological knowledge suggesting trait anxiety is a characteristic used to rationalise behaviour (Zhang et al, 2009). Further research may need to explore how both trait and medical construction differ in relation to how they are obtained through exposure to psychological knowledge.

Emotional construction of anxiety

The final construction of anxiety identified suggests that participants construct anxiety as an emotion with evolutionary connotations. The emotional construction suggests that we are biologically pre-disposed to feeling anxiety, through evolution, to avoid situations that could be potentially threatening.

Emma: "I think it's linked to sort of survival... you are in a situation where something is a threat to you... so, the job is linked to money which is linked to your food and house and everything." (Line: 4-5)

Dan: "... personally believe it to be a natural thing, it would be natural, by default, for everyone to experience it [anxiety]". (Line: 49-50)

The use of "natural" and "survival" has evolutionary undertones suggesting participants see anxiety as essential to ensuring survival. The normalisation of anxiety is suggested to oppose previously identified constructions such as anxiety as an illness or a trait. An evolutionary construction of anxiety is supported by the Broaden and Build theory, proposed by Frederickson (1998), where fear and anxiety are thought too narrow a person's attentional focus thus increasing survival rate. Therefore an emotional construction of anxiety suggests that anxiety is a normal biological response designed to increase survival.

An emotional construction of anxiety suggests that everyone, within the culture, understands and experiences anxiety in a similar way.

Carl: "Yet anxious you are more worried [in comparison to nerves] about it more, thinking about it more. You feel you are more involved." (Line: 17-18)

Dan: "...clinical side where you are scared to do anything and anxious is you are more likely to delay yourself to do something." (Line: 37-38)

Dan: "I felt anxious as it was a lot of responsibility [in reference to a new job]." (Line: 66-67)

Anxiety is suggested to be something you experience; anxiety is suggested to be a label that is attached to communicate how an individual feels to others. An evolutionary link is continually made, for anxiety suggested to ensure survival by increasing cautiousness within unfamiliar situations, for example a job. Continually, constructing anxiety within certain situations supports the Broaden and Build theory (Frederickson, 1998) for a job requires increased focus, due to the income produced, to ensure our survival. Therefore, anxiety constructed as an emotion is suggested to ensure our survival, thus everyone within the culture is suggested to experience anxiety to some degree.

The emotional construction of anxiety places participants within the construction based on situational factors.

Dan: "I felt anxious as it was a lot of responsibility [in reference to a new job]." (Line: 66-67)

Dan identifies himself within the construction of anxiety suggesting he has personally experienced anxiety. Furthermore, when Emma constructs anxiety as an emotion, she places her mother within the construction.

Emma: "for example my mum... I am an only child and being a girl, she would worry about me being out on my own... even though she knows I am perfectly safe, she may feel anxious." (Line: 86-90)

Emma placing her mother in the construction could suggest normalisation of anxiety for parent's influence on emotional learning has been suggested. Wilson and Gottman (1995) suggest that children learn to regulate and express emotion through modelling their parents, thus if Emma saw her mother experience 'anxiety' as a rational reaction to a situation Emma would learn and model that emotion. Empirical support is gained Garden et al (1997) who found that parental roles in emotion education are critical in how we perceive and express emotion during play. Furthermore, Wittgenstein (1953) claims that terms, such as emotion, obtain meaning through social interaction. Emma's construction of anxiety as an emotion is suggested to be obtained through a significant social interactions and modelling of her mother. Thus, the construction of anxiety as an emotion is suggested to be situational with additional suggestion of normalisation due to parental development theories of how constructions are obtained.

The construction of anxiety as an emotion disputes previous literature suggestions of anxiety being viewed, within society, as an illness. Previously, Gergen (2001a, 2007) suggested that once an individual becomes exposed to psychological or psychiatric knowledge it becomes a part of their reality. However, participants who constructed anxiety as an emotion were exposed to the same power and similar interactions, due to being from and within the same culture, yet construct anxiety differently. However, participants who constructed anxiety as an emotion additionally displayed the construction of anxiety medically. Therefore, it is questioned if anxiousness and anxiety are constructed differently. Findings of this research suggest that there is a potential difference in how participants construct anxiety and anxiousness. Further investigation is advised to investigate how constructions of anxiety and anxiousness differ.

How constructions are made

Participants constructions of anxiety thus far have suggested to originate from social interaction which supports past literature.

Lilly: "I think it was a friend at school... I remember talking and she said she was feeling bad and said they were having panic attacks and she thought it was because she was really anxious." (Line: 16-18)

Carl: "I have probably heard people say they are anxious or have anxiety." (Line: 59)

Anxiety as a discursive object is suggested to obtain meaning through social interaction. The exposure to those who are placed within the constructions is suggested to be influential on how the participants construct anxiety. Carl's description of "I have probably heard people say..." (Line-59) suggests that social interaction is how objects are usually constructed, supporting the suggestion that constructions originate through social interactions. Wittgenstein (1953) suggestion that psychological terminology gaining meaning through social interaction are therefore supported. Furthermore, cultural specificity is suggested to be applied to social interactions, for who is available to take part in conversations are limited, thus supporting anxiety being a social construction (Burr, 2015). Findings from the present research suggests that constructions are obtained through social interaction, suggesting anxiety is a social construction.

Limitations

This research focused on how the UK constructed anxiety and possible implications of such constructions. The participants were recruited through opportunity sampling which allowed for ease of data collection (Jones, 1995). However, the generalisability of findings, due to the sample, is questioned. Although all participants originated and lived in the UK, the advertisement for the study was predominantly in one location, Manchester, it is unknown if participants were from a range of locations within the UK. Therefore, the findings of the research may measure constructions of anxiety within one region of the UK rather than the UK in general. Furthermore, the age range of participants could be considered to lower generalisability. The findings may not be generalizable as SC suggests that constructions are culturally and historically significant (Gergen, 1985) thus having an age range of 4 years may not be representing the UK's construction of anxiety. It is suggested to investigate the UK's constructions of anxiety sampling, regarding age and regions of collection of data, needs consideration.

Applied implications

This study provides a base for further research as anxiety is suggested to be a social construction. Through the analysis of language through FDA, three constructions of anxiety were identified. The medical construction of anxiety provides empirical support for previous literature (Gergen, 2001a; 2007). Due to SC suggestion of construction being culturally specific, this research provided evidence for the UK constructing anxiety medically which previously had not been researched empirically. In addition, two alternative constructions were identified which suggests that, although anxiety can be constructed medically, anxiousness is constructed

differently. Thus expanding upon previous literatures suggestions of one medical construction.

The present research empirically supports the suggestion of stigmatisation surrounding 'sufferers' of anxiety. This research suggests that participant's who constructed anxiety medically attached stigma towards "sufferers". Previous research suggested the medical construction of schizophrenia expressed stigma due to recovery being perceived to be less obtainable (Williams and Collins, 2002). Therefore, this research suggests stigmatisation of 'sufferers' is due to anxiety being constructed medically. Potential application of future research is into the reduction of stigmatisation.

Conclusion and future research

Previous literature suggested that mental health is a social construction (Parker et al, 1995; Gergen, 2001a; 2007). Social constructionism challenges taken-for-granted assumptions and categories, such as mental health, to uncover marginalised populations (Gergen, 2001b). For it was suggested that a medical construction of mental health was linked to the stigmatisation of 'sufferers' (Williams and Collins, 2002). Yet, the majority of previous research was theoretically based with a lack of application to anxiety specifically. In addition, the majority of previous research was conducted in the US, due to SC suggestion of construction being culturally specific (Gergen, 1985), generalisability to the UK was unknown. This research aimed to fill the gap within literature by investigating how in the UK anxiety is constructed and any potential implications of such constructions.

Through FDA three constructions of anxiety were identified. The present research found that anxiety was constructed medically thus supporting previous literatures finding regarding mental health constructions (Gergen, 2007). Additionally, the medical construction of anxiety was suggested to produce stigmatisation and dehumanisation of 'sufferers' supporting previous literature (Williams and Collins, 2002). Therefore, this current research provides empirical evidence regarding the suggestion that anxiety is constructed medically with the projection of 'sufferers'. Future research is suggested to build upon these research findings, for there is an indication of cultural differences in constructions. Alongside, research is recommended into how stigmatisation and dehumanisation of 'sufferers' can be reduced, as previous literature suggests medical construction alter a 'sufferers' concept of self (Bardar, 2016).

However, this research identified alternative constructions of anxiety contrasting previous literature. In addition to the medical construction of anxiety being identified, anxiety was suggested to be constructed as a psychological trait and as an emotion. Trait anxiety construction is suggested to be a social construction, for when psychological knowledge was exposed to the public it becomes a part of their reality (Gergen, 2007). Yet, when anxiety was constructed as an emotion it contradicted previous SC theories, for the emotion was normalised and related anxiety to evolutionary survival. However, all participants who constructed anxiety as an emotion also displayed a construction of anxiety medically. Current findings suggest that anxiety was constructed as an illness, in contrast, anxiousness was constructed

as a rational emotion. Further investigation is needed to explore the differences in the constructions of anxiousness and anxiety within the UK.

Reflexivity

When undertaking qualitative research, the researcher's role is to understand and acknowledge how they have impacted upon the findings (Burr, 2015). I conducted this research project due to my keen interest in mental health, and my personal connection to anxiety. During my teenage years I believed I was experiencing anxiety. Due to the identification with a medical construction of anxiety, I felt my perception of self was altered, for example I felt I was unable to travel without experiencing anxiety. Furthermore, I had negative experiences due to my identification with anxiety, thus I perceive there to be stigmatisation surrounding mental health. However, through my education within psychology, I started reflecting upon my own relationship with anxiety. For my reading of Szasz (1960; 2010) changed my perception of mental illness and how it is presented within society. I started to reflect upon myself, for I was not a victim of my pathology, and by doing so my relationship with anxiety drastically changed. My personal view is that anxiety is a social construction. It is suggested that my personal view may have impacted the findings of the current research.

My personal view of anxiety may have impacted the collection and analysis of the data in the current study. It is suggested due to the use of semi-structured interviews, my personal view may have affected the discourse produced for an interview is suggested to be a form of conversation (Sharrard, 1991). In addition, it is suggested that my personal reading surrounding the topic of focus may influence how an interview is conducted (Mark, 1993). Furthermore, due to my strong connection with the topic of anxiety, alongside my personal opinion of anxiety being a social construction, I may have been unable to escape the power my knowledge has over my analysis (Parker and Burman, 1993). Thus the construction of anxiety medically was expected, however, unexpected constructions of anxiety were additionally identified. Therefore, although I may have personally influenced the research findings, this study still provides insight into the UK's constructions of anxiety and indication of the potential application of further investigation.

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